Dental Council

Te Kaunihera Tiaki Niho

Annual Report 2016

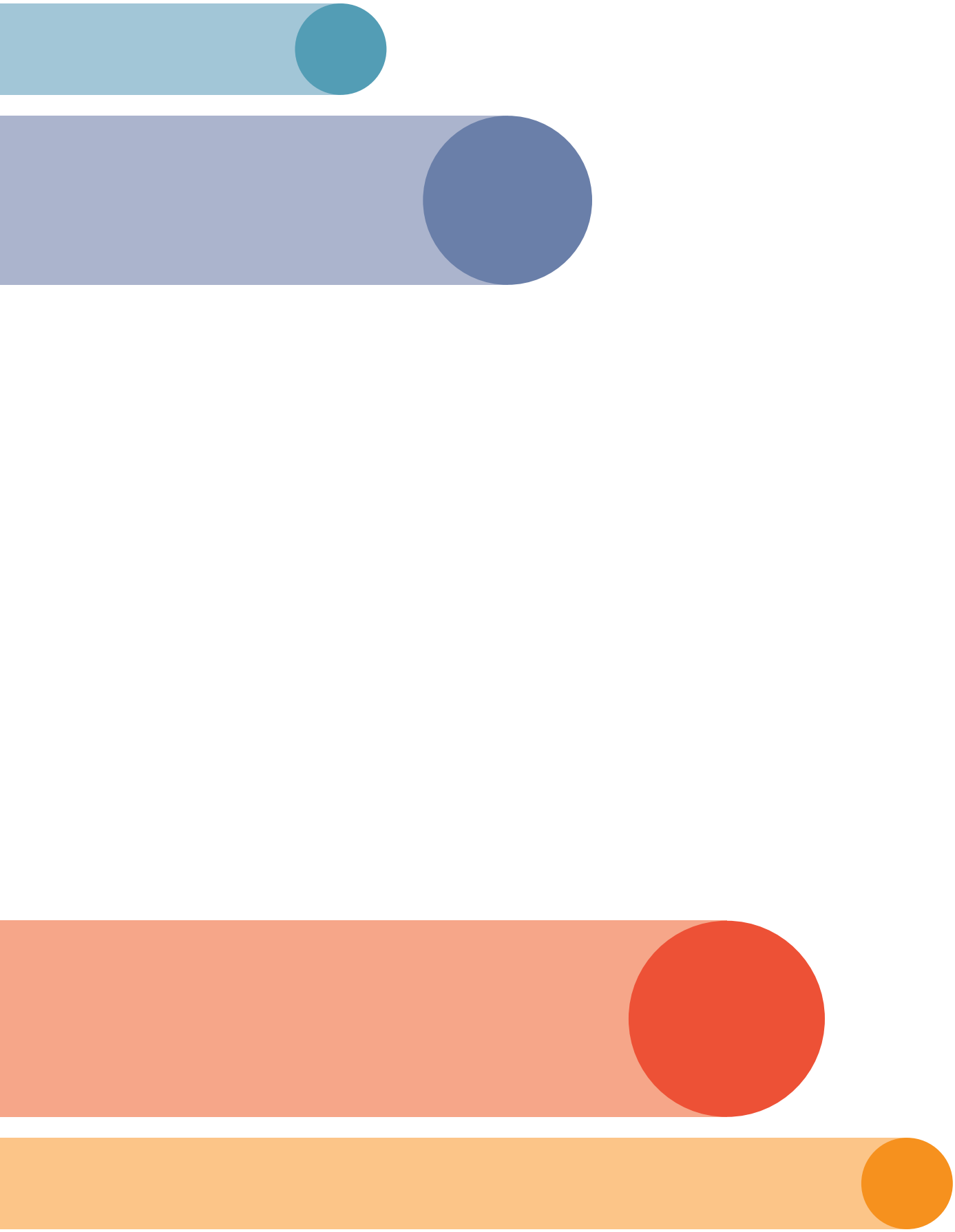
DENTISTRY

DENTAL HYGIENE

DENTAL THERAPY

DENTAL TECHNOLOGY

CLINICAL DENTAL TECHNOLOGY



Contents

Throughout this report:

- dentists, dental specialists, dental therapists, dental hygienists, orthodontic auxiliaries, dental technicians and clinical dental technicians are collectively referred to as oral health practitioners or practitioners
- the Health Practitioners Competence Assurance Act 2003 is referred to as the Act
- the Dental Council is referred to as the Council.

Dear Stakeholders

We are delighted to present the Dental Council's Annual Report for 2015/16.

It has been another busy and productive year for the Council.

One of the most significant milestones of the year was made in June 2015, when the Council agreed its strategic priorities for the period 2015–20. Incorporated into those priorities is an intent to move the way we regulate towards a risk-based regulatory model.

What does this mean? Essentially, it means we are moving towards a more modern way of regulation. Historically, we, along with most regulators, have taken a reactive approach, primarily reacting to complaints and concerns once they come to our attention.

We are now moving to a more proactive form of regulation that will involve more research and dialogue with those we regulate—with the aim of ensuring the actions we take are evidence-based, proportionate to the identified risk, and truly add value to ensuring public safety through professional practice.

As part of this shift, we are reviewing the frameworks we use to direct our work.

This year we launched the Standards Framework for Oral Health Practitioners. This framework will underpin much of what we do over the coming years and clarify for practitioners the standards we expect them to meet to help us ensure they are safe, competent and fit to practise.

The standards framework represents a foundation for all that we do—the threshold above which all our practitioners will operate. Now that we have completed this, our next focus is on the recertification framework. The recertification framework will ensure practitioners remain competent and fit to practise throughout their practising career.

This is a vital piece of work for everyone in the sector and represents an opportunity to establish a robust system that supports and extends practitioners throughout their career. It will also provide the right level of intervention to ensure those whose competence is not at the right level are assisted before they slip below the threshold.

We were pleased to see good progress this year on the oral health therapy scope of practice. A high level of engagement from practitioners has led to a significant reworking of the original draft, and we hope to finalise the revised scope over the next 12 months.

The Council established an orthodontic working group in response to an increase in concerns relating to the standards of orthodontic care, particularly those being provided by general dentists. The group is currently gathering information and working with various stakeholders to ensure it understands the extent and scope of the issues.

The Council has actively participated in the work of the International Society of Dental Regulators (ISDR). The Council's Chief Executive continued in the role of president of ISDR but will step down in 2016 to allow other jurisdictions the opportunity to lead the organisation. The primary focus for the ISDR is the development of international accreditation standards, attributes and competencies for dentists.

The Radiation Safety Act comes into force in March 2017 and will replace the current Radiation Protection Act 1965. The Council has worked closely with the Office of Radiation Safety during recent months, with the aim that dentists, dental specialists, dental therapists, dental hygienists and orthodontic auxiliaries[1] can provide radiography services—based on the competence attained through practitioners' education and the ongoing assurance provided through the annual renewal of their practising certificate.

We would like to acknowledge the contribution of outgoing Chair Dr Michael Bain, whose term ended in December 2015. Dr Bain was appointed to the Council in 2009 and served as Chair from September 2013. He was a driving force in developing the strategic framework the Council works within. We would also like to recognise Leslea Eilenberg, Minnie McGibbon and Dr David Stephens, who finished their terms with the Council last year. We thank them all for their time and dedication.

We welcome the four new members of the Council: Auckland dentist Dr Jocelyn Logan, Auckland dental therapist Gillian Tahi, Wellington dental hygienist Charlotte Neame and Karen Ferns, a layperson from Auckland. We look forward to their new insights and perspectives.

We acknowledge and thank everyone who helped the Council during the year—examiners, assessors and supervisors, those who served on committees and working groups, and those who provided remedial educational services to practitioners. The expertise and professionalism you all bring to your work greatly benefits the Council, its staff and the wider sector. We also thank the practitioners and other stakeholders who contributed to our consultation and submission processes. We appreciate that submissions take time and effort to make, but they do contribute substantially to the Council's consideration of the numerous issues it works on each year.

We also want to acknowledge the Dental Board of Australia for the ongoing collaboration that facilitates sharing of expertise and resources through our joint projects.

Finally, we would like to thank the Council members for their continued commitment and support, and the Council staff for the work they have done over the past year.

Robin Whyman
Chair

Marie Warner
Chief Executive

[1] Only for those therapists, hygienists and orthodontic auxiliaries where radiography falls within their scope of practice.

Stats at a glance

The register

Oral health practitioner numbers

5,100 registrants (↑3.1%)

4,362 holding APCs (↑4.5%)

New registrations

382 new registrations (↑1.9%)

13%↑ dental hygienists registered (↑12)

6%↓ dentists registered (↓11)

198 practitioners removed from register (↓48)

16%↓ overseas qualified practitioners registered (↓18)

Competence, fitness to practise, conduct

Competence

18 competence notifications (↓40%)

Fitness

19↑ new health notifications

Complaints

8 professional conduct committees (↑4)

2 Health Practitioners Disciplinary Tribunal cases (↓2)

2 judicial reviews

Year in review

Standards—the year in review

Complete and embed standards of clinical competence, cultural competence and ethical conduct

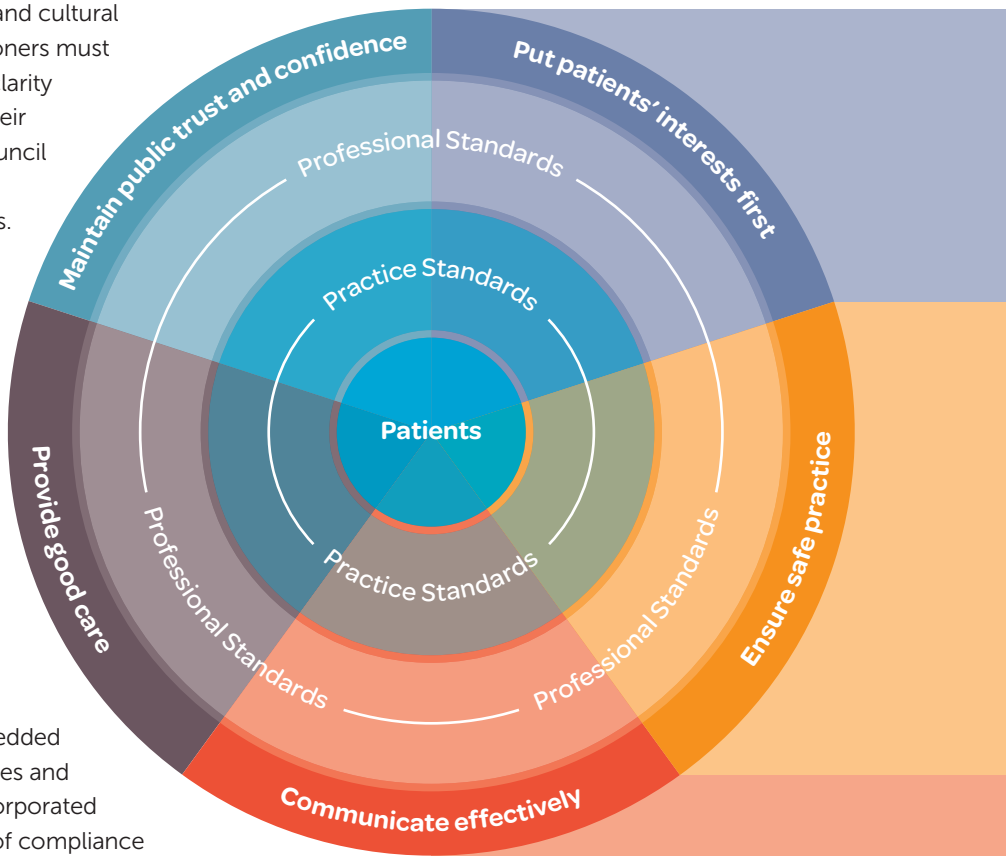
Standards Framework for Oral Health Practitioners

This year we were pleased to introduce the standards framework, which sets out the minimum standards of ethical conduct and the clinical and cultural competence all oral health practitioners must meet. The framework will provide clarity and guidance to practitioners on their obligations, while providing the Council with a clear roadmap of the work it needs to do in the area of standards.

The Council received strong support for the development of the framework, and the final result was refined through extensive consultation with practitioners.
We have received good feedback on the framework from stakeholders, and it is being embedded in the education content of the tertiary institutions' oral health programmes.

The framework has also been embedded within the Council's review processes and decision making, and has been incorporated into practitioners' self-declaration of compliance within the annual practising certificate renewal.

The standards framework, including all the practice standards, is available on the Council website in an interactive format that allows practitioners to easily access information on how they can meet the required standards. We encourage practitioners to visit the site and test it out.



dcnz.org.nz/standards-framework

Practice standards review

After we finalised the standards framework, we reviewed our approach to practice standards. All codes of practice have been rebranded as practice standards.

The Council has changed the template for practice standards to ensure absolute clarity for practitioners on what their obligations are. Practice standards now clearly set out the standards practitioners must meet. They are supported by guidance notes that describe how practitioners can achieve the standards.

Also this year, the Council reviewed and updated its internal practice standards development process, in recognition of the fact that the process was slow and costly. The development process previously involved multiple layers before a standard would be ready for public consultation—a draft standard would go through a working group process and then the Standards Review Standing Committee before it would be presented to the Council for approval.

Under the new process, standards development will reside with the Council staff. The Council staff will work with subject-matter experts, as required, before the Council considers the draft practice standard and releases it for consultation.

As a result, the Standards Review Standing Committee was formally disbanded in December 2015. The Council acknowledges the committee members' valuable contribution over the past three years.

The external consultation process will not change, and practitioners will still have the opportunity to provide us with valuable feedback before standards are approved and finalised by the Council.

We expect the new system will result in a more streamlined, cost effective and timely process.

Transmissible major viral infections practice standard

This practice standard was adopted and finalised in August. Following consultation with oral health practitioners, advice was also sought from the Health and Disability Commissioner (HDC) on a transmissible major viral infections (TMVI) infected practitioner's obligation under the Code of Rights to disclose their infection status to their patients. The Office of the Privacy Commissioner was also consulted on a TMVI infected practitioner's privacy rights.

The finalised standard is in line with similar international practice and achieves the dual aims of protecting the safety of the public and providing support to TMVI infected practitioners. A TMVI panel, with two subject-matter experts, has been established to advise the Council, and to manage TMVI infected practitioners' practising ability. The role of the TMVI panel is to work with the TMVI infected practitioner's medical team with the ultimate objective to get the practitioner back to health and return to practice, where possible.

Since the implementation of this practice standard, there has been an increase in disclosure by TMVI infected practitioners—the Council is pleased to see the standard has been effective in raising awareness and providing clarity to TMVI infected practitioners on what their obligations and rights are.

Infection prevention and control practice standard

The infection prevention and control practice standard was finalised in March 2016 with an implementation date of 1 May 2016. The exception is the requirement of a data recording device and/or printer for sterilisers, which has an implementation date of 1 May 2018.

This standard aims to improve patient safety through strengthening and clarifying the requirements relating to the prevention of transmission of infectious agents.

The finalised document introduces a single practice standard for all oral health practitioners.

Standards related to clinical competence

Proposed entry level competencies for dental specialties

The Trans-Tasman Mutual Recognition Act 1997 recognises Australian and New Zealand registration standards as equivalent. This allows registered oral health practitioners the freedom to work in either country.

Working jointly with the Dental Board of Australia, the Council this year was pleased to finalise the entry level competencies for dental specialties. This framework clarifies the educational competencies needed for specialists to qualify for registration in New Zealand and Australia and ensures they are consistent across the Tasman.

The new competencies and framework will provide clarity to tertiary institutions and practitioners as to what competencies are expected for registration, while also providing assurance to both practitioners and the public that their qualifications meet both countries' standards.

The competencies were developed following extensive consultation with dental specialists, tertiary institutions and professional bodies from both countries.

Standards—the year ahead

Complete and embed standards of clinical competence, cultural competence and ethical conduct

Practice standards under review this year:

- The sedation practice standard is under review, and the Council will be consulting on this later in 2016.
- Sexual boundaries in the dentist–patient relationship—it is intended that the title and purpose of this practice standard will be expanded to include other areas pertaining to oral health practitioners' professional relationships.
- Cultural competence—the Council will review the existing practice standards related to cultural competence and care for Māori patients and their whānau. The Council acknowledges culture is not confined to ethnic origin. It further recognises New Zealand as a multicultural society, while respecting the unique place Māori hold as tangata whenua in New Zealand.
- A review will also be undertaken of various existing practice standards and guidelines that relate to specific clinical practice areas and new technologies, for example, administration of Botulinum toxins, cone beam computed tomography and cosmetic dentistry. The Council will consider its approach to these areas with the introduction of the standards framework.

Engagement—the year in review

Grow understanding of, and engagement with, the Dental Council

Our work is improved when practitioners openly and actively participate. We are committed to making this easier for practitioners by providing as many ways as possible for people to receive information from us, talk with us, and provide us with feedback.

Engagement survey

This year, the Council undertook its first engagement survey. This involved a short multi-choice online survey sent to oral health practitioners and other key stakeholders, such as professional associations and the Ministry of Health. We received more than 1,000 completed surveys, which have provided valuable insights into how we can improve our communication and engagement.

The survey aimed to give the Council a better understanding of what respondents know about it and how they prefer to be communicated with.

We were pleased with the results, which showed there is generally a good understanding of the Council and the work it does. Most people were positive about their relationship with the Council and its performance. The results also showed our communications are generally well read and well received.

Main findings:

- Eighty-three percent of respondents say they know what the Council does.
- Ninety percent say they understand the Council's role in regulating the oral health professions.
- Nearly 90 percent say they understand the Council's role in setting standards.
- Seventy-four percent say they find communications from the Council useful and informative.

An overwhelming majority (85 percent) prefer to receive communications via email, and most would like to provide feedback to the Council via online surveys.

There is always room for improvement, and we will use the survey results to help us develop the ways we communicate with our stakeholders. Thank you to all who took part in the survey—your feedback is greatly appreciated. We will undertake a follow-up survey in the future to track our progress.

Council-led engagement

As part of our consultation on the draft standards framework, the Council led one targeted stakeholder, four practitioner forums (Wellington, Auckland, Dunedin, Christchurch) and one webinar. The forums were well attended and provided the Council with excellent feedback on the framework, as well as providing an opportunity for oral health practitioners to ask questions and raise concerns.

For those who are not familiar with the term, a webinar is a presentation hosted online using video conferencing software, which allows participants to give, receive and discuss information in real time. This year's webinar was successful and confirmed the format as a useful platform for future discussion forums, in particular for those participants who live outside the main city centres or are unable to physically attend workshops or forums.

Stakeholder meetings

Members of the Council and its staff have actively sought out more opportunities to meet practitioners and other stakeholders face to face.

This has resulted in a significantly increased number of meetings, presentations, appointments, and conferences, allowing Council members and staff to spend time with people throughout the sector.

Some of these engagements include:

- regular meetings with the Associate Minister of Health and the Ministry of Health staff, as well as participating in consultation workshops—allowing the Council to directly advocate about oral health issues, especially with regard to maintaining standards and public safety

- regular meetings with district health board clinical directors
- regular meetings with Auckland University of Technology and University of Otago representatives
- attending meetings and conferences of oral health practitioner professional associations—enabling direct and frank face to face discussion
- presentations to final year students at the University of Otago and Auckland University of Technology on their professional responsibilities once in practice.
- international conferences and meetings with our international regulatory partners, which enable us to ensure we are keeping on top of international standards and regulatory best practice

We have directly talked with hundreds of practitioners through this work—giving us invaluable insights into issues and concerns of those the Council regulates.

Engagement—the year ahead

Grow understanding of, and engagement with, the Dental Council

As a regulator, our primary role is to protect the public—we do this through setting and maintaining standards of practice for the regulated professions. Therefore our engagement must be twofold: with the public, and with the professions that we regulate.

It is essential we understand what is important to patients and what they want from their oral health providers. This year, we will be examining ways we can engage with members of the public more effectively, and how we can ensure they have a stronger voice in what we do.

Engagement survey

We will be working through the results of our engagement survey and following up on suggestions for improvement made by respondents. We will keep you updated on how this progresses.

Some of the main areas of work related to the survey we will be focusing on include the following:

- Our newsletter—74 percent of respondents said they read the newsletter every time, or most times. While this is pleasing, we would like everyone to read the newsletter regularly, so we are looking at ways to make it more engaging and inviting.
- Our website—only 33 percent of respondents visited the website at least once a month. We would like people to be visiting more regularly, so we will be looking at how we can make the website a more useful information and service hub for people.
- Social media—there were mixed responses on the use of social media. We will be evaluating the

use of social media this year to see whether it could be a useful tool for communicating with our stakeholders.

Consumer forum

To better understand what patients need from their oral health providers, we will look at ways we can talk with the public and receive their views.

We know other regulators use consumer forums as a mechanism for gathering patient feedback, and we will look at whether they are an appropriate tool for our sector or if other channels may work more effectively for us.

Other engagement

We will be developing an engagement plan that identifies how we can communicate more effectively on each of our strategic priorities. The Council has a clear roadmap to 2020 in terms of the work it wants to get done across the five identified strategic priorities—the challenge is to ensure we communicate what we are doing and why and how we are doing it with all of our key stakeholders.

We will continue to look for opportunities to meet stakeholders face to face, to ensure we are available for those who would like the opportunity to engage directly.

Lifelong practitioner competence—the year in review

Introduce an effective, quality assurance framework for ongoing practitioner competence and fitness to practise

Work has started on the review of the Council's recertification policy and the development of a framework for ongoing practitioner competence and fitness to practise.

The Council's recertification policy has operated largely unchanged since the introduction of the Health Practitioners Competence Assurance Act in 2004. Some 12 years on, it is timely for the Council to reflect on whether the programme is contemporary and fit for purpose in providing us all with the assurance of competence and fitness to practice.

In addition, the Council has the benefit of 12 years' worth of notifications on competence and conduct concerns. The total number received is relatively low, which has allowed the Council to review each case to inform its future work.

With the benefit of what we know what works well and not so well with the current model, we are now in a good position to improve it.

When thinking about a new framework, we also need to consider alternative models of regulation that are risk based and outcomes focussed to ensure the regulatory response to risk is proportionate and fair.

The Council engaged consultants in 2015 to lead the scoping stage of the review of its recertification policy. This initial work led to the following ongoing policy objectives agreed by the Council.

The framework should:

- provide assurance of ongoing competence
- promote ongoing competence and prevention of competence decline
- identify risky or unsafe practitioners, and remediate (or restrict from practice).

The three objectives must be achieved in a way that focuses on outcomes. The framework should be based on robust evidence to ensure it gains the acceptance of practitioners. The framework should not take a one-size-fits-all approach but instead, use a risk-based model that is proportionate and fair.

Lifelong practitioner competence—the year ahead

Introduce an effective, quality assurance framework for ongoing practitioner competence and fitness to practise

The initial stage of this review has identified several framework models that may achieve our objectives.

Our focus now is on working with practitioners to design the best possible and most practical framework for the future. We will be talking with practitioners and other stakeholders to get their views on the best way forward.

We will be asking two primary questions when seeking practitioner views on how our current programme could be improved.

- Does the programme deliver the necessary outcomes?
- Are there any unintended consequences?

We know this is a subject practitioners feel strongly about and will be able to contribute excellent insights into. It is a challenge to decide how best to ensure practitioners are competent and the overall safety and reputation of oral health care is upheld.

A timeframe for consultation has not yet been set, but we look forward to constructive engagement with the sector.

A capable organisation—the year in review

Ensure we have the policies, systems, skills and processes to deliver our functions—smarter, more consistently and in accordance with our principles and values

Human resources and information technology review

We have completed a human resources review of the Council staff, to ensure the organisation has the necessary capabilities and capacity to deliver the strategic plan.

This review was finished in March 2016, and it recommended the Council build capacity by recruiting staff with specialised skills in communication and engagement, strategic and operational policy development, programme management and business analysis. This will ensure the Council is able to deliver its strategic plan and provide improved services to practitioners.

Work is also progressing on the information technology review, focused on developing the capability to deliver more of our practitioner services online.

Office move

Due to a change of use for our old building (it has been converted into apartments), the Council has moved—just down the road—to 80 The Terrace. Our new offices are shared with the Pharmacy Council, Physiotherapy Board, Medical Sciences Council and Medical Technologists Board. The Medical Council occupies offices in the same building.

By sharing office space, we are able to make savings by pooling office resources. We also benefit from working alongside other health regulatory agencies.

A capable organisation—the year ahead

Ensure we have the policies, systems, skills and processes to deliver our functions—smarter, more consistently and in accordance with our principles and values

This year, we will commence the review of all of our operational policies to ensure they are aligned with our new risk-based governance model.

We will also be collaborating with agencies within the health sector to collate trend data. This will help us build a better picture of any trends in notifications or areas of concern.

Information technology review

The Council is undertaking a major system-wide review of its information technology systems that will enable it to improve the way it deliver its services.

As part of the review, we plan to make it possible for practitioners to apply for registration and their annual practising certificate renewals online, as well as undertake other actions, such as updating contact details. Our engagement survey found practitioners had a clear preference for providing information and feedback online.

The project will also streamline our workflow processes so practitioners will find it quicker and easier to deal with us.

This is a big project and a major component of our strategic priority of ensuring we are a capable organisation. The work involves seven separate strands of system reform, including the registry, the web portal, our electronic document management system, and building e-commerce functionality into our website.

Tenders for our request for proposal closed in June 2016. We are aiming for work to begin on 1 September—at this stage, we are not sure how long it will take, but we will keep you updated.

Governance—the year in review

Review and refresh our governance model

One of our main priorities for 2015–20 is to ensure that, as a governance board, we have the skills, policies and processes to operate efficiently and effectively, that we put our energy into areas of most value, and to be assured that decision-making is timely, fair and justifiable.

We began a review of the Council's governance operating model in June 2015. The wider context of governance of regulators was also explored.

Following consideration of various options presented, the Council agreed to move towards a risk-based governance model. This represents a stronger focus on a strategic regulatory function and a move towards routine or lower risk decisions being made under delegation by the Council staff.

In addition, the Council induction process has been strengthened, and a capability framework to support professional development and to evaluate member performance has been implemented.

Governance—the year ahead

Review and refresh our governance model

As part of the Council's shift to a risk-based governance model, we are developing a risk-assessment matrix to help ensure decisions being managed under delegation are assessed at the appropriate level. The matrix will be considered by the Council before it is implemented. Once implemented, the matrix will be regularly reviewed.

Performance scorecard—annual reporting

Because public outcomes often take many years to achieve, measurement frameworks can be used to track progress against a strategy and how well it is being executed.

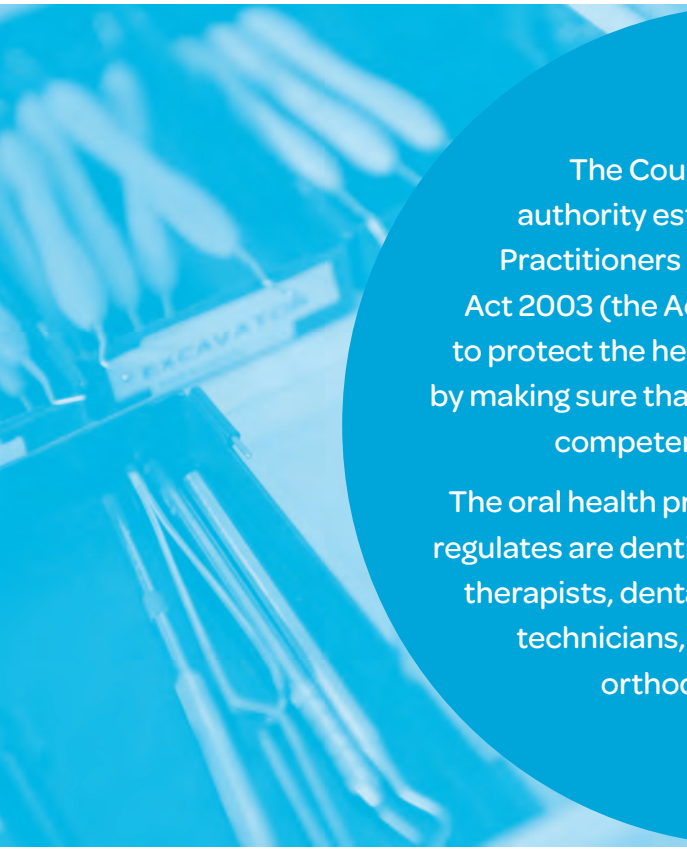
The Council has adopted a performance measurement framework, to help map its progress and report on it to stakeholders.

It is important that as we implement our strategic plan, we have a performance measurement system in place to understand our progress and to identify where to focus our efforts when improvement is needed.

The Council has chosen to use a performance 'balanced scorecard'. It examines each of our five strategic priorities from four perspectives (stakeholder satisfaction, financial performance, internal operations, and organisational capability) and uses questions to help the Council understand how well it is performing in each area.

The performance framework will be presented to the Council on a quarterly basis, and then reported on to our stakeholders annually. You can expect to see the first scorecard in next year's annual report.

What we do



The Council is a responsible authority established by the Health Practitioners Competence Assurance Act 2003 (the Act). Our primary purpose is to protect the health and safety of the public by making sure that oral health practitioners are competent and fit to practise.

The oral health practitioners that the Council regulates are dentists, dental specialists, dental therapists, dental hygienists, clinical dental technicians, dental technicians and orthodontic auxiliaries.

Our roles and functions

Section 118 of the Act defines our role and functions.

These include:

- setting accreditation standards and competencies for each of the dental professions and defining scopes of practices and the associated prescribed qualifications
- maintaining the public register of all registered oral health practitioners
- issuing annual practising certificates to oral health practitioners who have maintained their competence and fitness to practise
- receiving and acting on information from health practitioners, employers and the HDC about the competence of oral health practitioners
- reviewing and remediating the competence of oral health practitioners where concerns have been identified
- investigating the health of oral health practitioners where there are concerns about their performance and taking appropriate action
- setting standards of clinical and cultural competence and ethical conduct to be met by all oral health practitioners
- promoting education and training in the oral health professions
- promoting public awareness of the Council's responsibilities.

The Council's statutory functions are set out in section 118 of the Act.

Who we are

The Council is appointed by the Minister of Health. It has 10 members:

- four dentists
- one dental therapist
- one dental hygienist
- one dental technician or clinical dental technician
- three lay members.

The Council oversees the strategic direction of the organisation, monitors management performance and implements the requirements of the Act.

The Council is supported by its staff, who are responsible for delivering the Council's statutory functions, implementing the strategic direction and managing the projects required to support the Council's goals in the regulation of oral health practitioners in New Zealand.

The Council

Robin Whyman – Chair

Dental practice

- Dental specialist in public health and general dentist
- Clinical Director of Oral Health Services at the Hawke's Bay District Health Board (DHB)

Interests and positions held

- Clinical leadership and clinical governance
- Chair of the Credentialing Committee at Hawke's Bay DHB
- Chair of the Electronic Oral Health Record project governance group for the Ministry of Health
- Clinical advisor to the 20 DHBs oral health advisory group
- Member of the New Zealand Dental Association Research Foundation Board
- Elected as the Dental Council Deputy Chair in September 2013 and Chair in February 2016
- Former Regional Director for Oral Health Services Capital and Coast Health and Hutt Valley Health
- Former Executive Director of the New Zealand Dental Association (NZDA)
- Former General Manager Clinical Services at Dental Health Services Victoria (Australia)
- Former Chief Dental Officer for the New Zealand Ministry of Health

First appointed June 2011
Current term ends June 2017

Andrew Gray – Deputy Chair

Dental practice

- Dentist
- Director Defence Health/ Surgeon General, New Zealand Defence Force
- Queen's Honorary Dental Surgeon

Interests and positions held

- Practised in general dental practice in the United Kingdom
- Senior Dental Officer, Royal New Zealand Navy, Director Defence Dental Services
- Chair of the World Dental Federation Section of Defence Forces Dental Services
- Former clinical tutor, clinical coordinator and lecturer at University of Otago
- Fellow of the Royal College of General Dental Practitioners (UK) and Fellow of the Academy of Dentistry International
- Graduate of the United States Army Medical Strategic Leadership Program
- Member of the NZDA Board and Executive until his Council appointment
- Member of the New Zealand Institute of Directors

Appointed September 2013
Current term ends September 2016

John Aarts

Dental practice

- Clinical dental technician and registered in Implant Overdentures scope of practice
- Senior Teaching Fellow—Bachelor of Dental Technology, University of Otago; Postgraduate Diploma in Clinical Dental Technology course convenor
- Consulting at School of Dentistry Clinic

Interests and positions held

- Bachelor of Education (Applied) (Central Institute of Technology), Bachelor of Health Science (Central Institute of Technology) and Master of Health Sciences with Distinction (University of Otago)
- Executive member of the New Zealand Institute of Dental Technologists (NZIDT), Chair of the NZIDT Continuing Professional Development Sub-Committee until his Council appointment
- Holds committee memberships at the Faculty of Dentistry at the University of Otago, including:
  - Professional Development Committee
  - Dental Technology Studies Committee
- Currently the professional expert for the Tertiary Education Quality and Standards Agency Australia
- Australian dental council/ dental council accreditation committee assessor

First appointed December 2012
Current term ends December 2018

Karen Ferns

Layperson

Interests and positions held

- Background in sales and marketing and public relations
- Previous experience in market research
- Management consultant and independent director
- Former Chief Executive of Random House New Zealand
- Experienced in governance
- Member of the New Zealand Institute of Directors and Australian Institute of Company Directors
- Board Director of Auckland University Press and New Zealand Book Awards Trust (current)
- BA (Hons) Geography and History, Otago University and undertakes active learning and development in director and management topics
- Diploma in Teaching (Secondary)
- Has trained and worked as a volunteer for Citizens Advice Bureau

Appointed December 2015
Current term ends December 2018

Lyndie Foster Page

Dental practice

- Dental specialist in public health
- Senior Lecturer and Head of Discipline: Preventive and Restorative Dentistry, University of Otago

Interests and positions held

- First practised in general dental practice; five years working in public sector
- Specific interest in dental epidemiology, cariology and oral health related quality of life
- Completed doctorate in 2010
- Member of the NZDA, the International and American Association for Dental Research, and the European Organisation for Caries Research
- Current research: cross sectional surveys and various health services research and clinical projects
- Promoted to Associate Professor by the University of Otago in 2015

First appointed June 2011
Current term ends June 2017

Kate Hazlett

Layperson

Interests and positions held

- Former community board member and Director of a community hospital
- Experience in governance and decision making
- Serves on community committees, including the Otago Community Trust and Roxburgh Services Medical Trust
- Trained as a school dental nurse
- Worked mainly in rural areas

First appointed April 2010
Current term ends April 2019

Jocelyn Logan

Dental practice

- Dentist
- Associate in a dental practice in Thames

Interests and positions held

- Bachelor of Dental Surgery (Otago), Diploma in General Dental Practice from the Royal College of General Dental Practitioners (UK), MBA (Nottingham, UK)
- Current member of NZDA
- Chair of the NZDA National Peer Review Committee (2011–15)
- Mentor of new graduate in NZDA mentorship programme
- Author of Dental Protection Ltd column in NZDA News
- Past Chair and member of Dental Council Competence Review Committee
- Worked 27 years in the United Kingdom, mainly in private practice
- Vocational Training Advisor in UK training scheme
- Dental Practice Advisor for Nottinghamshire Primary Care Trust
- Dental Advisor for Dental Protection Limited in the United Kingdom

Appointed December 2015
Current term ends December 2018

Charlotte Neame

Dental practice

- Dental hygienist at dental practice in Wellington

Interests and positions held

- Dental Council's Professional Advisor—Hygienist (2013–15)
- Chair of New Zealand Dental Hygienists' Association (2011–12) and current member
- Member of the Council's accreditation site evaluation team for the University of Otago's Bachelor of Oral Health programme (2014)
- Diploma in Dental Hygiene (University of Otago, 2004)

Appointed December 2015
Current term ends December 2018

Gillian Tahi

Dental practice

- Dental therapist with the Auckland Regional Dental Service and Waitemata District Health Board.

Interests and positions held

- Active committee member (previous President and Chairperson (2009–14)) of New Zealand Dental and Oral Health Therapists Association (previously New Zealand Dental Therapists Association), Auckland Branch
- Continuing Professional Development Coordinator for the New Zealand Dental and Oral Health Therapists Association Auckland Branch
- Member of Te Ao Marama Association
- Certificate in Dental Nursing
- Bachelor of Arts in Education
- Oral Health Practice III Auckland University of Technology

Appointed December 2015
Current term ends December 2018

Wendy Tozer

Layperson

Interests and positions held

- Served the community in both professional and voluntary capacities in the health sector and through service organisations for many years
- Programme Coordinator for Alzheimers Eastern Bay of Plenty
- Secretary/Treasurer of the Disabled Persons Assembly
- Presiding member of Lotteries Bay of Plenty
- Provides volunteer services to several other charitable and community groups in the Bay of Plenty
- Event and campaign management experience

First appointed July 2009
Current term ends December 2018

Professional committees

Four Council committees operated during 2015/16. Committee membership was as follows.

Audit and Risk Management Committee	Brent Kennerley *(Chair—independent member, Partner Grant Thornton Chartered Accountants)* Michael Bain *(ex-officio—Council Chair*)* Robin Whyman *(ex-officio—Council Chair**)* John Aarts Leslea Eilenberg Wendy Tozer
Continuing Professional Development Advisory Committee	Lyndie Foster Page *(Chair, dental academic)* Andrew Gray *(dentist)* Leslea Eilenberg *(dental hygienist*)* Minnie McGibbon *(dental therapist*)* John Aarts *(dental and clinical dental technician)* Charlotte Neame *(dental hygienist**)* Gillian Tahi *(dental therapist**)*
Australian Dental Council/ Dental Council (NZ) Accreditation Committee	Mike Morgan *(Chair)* Lyndie Foster Page *(New Zealand member)* Robert Love *(New Zealand member)* Michael Bain *(New Zealand member, ex-officio as Chair of Dental Council*)* Robin Whyman *(New Zealand member, ex-officio as Chair of Dental Council**)* Werner Bischof Jan Connolly Mark Gussy Chris Handbury Audrey Irish Neroli Stayt Jane Taylor
Standards Review Standing Committee	Robin Whyman *(Chair, Council member, dental specialist)* Sue Ineson *(layperson)* Karl Lyons *(academic and dental specialist)* Anita Nolan *(academic and dental specialist)* Diane Pevreal *(dental therapist)* Tania Stuart *(dentist)* Sharmyn Turner *(academic and dental hygienist)* Justin Wall *(Māori representative and dentist)* Mike Williams *(dental technician and clinical dental technician)*

Note: The Standards Review Committee was disbanded on 31 December 2015 because the Council adopted a new process for setting practice standards.

*Term ended 9 February 2016

**Term started 9 February 2016

Council staff

The members of the Council staff were:

Chief Executive	Marie Warner
Executive Assistant/Council Secretary	Lagi Asi
Registrar	Mark Rodgers
Deputy Registrar	Alicia Clark
Registration and Recertification Officer	Kelly Douglas
Registration and Recertification Officer	Kirsten Millar
Registration and Recertification Officer	Caroline Morris
Registration and Recertification Officer	Trina Liu
Legal Advisor	Valentina Vassiliadis
Corporate Services Manager	Kevin Simmonds
Finance Officer	Kim Hopkinson
Administration Officer	Karen Zhu
Senior Business Development Advisor	Suzanne Bornman

Professional advisors

Professional Advisor—Standards & Policy	Duchesne Hall
Professional Advisor—Dentists	Dexter Bambery
Professional Advisor—Therapists	Marijke van der Leij Conway
Professional Advisor—Hygienists	Charlotte Neame*
Professional Advisor—Technicians	Barry Williams

The Council has five professional advisors. The Standards and Policy Advisor helps staff review standards and policies from a clinical perspective. The four profession-specific advisors provide clinical advice to the Council and its staff, undertake inquiries and advise the Council in relation to complaints and competence notifications and undertake practitioner audits.

*Charlotte Neame held the position until December 2015 when she was appointed to the Council.

Registration and practising certificates

To practise in New Zealand, all oral health practitioners need to be registered and hold a current annual practising certificate (APC). The Council is responsible for maintaining the register of practitioners and issuing APCs. These two requirements confirm to the public that the Council has certified a practitioner as being competent and fit to practise.

Registration

Practitioners can register in one or more of 20 scopes of practice. Practitioners can only practise within the scope or scopes of practice in which they are registered and for which they hold a current APC.

The same registration standards apply to all practitioners, regardless of where they were educated.

To practise in New Zealand, practitioners who qualified elsewhere need to have qualifications that have either been prescribed by the Council or are assessed as being equivalent to a New Zealand prescribed qualification.

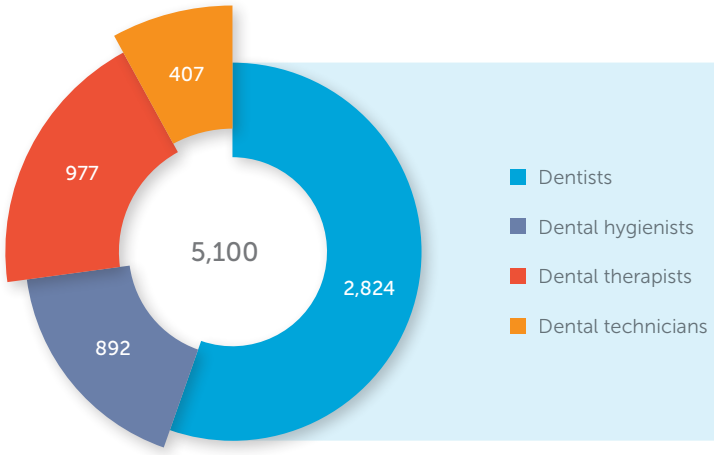
Potential practitioners may also gain eligibility for registration by sitting and passing the New Zealand Dental Registration Examinations in the particular profession they wish to practise. Australian registered practitioners are generally entitled as of right to register in a similar scope of practice in New Zealand under the Trans-Tasman Mutual Recognition legislation.

The public register is available on our website so anyone can view practitioners' qualifications, scope(s) of practice, the currency of their APC and any conditions or limitations placed on their practice. Information on the register is updated daily.

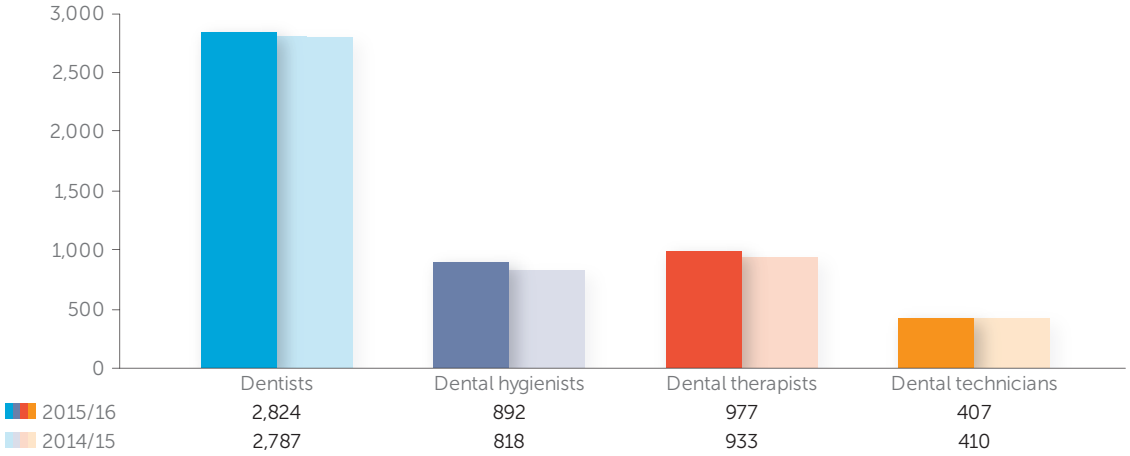
Registration statistics

As at 31 March 2016, 5,100 practitioners were registered with the Council, of which 4,362 held an APC. This is an increase of 152 practitioners (3.1 percent) from last year, in line with similar increases recorded over the past five years.

Number of registered oral health practitioners by profession as at 31 March 2016



Number of oral health practitioners registered by profession as at 31 March 2016



The increase in practitioners is made up of net increases of 9 percent more dental hygienists, 4.7 percent more dental therapists and 1.3 percent more dentists. The number of dental technicians decreased by 0.7 percent from the previous year. This continues an annual decline that started in 2009 and has seen an overall decrease of 14.7 percent since then.

Practitioners can be registered in more than one scope of practice. For example, there are 453 practitioners registered in both the dental hygiene and dental therapy scopes of practice.

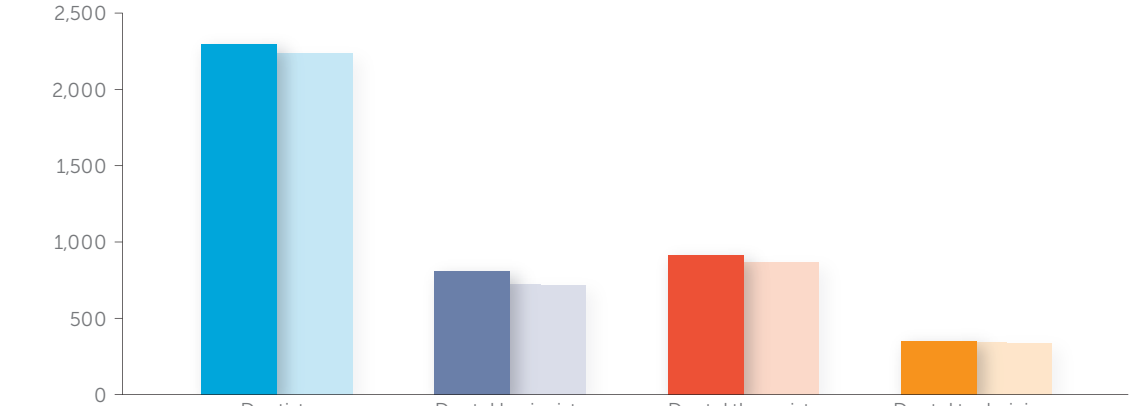
Number of registered practitioners by scopes of practice as at 31 March 2016

	2015/16	2014/15
General dental practice	2,714	2,681
Orthodontic specialist	112	110
Endodontic specialist	36	35
Oral and maxillofacial surgery specialist	51	49
Oral medicine specialist	5	5
Oral pathology specialist	8	8
Oral surgery specialist	10	10
Paediatric specialist	22	22
Periodontic specialist	40	37
Prosthodontic specialist	35	37
Restorative dentistry specialist	10	11
Public health dentistry specialist	21	23
Special needs dentistry specialist	10	8
Dental hygiene practice	784	714
Orthodontic auxiliary practice	124	118
Dental therapy practice	977	933
Adult care in dental therapy practice	13	13
Dental technology practice	407	410
Clinical dental technology practice	220	211
Implant overdentures in clinical dental technology	17	17

Annual practising certificates

All practising practitioners have to hold a current APC, which is renewed annually. To obtain an APC, practitioners need to assure the Council that they have maintained their competence and fitness to practise. The issue of an APC is the Council's way of confirming to the public of New Zealand that a practitioner has met the standards the Council sets. The Council will decline an APC application if it is not satisfied that a practitioner meets these standards.

Number of oral health practitioners holding an APC by profession as at 31 March 2016



The overall number of practitioners holding APCs increased 4.5 percent in 2015/16. By profession, increases occurred in numbers of practitioners holding APCs for each profession, with the most significant being an increase of 10.7 percent for dental hygienists.

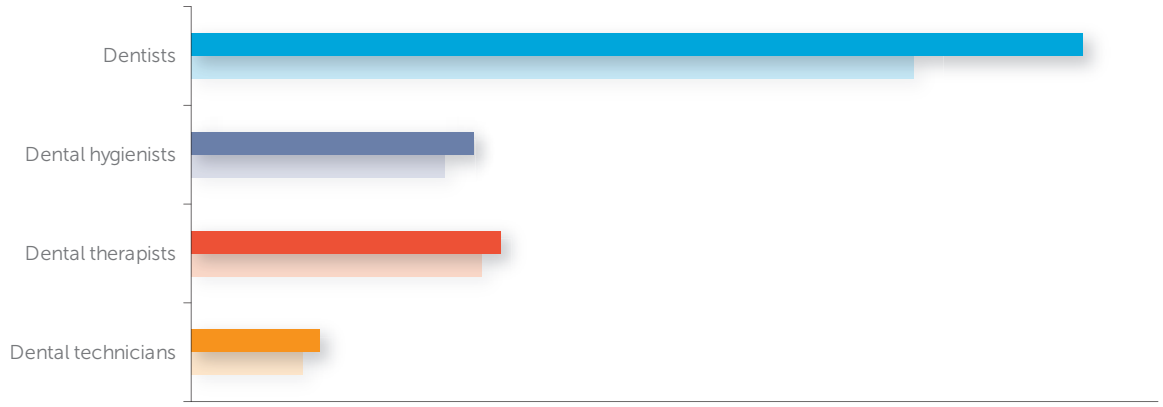
The number of dentists holding APCs increased by 2.4 percent, while the number of dental technicians holding APCs increased by 1.2 percent from the previous year.

Applications for an annual practising certificate

	Health Practitioners Competence Assurance Act 2003 – section	Applications	Outcomes			
			APC	APC with conditions	Interim APC	APC declined
Total		4,364	4,292	70	0	2
Reasons for non-issue						
Competence	27(1)(a)					2
Failed to comply with a condition	27(1)(b)					
Not completed required competence programme satisfactorily	27(1)(c)					
Recency of practice	27(1)(d)					
Mental or physical condition	27(1)(e)					
Not lawfully practising within three years	27(1)(f)					
False or misleading application	27(3)					

Note: APC = annual practising certificate.

Comparison of number of registered practitioners with those holding an annual practising certificate (APC) by profession as at 31 March 2016



	Dentists	Dental hygienists	Dental therapists	Dental technicians
Registered	2,824	892	977	407
APC	2,290	805	917	350

In 2015/16, of the total number of registered practitioners, 85.5 percent of them held current APCs. By profession, this percentage ranged from 81 percent of registered dentists holding APC certificates to 94 percent of dental hygienists.

Additions to the register

The Council received 393 applications for registration this year. Of these, 381 were registered and one was registered with conditions.

Please note, numbers in this section brought forward from last year do not all correspond with the figures from last year's annual report—this is because we have amended the way we calculate our totals to include all restorations to the register for those practitioners who have previously been removed from the register.

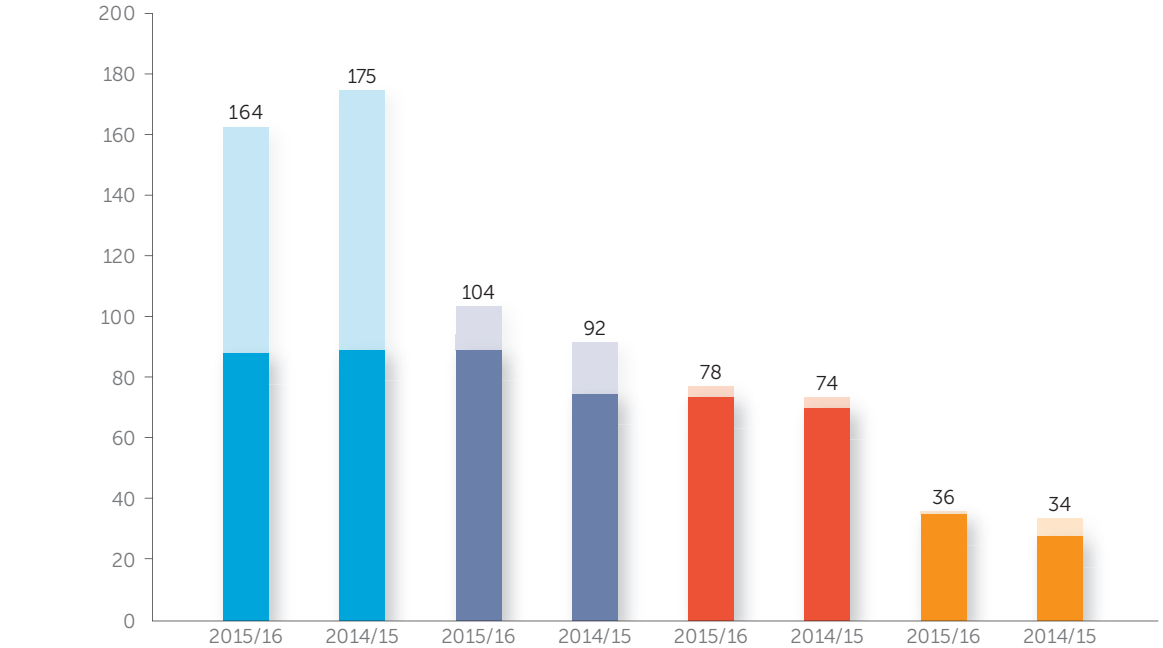
Applications for registration

	Health Practitioners Competence Assurance Act 2003 – section	Brought forward 2014/15	Outcomes				
			Total applications	Registered	Registered with conditions	Not registered	Pending 2015/16
Total		14	393	381	1	7*	18
Reasons for non-registration							
Application period lapsed or application withdrawn							
Applicant not considered competent to practise within scope of practice	15(1)(c)					1	
Qualification not deemed equivalent to a prescribed qualification	15(2)					6	
Communication, including English-language requirements	16(a) and 16(b)						
Conviction of any offence punishable by imprisonment for three months or longer	16(c)						
Mental or physical condition	16(d)						
Professional disciplinary procedure in New Zealand or overseas, otherwise under investigation	16(e), 16(f), 16(g)						
Other – danger to health and safety	16(h)						
Subject to preliminary investigations, disciplinary proceedings	TTMR Act sections 19 and 22						
Occupation in which registration is sought is not an equivalent occupation and equivalence cannot be achieved by imposition of conditions	TTMR Act section 22(1)(d)						

* Applicants not granted registration, by profession: dentists (7)

Note: TTMR Act = Trans-Tasman Mutual Recognition Act 1997.

Breakdown of registrations granted with New Zealand and overseas qualifications



Overall, we saw an increase of 1.9 percent in the number of new registrations in 2015/16 from last year. The largest increase was in dental hygienist registrations—up 13 percent from 2014/15. The number of registrations of dental technicians and dental therapists increased by 5.9 percent and 5.4 percent respectively. A 6.3 percent decrease occurred in dentists' registrations.

Most additions to the register across all the professions were New Zealand-educated practitioners.

We added 18 fewer overseas-qualified practitioners to the register than last year. The biggest decrease was from dentists, with 10 fewer registrations from dentists with overseas qualifications.

Breakdown by country of qualifications for registrations granted during 2015/16

	Dentists		Dental hygienists		Dental therapists		Dental technicians	
	2015/16	2014/15	2015/16	2014/15	2015/16	2014/15	2015/16	2014/15
Argentina		1						
Australia	15	17	3	2	3	1	1	3
Belgium		1						
Brazil		1						
Canada	1		1	6				
China	2	1						
Colombia		1						
Egypt		1						
Fiji			1		1			
Greece		2						
Hong Kong	1	1						
Hungary		1						
India	8	9	1	1		1		
Iraq	1	1						
Ireland		2						
Israel		1						
Italy	2							
Kosovo		1						
Malaysia	3	2						
Netherlands	2							
Pakistan		1						
Philippines	1			1		1		
Poland	1							
Romania								1
Singapore	2	1						
South Africa	5	9						2
Sweden	1							
Taiwan		1						
Thailand		1						
Turkey		1						
UK	24	21	5	2		1		
USA	6	7	3	5				
Total Overseas	75	85	14	17	4	4	1	6
Total New Zealand	89	90	90	75	74	70	35	28
TOTAL	164	175	104	92	78	74	36	34

Registration through Trans-Tasman Mutual Recognition Act 1997

The Trans-Tasman Mutual Recognition Act 1997 (TTMR) recognises Australian and New Zealand registration standards as equivalent. This allows registered oral health practitioners the freedom to work in either country. Under the TTMR, if a practitioner is registered as a practitioner in Australia they are entitled (subject to a limited right of refusal) to be registered in the same occupation in New Zealand. Thirty-three practitioners, of which one was a specialist, registered in New Zealand under the TTMR in 2015/16. This is a decrease of 10 TTMR applications and registrations, compared with the previous year.

Registrations in New Zealand under the Trans-Tasman Mutual Recognition Act 1997

	2015/16				2014/15			
	Brought forward	Received	Approved	Carried forward to 2016/17	Brought forward	Received	Approved	Carried forward to 2015/16
Dentists	2	17	18	1	1	31	30	2
Dental hygienists	–	10	9	1	–	5	5	–
Dental therapists	–	7	6	1	–	4	4	–
Clinical dental technicians	–	0	0	–	–	4	4	–
TOTAL	2	34	33	3	1	44	43	2

Individual assessment applications

Under the Act, applicants with non-prescribed qualifications who consider their education and experience to be equivalent to a prescribed qualification can apply for individual consideration of their eligibility for registration.

In 2015/16, we received 17 individual assessment applications—a similar number to the previous year. Eight applications were approved, six declined and nine were pending at the end of the reporting year.

Individual assessment applications

	2015/16					2014/15				
	Brought forward 2015/16	Received	Approved	Declined	Pending	Brought forward 2014/15	Received	Approved	Declined	Pending
Dentists	6	16	7	6	9	2	14	7	3	6
Dental hygienists	–	–	–	–	–	–	1	1	–	–
Dental therapists	–	–	–	–	–	–	1	1	–	–
Dental technicians	–	1	1	–	–	1	2	3	–	–
TOTAL	6	17	8	6	9	3	18	12	3	6

Removal of exclusions for dental hygienists, dental therapists and orthodontic auxiliaries

Dental hygienists, dental therapists and orthodontic auxiliaries can apply to remove exclusions from their scopes of practice, by providing evidence that they have successfully completed a Council-approved training course. These exclusions relate to areas of their scope of practice not covered in their formal education and training.

The number of applications for removal of exclusions that were approved in 2015/16 is reflected in the table below. The most significant movement is a 60 percent decrease in the removal of exclusions relating to stainless steel crowns, compared with the previous year.

Applications for removal of exclusions approved

	2015/16	2014/15
Dental hygiene and orthodontic auxiliary scopes of practice		
Orthodontic procedures	1	3
Local anaesthesia	15	7
Extra-oral radiography	5	3
Intra-oral radiography	5	3
Dental therapy scope of practice		
Pulpotomies	18	27
Stainless steel crowns	16	40
Radiography	2	3
Diagnostic radiography	3	4
TOTAL	**65**	**90**

Registration-related supervision

The Council uses supervision orders to ensure a practitioner is fit and competent to practise, and to protect public safety in a variety of situations, such as when a practitioner is returning to practise after more than three years. Supervision involves the monitoring of, and reporting on, the performance of a practitioner by a professional peer.

We managed 23 practitioners with supervision orders to address registration issues in 2015/16, compared with 35 the previous year. Three practitioners under supervision requested voluntary removal from the register over the course of this year.

Registration-related supervision

	2015/16	2014/15	2013/14
New supervision cases	1	5	14
Existing supervision cases	22	30	24
Total managed	**23**	**35**	**38**
Practitioners leaving supervision	3	13	8
Practitioners remaining under supervision	20	22	30

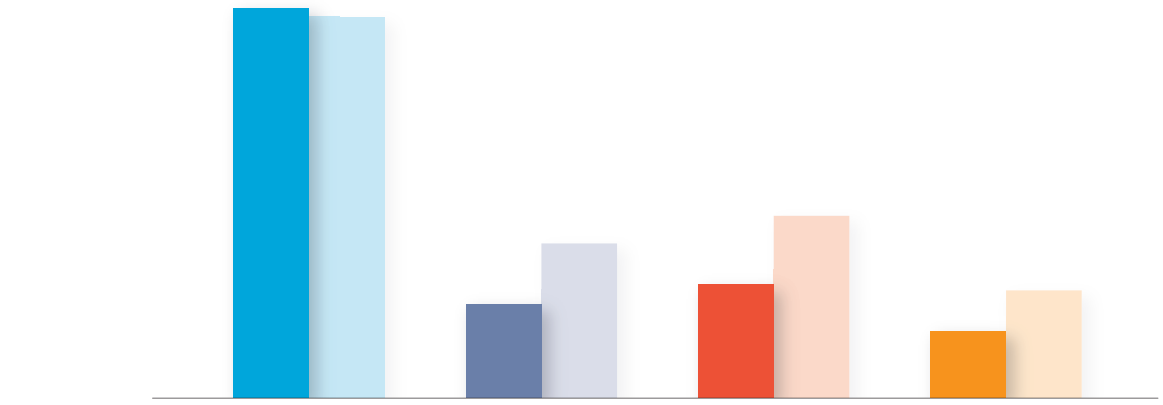
Registration-related supervision, by profession

	2015/16	2014/15	2013/14
Dentists	0	2	4
Dental hygienists	5	11	13
Dental therapists	6	7	8
Dental technicians	12	15	12
Total	**23**	**35**	**37**

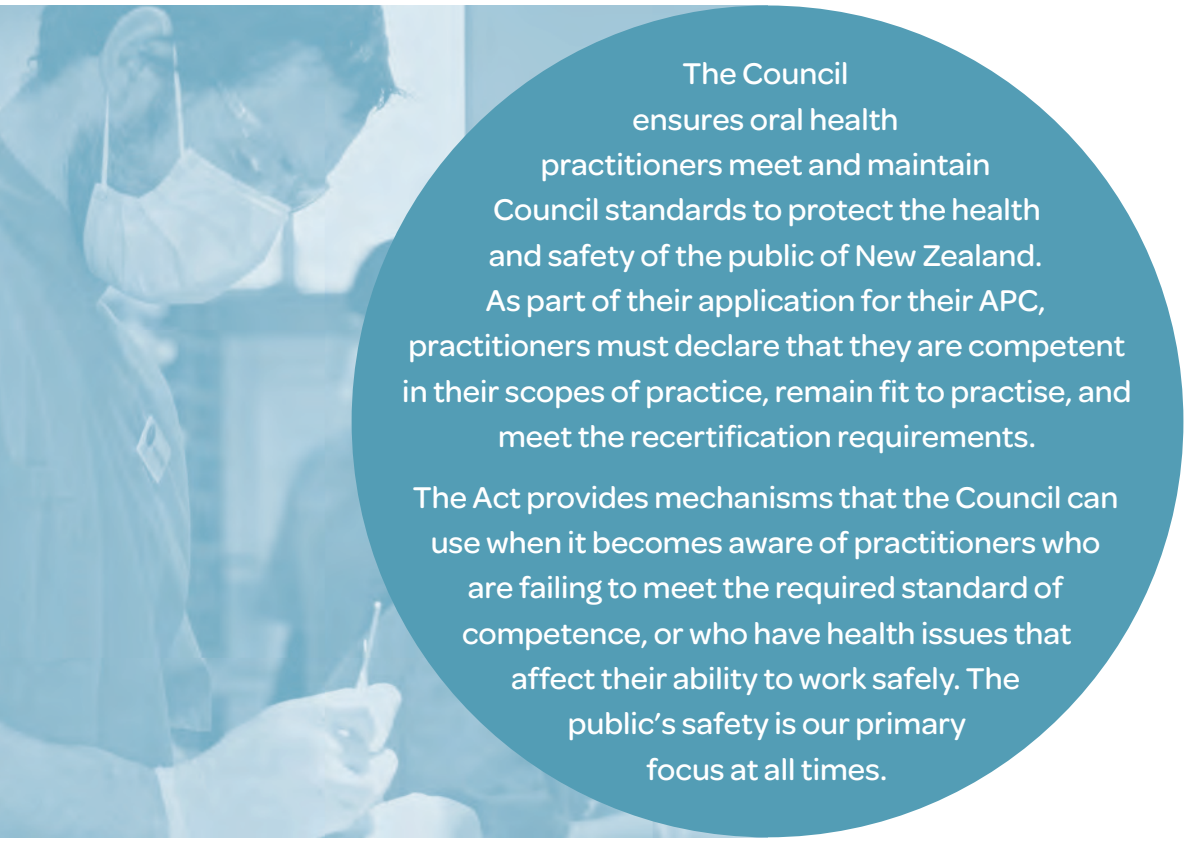
Removals from the register

During 2015/16, 198 practitioners were removed from the register. Of these, 102 were voluntarily removed under sections 142 or 144(3) of the Act, six were removed on notification of death, and the remaining 90 (45.5 percent) had their registration cancelled under section 144(5) because the Council was unable to make contact with them.

Removals from the register



Competence, fitness to practise and recertification



The Council ensures oral health practitioners meet and maintain Council standards to protect the health and safety of the public of New Zealand. As part of their application for their APC, practitioners must declare that they are competent in their scopes of practice, remain fit to practise, and meet the recertification requirements.

The Act provides mechanisms that the Council can use when it becomes aware of practitioners who are failing to meet the required standard of competence, or who have health issues that affect their ability to work safely. The public's safety is our primary focus at all times.

Competence

Under the Act, oral health practitioners may have their competence reviewed at any time or in response to concerns about their practice.

Unlike other jurisdictions, a concern about a practitioner's competence is not dealt with as a disciplinary matter in New Zealand. The Council does not bring charges against a practitioner in relation to competence, nor does the Council seek to establish guilt or fault. The Council aims, wherever possible, to review, remediate and educate.

Competence notifications

A concern or complaint about a practitioner's competence can be raised by:

- a patient
- a colleague
- an employer
- the Ministry of Health
- the Accident Compensation Corporation
- the Health and Disability Commissioner.

Competence notifications by source

Source	Health Practitioners Competence Assurance Act 2003 – section	2015/16	2014/15
Oral health practitioner	34(1)	2	13
Health and Disability Commissioner	34(2)	8	7
Employer	34(3)	3	3
Other		5	7
Total		18	30

The Council received 40 percent fewer competence notifications during 2015/16, compared with the previous year.

Outcomes of competence notifications

When the Council receives a notification or expression of concern about a practitioner's competence, it makes initial inquiries, usually through its professional advisors. Once we have a better understanding of the situation, the Council may decide to:

- take no further action
- put in place an individual recertification programme
- order a competence review.

If the Council orders a competence review and has grounds to believe the practitioner may pose a risk of serious harm to the public, an interim order can be made to suspend the practitioner or restrict their scope of practice. This is done to ensure the safety of the public.

Consequently, a single notification could result in multiple outcomes that could span an extended period.

Outcomes of competence notifications

Outcomes	Health Practitioners Competence Assurance Act 2003 – section	2015/16				2014/15			
		Existing	New	Closed	Still active	Existing	New	Closed	Still active
Initial inquiries	36	–	15	15	–	3	20	23	–
Initial inquiries pending	36	4	1	4	1	–	4	–	4
Preliminary assessments		–	2	2	–	–	6	6	–
Total inquiries/preliminary assessments		**4**	**18**	**21**	**1**	**3**	**30**	**29**	**4**
No further action		–	7	7	–	–	5	5	–
Notification of risk of harm to public	35	6	3	2	7	6	2	2	6
Orders concerning competence	38	21	5	3	23	22	2	3	21
Interim suspension/conditions	39	5	4	3	6	2	4	1	5
Competence programme	40	10	2	2	10	11	1	2	10
Individual recertification programme	41	8	2	5	5	5	5	2	8
Unsatisfactory results of competence or recertification programme	43	–	–	–	–	–	–	–	–
Competence review		5	4	5	4	3	7	5	5
Other action		–	9	9	–	–	11	11	–
Voluntarily removed from register		–	–	–	–	–	2	2	–
Outcome of inquiry pending		1	1	1	1	7	1	7	1

Competence reviews

The Council will order a competence review if it believes a practitioner may be operating below the required standards.

The objective is to assess a practitioner's competence and, if a deficiency is found, to put in place the appropriate training, education and safeguards to help the practitioner meet the standards while ensuring they are safe to practise. It is a supportive and educative process.

A competence review committee (CRC), comprising a layperson and at least two professional peers of the practitioner, undertakes the competence review.

The practitioner's competence is measured against the Council's threshold and the CRC provides a formal report to the Council.

This year, the Council ordered four new competence reviews, compared with seven new reviews undertaken last year, five of which were ongoing at the end of last year. This resulted in nine competence reviews being managed during 2015/16.

Competence reviews

	2015/16	2014/15	2013/14	2012/13	2011/12
New competence reviews	4	7	2	8	2
Existing practitioners in competence review	5	3	5	2	2
Total cases managed	**9**	**10**	**7**	**10**	**4**
Practitioners leaving competence review	5	5	4	5	2
Practitioners left in competence review	4	5	3	5	2

Competence reviews managed, by profession

	2015/16	2014/15	2013/14	2012/13	2011/12
Dentists	7	9	6	8	4
Dental hygienists	–	–	–	–	–
Dental therapists	1	–	–	2	–
Dental hygienist and Dental therapist	1	–	–	–	–
Dental technicians	–	1	1	–	–
Total	**9**	**10**	**7**	**10**	**4**

Competence programmes

If, following a competence review, the Council believes the practitioner fails to meet the required standard of competence, it can order the practitioner to undertake a competence programme.

The objective of a competence programme, and any other orders that may be made, is to produce the best possible outcome for the practitioner, while keeping the public safe.

A competence programme is an educational programme designed to address the practitioner's specific competence issues. It may include requirements to pass exams or assessments; to complete a period of practical training or experience; to have their clinical records examined by another practitioner; or to undertake a period of supervised practice.

In 2015/16, the Council ordered three practitioners to undertake competence programmes. This resulted in 13 competence programmes being managed during the year.

Many were followed by an assessment and frequently in conjunction with an order that the practitioner practise under supervision. Two practitioners have successfully completed their competence programmes, while one has elected not to undertake the programme.

Competence programmes

	2015/16	2014/15	2013/14	2012/13	2011/12
New competence programmes	3	1	3	5*	3
Existing practitioners in competence programmes	10*	11*	11*	7	6
Total cases managed	**13**	**12**	**14**	**12**	**9**
Practitioners leaving competence programmes	3	2	3	1	2
Practitioners left in competence programmes	10*	10*	11*	11*	7

*One dentist was ordered to complete two competence programmes.

Competence programmes managed, by profession

	2015/16	2014/15	2013/14	2012/13	2011/12
Dentists	11*	11*	13*	11*	9
Dental hygienists	–	–	–	–	–
Dental therapists	2	1	1	1	–
Dental technicians	–	–	–	–	–
Total	**13**	**12**	**14**	**12**	**9**

*One dentist was ordered to complete two competence programmes.

Individual recertification programmes

Individual recertification programmes (IRPs) are designed to ensure practitioners are competent to practise within their scope of practice. Similar in nature to competence programmes, they have a narrower focus on training and instruction, and are typically employed where a practitioner has a specific identified competence issue to be addressed.

During the reporting period, the Council ordered two new IRPs, while 10 programmes were managed. Five practitioners successfully completed their programmes.

Individual recertification programmes

	2015/16	2014/15	2013/14	2012/13	2011/12
New individual programmes	2	5	3	6	1
Existing programmes	8	5	6	5	6
Total managed	**10**	**10**	**9**	**11**	**7**
Practitioners leaving programme	5	2	4	5	2
Practitioners in programme	5	8	5	6	5

Individual recertification programmes managed, by profession

	2015/16	2014/15	2013/14	2012/13	2011/12
Dentists	9	9	8	10	6
Dental hygienists	–	–	–	–	–
Dental therapists	1	1	1	1	1
Dental technicians	–	–	–	–	–
Total	**10**	**10**	**9**	**11**	**7**

Fitness to practise

At the time of registration, an applicant must be able to demonstrate their fitness to practise and satisfy the Council that they meet a number of standards. These standards relate to conduct, the ability to speak and understand English well enough to protect the health and safety of the public, and mental or physical conditions that prevent the applicant from performing the functions of their profession.

Once registered, practitioners are required to annually recertify that they have retained their fitness to practise. This means that they have declared any convictions and disciplinary proceedings, both in New Zealand and internationally, and declared any physical and mental conditions that may render them unable to practise safely.

Health

Oral health practitioners, like anyone else, get ill and suffer injury. If a practitioner develops a physical or mental health problem, it may affect their ability to practise safely, endangering patients and the public. Such health conditions could include alcohol or drug dependence, psychiatric disorders, a temporary stress condition, an infection with a transmissible disease, physical disabilities or certain illnesses or injuries.

Practitioners, employers, or people in charge of an organisation that provides health services, are legally obliged to notify the Council if there is any reason that an oral health practitioner in their service is unable to perform the functions required for the practice of their profession.

To protect the health and safety of the public, the Act sets out a regime for the notification and management of practitioner health issues. This is a formal regime that permits us to require a practitioner to undergo medical assessments and, where appropriate, to suspend a practitioner's registration or to place conditions on their scope of practice. The Council uses this regime in more severe cases where less formal measures are not appropriate or where the practitioner is not prepared to enter into a voluntary undertaking.

Where the health and safety of the public is not otherwise compromised, and where the practitioner is prepared to cooperate, the Council uses more informal voluntary undertakings.

In all cases, the Council consults with relevant medical practitioners, who act in an independent advisory capacity. Cases are handled in a compassionate and non-judgemental way, with the emphasis being on a swift return to safe practice.

A rehabilitation programme for an impaired practitioner may include limiting the practitioner's practice to certain procedures, requiring the practitioner to work under supervision, carrying out laboratory tests and/or medical reports, participating in support groups or working with a mentor.

Source and number of notifications of inability to perform required functions due to mental or physical (health) condition

Source	Health Practitioners Competence Assurance Act 2003 – section	2015/16				2014/15*			
		Existing	New	Closed	Still active	Existing	New	Closed	Still active
Health service	45(1)(a)	–	–	–	–	1	–	1	–
Health practitioner	45(1)(b)	–	2	2	–	2	–	2	–
Employer	45(1)(c)	–	2	2	–	2	–	2	–
Medical Officer of Health	45(1)(d)	–	–	–	–	1	–	1	–
Any person	45(3)	–	2	1	1	–	–	–	–
Person involved with education	45(5)	–	–	–	–	–	–	–	–
Self-notification		–	14	13	1	8	2	10	–
Other regulatory authority		–	–	–	–	1	–	1	–
Professional conduct committee	80(2)(b)	–	1	1	–	1	–	1	–
Total		**–**	**21**	**19**	**2**	**16**	**2**	**18**	**–**

*Amendments to previous year have been made.

Outcomes of new health notifications*

Outcomes	Health Practitioners Competence Assurance Act 2003 – section	2015/16	2014/15
No further action		3	–
Order medical examination	49	5	–
Interim suspension	48	1	–
Conditions	48	2	1
Restrictions imposed	50	–	–
Voluntary undertaking		10	2
Still under review		2	–
Alteration of scope	21	–	–
Other action		4	–
Total		**27**	**3**

*Multiple outcomes per notification can apply.

Health programmes

	2015/16	2014/15	2013/14	2012/13	2011/12
New health programmes	12	2	11	6	5
Existing practitioners in health programmes	12	16	12	10	8
Total managed	**24**	**18**	**23**	**16**	**13**
Practitioners leaving health programmes	8	6	7	4	3
Practitioners in health programmes	16	12	16	12	10

During 2015/16, 12 new health programmes were established by the Council. This resulted in 24 health programmes being managed during the reporting period. Eight practitioners had left the health portfolio at the end of the period. Four practitioners were subject to orders of health-related supervision.

Competence-related supervision and oversight

Supervision and oversight are statutory tools provided to help us ensure that practitioners are fit and competent to practise and do not pose a risk of harm to the public.

The Council may make an order of supervision in a variety of situations, including:

- where a practitioner is returning to practice after more than three years out of practice
- where a practitioner is suffering from a health condition
- as an interim measure while a competence review is being conducted
- following a failure to satisfy the requirements of a competence programme.

The Council made two orders involving supervision relating to competence during the reporting period. The practitioners subject to these orders joined 10 already practising under supervision who had been the subject of orders last year. The nature of the supervision varies according to the needs of the practitioner, but is focused at all times on maintaining public safety.

Four practitioners were released from supervision programmes, based on the fulfilment of their supervision period and/or confirmation from their supervisor that they were safe and competent to practise.

Supervision orders relating to competence

	2015/16	2014/15	2013/14	2012/13
New supervision cases	2	2	5	7
Existing supervision	10	11	11	5
Total managed	**12**	**13**	**16**	**12**
Practitioners leaving supervision	4	3	5	1
Practitioners in supervision	8	10	11	11

Supervision orders relating to competence, by profession

	2015/16	2014/15	2013/14	2012/13
Dentists	10	12	15	11
Dental hygienists	–	–	–	–
Dental therapists	2	1	1	1
Dental technicians	–	–	–	–
TOTAL	12	13	16	12

Oversight is defined by the Act to mean "...professional support and assistance provided to a practitioner by a professional peer for the purposes of professional development".

The nature of oversight varies according to the needs of the individual practitioner but is focused at all times on maintaining public safety and is provided by a mentor.

One new oversight was ordered during 2015/16, while three practitioners were subject to oversight orders from the previous year. Three practitioners were released from oversight in 2015/16.

Oversight

	2015/16	2014/15	2013/14	2012/13
New oversight cases	1	3	–	–
Existing oversight cases	3	–	1	4
Total managed	**4**	**3**	**1**	**4**
Practitioners leaving oversight	3	–	1	3
Practitioners in oversight	1	3	–	1

Oversight by profession

	2015/16	2014/15	2013/14	2012/13
Dentists	3	3	1	4
Dental hygienists	–	–	–	–
Dental therapists	1	–	–	–
Dental technicians	–	–	–	–
TOTAL	4	3	1	4

Recertification

Ensuring practitioners remain competent and fit to practise throughout their careers is fundamental to what the Council does. The recertification process is an important tool for ensuring lifelong practitioner competence.

To continue to practise in New Zealand, practitioners must renew their APCs each year. As part of this renewal process, they declare their compliance with standards set by the Council, their competence to practise, and any health conditions or other issues that may affect their fitness to practise.

The Council declines applications for an APC renewal if it is not satisfied that the practitioner is fit to practise.

Practice standards compliance audit process

Following the APC renewal cycles, 10 percent of each practitioner group is randomly selected to complete a questionnaire on compliance with our practice standards. From this group, we randomly select a number of practitioners for visits to confirm compliance. We refer to these visits as practice audits. We follow up on any issues arising from the questionnaire.

Continuing professional development

Practitioners must meet the requirements of the recertification programme set for their profession under section 41 of the Act. This requires practitioners to complete the specified number of hours of continuing professional development and peer contact activities specified for their profession over a four-year cycle.

Practitioners who do not satisfactorily complete the programme may have their scope of practice altered by changing the health services they are permitted to perform, have conditions imposed on their scope of practice or their registration suspended.

At the end of each four-year cycle, 10 percent of each practitioner group is randomly selected for an audit of their continuing professional development activities.

Complaints and discipline

We work in conjunction with the HDC to ensure the public and oral health practitioners have access to a fair and responsive complaints and discipline system.

The Code of Health and Disability Services Consumers' Rights establishes the rights of health consumers and the duties of the providers of those services.

Oral health practitioners must respect patient rights and follow the principles of ethical conduct set out by the Council in its standards framework. Failing to provide good care or behaving in a way that shows a lack of professional integrity are matters of conduct.

Complaints

The Council's primary responsibility when receiving a complaint is the protection of the health and safety of the public. We receive complaints from many different sources—the actions we take depend on the nature of the complaint and who has made it.

All patients have the right to complain about an oral health practitioner. A patient may make a complaint to:

- the oral health practitioner or practitioners who provided the services complained of
- any person authorised to receive complaints about the oral health practitioner (ie, their employer)
- any other appropriate person, including:
  - an independent advocate provided under the Health and Disability Commissioner Act 1994
  - the HDC.

Complaints fall into two broad categories:

- those that allege the practice or conduct of a practitioner has affected a patient
- those that do not directly involve a patient. These could relate to a practitioner practising outside of their scope of practice, practising without an APC, having committed a disciplinary offence or being convicted by the courts.

Complaints that allege a patient has been affected must be made to the HDC. When the Council receives one of these complaints, we immediately refer it to the HDC. The HDC can refer the complaint back to the Council to establish whether there has been a breach.

Those notifications or complaints received by the Council that do not directly involve a patient are

reviewed on a case-by-case basis. Each notification or complaint is assessed, and we decide whether it should be handled as a competence, conduct or health issue.

The Council received 152 complaints during 2015/16, with most (125) complaints coming from consumers. This number of complaints is fairly similar to last year.

The Council does not deal directly with complaints from the public. We will either refer these complaints on to the HDC or provide information to the consumer on the different avenues available to them. It is then up to the consumer to take action and make their complaint to one of the individuals or agencies listed above.

Complaints from various sources and outcomes

Source	Complaints 2015/16	Outcomes 2015/16					Complaints 2014/15
		Not yet assessed	No further action	Other action	Referred to professional conduct committee	Referred to the Health and Disability Commissioner	
Consumer	125	–	113	1	–	11	109
Health and Disability Commissioner	8*	1	1	6	1	–	11
Oral health practitioner	6*	1	4	2	–	–	13
Other health practitioner	–	–	–	–	–	–	–
Courts notice of conviction	–	–	–	–	–	–	1
Employer	4	–	1	3	–	–	3
Self-notifications	4	–	–	–	4	–	1
Other	5	–	1	2	2	–	8
TOTAL	152	2	120	14	7	11	146

* Two notifications had two outcomes.

Discipline

Referrals to a professional conduct committee

A professional conduct committee (PCC) is a statutory committee appointed to investigate when issues of practitioner conduct arise. It is completely independent of the Council.

The Council will refer a case to a PCC in two situations. The first is when we are notified that a practitioner has been convicted of an offence in court. Certain offences automatically trigger a PCC investigation, as do convictions that are punishable by imprisonment for three months or longer.

The second situation is where the Council considers that information it holds raises questions about a practitioner's conduct or the safety of the practitioner's practice. The Council may refer these questions to a PCC in response to a complaint referred to the Council by the HDC, or the Council may do so on its own initiative.

A PCC comprises two professional peers of the practitioner and a layperson. A PCC may make recommendations to the Council or lay charges against the practitioner before the Health Practitioners Disciplinary Tribunal (HPDT).

In 2015/16, the Council referred seven practitioners to PCCs, while one outcome was pending from 2014/15. The PCC recommended one have their fitness to practise reviewed, two were counselled by the Council, one charged before the HPDT, and no further action was taken in one case. The outcomes of three cases are still pending.

Professional conduct committee cases

Nature of issue	Source	2015/16	Outcome(s)
Concerns about standards of practice	–	–	–
Notification of conviction			
– Drink driving offence	3 Self-notification	3	1 No further action 1 Counselled 1 Review fitness to practice
– Assault	–	–	–
– Fraud	–	–	–
– Theft	–	–	–
– Other conviction	1 Self-notification	1	1 Counselled
Conduct	2 HDC 1 Practitioner	3*	2 Outcome pending 1 HPDT
Practising outside scope	–	–	–
Practising without annual practising certificate	–	–	–
Practising while suspended	1 ACC	1	1 Outcome pending
Other	–	–	–
Total cases		8	

* One PCC was an existing case with the outcome pending from 2014/15, finalised this year.

Note: ACC = Accident Compensation Corporation; HDC = Health and Disability Commissioner; HPDT = Health Practitioners Disciplinary Tribunal.

Professional conduct committees

	2015/16	2014/15	2013/14	2012/13
New PCC cases	7	4	4	23
Existing PCC cases	1	_	6	4
Total managed	**8**	**4**	**10**	**27**
PCC finalised	5	3	10	21
Practitioners remaining	3	1	–	6

Note: PCC = professional conduct committee.

Professional conduct committees, managed by profession

	2015/16	2014/15	2013/14	2012/13
Dentists	5	2	6	13
Dental hygienists	1	–	–	1
Dental therapists	–	2	–	1
Dental technicians	1	_	3	11
Dental hygienist and dental therapist	1	_	1	1
TOTAL	8	4	10	27

Health Practitioners Disciplinary Tribunal

The HPDT hears and decides disciplinary charges brought against registered health practitioners. Charges may be brought by a PCC or the Director of Proceedings of the HDC office.

The tribunal operates independently of the Council.

For each disciplinary proceeding, the HPDT comprises a chair and deputy chair (barristers or solicitors) and four members from the panel maintained by the Ministry of Health. Three of those members must be from the same profession as the practitioner under investigation and one must be a layperson.

During 2015/16, PCCs appointed by the Council laid charges against one practitioner before the HPDT. For the one case finalised, the practitioner was censured, fined and required to pay costs.

Tribunal cases

	2015/16	2014/15	2013/14	2012/13
New HPDT cases	1	1	4	10
Existing HPDT cases	1	3	8	1
Total managed	**2**	**4**	**12**	**11**
HPDT finalised	1	3	9	3
Practitioners remaining	1	1	3	8

Note: HPDT = Health Practitioners Disciplinary Tribunal.

Appeals and judicial reviews

Decisions of the Council may be appealed to the District Court. No decisions were appealed during the reporting period.

Practitioners may also seek to judicially review decisions of the Council in the High Court. Essentially this involves the Court assessing whether, in making a decision, the Council has followed its own policies and processes; and that these are reasonable.

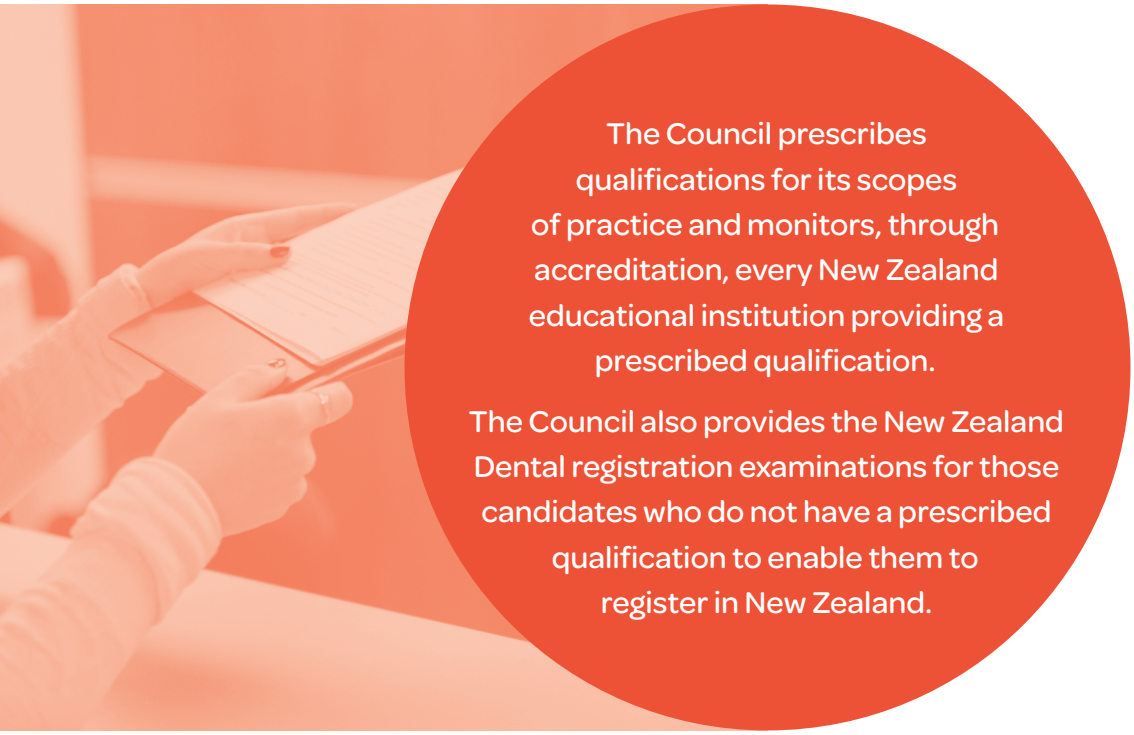
Two judicial reviews were brought against the Council in 2015/16.

A practitioner brought judicial review proceedings alleging that the Council's decision to suspend their practising certificate until a competence programme was successfully completed was unreasonable, as was the competence programme that the Council required them to undertake. The hearing was pending at the end of the reporting period.

A second judicial review was sought by a practitioner alleging that determinations of the Council had prevented them from practising for a protracted period, together with a claim for unquantified damages as compensation. The action was struck out as being without merit, and costs were awarded to the Council.

Practitioners who have appeared before the HPDT have the right to appeal the HPDT's decision in whole or in part to the High Court. During the prior year, a practitioner had appealed a determination of the HPDT not to grant permanent name suppression following a finding of professional misconduct. In May 2015, the High Court declined the practitioner's appeal.

Examinations and accreditation



The Council prescribes qualifications for its scopes of practice and monitors, through accreditation, every New Zealand educational institution providing a prescribed qualification.

The Council also provides the New Zealand Dental registration examinations for those candidates who do not have a prescribed qualification to enable them to register in New Zealand.

Examinations

In 2015/16, 45.7 percent of the dentists and dental specialists, 13.5 percent of the dental hygienists, 5.4 percent of the dental therapists and 2.8 percent of dental technicians registered in New Zealand gained their primary qualifications in countries other than New Zealand. A significant proportion of them did not hold a prescribed qualification.

The New Zealand oral health workforce relies on practitioners who gained their primary training in other jurisdictions. The Council has a responsibility to protect public safety by ensuring that all registered practitioners are competent and safe to practise regardless of where they were educated.

The Council offers eligible candidates a registration examination to fully assess their skills and competence and to ensure they meet the standards required of New Zealand-qualified practitioners. A pass in one of the registration examinations is a prescribed qualification for registration within New Zealand.

Registration examinations are available for dentistry, dental specialties, dental hygiene, dental therapy and dental technology.

As reported in the 2014/15 annual report, the National Dental Examining Board of Canada (NDEB) has been appointed as provider of the New Zealand Dentist Registration Examination (NZDREX). The first assessment of fundamental knowledge was offered to New Zealand candidates in August 2015. Consequently, in 2015/16, no written component of the joint Dental Council (NZ) and Australian Dental Council NZDREX was held during the transition phase to the new NDEB examination.

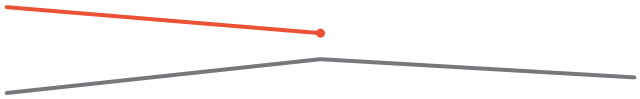
The clinical examinations offered by the University of Otago were being phased out for all eligible candidates during 2015/16, with the last clinical examination to be hosted in June 2016.

All new NZDREX candidates enrol directly into the NDEB equivalency process.

The dental therapy and dental hygiene examinations were held at the Auckland University of Technology. Registration examinations for dental specialists and dental technology were not held, because no applications were received.

Dentist registration examination

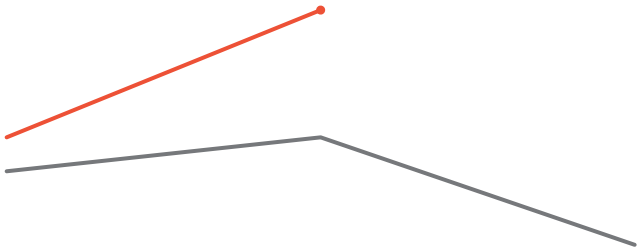
NZDREX candidates sitting the examination



	2013/14	2014/15	2015/16
Written	46	43	0
Clinical	36	40	38

During 2015/16, 38 NZDREX candidates sat the "Otago" clinical examination, a 5 percent decrease on last year. As reported above, no written examination was hosted.

NZDREX pass rates



	2013/14	2014/15	2015/16
Written	34.8%	51.2%	0.0%
Clinical	30.6%	35.0%	21.1%

In 2015/16, the pass rate for the clinical component decreased 13.9 percent to 21.1 percent.

Dental therapy registration examinations

In 2014/15, two candidates sat the written component, one did not pass. The other candidate proceeded to the clinical component, but did not pass.

Dental hygiene registration examination

In 2015/16, one candidate sat and passed both the written and clinical components of the dental hygiene examination.

Accreditation

The purpose of accreditation is to assure the quality of education and training and to promote continuous programme improvements. All New Zealand-prescribed qualifications must be accredited and monitored by the Council.

The Dental Council (NZ) and the Australian Dental Council have established a joint accreditation committee for the purpose of accrediting and monitoring New Zealand and Australian educational programmes to ensure common standards across both countries.[2]

The accreditation standards specify the criteria against which education and training programmes are assessed for accreditation. They support the defined knowledge, competencies and professional attributes required of graduates to register as oral health practitioners.

The accreditation of dental technology and orthodontic auxiliary programmes falls outside the ambit of the joint accreditation committee. The Council is responsible for the accreditation of these programmes.

The Council monitors 22 New Zealand-accredited programmes across the oral health professions.

During the 2015/16 period, the University of Otago dental technology programmes (undergraduate and postgraduate) were accredited, and the review resulted in accreditation being granted until December 2020. The University of Otago also submitted its Doctor of Clinical Dentistry (oral surgery) programme for accreditation for the first time. The programme was granted accreditation until December 2020.

The Royal College of Pathologists of Australasia has been granted accreditation for its fellowship in oral and maxillofacial pathology until 31 December 2018. The shorter accreditation period granted was to align with the Australian accreditation period to enable joint accreditation reviews where possible.

[2] The Australian Dental Council has been appointed by the Dental Board of Australia, under the Health Practitioner Regulation National Law Act 2009, as the accreditation authority responsible for accrediting Australian education and training programmes. The Dental Board of Australia is responsible for approving programmes accredited by the Australian Dental Council as providing a qualification for the purpose of registration.

General Dental Council (GDC) validation of prescribed qualifications

Validation is the process where the Council assures itself that international jurisdictions previously recognised as equivalent to New Zealand are still comparable to the entry-level standards for registration in New Zealand. These jurisdictions are recognised as equivalent through the gazetting of its accredited programmes as prescribed qualifications for registration in specific scopes of practice in New Zealand.

The Council started the GDC validation process at the end of 2014, and continued the process during this year.

It included comparisons of the entry-level standards, through the mapping of the accreditation standards, scopes of practice and profession specific competencies. This was followed by an observation of the GDC's quality assurance process of one of its accredited programmes, to observe the application of the GDC standards, processes and decision making process.

The Council's decision on the ongoing validation is expected to be completed in 2016.

Accreditation Standards

The Council and the Australian Dental Council embarked on a review of the accreditation standards during 2014. The purpose of the review was to ensure that the standards were fit for purpose, to develop a single set of standards for all oral health programmes, and for the standards to be outcomes-focussed.

Following wide engagement with educational providers, practitioners and other stakeholders, the new accreditation standards were adopted in 2015, and came into operation on 1 January 2016.

Accreditation status of New Zealand accredited oral health programmes as at 31 March 2016

Title	Provider	Status	Expiry date
Bachelor of Dental Surgery (BDS)	University of Otago	Full accreditation for seven years	31/12/2017
Bachelor of Dental Surgery (Honours)	University of Otago	Full accreditation for seven years	31/12/2017
Master of Community Dentistry (MComDent)	University of Otago	Full accreditation for five years	31/12/2016
Doctor of Clinical Dentistry (DClinDent) • Endodontics • Oral and maxillofacial surgery • Oral pathology • Oral medicine • Orthodontics • Paediatric dentistry • Periodontology • Prosthodontics • Special needs dentistry • Oral Surgery	University of Otago	Full accreditation for five years	31/12/2016 31/12/2020 (oral surgery only)
Master of Dental Surgery(MDS)/Bachelor of Medicine and Bachelor of Surgery (MBChB) in Oral Medicine	University of Otago	Full accreditation for five years	31/12/2016[3]
Master of Dental Surgery(MDS)/Bachelor of Medicine and Bachelor of Surgery (MBChB) in Oral and Maxillofacial Surgery	University of Otago	Full accreditation for five years	31/12/2016[4]
Fellowship of the Royal Australasian College of Dental Surgeons Oral and Maxillofacial Surgery	Royal Australasian College of Dental Surgeons	Full accreditation for five years	31/12/2018
Fellowship in Oral and Maxillofacial Pathology	Royal College of Pathologists of Australasia	Full accreditation for three years	31/12/2018
Bachelor of Oral Health (BOH)	University of Otago	Full accreditation for five years	31/12/2019
Bachelor of Health Science in Oral Health BHSc (Oral Health)	Auckland University of Technology	Full accreditation for five years	31/12/2018
Bachelor of Dental Technology (BDentTech)	University of Otago	Full accreditation for five years	31/12/2020
Bachelor of Dental Technology (Honours) (BDentTech (Hons))	University of Otago	Full accreditation for five years	31/12/2020
Postgraduate Diploma in Clinical Dental Technology (PGDipCDTech)	University of Otago	Full accreditation for five years	31/12/2020
Certificate of Orthodontic Assisting, New Zealand Association of Orthodontists: Orthodontic Auxiliary Training Programme	New Zealand Association of Orthodontists	Accreditation for five years	31/12/2018

[3] The MDS/MBChB (oral medicine) programme was replaced by the DClinDent (oral medicine) programme in 2013. The consultation process is still in process on the medical component of the prescribed qualification for the oral medicine scope of practice in New Zealand.

[4] Accreditation to allow current enrolled students in conjoint programmes to complete their programme during the transition phase to the DClinDent (oral and maxillofacial surgery) programme.

Our Financials

Staples Rodway Wellington
Level 6, 95 Customhouse Quay
Wellington 6011
New Zealand

PO Box 1208
Wellington
6140
New Zealand

Telephone 64 4 472 7919
Facsimile 64 4 473 4720
info@staplesrodway.com
www.staplessrodway.com

staplesrodway
CHARTERED ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT TO THE READERS OF DENTAL COUNCIL'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2016

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

We have audited the financial statements of the Council on pages 1 to 23, that comprise the statement of financial position as at 31 March 2016, the statement of comprehensive revenue and expenses, the statement of changes in net assets and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information.

Opinion

In our opinion the financial statements of the Council on pages 1 to 23:

- fairly reflect the Council's:
  - financial position as at 31 March 2016; and
  - financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards Reduced Disclosure Regime

Our audit was completed on 7 June 2016. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

staplesrodway
CHARTERED ACCOUNTANTS

An audit also involves evaluating:

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

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

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

Responsibilities of the Council

The Council is responsible for preparing financial statements that:

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

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

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

Responsibilities of the Auditor

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

Independence

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

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

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

Statement of Financial Position

AS AT 31 MARCH 2016

	Note	2016 $	2015 Restated* $
Current assets			
Cash and cash equivalents	9	1,832,921	2,500,829
Investments	10	2,063,748	1,260,000
Receivables from exchange transactions		112,756	92,384
Receivables from non-exchange transactions		46,928	7,376
Prepayments		33,889	14,332
		4,090,242	**3,874,921**
Non-current assets			
Intangible assets	11	65,194	104,145
Property, plant and equipment	12	234,771	86,448
		299,965	**190,593**
Total assets		**4,390,207**	**4,065,514**
Current liabilities			
Accounts payable		527,854	318,930
Other liabilities		22,930	-
Revenue in advance		922,500	978,953
Employee entitlements		216,893	168,087
GST payable		98,213	102,852
Total liabilities		**1,788,390**	**1,568,822**
Net assets		**2,601,817**	**2,496,692**
Equity			
Operational reserves - profession	13	1,452,286	1,813,724
Disciplinary reserves - profession	13	601,295	260,145
Capital asset reserve - Council	13	548,236	422,823
Total net assets attributable to the owners of the controlling entity		**2,601,817**	**2,496,692**

Signed for and on behalf of Council members who authorised these financial statements for issue on 7 June 2016

Chair of Council

Deputy Chair

*Certain amounts shown here do not correspond to the 2015 financial statements and reflect adjustments made due to first time adoption of Public Benefit Entity International Public Sector Accounting Standards (PBE-IPSAS). Refer to Note 3.

These financial statements should be read in conjunction with the notes to the financial statements.

Statement of Changes in Net Assets

FOR THE YEAR ENDED 31 MARCH 2016

	Note	Disciplinary reserve $	Operational reserve $	Capital asset reserve $	Total equity $
Opening balance 1 April 2015		260,145	1,813,724	422,823	2,496,692
Total surplus/ (deficit) for the year		341,150	(361,438)	125,413	105,125
Other comprehensive revenue		-	-	-	-
Closing equity 31 March 2016		**601,295**	**1,452,286**	**548,236**	**2,601,817**
Opening balance 1 April 2014 - (Restated*)	3	68,151	1,732,199	487,584	2,287,934
Total surplus/ (deficit) for the year		191,994	81,525	(64,761)	208,758
Other comprehensive revenue		-	-	-	-
Closing equity 31 March 2015		**260,145**	**1,813,724**	**422,823**	**2,496,692**

*Certain amounts shown here do not correspond to the 2015 financial statements and reflect adjustments made due to first time adoption of Public Benefit Entity International Public Sector Accounting Standards (PBE-IPSAS). Refer to Note 3.

These financial statements should be read in conjunction with the notes to the financial statements.

Statement of Comprehensive Revenue and Expenses

FOR THE YEAR ENDED 31 MARCH 2016

	Note	2016 $	2015 Restated* $
Revenue from non-exchange transactions			
Annual practising certificate (APC) fees	6	2,561,164	2,437,856
Disciplinary levies	6	419,891	347,773
Discipline fines/costs recovered		67,959	32,458
Total revenue from non-exchange transactions		**3,049,014**	**2,818,087**
Revenue from exchange transactions			
Interest on investments		116,383	128,756
Sale of Dental Register extracts		2,000	1,400
Certificate of good standing fees		6,436	10,681
Registration fees		235,982	246,458
Retention on Dental Register (non-practising) fees		63,901	65,597
Restoration to Dental Register fees		2,739	2,739
New Zealand dental registration examination fees		265,857	309,142
Competence programme contributions		21,698	13,548
Fitness to practise contributions		1,905	4,380
Recertification programme contributions		13,848	540
Accreditation contributions		44,532	22,192
Workforce survey contribution		-	10,137
Sundry income		418	-
Total revenue from exchange transactions		**775,699**	**815,570**
Total revenue		**3,824,713**	**3,633,657**
Expenses as per schedules	7		
Administration expenses		1,851,715	1,678,984
Council project and profession expenses		1,867,873	1,745,915
Total expenditure		**3,719,588**	**3,424,899**
Total surplus for the year		**105,125**	**208,758**
Other comprehensive revenue and expenses		-	-
Total comprehensive revenue and expenses for the year		**105,125**	**208,758**

*Certain amounts shown here do not correspond to the 2015 financial statements and reflect adjustments made due to first time adoption of Public Benefit Entity International Public Sector Accounting Standards (PBE-IPSAS). Refer to Note 3.

These financial statements should be read in conjunction with the notes to the financial statements.

Statement of Cash Flows

FOR THE YEAR ENDED 31 MARCH 2016

	Note	2016 $	2015 Restated* $
Cash flows from operating activities			
Receipts			
Receipts from APC fees and disciplinary levies (non-exchange)		2,977,121	2,772,787
Receipts from other non-exchange transactions		26,989	56,721
Receipts from exchange transactions		595,713	746,945
Interest received		112,834	126,350
		3,712,657	3,702,803
Payments			
Payments to suppliers and employees		3,366,729	3,316,427
		3,366,729	3,316,427
Net cash flows from operating activities		345,928	386,376
Cash flows from investing activities			
Receipts			
Sale of property plant and equipment		-	-
Net withdrawal of short term investments		-	755,405
		-	755,405
Payments			
Purchase of property, plant and equipment and intangibles		210,088	109,090
Net investments in short term investments		803,748	-
		1,013,836	109,090
Net cash flows from investing activities		(1,013,836)	646,315
Net cash flows from financing activities		-	-
Net increase/ (decrease) in cash and cash equivalents		(667,908)	1,032,691
Cash and cash equivalents at 1 April		2,500,829	1,468,138
Cash and cash equivalents at 31 March		1,832,921	2,500,829
This is represented by:			
ANZ Bank Account		1,832,921	2,500,829
		0	0

*Certain amounts shown here do not correspond to the 2015 financial statements and reflect adjustments made due to first time adoption of Public Benefit Entity International Public Sector Financial Statements (PBE-IPSAS) standards. Refer to Note 3.

These financial statements should be read in conjunction with the notes to the financial statements.

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016

1 Reporting entity

The Dental Council (the Council) is a body corporate constituted under the Health Practitioners Competence Assurance Act 2003 (the Act). The Act established the Council with effect from 18 September 2004.

These financial statements and the accompanying notes summarise the financial results of activities carried out by the Council. In order to protect the health and safety of the New Zealand public, the Council provides mechanisms to ensure that oral health practitioners are competent and fit to practise their professions. The Council is a charitable organisation registered under the Charities Act 2005.

These financial statements have been approved and were authorised for issue by the Council on 7 June 2016.

2 Statement of compliance

The financial statements have been prepared in accordance with generally accepted accounting practice in New Zealand (NZ GAAP). They comply with public benefit entity international public sector accounting standards (PBE IPSAS) and other applicable financial reporting standards as appropriate that have been authorised for use by the External Reporting Board for public sector entities. For the purposes of complying with NZ GAAP, the Council is a public benefit public sector entity and is eligible to apply Tier 2 public sector PBE IPSAS on the basis that it does not have public accountability and is not defined as large.

The Council has elected to report in accordance with Tier 2 public sector PBE accounting standards and, in doing so, has taken advantage of all applicable reduced disclosure regime (RDR) disclosure concessions, except for PBE FRS 47 First-time adoption of PBE standards by entities other than those previously applying NZ IFRS paragraphs RDR27.2 and RDR27.3.

3 Effect of first-time adoption of public benefit entity standards on accounting policies and disclosures

This is the first set of financial statements that is presented in accordance with PBE standards. The Council has previously reported in accordance with New Zealand financial reporting standards (NZ FRS). These have now been restated to public sector PBE IPSAS-RDR. An explanation of how the transition to Tier 2 public sector PBE accounting standards has affected the reporting of the Statement of Financial Position and Statement of Comprehensive Revenue and Expenses is provided below.

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

Reconciliation of net assets/reserves

Reserve		Disciplinary reserve $	Operational reserve $	Capital asset reserve $	Total equity $
Opening balance 1 April 2014 as per the Dental Council's 2014/15 Annual Report – balance under previous NZ FRS		48,882	973,645	457,142	1,479,669
Recognition in 2013/14 of annual practising certificate fees as non-exchange revenue	(a)	–	758,554	30,442	788,996
Recognition in 2013/14 of disciplinary levies as non-exchange revenue	(a)	19,269	–	–	19,269
Net assets/reserves restated under PBE IPSAS (RDR) as at 1 April 2014		**68,151**	**1,732,199**	**487,584**	**2,287,934**
Surplus/(deficit) as per the Dental Council's 2014/15 Annual Report		114,652	54,246	(39,624)	129,274
Recognition in 2014/15 of net annual practising certificate fees as non-exchange revenue	(a)	–	27,279	(25,137)	2,142
Recognition in 2014/15 of disciplinary levies as non-exchange revenue	(a)	77,342	–	–	77,342
Surplus/(deficit) 2014/15 restated under PBE IPSAS (RDR)		**191,994**	**81,525**	**(64,761)**	**208,758**
Net assets/reserves restated under PBE IPSAS (RDR) as at 31 March 2015		**260,145**	**1,813,724**	**422,823**	**2,496,692**

(a) Previously, annual practising certificate (APC) fees and disciplinary levies received were recognised over the 12-month period to which the revenue related. However, PBE IPSAS 23 Revenue from Non-exchange Transactions requires revenue from non-exchange transactions, such as APC fees and disciplinary levies, to be recognised as revenue in full as it is received, unless the income meets the definition of and the recognition criteria for a liability.

A liability exists where revenue is received in advance for a specific purpose and the entity has an explicit return obligation if funds are not applied to that purpose. APC fees and disciplinary levies are recognised in full on the first day of the recertification year to which they relate or immediately on receipt if received within the recertification year to which they relate.

The Council's transition date is 1 April 2014 and it has prepared its opening PBE IPSAS (RDR) Statement of Financial Position as at that date.

4 Summary of accounting policies

The significant accounting policies used in the preparation of these financial statements as set out below have been applied consistently to both years presented in these financial statements.

4.1 Basis of measurement

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

4.2 Functional and presentational currency

The financial statements are presented in New Zealand dollars ($), which is the Council's functional currency. All information presented in New Zealand dollars has been rounded to the nearest dollar.

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

4.3 Revenue

Revenue is recognised to the extent that it is probable that the economic benefit will flow to the Council and revenue can be reliably measured. Revenue is measured at the fair value of the consideration received. The following specific recognition criteria must be met before revenue is recognised.

Revenue from non-exchange transactions

Annual practising certificate fees

The Council's annual practising cycle runs from 1 October to 30 September for dentists and dental specialists, and from 1 April to 31 March for the other dental professions that the Council regulates, that is, dental therapists, dental hygienists, orthodontic auxiliaries, dental technicians and clinical dental technicians. Fees received in advance of the commencement of the annual practising cycle are recognised on the first day of the recertification year, that is, either 1 October or 1 April. Fees received within the recertification year to which they relate are recognised in full on receipt.

Disciplinary levies

Disciplinary levies imposed and collected as part of the annual recertification cycle are recognised in full on the first day of the recertification year, that is, on 1 October for dentists and dental specialists, and 1 April for the other dental professions that the Council regulates. Levies received within the recertification year to which they relate are recognised in full on receipt.

Disciplinary fines and recoveries

Disciplinary fines and costs recovered represent fines and costs awarded against practitioners by the Health Practitioners Disciplinary Tribunal (HPDT). Costs represent recoveries of a portion of the costs of professional conduct committees and the HPDT.

Once awarded by the HPDT, disciplinary recoveries are reflected in the accounts at the time those costs were incurred and at the amount determined by the HPDT.

Revenue from exchange transactions

Professional standards fees recovered

Professional standards fees recovered represent the recovery of costs from individual practitioners undergoing competence, recertification and fitness to practise programmes ordered by the Council. Revenue from these exchange transactions is recognised when earned and is reported in the financial period to which it relates.

Retention on the dental register (non-practising) fees

Only those fees attributable to the current financial period are recognised in the statement of comprehensive revenues and expenses.

Interest income

Interest revenue is recognised as it accrues, using the effective interest method.

All other income

All other revenue from exchange transactions is recognised when earned and is reported in the financial year to which it relates.

4.4 Financial instruments

Financial assets and financial liabilities are recognised when the Council becomes a party to the contractual provisions of the financial instrument.

The Council ceases to recognise a financial asset or, where applicable, a part of a financial asset or part of a group of similar financial assets when the rights to receive cash flows from the asset have expired or are waived, or the Council has transferred its rights to receive cash flows from the asset or has

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

assumed an obligation to pay the received cash flows in full without material delay to a third party; and either:

- The Council has transferred substantially all the risks and rewards of the asset; or
- The Council has neither transferred nor retained substantially all the risks and rewards of the asset but has transferred control of the asset.

Financial assets

Financial assets within the scope of PBE IPSAS 29 Financial Instruments: Recognition and Measurement are classified as financial assets at fair value through surplus or deficit, loans and receivables, held-to-maturity investments or available-for-sale financial assets. The classifications of the financial assets are determined at initial recognition.

The categorisation determines subsequent measurement and whether any resulting revenue and expense is recognised in surplus or deficit or in other comprehensive revenue and expenses. The Council's financial assets are classified as loans and receivables. The Council's financial assets include: cash and cash equivalents, short-term investments, receivables from non-exchange transactions, receivables from exchange transactions and non-equity investments.

All financial assets are subject to review for impairment at least at each reporting date. Financial assets are impaired when there is any objective evidence that a financial asset or group of financial assets is impaired. Different criteria to determine impairment are applied for each category of financial assets, which are described below.

Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. After initial recognition, these are measured at amortised cost using the effective interest method, less any allowance for impairment. The Council's cash and cash equivalents, short-term investments, receivables from non-exchange transactions, receivables from exchange transactions and non-equity investments fall into this category of financial instruments.

Impairment of financial assets

The Council assesses at the end of each reporting date whether there is objective evidence that a financial asset or a group of financial assets is impaired. A financial asset or a group of financial assets is impaired and impairment losses are incurred if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset (a 'loss event') and that loss event has an impact on the estimated future cash flows of the financial asset or the group of financial assets that can be reliably estimated.

For financial assets carried at amortised cost, if there is objective evidence that an impairment loss on loans and receivables carried at amortised cost has been incurred, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. The carrying amount of the asset is reduced through the use of an allowance account. The amount of the loss is recognised in the surplus or deficit for the reporting period.

In determining whether there is any objective evidence of impairment, the Council first assesses whether there is objective evidence of impairment of financial assets that are individually significant, and individually or collectively significant for financial assets that are not individually significant. If the Council determines there is no objective evidence of impairment for an individually assessed financial asset, it includes the asset in a group of financial assets with similar credit risk characteristics and collectively assesses them for impairment.

Assets that are individually assessed for impairment and for which an impairment loss is or continues to be recognised are not included in a collective assessment for impairment.

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed by adjusting the allowance account. If the reversal results in the carrying amount exceeding its amortised cost, the amount of the reversal is recognised in surplus or deficit.

Financial liabilities

The Council's financial liabilities include trade and other creditors (excluding goods and services tax (GST) and pay as you earn (PAYE) tax and employee entitlements.

All financial liabilities are initially recognised at fair value (plus transaction costs for financial liabilities not at fair value through surplus or deficit) and are measured subsequently at amortised cost using the effective interest method except for financial liabilities at fair value through surplus or deficit.

4.5 Cash and cash equivalents

Cash and cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that are subject to an insignificant risk of changes in value.

4.6 Short-term investments

Short-term investments comprise term deposits that have a term of greater than three months and therefore do not fall into the category of cash and cash equivalents.

4.7 Property, plant and equipment

Items of property, plant and equipment are measured at cost less accumulated depreciation and impairment losses. Cost includes expenditure that is directly attributable to the acquisition of the asset. Where an asset is acquired through a non-exchange transaction, its cost is measured at its fair value as at the date of acquisition.

Depreciation is charged on a straight-line basis over the useful life of the asset. Depreciation is charged at rates calculated to allocate the cost or valuation of the asset less any estimated residual value over its remaining useful life:

- office refit 10% per annum
- office furniture 10% per annum
- office equipment 5.5% – 30% per annum
- computer equipment 30% per annum

Depreciation methods, useful lives and residual values are reviewed at each reporting date and are adjusted if there is a change in the expected pattern of consumption of the future economic benefits or service potential embodied in the asset.

4.8 Intangible assets

Intangible assets acquired separately are measured on initial recognition at cost. The cost of intangible assets acquired in a non-exchange transaction is their fair value at the date of the exchange. The cost of intangible assets acquired in a business combination is their fair value at the date of acquisition.

Following initial recognition, intangible assets are carried at cost less any accumulated amortisation and accumulated impairment losses. Internally generated intangibles, excluding capitalised development costs, are not capitalised and the related expenditure is reflected in surplus or deficit in the period in which the expenditure is incurred.

The useful lives of intangible assets are assessed as either finite or indefinite.

Intangible assets with finite lives are amortised over the useful economic life and assessed for impairment whenever there is an indication that the intangible asset may be impaired.

The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each reporting period. Changes in the expected useful life or the expected pattern of consumption of future economic benefits or service potential embodied in the

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

asset are considered to modify the amortisation period or method, as appropriate, and are treated as changes in accounting estimates.

The amortisation expense on intangible assets with finite lives is recognised in surplus or deficit as the expense category that is consistent with the function of the intangible assets.

The Council does not hold any intangible assets that have an indefinite life.

The amortisation rate for the Council's intangible assets is:

- software 30% per annum

4.9 Leases

Payments on operating lease agreements, where the lessor retains substantially the risk and rewards of ownership of an asset, are recognised as an expense on a straight-line basis over the lease term.

4.10 Employee benefits

Wages, salaries and annual leave

Liabilities for wages, salaries and annual leave are recognised in surplus or deficit during the period in which the employee provided the related services. Liabilities for the associated benefits are measured at the amounts expected to be paid when the liabilities are settled.

4.11 Income tax

Due to its charitable status, the Council is exempt from income tax. The Dental Council was registered as a charitable entity under the Charities Act 2005 on 7 April 2008 to maintain its tax exemption status.

4.12 Goods and services tax

Revenues, expenses and assets are recognised net of the amount of GST except for receivables and payables, which are stated with the amount of GST included.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department is included as part of receivables or payables in the statement of financial position.

Cash flows are included in the statement of cash flows on a net basis, and the GST component of cash flows arising from investing and financing activities, which is recoverable from, or payable to, the Inland Revenue Department is classified as part of operating cash flows.

4.13 Equity

Equity is measured as the difference between total assets and total liabilities. Equity is the accumulation of reserves made up of the following components.

Operational reserves

Operational reserves by individual dental profession group are funded from APC fee revenue after each profession's share of Council costs has been provided for. The gazetted practitioner APC fee will vary across dental profession groups, depending on shares of Council costs and activity within a dental profession and direct profession costs.

Disciplinary reserves

Disciplinary reserves are funded from disciplinary levy revenue for each profession group. The gazetted practitioner disciplinary levy will vary across dental profession groups, depending on the number of disciplinary cases projected to be heard by each profession group in any one year.

Capital asset reserve

The capital asset reserve is represented by the net book value of fixed assets already purchased and liquid assets set aside for capital expenditure to meet future capital replacement requirements. Capital replacement reserve funding is provided through the APC fee at a standard rate across all professions. The capital replacement portion of the APC fee is based on planned capital expenditure requirements after taking current capital reserve levels into account.

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

5 Significant accounting judgements, estimates and assumptions

The preparation of the Council's financial statements requires management to make judgements, estimates and assumptions that affect the reported amounts of revenues, expenses, assets and liabilities, and the accompanying disclosures, and the disclosure of contingent liabilities. Uncertainty about these assumptions and estimates could result in outcomes that require a material adjustment to the carrying amount of assets or liabilities affected in future periods.

Judgements

In the process of applying the accounting policies, management has not made any significant judgements that would have a material impact on the financial statements.

Estimates and assumptions

The key assumptions concerning the future and other key sources of estimation uncertainty at the reporting date, which have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year, are described below.

Council based its assumptions and estimates on parameters available when the financial statements were prepared. Existing circumstances and assumptions about future developments, however, may change due to market changes or circumstances arising beyond the control of the Council. Such changes are reflected in the assumptions when they occur.

Useful lives and residual values

The useful lives and residual values of assets are assessed using the following indicators to determine potential future use and value from disposal:

- the condition of the asset
- the nature of the asset, its susceptibility and adaptability to changes in technology and processes
- the nature of the processes in which the asset is deployed
- availability of funding to replace the asset
- changes in the market in relation to the asset.

The estimated useful lives of the asset classes held by the Council are listed in notes 4.7 and 4.8.

6 Annual practising fees and disciplinary levies

The Council is responsible for regulating all the oral health professions specified in the Act. The details of registered oral health practitioners are in the Annual Report under the registration section.

Annual practising fee and disciplinary levy revenue by profession

Profession	2016 $ Annual practising fees	2016 $ Disciplinary levies	2015 $ Annual practising fees	2015 $ Disciplinary levies
Dentists and dental specialists	1,655,574	328,107	1,596,579	193,598
Dental therapists	376,840	16,627	378,741	63,123
Dental hygienists and orthodontic auxiliaries	331,582	17,505	279,904	33,367
Dental technicians and clinical dental technicians	197,168	57,652	182,632	57,685
Total fees and levies	2,561,164	419,891	2,437,856	347,773

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

7 Components of net surplus

Expenditure	Note	2016 $	2015 $
Administration expenses			
Salaries		1,262,968	1,185,635
Staff welfare, training, ACC levies and recruitment		170,471	54,200
Telephone call charges and services		16,181	20,976
Photocopying, printing, postage and couriers		26,054	34,924
Doubtful debts/(doubtful debts recovered)		(9,700)	45,411
Office expenses		36,406	28,098
Publications and media monitoring		4,781	4,710
Audit fees	8	14,195	13,908
Advertising		2,667	2,040
Rent and building outgoings		143,382	129,703
Insurance		40,807	36,195
Bank charges		33,840	32,188
Legal		6,253	7,700
Finance		2,693	–
Amortisation of intangible assets	11	46,399	37,401
Depreciation of physical assets	12	49,831	37,791
Loss on disposal of assets		4,487	8,104
Total administration expenses		**1,851,715**	**1,678,984**
Council project and profession expenses			
Dental Council – fees and expenses		232,213	250,562
Audit and risk and remuneration standing committees		31,301	26,632
Information technology		147,874	88,149
New Zealand and international liaison		59,524	124,417
Strategic and organisational planning		245,812	71,850
Registration and recertification standards		153,690	144,267
Continuing professional development		228	335
Scopes of practice		96,332	91,852
Policy		73,546	152,343
Communications – stakeholders		41,608	22,348
Workforce data analysis		–	7,894
Education and accreditation		123,789	154,918
Examinations		133,810	181,028
Registration		32,801	7,605
Recertification		93,136	80,410
Complaints		103,982	89,882
Fitness to practise		8,638	9,501
Competence assessments and reviews		155,243	99,096
Discipline – overhead recoveries		(22,054)	–
Discipline – sundry expenses		23,131	155
Discipline – professional conduct committees		48,539	22,857
Discipline – Health Practitioners Disciplinary Tribunal		82,616	65,174
Discipline – disciplinary case appeals		2,114	54,640
Total Council project and profession expenses		**1,867,873**	**1,745,915**
Total expenditure		**3,719,588**	**3,424,899**

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

8 Auditor's remuneration

Staples Rodway, Wellington, provide audit services to the Council. The total amount recognised for audit fees is $14,195 (2015: $13,908). No non-audit services are provided by Staples Rodway.

9 Cash and cash equivalents

Cash and cash equivalents include the following components:

	2016 $	2015 $
Cash at bank	1,832,721	2,500,629
Petty cash	200	200
Total Cash and Cash Equivalents	**1,832,921**	**2,500,829**

10 Investments

	2016 $	2015 $
Term deposits – maturing within 12 months of balance date	2,063,748	1,260,000
Total investments	**2,063,748**	**1,260,000**

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

11 Intangible assets

2016	Software $
Cost	269,027
Accumulated amortisation	203,833
Net book value	**65,194**

2015	Software $
Cost	277,862
Accumulated amortisation	173,717
Net book value	**104,145**

Reconciliation of the carrying amount at the beginning and end of the period:

2016	Software $
Opening balance	104,145
Additions	7,448
Disposals	–
Amortisation	46,399
Closing balance	**65,194**

2015	Software $
Opening balance	58,238
Additions	83,308
Disposals	–
Amortisation	37,401
Closing balance	**104,145**

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

12 Property, plant and equipment

2016	Office furniture $	Office refit $	Computer equipment $	Office equipment $	Total $
Cost	83,414	185,169	105,358	22,456	396,397
Accumulated depreciation	41,265	14,790	85,149	20,422	161,626
Net book value	**42,149**	**170,379**	**20,209**	**2,034**	**234,771**

2015	Office furniture $	Office refit $	Computer equipment $	Office equipment $	Total $
Cost	84,764	15,757	101,546	24,370	226,437
Accumulated depreciation	51,602	–	69,033	19,354	139,989
Net book value	**33,162**	**15,757**	**32,513**	**5,016**	**86,448**

Reconciliation of the carrying amount at the beginning and end of the period:

2016	Office furniture $	Office refit $	Computer equipment $	Office equipment $	Total $
Opening balance	33,162	15,757	32,513	5,016	86,448
Additions	20,559	169,412	12,248	421	202,640
Disposals	4,026	–	460	–	4,486
Depreciation	7,546	14,790	24,092	3,403	49,831
Closing	**42,149**	**170,379**	**20,209**	**2,034**	**234,771**

2015	Office furniture $	Office refit $	Computer equipment $	Office equipment $	Total $
Opening balance	33,147	10,890	54,045	8,479	106,561
Additions	7,120	15,758	2,906	–	25,784
Disposals	–	8,106	–	–	8,106
Depreciation	7,105	2,785	24,438	3,463	37,791
Closing	**33,162**	**15,757**	**32,513**	**5,016**	**86,448**

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

13 Movement in equity

Dental Council	Dentists $	Dental hygienists $	Dental therapists $	Dental technicians $	Total 2016 $
Operational reserves – profession					
Balance 1 April 2015	1,456,720	104,323	136,646	116,035	1,813,724
Surplus/(deficit) 2015/16	(255,572)	(11,114)	(84,232)	(10,520)	(361,438)
Balance 31 March 2016	**1,201,148**	**93,209**	**52,414**	**105,515**	**1,452,286**
Disciplinary reserves – profession					
Balance 1 April 2015	144,598	60,000	55,119	428	260,145
Surplus/(deficit) 2015/16	257,491	12,208	15,016	56,435	341,150
Balance 31 March 2016	**402,089**	**72,208**	**70,135**	**56,863**	**601,295**
Total profession reserves	**1,603,237**	**165,417**	**122,549**	**162,378**	**2,053,581**
Capital asset reserve – Council					
Balance 1 April 2015					422,823
Capital replacement annual practising certificate fee					226,130
Depreciation, amortisation and loss on disposal of fixed assets					(100,717)
Capital Asset Reserve – Council 31 March 2016					**548,236**
Total net assets attributable to the owners of the controlling entity 31 March 2016					**2,601,817**

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

Dental Council	Dentists* $	Dental hygienists $	Dental therapists $	Dental technicians $	Total 2015 $
Operational reserves – profession					
Balance 1 April 2014	562,817	138,715	177,359	94,754	973,645
Opening balance PBE IPSAS 23 adjustment	758,554	–	–	–	758,554
Surplus/(deficit) 2014/15 as reported	108,070	(34,392)	(40,713)	21,281	54,246
PBE IPSAS 23 adjustment 2014/15	27,279	–	–	–	27,279
Balance 31 March 2015	**1,456,720**	**104,323**	**136,646**	**116,035**	**1,813,724**
Disciplinary reserves – profession					
Balance 1 April 2014	39,252	26,633	(5,035)	(11,968)	48,882
Opening balance PBE IPSAS 23 adjustment	19,269	–	–	–	19,269
Surplus/(deficit) 2014/15 as reported	8,735	33,367	60,154	12,396	114,652
PBE IPSAS 23 adjustment 2014/15	77,342	–	–	–	77,342
Balance 31 March 2015	**144,598**	**60,000**	**55,119**	**428**	**260,145**
Total profession reserves	**1,601,318**	**164,323**	**191,765**	**116,463**	**2,073,869**
Capital asset reserve – Council*					
Balance 1 April 2014					457,142
Opening balance PBE IPSAS 23 adjustment					30,442
Surplus/(deficit) 2014/15 as reported					(39,624)
PBE IPSAS 23 adjustment 2014/15					(25,137)
Capital Asset Reserve – Council 31 March 2015					**422,823**
Total net assets attributable to the owners of the controlling entity 31 March 2015					**2,496,692**

*The balances of reserves as at 31 March 2015 have been restated to capture by profession and Council PBE IPSAS adjustments recorded in note 3 above.

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

14 Related party transactions

Remuneration paid to the Council members

The Council has related party transactions with respect to fees paid to the Council members and with respect to the Council members who pay to the Dental Council APC fees and disciplinary levies as dental practitioners. Fees paid to the Council members for attending Council, committee and working party meetings and participating in other forums are disclosed below.

Council members	2016 $ Fees	2015 $ Fees
M Bain	48,507	86,156
R Whyman	29,114	22,890
A Gray	17,930	21,405
J Aarts	19,530	17,145
L Eilenberg	20,910	24,159
K Ferns	4,500	–
L Foster Page	20,271	24,214
K Hazlett	20,812	19,395
J Logan	8,798	–
M McGibbon	19,463	18,621
C Neame	8,060	–
D Stephens	7,335	21,195
G Tahi	3,780	–
W Tozer	23,002	18,585
Total fees paid	252,012	273,765

Key management personnel

The key management personnel, as defined by PBE IPSAS 20 Related Party Disclosures, are the members of the governing body comprising the Council members, the Chief Executive, Registrar and Corporate Services Manager, who constitute the governing body of the Council with authority and responsibility for planning, directing and controlling the activities of the entity. The aggregate remuneration paid to the Council members is set out above. The aggregate remuneration of key management personnel and the number of individuals, determined on a full-time equivalent basis, receiving remuneration are as follows:

	2016 $	2015 $
Total remuneration	543,323	495,813
Number of persons	3	3

Remuneration and compensation provided to close family members of key management personnel

During the reporting period, total remuneration and compensation of $20,175 (2015: $0) was provided by the Council to an employee who is a close family member of key management personnel.

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

15 Leases

As at the reporting date, the Council has entered into the following non-cancellable operating leases:

Lease of premises 80 The Terrace (Dental Council share)	2016 $	2015 $
Not later than one year	142,101	92,052
Later than one year and no later than five years	710,506	690,963
Later than five years	224,994	370,938
	1,077,601	1,153,953

The lease agreement at 80 The Terrace (commencement date 1 November 2014) is in the names of the Dental Council, Physiotherapy Board of New Zealand, Medical Sciences Council of New Zealand, New Zealand Medical Radiation Technologists Board and the Pharmacy Council of New Zealand (five responsible authorities) all of which have joint and several liability. This lease expires on 31 October 2023 with a right of renewal of a further six years.

Lease of premises 80 The Terrace (five responsible authorities)	2016 $	2015 $
Not later than one year	434,203	279,537
Later than one year and no later than five years	2,171,015	2,111,108
Later than five years	687,488	1,134,507
	3,292,706	3,525,152

Lease of multi-function devices (photocopier, printer etc)	2016 $	2015 $
Not later than one year	2,926	2,926
Later than one year and no later than five years	3,658	6,584
Later than five years	–	–
	6,584	9,510

Notes to the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2016 (continued)

16 Categories of financial assets and liabilities

The carrying amounts of financial instruments presented in the Statement of Financial Position relate to the following categories of assets and liabilities:

Financial assets	2016 $	2015 $
Receivables		
Cash and cash equivalents	1,832,921	2,500,829
Investments	2,063,748	1,260,000
Receivables from exchange transactions	112,756	92,384
Receivables from non-exchange transactions	46,928	7,376
	4,056,353	**3,860,589**

Financial liabilities	2016 $	2015 $
Accounts payable	648,997	421,782
Employee entitlements	216,893	168,087
	865,890	**589,869**

17 Capital commitments

There were no capital commitments at the reporting date (2015: $187,123). At 31 March 2015, the Council had a capital commitment of $187,123 with respect to the Council's share of the fit-out of its new office premises at 80 The Terrace, Wellington. The total capital commitment for the five responsible authorities at 31 March 2015 for the 80 The Terrace fit-out was $568,660.

As at 31 March 2016, the Council has a credit card facility of $20,000 of which $2,191 has been utilised on a short-term basis at this date (2015: $35,000 facility – $2,054 utilised).

18 Contingent liabilities

At year-end, a judicial review case was in progress relating to an application for review of the decisions of the Council regarding suspension and establishment of a competence programme for a dentist. The High Court hearing was held on 18 April 2016 with the judge's decision reserved. This is an insured claim, and the Council has paid the legal fees up to its insurance excess ($25,000, including GST and disbursements). All further legal costs are now met by the Council's insurer (2015: two contingent liabilities were recorded, a potential judicial review and an appeal to the High Court).

19 Contingent assets

At year-end, a judicial review case was awaiting finalisation in respect of costs to be awarded to the Council as respondent. The case related to an application for review of the decisions of the Council to remove a dentist from the register of dental practitioners. The case was heard in the High Court on 17 February 2016 with the case being struck out on 4 March 2016 (2015: Nil contingent assets).

20 Events after the reporting date

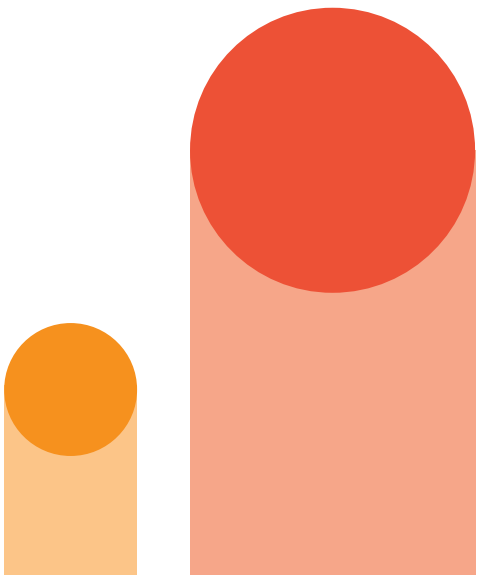
The Council and management are not aware of any other matters or circumstances since the end of the reporting period not otherwise dealt with in these financial statements that have significantly affected or may significantly affect the operations of the Council (2015: $Nil).

Glossary

accounts payable	Amounts payable to creditors for goods and services provided to an entity.
accounts receivable	Amounts receivable from debtors for goods and services provided by an entity.
accreditation	The Council process of assuring the quality of education and training of oral health programmes. All New Zealand–prescribed qualifications must be accredited.
administration expenses	The expenses incurred to support an entity's day to day operations.
annual practising certificate	The certification that an oral health practitioner is considered competent and fit to practise their registered profession. A practitioner must not practise their profession if they do not hold a current annual practising certificate.
audit	The process of verifying and validating an oral health practitioner's compliance with the ethical and professional standards set by the Council. Audits may include practice visits, electronic reviews or self-declarations of compliance.
cash flows	Cash Flows are the movement of money in and out of an entity's bank accounts.
codes of practice	The detailed standards established by the Council relate to specific dental practice areas. These enable oral health practitioners to meet the standards of cultural and clinical competence, and ethical conduct.
competence	A practitioner who practises their profession at the required standard of competence applies knowledge, skills, attitudes, communication and judgement in their delivery of appropriate oral health care within their registered scope of practice.
competence review	A review of an oral health practitioner's competence typically undertaken in response to concerns about the practitioner's practice, but may be undertaken at any time as determined necessary by the Council. The review is a measure of the quality of the practitioner's performance, based on competencies and the evaluation of these in relation to standards.
competence review committee	A committee appointed by the Council to undertake a competence review.
continuing professional development	Educational activities and interactive peer contact activities aimed at ensuring an oral health professional's continuing competence to practise.
Council	The Dental Council established by the Health Practitioners Competence Assurance Act 2003.
current assets	The assets that are capable of being converted into cash within a year.
current liabilities	An entity's debts and obligations that are due within a year.
dental register	A public register maintained by the Council of all registered oral health practitioners, including those practitioners not currently practising. The register is available on the Council's website (www.dcnz.org.nz).
disciplinary expenses	The expenses resulting from disciplinary actions taken against oral health practitioners through Professional Conduct Committees and Health Practitioner Disciplinary Tribunal hearings and can include court costs resulting from appeals against the decisions of those bodies.
fixed assets	The long term tangible assets held for more than a year for the purposes of sustaining an entity's ability to continue in operation over a period of time.
Health and Disability Commissioner, Office of the	The Office of the Health and Disability Commissioner promotes and protects the rights of health and disability services consumers and facilitates the fair, simple, speedy and efficient resolution of complaints.

Health Practitioners Competence Assurance Act 2003	The Act that provides a framework for the regulation of health practitioners. The principal purpose of the Act is to protect the public's health and safety. The Act includes mechanisms to ensure practitioners are competent and fit to practise their professions.
Health Practitioners Disciplinary Tribunal	The tribunal that hears and decides disciplinary charges brought against registered health practitioners. The charges may be brought by a professional conduct committee or the Director of Proceedings from the Office of the Health and Disability Commissioner.
income from fees and levies	Revenue received from oral health practitioners and applicants provided with services relating to dental professions.
intangible assets	Assets that are not of a physical nature such as computer software and intellectual property.
oral health practitioner	The collective term used to describe any person registered in one of the regulated professions associated with the delivery of dentistry. The regulated professions include dentists, dental specialists, dental therapists, dental hygienists – including orthodontic auxiliaries, dental technicians and clinical dental technicians.
order	A formal direction from the Council or the Health Practitioners Disciplinary Tribunal of a decision made under the Health Practitioners Competence Assurance Act 2003. An order by the Council may, for example, require a practitioner to undertake a competence programme, assessment or examination or that conditions be included in a practitioner's scope of practice.
other income	The income from investments and the recovery of costs from organisations and individuals.
prescribed qualification	A qualification specified by the Council as delivering a competent graduate to practise a particular scope of practice in New Zealand once registered. Prescribed qualifications are published in the New Zealand Gazette.
professional conduct committee	A committee appointed by the Council to independently investigate matters referred to it, such as concerns about a practitioner's conduct or safety or a notice of conviction. A professional conduct committee may make recommendations to the Council or determinations, including about the laying of charges before the Health Practitioners Disciplinary Tribunal.
project expenses	The expenses incurred on projects or activities that are distinct from an entity's day to day operations, and tend to be less routine than administration expenses.
recertification	The process for ensuring registered oral health practitioners are competent and fit to practise their professions. The annual recertification process requires practitioners to declare yearly: • their compliance with the Council's codes of practice • their competence to practise • any health conditions, fitness, competence or disciplinary issues that may affect their competence or fitness to practise. Practitioners are also required to meet the recertification programme set by the Council for each profession, requiring them to complete a specified number of hours of continuing professional development and peer contact activities over a four-year cycle. Individual recertification programmes can also be developed by the Council to remediate the competence of a practitioner found to be practising below the required standard of competence.
registration	The process of adding an oral health practitioner to the dental register when they have satisfied the Dental Council that they are fit for registration; have the prescribed qualifications for their profession; – or qualifications deemed equivalent to the prescribed qualifications, and are competent to practise their profession.
removal	The cancellation of the entry in the dental register relating to an oral health practitioner.

reserves	The accumulation of net surpluses during the period of an entity's operation, which are held for defined purposes.
restoration	The reinstatement of an oral health practitioner on the dental register following the cancellation of their entry.
retention	The process of maintaining a non-practising registered oral health practitioner without an annual practising certificate on the dental register.
risk of harm	The risk of harm is that posed to the health and safety of the public by a practitioner's competence, health or conduct.
schedule of expenses	The entity's expenditure against a set of reporting categories that are pertinent to the entity's particular operation.
scope of practice	The scope of practice of a profession describes the activities permitted for the practice of that profession.
statement of cash flows	Analysis of the cash flows coming into and leaving an entity.
statement of financial performance	The entity's income and expenditure and net surplus or deficit for a period in time.
statement of financial position	The entity's assets, liabilities and accumulated surpluses or reserves at a point in time.
statement of movement in reserves	The movement in reserves that results from an entity's financial performance in a defined period.
surplus / deficit	A surplus occurs when income is larger than expenditure and a deficit occurs when expenditure is larger than income, over a defined period of time.
suspension	The outcome of either: • a temporary order made by the Council to prevent an oral health practitioner from practising their profession when their competence is under review or assessment and they pose a risk of serious harm to the public, or when a practitioner is suspected of being unable to perform the required functions of their profession because of health issues, or there is a pending prosecution or investigation casting doubt on the practitioner's professional conduct • an order made by the Health Practitioners Disciplinary Tribunal to suspend the registration of an oral health practitioner.
Trans-Tasman Mutual Recognition Act 1997	The Act that recognises Australian and New Zealand registration standards as equivalent and allows registered oral health practitioners to work in either country in the same scope of practice.



LEVEL 5
80 THE TERRACE
WELLINGTON
NEW ZEALAND

PO BOX 10–448
WELLINGTON 6143
NEW ZEALAND

+64 4 499 4820

INQUIRIES@DCNZ.ORG.NZ