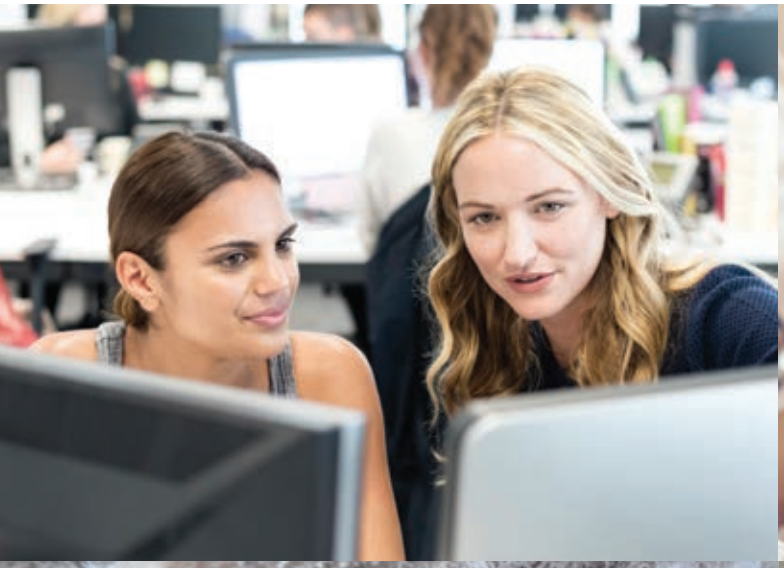


ANNUAL REPORT

2017-2018

Australian College of Rural & Remote Medicine

WORLD LEADERS IN RURAL PRACTICE

CONTENTS

PRESIDENT'S REPORT

It has been an honour and a privilege to serve as ACRRM president since October 2016. The role is never a quiet one, but the past 12 months have brought a series of landmark events.

The ACRRM-Commonwealth Government Compact signing, recognised our national leadership in the work to improve health services for our rural, remote and Aboriginal and Torres Strait Islander communities. It signaled the Government's commitment to working with us to attain our key goals.

There are exciting developments in training for rural generalist practice.

The Government's commitment to supporting the National Rural Generalist Pathway will enable the College to expand and strengthen our leadership in rural health and transition to ACRRM delivered general practice training of all our registrars including in AGPT by 2022.

This transition is well underway and key interim steps have already been made, including ear-marked AGPT 'rural generalist' places and a dedicated AGPT Rural Generalist Policy to address the key barriers to ACRRM Fellowship training.

In parallel, through the National Rural Health Commissioner's Rural Generalist Taskforce and its associated working and expert reference groups, the College has been able to take a lead role in developing detailed recommendations for a national approach to supporting rural generalist training and practice.

ACRRM received full re-accreditation with AMC. This is recognition of the excellence of our program and marks more than a decade of providing accredited Fellowship training. It comes in the same year that we look toward graduating our 700th Fellow through the training program.

With such changes underway it's more important than ever for us to ensure that we hear the voices of rural and remote community members.

I am therefore very pleased to welcome Annabelle Brayley, farmer, author, rural advocate and rural resident as director and inaugural community representative to ACRRM Board. A second key initiative has been our taking Board on the road across Australia. Over 2018, Board meetings will have been held in Adelaide, Brisbane, Melbourne, Sydney and Darwin each accompanied by member and stakeholder engagement events.

When one takes on a role like this you need touchstones. Are we heading in the right direction? Our College ideal of "the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care" clearly describes our destination and I thought it a good exercise to measure our recent travels against it.

The Right Doctors

ACRRM members are strongly united in our vision for healthcare excellence for rural and remote communities.

This is enhanced by our Fellowship program that now has a common selection process for AGPT positions and the Independent Pathway. Doctors are selected based on their propensity for full scope community-oriented, long term rural practice. Ardnell Group's external evaluation of the new AGPT selection has affirmed the processes' rigor and capacity to select for rural intent.

The Government's national survey of AGPT registrars has reinforced that our registrars are leaders in addressing national priority needs. ACRRM registrars were 3.5 times more likely to be planning long-term rural careers, 1.8 times more likely to want to work long-term in Aboriginal and Torres Strait Islander health, and significantly more likely to want to give back in training rural workforces of the future.

In the Right Places

Some 80% of Fellows continue to be based in rural and remote locations, and our long-term rural retention rate for Fellows trained through ACRRM pathways is around 70-75%.

With the Right Skills

The ACRRM curriculum is unique and Fellows are assessed based on their capacity to provide the full scope of services and responsibilities the College considers essential to maintain safe, quality services in rural and remote locations. This has translated to a broad range of skilled services being available within rural and remote communities. For example, this year over 2,000 of our Fellowed members participated in the Rural Procedural Grants program because they practice in obstetrics, emergency medicine, surgery or anaesthetics; and over 800 Fellows had reporting on requirements for their mental health and radiology skilled services.

The next chapter

I want to salute our members who served rural and remote communities through the difficult years when there were no rural trainees and no workforce plan, including the many overseas-trained doctors who came to fill the gaps and stayed, and those doctors now approaching retirement. Without these doctors there would be no ACRRM and few doctors in rural communities.

To create and sustain a skilled rural workforce we need the knowledge, experience and wisdom of experienced dedicated doctors, the leaders of our health services who continually strive to maintain and improve services.

The College is justifiably proud of the outstanding new Fellows that we are training and graduating. Our emerging generation of rural generalist doctors need guidance from those who went before. It is a precious gift that experienced doctors can give those who follow; an understanding of how to thrive in rural generalism.

In this my last president's report I would like to thank our dedicated Board, the Council, Marita Cowie our inestimable CEO, and the wonderfully skilled and dedicated staff of the College for the vision and determination to see health in rural and remote Australia change for the better. I am proud to have been able to serve ACRRM as its tenth president.

Ruth Stewart
President

SOME 80% OF FELLOWS CONTINUE TO BE BASED IN RURAL AND REMOTE LOCATIONS, AND OUR LONG-TERM RURAL RETENTION RATE FOR FELLOWS TRAINED THROUGH ACRRM PATHWAYS IS AROUND 70-75%.

CEO'S REPORT

This year has been something of a watershed for our College with many of our long-term goals becoming reality.

At one level, this is a call to action stations for us as we rapidly develop systems for the changes ahead. These are however exactly the outcomes we have been working toward for over twenty years. Our processes have been designed with these end-goals in mind, and we proceed with confidence that we are ready and that solid foundations have been established.

The Government has taken clear action this year on its commitment to a National Rural Generalist Pathway and ACRRM has been kept busy in the negotiations that have ensued.

National Rural Generalist Taskforce

ACRRM has had a leadership role in the National Rural Generalist Taskforce which is due to submit recommendations by the end of 2018. This work is viewed as a vital step toward better coordination and recognition of our members' expertise and scope of practice, the training pathways for our registrars, and the models of care required to meet community needs in rural and remote Australia.

Australian General Practice Training (AGPT) Program arrangements

The College is working towards a three-year transition to ACRRM fully-managing its training including in the AGPT Program, and to this being fully aligned to our rural generalist Fellowship training model. Our substantively expanded education management staff and structures are established. We remain committed to the principle of consistent standards for all ACRRM Fellowship training irrespective of entry point, and these new arrangements will strengthen our capacity to deliver this and to more directly support our registrars.

Advanced Specialised Training Governance

The year has also involved extensive and ongoing consultations with various specialty colleges regarding management of our Advanced Specialised Training programs and qualifications. ACRRM uniquely has its Fellowship curriculum and assessment standards across its primary and advanced specialist skills areas, assessed and accredited through the Australian Medical Council process. Our Fellows' registration status reflects these attainments. ACRRM has maintained its obligation to ensure that all educational standards and clinical governance for our Fellowship ultimately rest within our profession and has sought to encourage all opportunities for ongoing positive collaboration.

Fellowship Support Program

From 2019, registrars on our Independent Pathway are expected to be eligible to receive a subsidy towards their training costs thanks to the Commonwealth Government's new Fellowship Support Program. ACRRM has been delivering nationally accredited training in-house through the Independent Pathway for over a decade. While some financial contribution for our registrars who are otherwise paying for all their own training is warmly welcomed, the program will otherwise represent a continuity of our operations and standards.

Junior Doctor Training

This year saw the welcome extension to government support for its rural junior doctor training and infrastructure. ACRRM welcomes all registrar journeys to Fellowship but seeks to ensure that a pathway is available from medical school, that is structured, well-supported and rurally-centric. To this end, we have continued to engage with Rural Training Hubs and junior doctor training programs across the country to identify opportunities for collaboration, provision of its rural junior training curriculum, and facilitated entry to our Fellowship training. ACRRM continues to build on its junior doctor curriculum and its Primary Curriculum to help guide prevocational learning for rural practice.

Professional Performance Framework (PPF)

We continue to engage at all opportunities with the Medical Board of Australia as it further develops its PPF. We are mindful that the new framework categorises many of our members with potentially higher compliance requirements based on circumstances not related to their individual professional performance.

We recognise the concerns this may bring and are continuing to advocate for fairness in the unfolding process arrangements. We are also working to ensure that our Professional Development Program continues to offer a fit-for-purpose mechanism for meeting these requirements without being unduly onerous. ACRRM will continue to use its newsletters and direct communications to make sure members stay informed on all developments.

As we close on a hectic year, poised to move to full capacity training program delivery, with consolidated national recognition of our unique qualifications, I would like to say a special word of thanks. This year saw the retirement of one of our longest serving staff members and most loyal friends of the College, Maggie Bryan. She exemplified all of that we value here at ACRRM – commitment, passion, courage, caring and (very importantly!) a wicked sense of humour.

In that spirit I want to acknowledge the tireless and visionary work of Maggie, as well as the many ACRRM members and staff both current and over the past 21 years that have developed the systems, curricula, standards and governance structures that have brought us to where we are now. Our current success has been built on your vision and hard work. Thank you all.

Marita Cowie
CEO

ACRRM WELCOMES ALL REGISTRAR JOURNEYS TO FELLOWSHIP BUT SEEKS TO ENSURE THAT A PATHWAY IS AVAILABLE FROM MEDICAL SCHOOL, THAT IS STRUCTURED, WELL-SUPPORTED AND RURALLY-CENTRIC.

CENSOR-IN-CHIEF'S REPORT

In the past 12 months rural Australia has had the burger with the lot – a chronic undersupply of doctors, closure of rural hospitals and maternity services, and another year of a prolonged drought; do you want flies with that?

We should never underestimate the cumulative impact of such stress on rural communities, testing their resilience and resistance to despair.

What is there to do? In political terms there is "drought relief", supporting the "regions" and "addressing the maldistribution" of doctors in Australia.

Despite this maldistribution, the structure of a sustainable rural medical workforce in Australia has been under development for some time.

The foundations were laid more than two decades ago with the translation of solid research into policy, led by a timely intersection of disparate forces such as Norrington, Best, Morey, Strasser, Hays, Humphreys, Worley, White and Wooldridge. The UDRH and Rural Clinical School programs challenged the orthodoxy of education of the health professions, and has produced extensive research into the various elements of rural health in Australia, including the drivers for a sustainable workforce.

ACRRM was born around this time because of the close involvement of rural doctors in these developments. It is interesting to reflect that ACRRM has not only been at the forefront of change around recognition and accreditation of medical professional bodies via the Australian Medical Council (AMC), but has also been the major influence in the distribution of investment in Australia in general practice education, now totaling more than $250 million annually.

This tapestry is the backdrop to the next Act in this very long production. Enter at Stage Left the Rural Health Commissioner and the National Rural Generalist Pathway. ACRRM has provided the intellectual and academic conceptualisation of "Rural Generalist Medicine", hosting three international conferences and developing the curriculum for the Queensland Rural Generalist Program over the past decade.

The National Rural Generalist Pathway will bring together the various strands of rural medical education in Australia. The change to College-led selection into GP training has already enabled ACRRM to employ merit-based selection into training for rural practice. The transition to College-led training over the next two years will enable ACRRM to recruit and train Rural Generalists with the skills to meet the health needs of rural Australia.

College Selection Process

ACRRM has now had responsibility for two cycles of selection into the Australian General Practice Training (AGPT) Program.

Our selection program has been refined from our well-established process that has been in operation through the Independent Pathway for over a decade, and the new AGPT program has received positive feedback from a comprehensive external assessment of its first year of operation, particularly with regard to the capacity to select for rural intent. Another pleasing outcome of the process was that there has been a record number of Aboriginal and Torres Strait Islander ACRRM registrars recruited to the AGPT and we look well on track to match this in 2019.

Amongst the AMC-accredited medical colleges in Australia, ACRRM is a leader in the application of rigor and transparency in selecting Trainees, and ACRRM's program has understandably

attracted international significance as an important tool for rural workforce policy and has received acclaim at international conferences over the past 12 months.

Rural Generalist Policy in AGPT

A precursor to the establishment of a National Rural Generalist Pathway has been the new 'Rural Generalist policy' within the current AGPT. This has introduced greater flexibility of location of training and provided an extra twelve months for rural trainees to complete their training. These changes will provide ACRRM registrars with flexibility of choice in the clinical training sites for each of the three stages of our training. Additional time to complete the Advanced Specialised Training (AST) phase of the ACRRM program is also provided for, in particular where this may be required to complete assessment or logbook requirements.

Quality improvement of Assessment

The College has worked with our registrars to identify and implement a broad range of quality improvements to our assessment program.

- Registrar remediation program – this is now in place to provide an individually tailored program of learning and training support to registrars identified as needing additional assistance.
- Technical review of Primary Curriculum StAMPS – as part of its program of continued quality improvement the College is conducting an expert review of this assessment, examining historic data trends, success factors and standard setting.
- Registrar Assessment Workshops - The College conducted a webinar open to all registrars to improve their understanding of our assessment processes. This was led by the Registrar Committee and our assessment program leaders and included input from external expert medical educationalists. Further workshops will be included at RMA2018.
- Public reports and feedback – the College now provides comprehensive information to all registrars regarding exam processes and results after each major assessment. Individuals that are unable to pass assessment receive detailed feedback to assist them in their remediation process.
- Unconscious bias training – the College recognises the need to continuously guard against implicit or unconscious bias. Our Assessment Committee and key staff have undertaken a training workshop on this topic, the College now undertakes a cultural and linguistic check of exam questions and scenarios, and we are continuing to explore new mechanisms by which the College can increase its rigor in addressing this.

The National Rural Generalist Pathway

As mentioned earlier, the ACRRM Fellowship training program was the first in Australia to be developed entirely under the revised AMC accreditation standards.

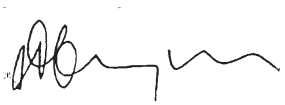
We have ensured that assessment of qualification for Fellowship is consistent for all trainees, and that this assessment examines the breadth of clinical practice competencies required to meet the needs of rural and remote communities, including the Advanced Specialised Training skill-set.

The National Rural Generalist Pathway legitimises two decades of intellectual effort and advocacy by ACRRM to identify the role, skill-set and training requirements of the Rural Generalist, and ACRRM's expertise in the standards required for rural medical practice has contributed significantly to the development this year of the National Rural Generalist training program. ACRRM is represented on the Rural Generalist Taskforce by the President, CEO and Censor in Chief.

As we progress towards establishment of a nationally-supported rural generalist training program, we anticipate that the identification and status of the FACRRM Rural Generalist will become part of the fabric of health service delivery in Australia, with appropriate recognition by the profession and rural communities alike, and support from state and federal governments.

We may not be able to bring rain to drought-stricken parts of rural Australia, but ACRRM can ensure that its Fellows are able to support farmers and other members of rural communities affected by drought; we can go a long way to addressing the undersupply of rural doctors by promoting the recognition and status of the FACRRM Rural Generalist, and a sustainable rural medical workforce is crucial to the retention of rural hospital service infrastructure.

And the flies? Well, just give them the Aussie salute.



David Campbell
Censor-in-Chief

COLLEGE COMPACT WITH THE COMMONWEALTH GOVERNMENT

In May 2018, we signed a Compact with the Commonwealth Government. It represents a shared commitment by ACRRM and the Government to work together to improve health outcomes for rural and remote communities through securing an appropriately skilled and sustainable rural medical workforce.

The Compact acknowledges ACRRM's role as a key national stakeholder and peak body in setting standards for training general practitioners and rural generalist doctors, and highlights the important role that ACRRM and our members play in providing high quality health care to people living in rural and remote communities.

Consistent with our vision for better health for rural and remote people through access to skilled rural doctors, it recognises that disparities in health outcomes for rural Australians still exist, and that proactive policies are required to address these inequities. This is particularly the case for Aboriginal and Torres Strait Islander peoples.

Our Compact was developed in consultation with members and we thank them for their positive response and engagement during its development. We also thank Ministers Hunt and McKenzie, former Minister Gillespie, and the Department of Health for their work in finalising this important document.

While confirming the commitment of ACRRM and the Commonwealth to engage in positive policy discussions, the Compact will not compromise our ability to advocate strongly for rural and remote communities and represent the interests of our members.

Key areas covered in the Compact:

Rural Generalism – the Compact recognises our expertise and leadership of rural generalism and our role in working with the Rural Health Commissioner to develop National Rural Generalist Pathways.

Training the Future Rural and Remote Medical Workforce – both parties will work to reform general practice training arrangements and support non-vocationally registered doctors to obtain Fellowship.

ACRRM and the Commonwealth will work with key stakeholders in Aboriginal and Torres Strait Islander peoples' health to **increase the number of Aboriginal and Torres Strait Islander doctors achieving Fellowship**.

Rural Workforce Policy, Planning and Distribution – work will continue to improve workforce distribution and support rural and remote communities with improved access to quality health care services.

Digital Health – ACRRM will work with the Government to foster innovation and the adoption of digital health strategies including the My Health Record, recognising that telehealth can enhance, but not replace, face-to-face services.

Rural and Remote Mental Health – the Government will support ACRRM to further develop and enhance our training and professional development to increase the capacity of members to provide mental health services, in addition to working on a range of strategies to improve access to mental health services.

Doctor Health and Wellbeing – ACRRM will continue to play a key role in setting quality standards and developing innovative models of care to support rural and remote practitioners at all stages of their career and promote their health and wellbeing.

WHILE CONFIRMING THE COMMITMENT OF ACRRM AND THE COMMONWEALTH TO ENGAGE IN POSITIVE POLICY DISCUSSIONS, THE COMPACT WILL NOT COMPROMISE OUR ABILITY TO ADVOCATE STRONGLY FOR RURAL AND REMOTE COMMUNITIES AND REPRESENT THE INTERESTS OF OUR MEMBERS.

TRANSITIONING TO COLLEGE LED TRAINING

FOR THE AUSTRALIAN GENERAL PRACTICE TRAINING PROGRAM

In early 2017, the Commonwealth Department of Health (DoH) announced a formal three-year transition of management of the Australian General Practice Training (AGPT) Program from the Commonwealth Government to the General Practice Colleges. This formal transition will occur over 2019-2021.

With these changes, ACRRM looks forward to our registrars having a much more direct relationship with our staff and being able to receive training fully aligned to their distinctive training needs.

Since 1999, the AGPT Program has created government sponsored Fellowship training positions and contracted Regional Training Organisations (RTOs) to provide training support. ACRRM registrars awarded these positions have been required to navigate the AGPT policies and guidelines, while meeting their ACRRM Fellowship requirements.

This year, ACRRM has been actively preparing for the transition, with College led selection successfully undertaken for the AGPT Program for the first time in 2017 and again refined in 2018. True to our commitment to providing a consistent training experience for all ACRRM registrars, the selection process is built upon the mechanisms used for over a decade in ACRRM's Independent Pathway.

It has involved members and Fellows from across the country. Key criteria now have a rural focus and are directly linked to propensity for attaining ACRRM Fellowship. We were pleased to see a 20 per cent increase in applications received this year.

Since January 2018, ACRRM has been involved in formal discussion and planning with the DoH to prepare for the full transition of the AGPT Program to ACRRM by the end of 2021. We continue to invest time and resources into building and supporting the systems required to ensure seamless transition and effective continuation of the AGPT Program by ACRRM.

TRUE TO OUR COMMITMENT TO PROVIDING A CONSISTENT TRAINING EXPERIENCE FOR ALL ACRRM REGISTRARS, THE SELECTION PROCESS IS BUILT UPON THE MECHANISMS USED FOR OVER A DECADE IN ACRRM'S INDEPENDENT PATHWAY

10 YEARS OF AMC ACCREDITATION

Following its comprehensive review by the Australian Medical Council (AMC) in 2017, ACRRM had its accreditation status reaffirmed for another four years. This marks over a decade for ACRRM as an accredited medical college.

This accreditation status enables our Fellows to registrar with AHPRA as general practitioners, recognising all their assessed Fellowship skills including their advanced specialised training.

As part of this process, ACRRM welcomed the AMC's assessment teams' comments that *"the College continues to enhance the quality of its educational offerings and is growing as a major influence and stakeholder in the rural and remote general practice environment."*

We were pleased to be found to have met nine standards, to have substantially met the remaining standard, and to have only three conditions upon our continuing accreditation.

ACRRM provides annual progress reports to the AMC and is scheduled to undertake its next comprehensive review in 2022.

ACRRM was the first new Australian College to undertake assessment for accreditation under the newly established, more rigorous AMC regime. We were established in all aspects against the most exacting of quality assurance processes.

With well-established accreditation of our unique training program, selection processes, and advanced skills training, we look to embrace the exciting new challenges that lie ahead with the assurance of solid foundations.

BUILDING NATIONAL SUPPORT FOR RURAL GENERALIST PRACTICE

ACRRM and our Fellowship program were formed to preserve and advance the Rural Generalist practice model for rural communities, and 2017-2018 has been a watershed year in our long road to full recognition of Rural Generalist practice.

For some ten years, we have sought Government backing for a nationally coordinated framework to support Rural Generalist training and practice. ACRRM set out key elements for this in our 2014 scoping paper, 'The Rural Way', prepared for the Commonwealth Department of Health. Consensus support appears to be emerging around the document's key recommendations, including:

- The Rural Generalist practice definition incorporating primary care, hospital and other advanced care, emergency care, and population health, and is flexible and responsive to local needs
- Training as much as possible in rural areas and by Rural Generalist trainers
- Continuous training pathway from internship to Fellowship with lateral entry options
- Industrial recognition of the Rural Generalist scope of practice
- Funding and frameworks to enable a structured, supported training experience
- Industrial and administrative mechanisms to enable mobility across jurisdictions.

The past 12 months have seen major steps forward:

The **signing of the College Compact** in May 2018, that reaffirmed ACRRM's status as a national stakeholder toward advancing the rural health agenda.

The **appointment of the Rural Health Commissioner**, Professor Paul Worley, with a specific brief to develop recommendations for a supporting framework for Rural Generalist practice was announced in October 2017. Then followed the signing of the Collingrove Agreement, which specified that ACRRM would work together with the Commissioner and the RACGP to lead development of a framework plan.

The **National Rural Generalist Taskforce** was formed to operationalise this plan and has been meeting in 2018. ACRRM's President, Chief Executive, Censor in Chief, and other Board Directors have membership and leadership roles in the group.

In parallel with these discussions, some key developments that support and strengthen the national program have occurred:

- The implementation of the Integrated Rural Training Hubs and the expansion to the Rural Junior Doctor Training Infrastructure Grants strengthening national capacity for junior doctor training.
- The Australian General Practice Training (AGPT) Program arrangements are incrementally changing to better support Rural Generalism and particularly ACRRM Fellowship training. Dedicated Rural Generalist training positions have been created and a range of policies have been amended to recognise the extended time and multiple training contexts associated with this training. ACRRM has been able to apply its own registrar selection process, selecting based on assessed propensity for the rural generalist model of practice.

BUILDING A NATIONAL RURAL GENERALIST PATHWAY

1997

ACRRM formed to train and set professional standards that matched its doctors' practice scope and met their patients' needs

2005

Roma Agreement sets agreed principles for Rural Generalist training

2007

ACRRM Fellowship and programs recognised by Australian Medical Council

2008

Queensland Rural Generalist Program commences, Queensland Government legislates recognition of Rural Generalist discipline as defined by ACRRM curriculum

2010

WA Country Health Service Rural Practice Program commenced

2011

NSW Rural Generalist Training Program commenced

2013

Victorian General Practice – Rural Generalist program commenced

NT Rural Generalist Pathway commenced, position of Rural Generalist recognised in NT industrial agreements

First ever World Summit on Rural Generalist Medicine, hosted by ACRRM in Cairns

2014

Cairns Consensus - International Statement on Rural Generalist Medicine endorsed by World Summit delegates

ACRRM publishes 'The Rural Way' scoping study for national rural generalist pathway commissioned by Commonwealth Government

Tasmania Rural Generalist Pathway commenced

2015

2nd World Summit on Rural Generalist Medicine, hosted by Society of Rural Physicians of Canada (SRPC) in Montreal

National Rural Generalist Jurisdictional Forum established by Commonwealth Department of Health

2016

National Rural Generalist pathway commitment by Minister for Rural Health

2017

Rural Health Commissioner appointed with brief to recommend national framework for rural generalist training and practice

2018

ACRRM–Commonwealth Government Compact signed recognising ACRRM's role as national stakeholder for advancing rural health and rural generalist practice

Agreement for staged transition of AGPT Program management to Colleges. Rural Generalist AGPT Program positions established

Collingrove Agreement signed, and National Rural Generalist Pathway Taskforce commences

COMMUNITY DIRECTOR POSITION ADDED TO ACRRM BOARD STRUCTURE

This year, we appointed Annabelle Brayley to the Community Director position on the ACRRM Board. Ms Brayley brings a wealth of knowledge and experience of rural communities to the position.

As a consumer of rural health services and a rural resident herself, Annabelle will introduce a unique point of view to Board discussions.

Annabelle lives in Morven, nearly 700 kilometres west of Brisbane. Morven has fewer than 300 people in the town, with a local medical clinic that's staffed once a week, and hospital services in Charleville, which is about an hour away by car. She has lived rural almost her whole life, working both on the land and as a rural and remote nurse. Her family is now three-generations rural-based, with children and grandchildren located in Wodonga in Victoria, and Charleville in Queensland.

Annabelle has held a number of health and education related roles within her community, as well as twenty years with her husband running a remote sheep station.

ACRRM is the only College whose mission is entirely defined by its commitment to community. The decision to appoint a Community Director to the Board was one made based on achieving our vision of better health outcomes for rural and remote people.

Through this appointment, we believe we will gain a unique perspective on rural life that will help us better understand the needs of patients, enabling better informed strategic decisions.

We need to ensure that our curricula and professional development programs are relevant and responsive to the changing needs and contexts of rural and remote practice.

It will be invaluable to have rural community input to assist us in this area, and to bring a non-clinical community perspective to the work of ACRRM.

We warmly welcome Annabelle to the ACRRM family.

MEMBERSHIP AND EDUCATION

YEAR AT A GLANCE

15% increase in membership numbers

86 new Fellows

566 current registrars across all pathways and all states and territories

20% increase in AGPT applications

15 Aboriginal or Torres Strait Islander registrars

131 Fellows contributing to ACRRM education and assessment programs

654 assessments conducted

MEMBERSHIP REPORT

Member numbers are steadily rising, with overall growth of over 15 per cent over the past two years, and a strong retention rate.

Importantly, member engagement and satisfaction has also improved year-on-year and we are on track to reach strategic targets.

This year saw ACRRM pilot a Mentoring Program for Registrars and Fellows, based on requests from registrars. The program engaged over 120 participants in its pilot year, with Fellows providing career advice to Registrars that will assist in their professional development. The program is provided in conjunction with official medical education services, and is designed to provide real, lived advice to registrars about their career development.

IMPORTANTLY, MEMBER ENGAGEMENT AND SATISFACTION HAS ALSO IMPROVED YEAR-ON-YEAR AND WE ARE ON TRACK TO REACH STRATEGIC TARGETS

JUNIOR DOCTORS REPORT

ACRRM sees great value in our members being able to travel with like-minded peers throughout their journey to becoming rural doctors.

Our vision for a national rural generalist pathway has always stressed the linking up opportunities throughout this journey to offer those who seek it have the opportunity for continuity of relationships and for structure to their learning pathway with lots of points and flexibility along the way.

Our efforts in this area are led by future generalists. The Future Generalists' Committee consists of 18 College members from across Australia. Its Chair, Justin Azzopardi, represents our junior doctor and medical student members on Board and Council. The group delivers a students and junior doctor stream at RMA each year, which in 2017 included a range of training workshops and social events. The group also hosted a special forum on Junior Doctor Well Being to over 100 conference delegates, led by a panel of educators, supervisors and junior doctors.

This year saw a welcome return to investment in prevocational rural training with the federal budgets expansion to both the Rural Junior Doctor Training Infrastructure Grants and the Integrated Rural Training Hubs programs. ACRRM has been actively engaging with many of these programs across several jurisdictions with a view to collaborating and supporting their work. We seek to ensure that training available through these programs can incorporate foundational skills for vocational training and careers as specialist rural general practitioners and rural generalists and facilitate a seamless training experience.

This year, we also developed standards for prevocational training and a prevocational rural generalist curriculum delivered through five online modules that introduce the unique aspects of rural practice. These modules were developed in collaboration with Queensland Health and are currently being used in their QCjDocs and QCiDocs programs.

PROFILE OF AN ACRRM STUDENT

Jaffly Chen

What does rural generalism look like for a student?

I'm quite thankful that ACRRM has made it so easy for students to understand what the path to a career as a rural generalist is. A passion for rural medicine has led to opportunities as a John Flynn scholar, Rural Doctors' Network Cadet, RMA Ambassadorship and even a health policy internship with the Federal Government! Looking to the future, I'll be doing my internship and residency in a rural base hospital and I'm hoping to complete a REST course with ACRRM as soon as possible!

Why did you choose this career path?

As someone who is interested in a varied scope of practice and increased responsibility, I couldn't see myself as anything but a rural generalist. Knowing how to do more with less has always been important and desirable in the rural health workforce, but it is only recently that a formal program for junior doctors in training has been available.

How does it feel knowing your broad scope of practice can take you anywhere?

Incredibly empowering. A dream of mine is to be able to travel the world as a doctor and work in many different environments without fear that I would be unprepared for the many clinical scenarios I might come across.

How do you think ACRRM leads the way in education?

The significant amount of resources ACRRM has invested in education platforms such as ACRRM Online Learning, workshops, and courses is easily evidenced by their quality and popularity.

In the junior sphere, ACRRM has always been committed to ensuring that medical students and young doctors have access to these same resources. There is a treasure-trove of resources available and ACRRM truly makes every effort to be a leader in providing education as a service.

The future of rural generalism is thrilling to say the least and I'm fortunate to be a part of it.

IN THE JUNIOR SPHERE, ACRRM HAS ALWAYS BEEN COMMITTED TO ENSURING THAT MEDICAL STUDENTS AND YOUNG DOCTORS HAVE ACCESS TO THESE SAME RESOURCES

REGISTRARS, EDUCATION AND VOCATIONAL TRAINING

It has been a big year for ACRRM's education and training arms, with many new responsibilities and opportunities added.

College led selection for the Australian General Practice Training (AGPT) Program

This year saw the culmination of some years' effort to transition the selection process for the AGPT Program to the Colleges. ACRRM is now able to select its trainee doctors for the AGPT Program according to our own selection criteria:

1. Demonstrated commitment to a career as a specialist general practitioner working in a rural or remote Australia.
2. Demonstrated capacity and motivation to acquire abilities, skills and knowledge in the ACRRM domains of practice.
3. Demonstrated connection with rural communities.
4. Demonstrated commitment to meeting the needs of rural and remote communities through an extended scope of practice.
5. Possession of the personal characteristics associated with a successful career in rural or remote practice.

With a six-month lead time, we were delighted to find that initial applications exceeded the quota of 150 places that had been allocated by the Department of Health.

All ACRRM applicants will train on the rural pathway and education in the Program will continue to be delivered through the Regional Training Organisation network.

WITH A SIX-MONTH LEAD TIME, WE WERE DELIGHTED TO FIND THAT INITIAL APPLICATIONS EXCEEDED THE QUOTA OF 150 PLACES THAT HAD BEEN ALLOCATED BY THE DEPARTMENT OF HEALTH

This year also saw the transition of other important programs from Department of Health to ACRRM. These programs include: Regional Training Organisation Education Research Grants, Registrar Academic Posts, and the management of Appeals and Remediation involving ACRRM registrars on the AGPT Program.

ACRRM's Independent Pathway

We are pleased to report the commencement of a strategic program of quality enhancements to the ACRRM Independent Pathway education program and resources. This includes placing greater focus on hands-on, practical activities during the biannual workshop including small group work and skills stations. The workshop is facilitated and supported by Medical Educators and Fellows ensuring a rural general practice focus.

We have also increased the number of Medical Educators from 6 to 10 and increased their time allocation to the program.

An increased presence of Independent Pathway registrars in the Northern Territory and South Australia can be reported. This is particularly pleasing to see as these underserved communities welcome a stronger workforce of rural doctors with the extended scope of practice in which FACRRM general practitioners excel.

Support for registrars

We have focused on increased support for registrars with several initiatives and a focus on practical support:

- Expansion of face-to-face workshop programs for Independent Pathway registrars to include more practical sessions and a broader range of topics.
- Expansion of the 16-week virtual classroom program each semester for Independent Pathway registrars.
- Increased capacity in study groups for facilitated preparation for assessments for registrars on all pathways. Study group participants are now grouped geographically to facilitate peer to peer interaction and to open informal channels with other registrars in the same region.

Education and Training Delivery and Support

A bi-monthly regionally focussed webinar series facilitated by the Medical Educators was introduced in June 2018, the focus of which is for registrars to network, collaborate and discuss non-clinical curriculum topics.

Focused remediation and support programs for registrars who have had multiple assessment attempts have been developed for two assessment modalities.

- StAMPS program is comprised of a two-day face to face workshop and follow up webinars and individual Medical Educator sessions.
- MCQ program is comprised of a detailed analysis of individual registrar MCQ responses, a survey, group webinar, followed by an individualised program.

The first group of registrars are currently undertaking these programs.

Several staffing additions have allowed us to offer greater support to registrars. Dr Greg Gladman is a new appointment as the Director of Training since November 2017. In addition, a new position Manager for Education Development has been established and appointed.

We would like to acknowledge and thank the work of the Medical Educators and Fellows who have contributed to the delivery, development and support of our Independent Pathway Education and Training program.

Assessment

The ACRRM assessment approach maintains a commitment to a programmatic style of assessment, balancing formative assessment for feedback purposes and summative assessment to determine progression.

We conducted a total of 654 assessments in the financial year. Key developments in assessment include:

- Increase in quality assurance across all assessment modalities.
- Hiring of professional assessment space in Brisbane to facilitate StAMPS exams.
- Publication of Public Reports at the completion of each StAMPS and MCQ exam.
- Public report for Case Based Discussion.
- Induction and training of an additional 14 examiners and three new writers.
- MCQ FA increased to 100 questions.
- CBD enrolment open all year round.
- New policy on reconsideration, review and appeals.
- New academic code of conduct.

Advanced skills for better doctors

The most popular Advanced Specialised Training (AST) for the year was Emergency Medicine with 49 candidates sitting this examination. Anaesthetics and Adult Internal Medicine also have significant numbers which is a positive result as in recent years ACRRM has increased our support for Adult Internal Medicine particularly.

The workload for examining and writing assessment items continues to grow to meet this increased demand.

We would like to thank the following Fellows for their contribution to the management and implementation of the various ACRRM assessment modalities: Drs Peter Arvier, Chris Carroll, Ralph Chapman, Paul De-Jong, Katie Goot, Karin Jodlowski-Tan, Raymond Lewandowski, Stephen Margolis, Johanna Mostofizadeh, and John Togno.

Accreditation

Training Organisation accreditation reviews were undertaken in conjunction with RACGP this year for the following organisations: GPTQ, RVTS, NTGPE, WAGPET, GPTT. All ten ACRRM accredited training organisations have now been reviewed for the 2016-2018 period. We noted improvements in training organisation compliance with ACRRM Training Organisation Standards in areas such as training and assessment planning and support and delivery of education against the ACRRM Primary Curriculum.

Standards and Policy

It was an active year for the development and review of resources, including the revision of the following:

- Policies: Reconsideration, Review and Appeals, Doctors in Training Review, Special Consideration, Academic Code of Conduct and Academic Misconduct.
- Standards: Core Clinical Training (Junior Doctor) and Primary Rural and Remote Training for teaching posts and supervisors.
- Curriculum: Junior Doctor Core Clinical Training and Advanced Specialised Training Rural Generalist Surgery.

WE ARE PLEASED TO REPORT THE COMMENCEMENT OF A STRATEGIC PROGRAM OF QUALITY ENHANCEMENTS TO THE ACRRM INDEPENDENT PATHWAY EDUCATION PROGRAM AND RESOURCES

CONGRATULATIONS TO NEW FELLOWS

ACRRM's first ever Fellowship Ceremony saw more than 35 new Fellows awarded their Fellowship Certificate in an official ceremony in front of friends, family, and hundreds of delegates at the 2017 Rural Medicine Australia conference.

New Fellows wore a cap and gown, and received their certificate from ACRRM President Ruth Stewart, after shaking hands with past Presidents. Guests then enjoyed a private party with family, friends and ACRRM dignitaries.

The success of the event will see it become a standing item at future Rural Medicine Australia conferences.

The journey towards Fellowship with ACRRM involves hard work and a deep commitment to rural and remote medicine. We are delighted to welcome the below doctors as Fellows and look forward to continuing to support them as they enter the next phase of their careers.

THE SUCCESS OF THE EVENT WILL SEE IT BECOME A STANDING ITEM AT FUTURE RURAL MEDICINE AUSTRALIA CONFERENCES

CONGRATULATIONS TO NEW FELLOWS IN 2017-2018

Paul Adams
Olusegun Ajiboye
Tariq Aziz
Atheel Badir
Laura Banner
Sally Barkla
Hannah Bennett
Afshan Bhagat
Charles Blair
Dale Bosenberg
Bianca Byrnes
Nicholas Cairns
Barbara Cameron
Gregory Ceccato
Freddy Chafota
Jotham Chikwakukire
Peter Christensen
Carmel Cockburn
Matthew Cockburn
Jason Coventry
Sandi Dawson
Jahde Dennis
Matthew Di Palma
David Donnelly
Deepak Doshi
Sabina Eliseeva
Mark Farrugia
Liam Flynn
Josephine Gabriel
Christopher Garland
Russell Garnett
Justin Gibbs
Lauren Gibson
Donna Girgenti
Thomas Gleeson
Michelle Hannan
Maxim Hatton
Megan Helper
Gregory Hill
Simon Holmick
David Hooper
David Hunchak
Akil Islam
Grant Jasiunas
Dean Jones
Caitlin Kerrigan
Mehdi Khalighimonfared
Funmilola Komolafe
Yolanda Lucas
Hassan Mahmood
Cheng Mao Shiao
Joshua Mark
Gabriel Mayland
Mary McKinnon
Min Min Moe
David Moniz
Michael Moran
Jurgen Mross
Timothy Mulherin
Sultan Najmudeen Nonjai
Bryce Nicol
Davina Oates
Bandele Orebanwo
Jake Parker
Emma Pickstone
Sallyanne Reid
Paul Ricciardo
Erin Ridler
Steven Scally
Reena Sinha
Kyran Smith
Katrina Thackeray
Hannah Trimble
Muhammad Tufail
Joel Van Der
Kirsten Van Wunnik
Miljan Vlahovic
Fiona Wallace
Sean Warfe
Rebecca Warren
Kenneth Wells
Jennifer Wharton
Tracy Wilmington
Sarah Wilmot
Jennifer Wilson
Peter Wyllie

PROFILE OF AN ACRRM REGISTRAR

Dr Kari Sims ACRRM Registrar

What steps did you take to become a rural generalist?

I returned to university to study medicine to become a Rural Generalist and fulfil what was a childhood dream. As a medical student I had the benefit of spending a year in a country town working with a rural generalist who demonstrated the benefits, challenges and variety of work available. I was also able to complete several of my medical school rotations rurally.

These early training opportunities helped prove to me that I was choosing the right type of medicine for me. Although I enjoyed my hospital-based training and working within different subspecialties, it confirmed that Rural Generalism was right for me.

Why did you choose rural generalism as opposed to general practice?

I truly am passionate about the holistic care and longer-term relationships that you can have with patients in general practice. I love the constant variety of rural generalism – sometimes being on call for the local hospital can mean it's a hectic day but the variety and challenges that can present are part of what I love about my job.

How do you pursue other passions as a rural generalist in a relatively small town?

One of the most amazing things about being a rural generalist is becoming involved in the community within which you work. Most rural communities have many opportunities for involvement – I play netball and tennis and have some involvement in a few committees.

Initially I had some reservations about the boundaries between the "social me" and the "professional me" – but I have found that people are respectful of boundaries and I remind myself that I am both a person and a doctor.

What does a typical day look like for you when practicing?

My day is always different. My day is never predictable. My day is always an adventure. That's the beauty of Rural General Practice: you get to make it what you want, and you never know what adventure you will go on each day. I work at the hospital, I work at the general practice clinic, I visit the local nursing homes and I even do roadside trauma work when its needed.

I think it is commonly thought that rural GPs work non-stop, are poorly supported and struggle to maintain a balance between work and personal lives. In my experience, nothing is further from the truth. I have the benefit of some amazingly supportive colleagues and we all work together to balance our work and personal lives – the collaboration is fantastic and the whole community becomes involved.

> THAT'S THE BEAUTY OF RURAL GENERAL PRACTICE: YOU GET TO MAKE IT WHAT YOU WANT, AND YOU NEVER KNOW WHAT ADVENTURE YOU WILL GO ON EACH DAY

RURAL MEDICINE AUSTRALIA 2017

535
delegates

19,000
live stream views

112
presentations

359
app users

3,800
tweets

60
sponsors and exhibitors

POLICY AND ADVOCACY

YEAR AT A GLANCE

Signing of Compact with Commonwealth Government

Launch of the ACRRM Reconciliation Action Plan

Landmark event in the signing of the Collingrove Agreement

POLICY REPORT

It has been a red-letter year for ACRRM and our mission to get the right doctors with the right skills in the right places to improve health for rural, remote, and Aboriginal and Torres Strait Islander communities.

Greater recognition of ACRRM and its role in national policy development has seen us strongly positioned to advocate for our members' and their priorities.

Major steps forward have been made toward a nationally-supported framework to nurture rural generalist training and practice. We were also pleased to see the federal budget's Stronger Rural Health Strategy reflecting many of our key advocacy priorities, including the need for strengthened junior doctor training capacity, dedicated rural generalist positions on the AGPT Program, and support for rural mental health.

We have continued our advocacy work in a wide range of areas including Closing the Gap, rural mental health, rural maternity services, rural digital health and doctor mental health and well-being.

Lead achievements for 2017-2018

- Signing of Compact between ACRRM and Commonwealth Government
- ACRRM joins NMTAN, Health Minister's Workforce Distribution Working Group, National Rural Generalist Jurisdictional Forum
- Signing of Collingrove Agreement
- Leadership role in National Rural Generalist Pathway Taskforce
- AMC Reaccreditation
- Rural Generalist Medicine position statements
- Staged transition to College-led AGPT Program by 2020
- Codeine Education Project delivered

Key campaigns and consultations for 2017-2018

- ACRRM/RDAA proposal for expanded support for rural e-health services
- National Maternity Services Framework development
- Rural Procedural Grants Program Review
- Review of Medical Indemnity Fund support for rural proceduralists
- Member's mental health and well being support
- Rural Training Hubs and Junior Doctor Training programs engagement and collaboration
- Senate enquiry into Access to Diagnostic Imaging Services in rural areas submission and presentation to enquiry
- MBS review General Practice and primary care Clinical Committee submission and presentation

MAJOR STEPS FORWARD HAVE BEEN MADE TOWARD A NATIONALLY-SUPPORTED FRAMEWORK TO NURTURE RURAL GENERALIST TRAINING AND PRACTICE

CLOSING THE GAP REPORT

ACRRM has developed a multi-faceted framework to guide our work toward advancing the health of our Aboriginal and Torres Strait Islander communities and has progressed all of these over the year.

Aboriginal and Torres Strait Islander Members' Group

ACRRM has a members' group with the principle goal of providing a professional home and support network with which to grow and nurture our Aboriginal and Torres Strait Islander Fellows. The group facilitates peer networking and mentoring, liaises with dedicated ACRRM staff to address issues of concern for its members, and acts as a reference group reviewing key ACRRM policy decisions and documents of importance to Aboriginal and Torres Strait Islander health. ACRRM is proud to currently have 50 members identifying as Aboriginal or Torres Strait Islander people.

Closing the Gap Steering Committee

ACRRM continues its membership of the Closing the Gap Steering Committee, advocating for improvements to the national effort to improve standards of health and wellbeing for our Aboriginal and Torres Strait Islander people. Closing the Gap targets have been incorporated into our evaluation framework to be reported against annually.

College Selection supports recruitment

Our first year of being able to apply our own selection model for the AGPT Program has seen a record number of Aboriginal and Torres Strait Islander registrars being selected to these government-supported positions. The 2019 selection round looks set to deliver a similar number. The new process selects registrars based on their assessed proficiency as rural doctors and includes positive recognition of their demonstrated experience and commitment in Aboriginal and Torres Strait Islander community and health services.

Reconciliation Action Plan

ACRRM President A/Prof Ruth Stewart and Fellow Dr Louis Peachy jointly launched the College Reconciliation Action Plan (RAP) at our Rural Medicine Australia conference in Melbourne in October 2017.

Our RAP formalises ACRRM's commitment to reconciliation and exploring opportunities to further enhance our efforts toward its advancement. It is strongly supported by the Board and Council. RAP activities are coordinated by a staff Steering Committee in consultation with the ACRRM Aboriginal and Torres Strait Islander Reference Group.

As part of our RAP, we celebrated National Reconciliation Week with a staff morning tea at the ACRRM office with local Elder Aunty Flo Watson as guest speaker. Later in the week, ACRRM Fellow Dr Louis Peachy conducted cultural awareness sessions for staff. Both events increased our appreciation of our indigenous history and culture.

Other RAP activities have included formalising an Acknowledgement which now appears on ACRRM website, email signatures, meeting agendas and submissions. We are also taking steps to ensure that Aboriginal and Torres Strait Islander peoples feel welcome and encouraged to apply to employment positions.

COLLEAGUES GIVE A FOND FAREWELL TO RETIRING ACRRM FELLOW

Australian College of Rural and Remote Medicine Fellow, Dr Michael Connor has retired from practice after nearly half a century of delivering high standard rural medicine to the town of Colac.

It all began for Dr Michael Connor when he moved to Beeac in rural Victoria after graduating from Melbourne University in 1967.

With a great understanding of what is required to be a rural GP thanks to his father who was also a rural GP, Dr Connor moved into a group practice, where he would gently guide community members into the world and farewell others.

Dr Connor said moving to Beeac was prompted by family members who lived rurally at the time, and the continuity of care that came along with being a rural generalist.

"I just saw it as a much better way of life" said Dr Connor.

To Dr Connor, "cradle to grave care" seems like a fitting way to describe his time as a rural GP, recalling families he's looked after for five generations.

"I've got one bloke who lives about 70km away from here and he's followed me down to Colac for the last 48 years."

"When I retired, he said 'who am I going to see now?'

Practice Manager of Otway Medical Centre in Colac Diane Loubey, has come to terms with the fact that no one will ever be able to fill his enormous shoes.

"His colleagues will miss his support and guidance, and our patients will miss his care and dedication, and the team at Otway Medical Centre will miss his 'dad jokes'".

"We could always bank on Mike coming to lend a hand in times of need, even when he had a day off" said Diane.

Dr Connor recalled one his patients reminding him of a home visit he did.

"I did a home call after midnight one night and I arrived on my motorbike in my pyjamas" said Dr Connor.

After spending six years building his own plane, Dr Connor had the flexibility of working and teaching where he was needed, flying himself all over Australia for locum positions. Colac also became a home for him and his wife of now 51 years, Denise, where they raised six children. He and Denise enjoyed the country lifestyle and all their children attended local schools where they were involved in sporting and community activities.

"I've been able to fit my other passions in with work – I've raced cars, raced motorbikes, water skied, flown planes, built my own plane, and learnt to play bagpipes, none of which would have been possible in an urban town" said Dr Connor.

Dr Connor has held a role as the Vice President of the Victorian Branch Council of the Australian Medical Association (AMA), trained and mentored registrars, gained his Diploma from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), obtained aviation medicine qualifications, and has been a member of the Australian Society of Anaesthetists.

ACRRM wishes Dr Michael Connor and his family all the best as he enters retirement, and send a heartfelt thank you for your contribution to rural and remote medicine.

QUALITY AND SAFETY

YEAR AT A GLANCE

1,842
PDP activities accredited

2,463
Procedural Grants Program participants

1,121
Course attendees

58
Courses delivered

55
Members engaged to deliver courses

26
Courses delivered in locations

COURSES REPORT

In 2017-2018, ACRRM directly delivered training in tailor-made priority skills courses for over 1,120 participants. Members have benefited from access to 58 face-to-face course presentations.

Rural Emergency Skills Training (REST)

We developed the Rural Emergency Skills Training course to define emergency skills that are foundational to safe, quality rural practice for registrars, IMGs and experience doctors. The two-day course was successfully delivered on 32 occasions this financial year including nine courses direct to organisations. Across all courses, 615 doctors from all of Australia's states and territories undertook a REST course including for the first time in Tasmania.

Advanced Life Support (ALS)

Our tailor-made Advanced Life Support program continued to see strong connections being fostered amongst our membership. The one-day course was successfully presented on 10 occasions to over 190 medical professionals in Brisbane, Melbourne, Tweed Heads, Orange, Victor Harbor, Launceston, Pokolbin, Kingscliff and Creswick.

Rural Emergency Obstetrics Training (REOT)

The one-day Rural Emergency Obstetrics Training course is designed for non-obstetricians working in emergency departments or in primary health care settings and aims to provide a practical foundation for management of emergency labour and birth in these clinical settings. A total of five REOT courses were held in Melbourne, Sydney, Brisbane and Cowra for 99 medical professions.

Introduction to Ultrasound Use in Rural Emergency Medicine

The one-day Ultrasound Use in Rural Emergency Medicine course continues to be supported by and presented in conjunction with SonoSite FujiFilm, who provide the portable ultrasound machinery and expert clinical specialist sonographer input into these popular "hands-on" workshops. Five workshops were delivered in Perth, Melbourne, Adelaide and Brisbane for 95 participants. In addition, 30 medical students attended as patient models.

Mental Health Skills Training

Mental health continues to be an area of national priority and critical importance for rural practitioners. The ACRRM course was developed for members working in primary health care settings with minimal mental health skills training. It is accredited by the General Practice Mental Health Standards Collaboration (GPMHSC) and includes a focus on developing skills in assessment, planning and review. During the year, 115 Fellows, members and registrars attended through face-to-face or virtual classroom options.

THE TWO-DAY REST COURSE WAS SUCCESSFULLY DELIVERED ON 32 OCCASIONS THIS FINANCIAL YEAR INCLUDING NINE COURSES DIRECT TO ORGANISATIONS

PROFESSIONAL DEVELOPMENT PROGRAM (PDP) REPORT

The aim of ACRRM's PDP is to ensure that doctors can access and benefit from a range of continuing educational activities to enhance their clinical, management, and professional skills throughout their careers, to maintain an excellent standard of patient care for their communities.

Professional Development Program

The 2017-2018 financial year has seen an increase of 388 new members using ACRRM's Professional Development Program (PDP) with 1,842 new activities accredited in this period. Advanced Life Support continues to be a mandatory component for all Fellows of ACRRM, and we are considering a range of measures to improve and enhance the program for next triennium, taking Medical Board Professional Performance Framework recommendations into account.

The Professional Development Committee, chaired by Dr Ian Kamerman, is committed to including meaningful options for performance review, outcome measurement and educational activities that will continue to enhance the practice of our members.

Procedural Grants Program

The Rural Procedural Grants Program (RPGP) was first introduced in 2004 and aims to retain and increase the numbers of procedural and emergency general practitioners (GPs) in rural and remote areas and maintain their skill levels by increasing their access to relevant educational activities.

Grants are calculated on the number of days of training, with eligible doctors able to claim $2,000 per day for up to 10 days of upskilling per financial year in the procedural components of Anaesthetics, Obstetrics and Surgery and up to three days under the Emergency component for attending relevant educational activities.

In the 2017-2018 financial year, there were 119 new registrations to access the program, bringing the total for procedural and emergency registrations to 2,463. There has also been a steady increase in the total number of training activities accessed annually since the inception of the program, with 1,933 new claims processed this financial year.

THERE HAS ALSO BEEN A STEADY INCREASE IN THE TOTAL NUMBER OF TRAINING ACTIVITIES ACCESSED ANNUALLY SINCE THE INCEPTION OF THE RURAL PROCEDURAL GRANTS PROGRAM

General Practitioner Procedural Training Support Program

ACRRM also administers the anaesthetics component of the General Practitioner Procedural Training Support Program (GPPTSP). The program aims to help overcome workforce shortages and increase the availability of anaesthetics services in rural and remote areas by supporting rural and remote GPs to complete the procedural training program in anaesthetics. This is intended to improve birthing services in rural and remote areas.

Round 8 of the annual funding rounds occurred during the 2017-2018 financial year. We received a total of 43 applications for 15 available scholarships. These applicants have all secured training posts and are progressing towards their anaesthetics qualification.

PROFESSIONAL PERFORMANCE FRAMEWORK TRANSITION

This year, the Medical Board of Australia (MBA) announced a Professional Performance Framework with the stated aim being to 'ensure that all registered medical practitioners in Australia practise competently and ethically throughout their working lives and provide safe care to patients.'

Core features are:

- Strengthened Continuing Professional Development (CPD), using evidenced-based approaches to CPD to drive practice improvement and better patient healthcare outcomes.
- Identifying and assessing at risk and poorly performing practitioners, including developing accurate and reliable ways to identify practitioners at risk of poor performance and remediating them early, and identifying, assessing and ensuring there is effective remediation for practitioners who are already performing poorly.

The MBA started work on the framework by establishing an Implementation Group to coordinate the various elements. They have also established a CPD Advisory Group to provide advice to stakeholders on issues related to CPD.

ACRRM has been engaging in regular discussions with the MBA to gain insight into potential impacts of the new framework, to provide feedback, and to find the best solutions for our members to meet their Professional Development needs. ACRRM takes an evidence-based approach and strives to ensure activities will add value by improving our members' quality and safety in practice.

One performance review option being considered is Multi-Source Feedback (MSF). This is a process that gathers feedback from nominated colleagues and patients on a clinician's performance via a series of questions and compares the results with benchmarks from those in a similar professional setting. The answers are anonymous, and the candidate receives a report on the results with a guide to reflecting on the outcomes.

We have conducted a survey of PDP members to gather feedback about this option and are currently undertaking a targeted MSF trial for Fellows across a heterogeneous cohort so that we can learn from a wide range of practice types and locations. This trial will provide crucial information on the real-world experience of completing MSF and will assist in our efforts to identify tangible benefits and real or potential barriers for our members.

In our endeavour to maintain a PDP that is value adding and fit for purpose for our members, ACRRM is intends to implement a suite of tools for performance review to support our members going forward, and MSF is just one in a range of options. We will continue to consult with all stakeholders to find the best solutions for the future.

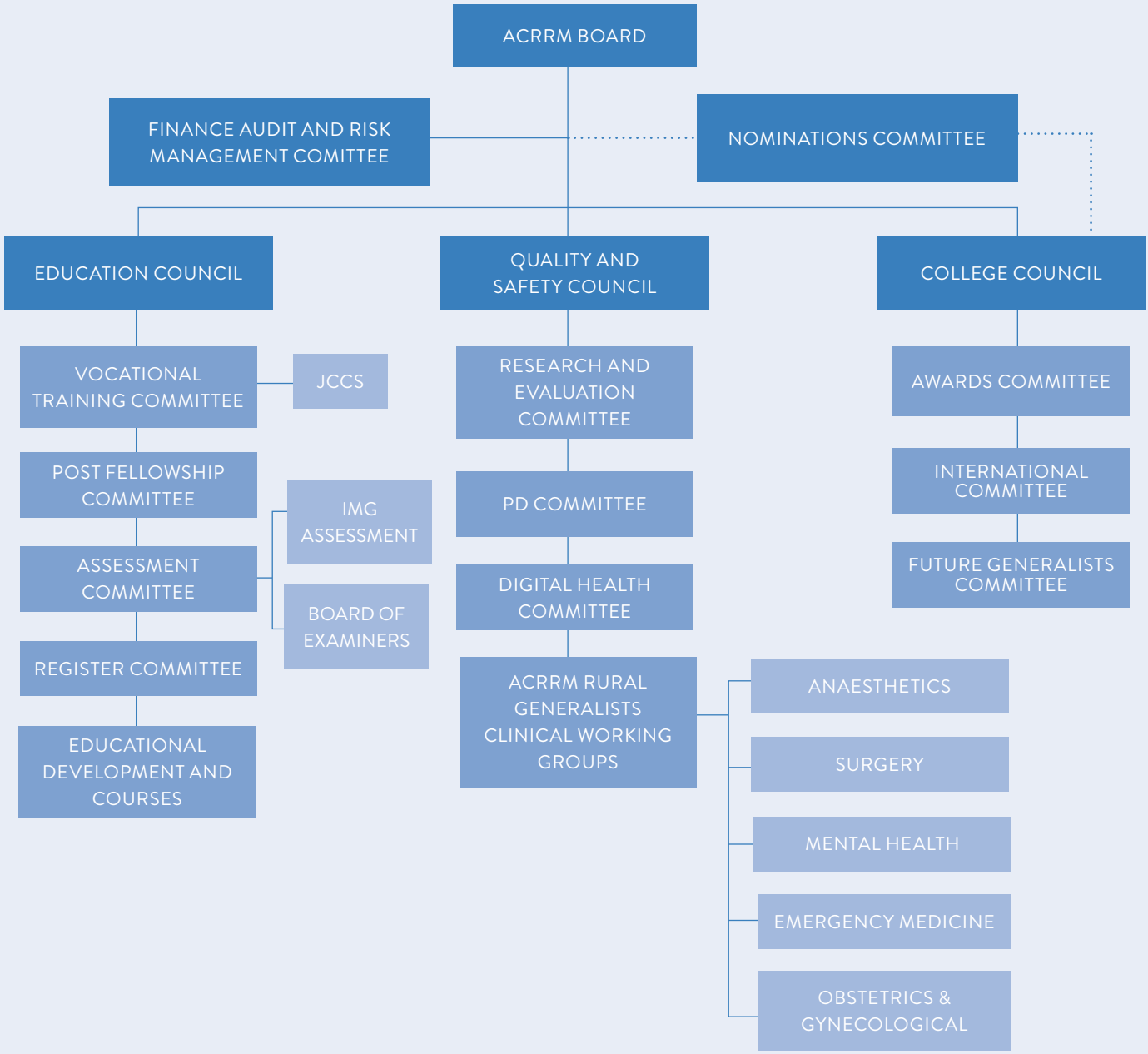
Importantly, we will continue to advocate for our members whose unique practice characteristics should be considered as the framework is developed and implemented. We will also work to ensure that our PDP continues to enable rural and remote doctors to be in control of their professional development and support their needs and those of their communities.

IN OUR ENDEAVOUR TO MAINTAIN A PROFESSIONAL DEVELOPMENT PROGRAM THAT IS VALUE ADDING AND FIT FOR PURPOSE FOR OUR MEMBERS, ACRRM IS INTENDS TO IMPLEMENT A SUITE OF TOOLS FOR PERFORMANCE REVIEW TO SUPPORT OUR MEMBERS GOING FORWARD

COMMITTEE/COUNCIL GOVERNANCE STRUCTURE

Two new working groups were this year added to the ACRRM Governance Structure; Emergency Medicine Group and the Obstetrics and Gynecology Group.

These working groups now complete phase one of our clinical quality and safety developments and as such will work in parallel with current groups for Anaesthetics, Surgery, and Mental Health, and form part of the clinical governance structure reporting to the ACRRM Quality and Safety Council.



DIGITAL INNOVATION

YEAR AT A GLANCE

Over **100** College accredited education modules made available on RRMEO

9,700 RRMEO modules undertaken

6,800 Enrolments in ACRRM Online Learning

451 Virtual classroom sessions facilitated

3,695 Doctors with access to the ACRRM Clinical Guidelines for Rural Practice

319 Enrolled in Q Fever – early diagnosis and vaccination

103 Enrolled in Rural Doctors Family and Domestic Violence Education Package

DIGITAL INNOVATION REPORT

It has been a year of great innovation at ACRRM, with the launch of our new online learning system, plus the introduction of several new, timely courses for junior doctors, registrars and Fellows.

ACRRM Online Learning goes live

This year saw the fruition of a major project to replace our the RRMEO learning management system with a new, state of the art learning management system. The new ACRRM Online Learning platform began rolling out to members in February 2018.

Throughout the year, ACRRM developed and implemented the new system, migrating a number of flagship courses to the new system. These courses include:

- Jim talks about eczema
- PESCI application preparation
- Youth friendly consultation skills
- A users guide to skin surgery
- Palliative care - a doctor's bag
- Cultural awareness
- Introduction to population health
- RCH - practical paediatrics program

This represents over 6,800 enrolments.

We expect to launch the Basics of Radiology, ruralEM forum, 150 shades of radiology, and Tele-Derm within the opening weeks of the new financial year.

Domestic Violence Education

The 'Rural Doctors Family and Domestic Violence Education Package' went live this year. The module was developed by rural doctors for rural doctors and draws on the diverse experience of a national team of clinicians. It aims to strengthen doctors' capacity to address family violence within their rural and remote practice community. It is based on a series of clinically focused case-based discussions with emphasis on providing best practice responses at both the individual and the community level. There are currently over 100 users enrolled in the module.

Rural Generalist Foundation Skills for Junior Doctors

ACRRM worked closely with Queensland Country Practice to publish five online modules specifically designed to support rural junior doctor training through the Queensland Country jDocs program. The modules cover: Rural and Remote Context, Self-Care and Well Being, Aboriginal and Torres Strait Islander Health, Population Health and Digital Health. Over 150 junior doctors are currently enrolled in the modules.

Q Fever

The 'Q fever: early diagnosis and vaccination' online learning module was developed by the Communicable Diseases Branch, Health Protection New South Wales in collaboration with experts in clinical infectious diseases, vaccinology, veterinary microbiology, public health and rural general practice. We currently have over 300 users enrolled in the module.

New 'dial in' feature for Virtual Classrooms

Functionality of ACRRM's virtual classroom software has continued to be improved with users now being able to connect their audio via telephone. This again provides different options to meet the diverse scenarios of users.

Number of virtual classrooms and webinars increases

We saw an increase in the number of webinars being offered by ACRRM and in partnership with external organisations. Many of these sessions saw up to 200 attendees in a single live session. Over 450 sessions were delivered (or over 450,000 minutes online) which included almost 300 education sessions and various other training sessions and meetings.

DIGITAL HEALTH REPORT

ACRRM's Digital Health Committee this year focused on digital health solutions that support team-based care, distributed care and isolated care, the uptake of telehealth, and point of care testing. The Digital Health Committee reports to the Quality and Safety Council and is chaired by A/Prof Chris Pearce.

Telehealth

We continue to collaborate with several organisations on the barriers to increasing the uptake of telehealth for rural and remote communities.

ACRRM's national telehealth advisory committee updated its terms of reference this year to expand its scope to digital health technologies that support care at a distance for rural, remote and Aboriginal and Torres Strait Islander communities across primary and secondary care and renamed the committee to the 'rural and remote digital innovation group'.

Australian Digital Health Strategy and Framework

ACRRM has worked with the Australian Digital Health Agency in its review and update of the Australian Digital Health Strategy and Framework for action. The strategy has seven priorities including a national secure messaging platform and support for wider use of telehealth. ACRRM is a member of the Agency's Quality and Safety governance committee, National Medicines Safety Steering Committee, Pathology and Diagnostic imaging steering committees, and the My Health Record Expansion steering committee.

Rural Health Outreach fund

Funded by the Commonwealth Government under the Rural Health Outreach Fund, Tele-Derm provided 1,400 occasions of service online for 600 rural patients this year so they could be treated locally. Without this service, these patients would have been referred to a distant specialist practice in a metropolitan centre.

Over 3,450 rural doctors registered to access both the dermatology and ophthalmology specialist advice services.

The ACRRM telehealth provider directory contains the details of 1,250 providers providing telehealth with 32 joining the directory this year.

OVER 3,450 RURAL DOCTORS REGISTERED TO ACCESS BOTH THE DERMATOLOGY AND OPHTHALMOLOGY SPECIALIST ADVICE SERVICES

ACRRM BOARD AND STANDING COMMITTEES

CHAIRS AND MEMBERS 2018

ACRRM Board

A/Prof Ruth Stewart	President
Dr Michelle Hannan	Registrar Director
Dr Sue Harrison	Director
Dr Mike Beckoff	Director
Dr Dan Halliday	Director
Dr Ewen McPhee	Director
Ms Annabelle Brayley	Director
A/Prof David Campbell	Censor in Chief (ex-officio)
Ms Marita Cowie	Chief Executive Officer (ex-officio)
Prof Lucie Walters	Immediate Past President (ex-officio)

College Council

Professor Lucie Walters	Immediate Past President
A/Prof Ruth Stewart	President
Dr James Ricciardone	Registrar representative
Dr Justin Azzopardi	Future Generalists Committee
Dr Michelle Hannan	Board member
Dr Sue Harrison	Board member
Dr Eve Merfield	Tasmanian Councillor (Chair)
Dr Andrew Miller	SA Councillor
Dr Viney Joshi	WA Councillor
Dr Bruce Thorpe	VIC Councillor
Dr Sarah Chalmers	NT Councillor
Dr Rod Martin	NSW Councillor
Dr Ewen McPhee	Board member
A/Prof Ruth Stewart	Board member
Dr Mike Beckoff	Board member
Dr Dan Halliday	Board member
Dr Francois Pretorius	QLD Councillor
A/Prof David Campbell	Censor in Chief (ex-officio)
Ms Marita Cowie	Chief Executive Officer (ex-officio)

Quality and Safety Council

Prof Dennis Pashen	Chair
Dr Anthony Lembke	Member
A/Prof Aniello Iannuzzi	Member
Dr Ian Kamerman	Member
Dr Elisabeth Dodd	Member
Dr Sally Banfield	Member
Dr Neil Beaton	Member
Dr David Rosenthal	Member
Prof Lucie Walters	Member
A/Prof Christopher Pearce	Member
Dr Andrew Jamieson	Member
Mr Sean Mutchmor	General Manager – Quality and Safety (ex-officio)
Ms Denise O'Sullivan	Executive Assistant – Quality and Safety (ex-officio)

Board of Examiners

A/Prof David Campbell	Censor in Chief and Chair
Prof Tarun Sen Gupta	Assessment Committee Chair
Dr Pat Giddings	Member
A/Prof David Rosenthal	Member
Dr Peter Arvier	Attends twice per year to present EM StAMPS papers
Dr Katie Goot	Attends twice per year to present MCQ papers
Dr RT Lewandowski	Attends twice per year to present PC StAMPS papers
Ms Karen Connaughton	Assessment Manager (ex-officio)
Ms Maxine Crowley	Assessment Coordinator

Finance and Risk Management Committee

Dr Mike Beckoff	Board director
Dr Dan Halliday	Board director
Dr Bruce Thorpe	Council member
Dr Ewen McPhee	Board director
Dr Justin Azzopardi	Council member
Dr Sarah Chalmers	Council member
Mr Darryl Perkins	General Manager Corporate Services
Ms Marita Cowie	Chief Executive Officer

Education Council

Dr David Rosenthal	Chair
A/Prof David Campbell	Censor in Chief
Dr Tom Doolan	Education & Training Committee Chair
Prof Tarun Sen Gupta	Assessment Committee Chair
Dr Allison Hempenstall	Registrar Committee Member
Dr Paul de Jong	IMG Assessment Committee Chair
Dr Stephen Lambert (PhD)	General Manager – Education Manager (ex-officio)
Ms Lynn Saul	Standards & Accreditation Manager (ex-officio)

Professional Development Committee

Dr Ian Kamerman	Chair
Dr April Armstrong	Member
Dr Carol Reeve	Member
Dr David Rosenthal	Member
Dr Ralph Chapman	Member

Dr Peter Baker	Member
Dr Suresh Badami	Member
Sean Mutchmor	General Manager – Quality and Safety (ex-officio)
Ms Leisa Ryan	PDP Coordinator (ex-officio)
Dr Ian Kamerman	Chair

Education and Training Committee

Dr Tom Doolan	Chair
Dr Charles Evill	Member
Dr Rod Martin	Member
Dr Peter Chilcott	Member
Dr Vimbai Kapuya	Member
Dr Jessica Hockey	Member
Ms Lynn Saul	Standards and Accreditation Manager (ex-officio)
Ms Sandra Johanson	Vocational Training Manager (ex-officio)

Assessment Committee

Prof Tarun Sen Gupta	Chair
A/Prof Bruce Chater	Member
A/Prof Lucie Walters	Member
Dr Ajay Chipiri	Member
Dr David Rosenthal	Member
Dr Deborah Simmons	Member
Dr Paul De Jong	Member
Dr Kari Sims	Registrar Member
Mr Richard Hays	Consultant
Ms Karen Connaughton	Assessment Manager
Ms Maxine Crowley	Assessment Coordinator

Registrar Committee

Dr James Ricciardone	Chair
Dr Nicholas Jones	Member
Dr Kari Sims	Member
Dr Angus Brown	Member
Dr Sanjay Bhargava	Member
Dr Michael McLaughlin	Member
Dr Michelle Hannan	Member
Dr Vimbai Kapuya	Member
Dr Amranthir Dhillon	Member
Dr Jessica Hockey	Member
Dr Allison Hempenstall	Member
Dr John Lancashire	Member
Ms Sandra Johanson	Vocational Training Manager (ex-officio)
Mrs Leanne Emery	Education Services Support Officer

IMG Assessment Committee

Dr Paul de Jong	Chair
Prof Tarun Sen Gupta	Assessment Committee Chair
Dr Michael Douglas	Member
Dr Peter Finlayson	Member
Prof Dennis Pashen	Member
Dr Christina Carroll	Medical Educator (ex-officio)
Ms Karen Connaughton	Assessment Manager (ex-officio)
Ms Maxine Crowley	Assessment Coordinator (ex-officio)

Post Fellowship Committee

Prof Dennis Pashen	Chair
Prof Scott Kitchener	Member
Dr Ulrich Orda	Member
Dr John Russell	Member
Dr Tim Kelly	Member
Ms Lynn Saul	VT and Assessment Manager

Research Committee

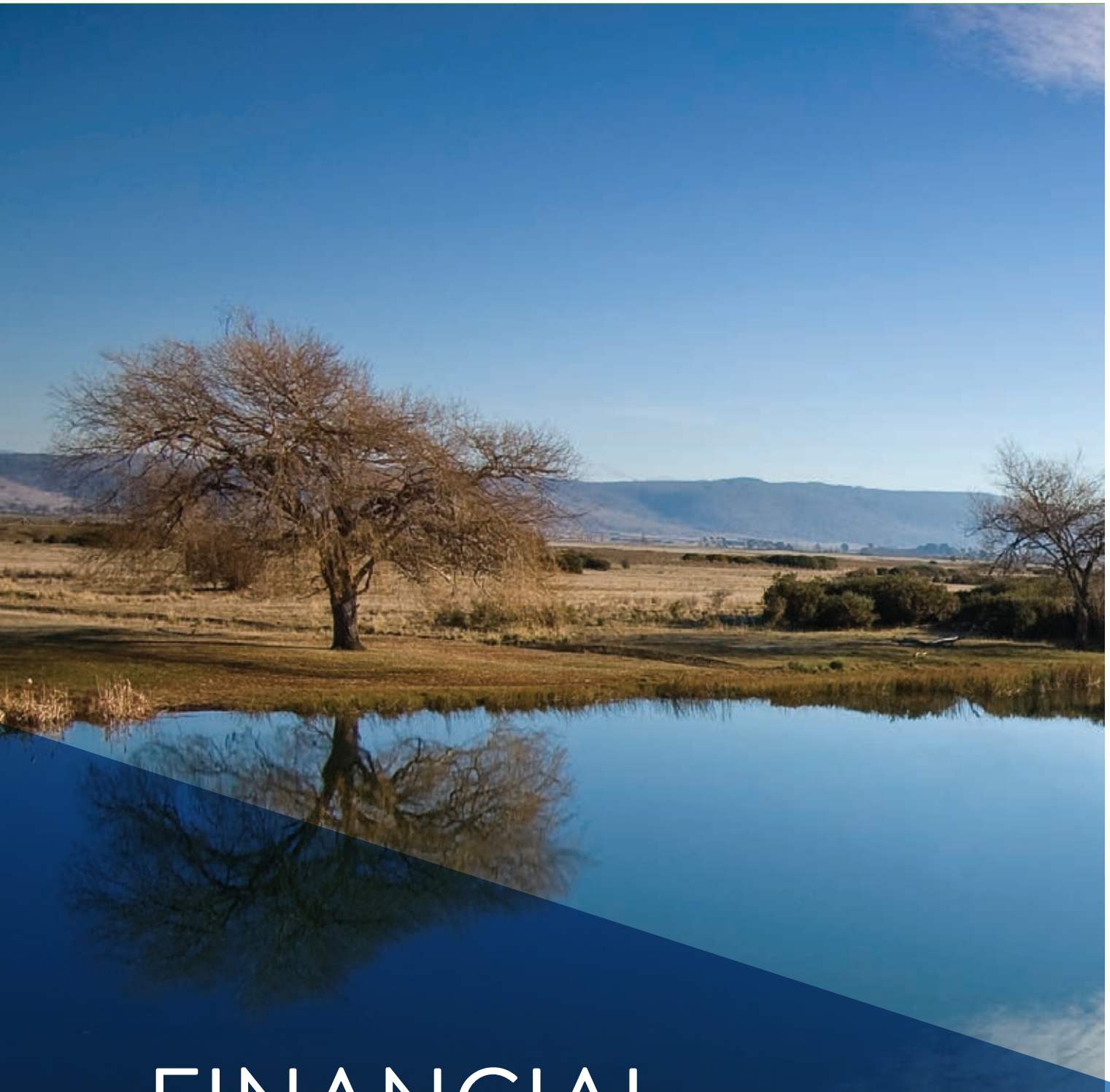
A/Prof Lucie Walters	Chair
A/Prof David Campbell	ACRRM member
A/Prof Ronny Gunnarson	AAAPC representative
Prof John Hall	ACRRM member
Prof Jill Konkin	International member
Prof Stephen Margolis	ACRRM member
Prof Jonathan Newbury	ACRRM member
A/Prof Denese Playford	FRAME representative
A/Prof Louise Young	ACRRM member
Mr Sean Mutchmor	General Manager – Quality and Safety (ex-officio)
Ms Denise O'Sullivan	Executive Assistant – Quality and Safety Officer (ex-officio)

Digital Health Committee

A/Prof Christopher Pearce	Chair
Dr Ewen McPhee	Member
Dr Jeff Ayton	Member
Dr Anthony Lembke	Member
Dr Shannon Nott	Member
Dr Francois Pretorius	Member
Dr Viney Joshi	Member
Mr Sean Mutchmor	General Manager – Quality and Safety (ex-officio)
Ms Jane Connolly	Program Coordinator eHealth Services

Future Generalists Committee

Dr Justin Azzopardi	Chair
Dr Louise Manning	Events officer
Dr Laura Harris	Member
Dr Daniel Wilson	Member
Dr Joshua Mortimer	Member
Mr Jaffly Chen	Member
Ms Megan Telford	Member
Ms Rene Lazzaro	Member
Mr Clay Rowe	Member
Dr Stephen Johnston	Member
Dr Andreas Hendarto	Member
Dr Thomas Currie	Member
Ms Julie Graham	Member
Dr Lisa Waters	Member
Dr Rebecca Irwin	Member



FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2018

DIRECTORS' REPORT

The Directors submit the following report for the year ended 30 June 2018 under Sections 298 and 300B of the *Corporations Act 2001* and in accordance with a resolution of the Board of Directors.

Directors

The names of the Directors of Australian College of Rural and Remote Medicine Limited (ACRRM) in office at any time during the year or since the end of the year:

Dr Sally Banfield (resigned 19/10/2017)

Dr Michael Beckoff

Dr Suzanne Harrison

Professor Lucie Walters

Dr Ewen McPhee

Associate Professor Ruth Stewart

Dr Daniel Halliday

Dr Michelle Hannan (appointed 19/10/2017)

Principal Activities, Objectives & Strategies

The principal strategies of ACRRM during the year were to promote the interests of rural and remote doctors through the delivery of high quality specialist medical education and training, research, policy and advocacy.

There was no significant change in the nature of the activities during the year. The company's financial accounts have been prepared in accordance with Australian Accounting Standards.

In order to meet the long term objectives of the College, the company will strive to:

- Be recognised as the leading voice for best practice in rural and remote medicine in Australia
- Proactively support students, members and Fellows with quality education, training and resources
- Engage with and bring value to the full range of medical and rural health professions.

The company's short term objectives is to focus on growth within existing target markets for the next 12 months and maintain strong member retention.

In order to meet the short term objectives of the College, the company will continue to:

- Encourage a targeted approach to member recruitment
- Place greater emphasis on generating income sources that are independent of government
- Broaden the range of College programs and activities
- Emphasise member and staff satisfaction as a key priority

Key Performance Measures

Management and the Board (through the Finance Audit and Risk Management Committee) monitor ACRRM's overall performance, from its implementation of the vision statement and strategic plan through to the performance against operating plans and financial budgets.

At this point in time, regular monitoring of revenue targets and delivery of service are a key focus however the Board and management are currently working on a series of quantitative and qualitative key performance indicators for use in future years.

Review and Results of Operations

The profit from ordinary activities for the year ended 30 June 2018 amounted to $256,319 (2017 profit: $611,823).

Winding up Provisions

Every member undertakes to contribute to the assets of the Company if it is wound up while the member is a member or within one year after it ceases to be a member, for payment of the debts and liabilities of the Company contracted before it ceased to be a member, and of the costs, charges and expenses of winding up and for the adjustment of the rights of contributories among themselves, such amount as may be required, not exceeding $10.

Information on Directors

The following persons were Directors of the Australian College of Rural and Remote Medicine during this financial year. No payments (financial or otherwise) were made for their services.

Dr Sally Banfield (resigned 19/10/2017)

MBBS, FACRRM

Dr Banfield has been involved in medical education and advocacy at both local and state levels. She has a passion for rural generalism and Indigenous health.

Dr Michael Beckoff

MBBS, FACRRM, FAICD, Assoc. Dipl. Agric (Dist)

Dr Beckoff is a practising rural generalist based in South Australia with over 40 years' experience, both as an equity partner and now as a rural and remote locum. He is a company director involved in various health corporate roles at a state and national level.

Dr Suzanne Harrison

MBBS, DA, FACRRM, MSP Medicine, Grad Cert Health Professional Education

Dr Harrison is a rural generalist in Echuca and part time medical educator for Melbourne University. She is a Board member of Murray City Country Coast GP Training.

Dr Ewen McPhee

MBBS (Hons), FRACGP, FACRRM, DRANZCOG (Adv)

Dr Ewen McPhee is a rural generalist GP Obstetrician in private practice. As a long term resident of Emerald in Central Queensland, Dr McPhee has an interest in supporting the future rural medical workforce.

Associate Professor Ruth Stewart

MBBS, PhD(Flin), FACRRM, DRANZCOG

Dr Ruth Stewart is the President of ACRRM and is Associate Professor of Rural Medicine at James Cook University. She lives on Thursday Island where she works as a Senior Medical Officer delivering women's health clinics to the outer islands of The Torres Strait and is a credentialed GP obstetrician. Dr Stewart is also a board director for the Torres and Cape Hospital and Health Service.

Dr Daniel Halliday

MBBS, BBioMedSc, FACRRM, DRANZCOG, FRACGP, GAICD, GCAHM

Dr Dan Halliday is a Rural Generalist with special interest in Obstetrics and Medical Superintendent of Stanthorpe Hospital, Queensland. Dan is a Past-President of Rural Doctors Association of Queensland (RDAQ) and current Secretary of the RDAQ Foundation.

Dr Michelle Hannan

(appointed 19/10/2017) BMedSc(Hons), MBBS, FACRRM, DCH

Dr Michelle Hannan is a Rural Generalist who divides her time working with the Royal Flying Doctor Services in Mount Isa Queensland and her home base in Tasmania.

Ms Marita Cowie

BA (Psych), BBus (Com)

Marita Cowie is the foundation Chief Executive Officer and Company Secretary of the College. She has more than 25 years' experience in medical education, training and business management. Marita is also Deputy Chair of the Board of Asthma Australia.

Meetings of Directors

During the 2017-2018 financial year, 8 meetings of Directors were held with attendance as follows:

Directors	Directors Meetings	
	Eligible to attend	Attended
Dr Michael Beckoff	8	7
Dr Michelle Hannan	5	5
Dr Sally Banfield	3	2
Dr Suzanne Harrison	8	7
Dr Ewen McPhee	8	7
Associate Professor Ruth Stewart	8	8
Dr Daniel Halliday	8	7

Attendance of Ex Officio Board Members at Meetings of Directors

EX OFFICIO MEMBERS	Directors Meetings	
	Eligible to attend	Attended
Associate Professor David Campbell, Censor in Chief	8	7
Ms Marita Cowie, Chief Executive Officer	8	8
Professor Lucie Walters, Immediate Past President	8	8

There is one formally constituted committee of the Board being the College Council. During the financial year 4 meetings of the Council were held with attendance as follows:

COUNCIL MEMBERS	Council Meetings	
	Eligible to Attend	Attended
Dr Michael Beckoff	4	4
Professor Lucie Walters	4	3
Dr Francois Pretorius	3	3
Dr Sally Banfield	2	2
Dr Suzanne Harrison	4	3
Ms Marita Cowie	4	3
Associate Professor David Campbell	4	3
Dr Ewen McPhee	4	3
Associate Professor Ruth Stewart	4	4
Dr Daniel Halliday	4	4
Dr Rod Martin	4	4
Dr Eve Merfield	4	4
Dr Bruce Thorpe	4	1
Dr James Ricciardone	4	4
Dr Justin Azzopardi	4	4
Dr Sarah Chalmers	4	4
Dr Michelle Hannan	4	3
Dr Andrew Miller	4	2
Dr Sally Singleton	2	2
Dr Viney Joshi	3	2

The Finance and Risk Management Committee during the financial year held 6 meetings with attendance as follows:

FINANCE AUDIT AND RISK MANAGEMENT COMMITTEE MEMBERS	FINANCE AUDIT AND RISK MANAGEMENT COMMITTEE MEETINGS	
	Eligible to attend	Attended
Dr Michael Beckoff	6	6
Dr Justin Azzopardi	3	2
Dr Bruce Thorpe	3	3
Dr Daniel Halliday	3	3
Dr Viney Joshi	3	2
Ms Marita Cowie	6	5
Dr James Ricciardone	3	2
Dr Ewen McPhee	6	6
Dr Michelle Hannan	3	1
Dr Sarah Chalmers	3	2

Auditor's independence declaration

The lead auditor's independence declaration under section 307C of the Corporations Act 2001 for the year ended 30 June 2018 has been received by the directors.

Signed in accordance with a resolution of the Board of Directors.

Director
Dated at this 18th day of September, 2018

AUDITOR'S INDEPENDENCE DECLARATION
UNDER SECTION 60-40 OF THE AUSTRALIAN CHARITIES AND NOT-FOR-PROFIT COMMISSION ACT 2012

TO THE DIRECTORS OF
AUSTRALIAN COLLEGE OF RURAL AND REMOTE MEDICINE LIMITED

I declare that, to the best of my knowledge and belief, during the year ended 30 June 2018 there have been:

(i) no contraventions of the auditor independence requirements as set out in the *Australian Charities and Not-for-Profit Commission Act 2012* in relation to the audit; and

(ii) no contraventions of any applicable code of professional conduct in relation to the audit.

Bentleys Brisbane (Audit) Pty Ltd

Stewart Douglas
Director
Brisbane
21 September 2018

STATEMENT OF PROFIT AND LOSS AND OTHER COMPREHENSIVE INCOME

For the year ended 30 June 2018

	Notes	2018 $	2017 $
Revenues from Ordinary Activities	2	12,551,157	15,134,175
Expenses from Ordinary Activities	3	(12,294,838)	(14,522,352)
Surplus/(Deficit) from Ordinary Activities		256,319	611,823
Income Tax Expense		-	-
Surplus/(Deficit)		256,319	611,823
Other comprehensive income		-	-
Total comprehensive income for the year		256,319	611,823

The above Statement of Profit and Loss and Other Comprehensive Income should be read in conjunction with the attached notes

BALANCE SHEET

As at 30 June 2018

	Notes	2018 $	2017 $
CURRENT ASSETS			
Cash and Cash Equivalents	5	13,164,128	12,149,331
Trade and Other Receivables	6	1,666,077	1,758,007
Other Assets	7	415,452	315,511
TOTAL CURRENT ASSETS		15,245,657	14,222,849
NON-CURRENT ASSETS			
Intangible Assets	8	906,544	884,483
Plant and Equipment	9	179,076	104,063
TOTAL NON-CURRENT ASSETS		1,085,620	988,546
TOTAL ASSETS		16,331,277	15,211,395
CURRENT LIABILITIES			
Trade and Other Payables	10	10,320,589	9,469,942
Provisions	11	283,241	290,075
Other Liabilities	12	55,920	44,620
TOTAL CURRENT LIABILITIES		10,659,750	9,804,637
NON-CURRENT LIABILITIES			
Provisions	11	198,337	189,887
Other Liabilities	12	-	-
TOTAL NON-CURRENT LIABILITIES		198,337	189,887
TOTAL LIABILITIES		10,858,087	9,994,524
NET ASSETS		**5,473,190**	**5,216,871**
EQUITY			
Retained Earnings	13	5,473,190	5,216,871
TOTAL EQUITY		**5,473,190**	**5,216,871**

The above Balance Sheet should be read in conjunction with the attached notes

STATEMENT OF CASH FLOWS

For the year ended 30 June 2018

	Notes	2018 $	2017 $
Cash Flows from Operating Activities			
Receipts from Members & Other Consultancies		10,991,588	11,697,762
Interest Received		187,083	186,063
Grants Received		3,537,003	6,617,056
Payments to Suppliers and Employees		(13,245,534)	(16,201,212)
Net Cash (used in)/provided by Operating Activities	21(i)	1,470,140	2,299,669
Cash Flows from Investing Activities			
Payments for Property, Plant, Equipment and Capital WIP		(455,343)	(57,055)
Net Cash (used in) Investing Activities		(455,343)	(57,055)
Net Increase (Decrease) in Cash held		1,014,797	2,242,614
Cash at the beginning of the Financial Year		12,149,331	9,906,717
Cash at the end of the Financial Year	21(ii)	13,164,128	12,149,331

The above Statement of Cash flows should be read in conjunction with the attached notes

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2018

	Retained Earnings $	Total $
Balance at 30 June 2016	**$4,605,048**	**$4,605,048**
Comprehensive Income		
Net Surplus/(Deficit)	611,823	611,823
Other Comprehensive Income	-	-
Total Comprehensive Income	611,823	611,823
Balance at 30 June 2017	**$5,216,871**	**$5,216,871**
Comprehensive Income		
Net Surplus/(Deficit)	256,319	256,319
Other Comprehensive Income	-	-
Total Comprehensive Income	256,319	256,319
Balance at 30 June 2018	**$5,473,190**	**$5,473,190**

The above Statement of Changes in Equity should be read in conjunction with the attached notes

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2018

1. SUMMARY OF ACCOUNTING POLICIES

These financial statements constitute a general purpose financial report which has been drawn up in accordance with Australian Accounting Standards (including other authoritative pronouncements of the Australian Accounting Standards Board and Australian Accounting Interpretations), the Corporations Act 2001 and the Australian and Not-for-Profits Commission Act 2012. The company is a not-for-profit entity for financial reporting purposes under Australian Accounting Standards.

A statement of compliance with International Financial Reporting Standards cannot be made due to the Company applying the not-for-profit sector specific requirements contained in Australian Accounting Standards.

Basis of Preparation

The financial statements, except for the cash flow information, are prepared on the accrual basis of accounting using the historical cost assumption and except where stated do not take into account changing money values nor current valuations of non-current assets and their impact on operating results.

Material accounting policies adopted in the preparation of these financial statements are presented below and have been consistently applied unless stated otherwise. The accounting policies below have been consistently applied to all years presented.

Critical Accounting Estimates and Judgments

The directors evaluate estimates and judgments incorporated into the financial statements based on historical knowledge and best available current information. Estimates assume a reasonable expectation of future events and are based on current trends and economic data, obtained both externally and within the company. Significant estimates and judgment employed by the company concern the useful life and depreciation rates for plant and equipment and the useful life and amortization rates for intangibles which are reviewed annually by the company (detailed in Note 1) and the basis of estimating the provision for make-good, detailed in Note 11.

Income Tax

The College is exempt from income tax under provisions of the Income Tax Assessment Act.

Property, Plant and Equipment

Property, plant and equipment are brought to account at cost, less, where applicable, any accumulated depreciation. Rates as per below:

		Depreciation method	Depreciation rate
Plant & Equipment	Purchased before 30/06/11	Diminishing value	20% - 40%
Plant & Equipment	Purchased after 30/06/11	Straight Line	10% - 33%
Leasehold Improvements		Straight Line	20%

Revenue Recognition

(a) Non-reciprocal grant revenue is recognised in the statement of profit and loss and other comprehensive income when the entity obtains control of the grant and it is probable that the economic benefits gained from the grant will flow to the entity and the amount of the grant can be measured reliably. If conditions are attached to the grant which must be satisfied before it is eligible to receive the contribution, the recognition of the grant as revenue will be deferred until those conditions are satisfied.

When grant revenue is received whereby the entity incurs an obligation to deliver economic value directly back to the contributor, this is considered a reciprocal transaction and the grant revenue is recognised in the state of financial position as a liability until the service has been delivered to the contributor, at which time the grant is recognised as income.

(b) Interest Revenue is recognised on a time proportionate basis that takes into account the effective yield on the financial asset.

(c) Subscriptions are recognised on an accrual basis proportionate to when the service is provided.

Employee Benefits

The following liabilities arising in respect of employee entitlements are measured at the amount expected to be paid when the liability is settled:

- wages and salaries, annual leave and sick leave regardless whether they are expected to be settled within twelve months of balance date.
- other employee entitlements which are expected to be settled within twelve months of balance date.

Long service leave liabilities are determined after taking into consideration years of service, current level of wages and salaries and past experience regarding staff departures.

Leases

Lease payments for operating leases, where substantially all the risks and benefits remain with the lessor, are charged as expenses in the periods in which they are incurred.

Incentives received under lease arrangements are recognised in profit and loss over the term of the lease.

Intangible Assets

The cost of implementing a Customer Relationship Management System and the Learning Management System have been capitalised under the conditions set out in Australian Accounting Interpretations. The cost is to be amortised over a period of five years and any further expenses incurred for maintenance will be expensed in profit and loss.

Financial Instruments

Initial recognition and measurement

Financial assets and financial liabilities are recognised when the College becomes a party to the contractual provisions to the instrument. For financial assets, this is equivalent to the date that the company commits itself to either purchase or sell the asset (i.e. trade date accounting is adopted). Financial instruments are initially measured at fair value plus transaction costs except where the instrument is classified "at fair value through profit or loss", in which case transaction costs are recognised in profit or loss immediately.

Classification and subsequent measurement

Financial instruments are subsequently measured at fair value, amortised cost using the effective interest rate method, or cost. Where available, quoted prices in an active market are used to determine fair value. In other circumstances, valuation techniques are adopted.

Amortised cost is calculated as the amount at which the financial asset or financial liability is measured at initial recognition less principal repayments and any reduction for impairment, and adjusted for any cumulative amortisation of the difference between that initial amount and the maturity amount calculated using the effective interest method.

The effective interest method is used to allocate interest income or interest expense over the relevant period and is equivalent to the rate that exactly discounts estimated future cash payments or receipts (including fees, transaction costs and other premiums or discounts) through the expected life (or when this cannot be reliably predicted, the contractual term) of the financial instrument to the net carrying amount of the financial asset or financial liability. Revisions to expected future net cash flows will necessitate an adjustment to the carrying value with a consequential recognition of an income or expense item in profit or loss.

Fair value is determined based on current bid prices for all quoted investments. Valuation techniques are applied to determine the fair value for all unlisted securities, including recent arm's length transactions, reference to similar instruments and option pricing models. The net fair value of all financial assets and liabilities are represented by their book value unless otherwise stated.

(i) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market and are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised. Trade receivables represent the principal amounts outstanding at balance date, are non-interest bearing and are usually settled within 30 days.

(ii) Financial liabilities

Non-derivative financial liabilities other than financial guarantees are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial liability is derecognised.

Payables represent the principal amounts outstanding at balance date, are non-interest bearing and are usually settled within 30 days.

(iii) Cash and Cash Equivalents

Cash and cash equivalents include cash on hand, deposits held at-call with banks, other short-term highly liquid investments with original maturities of three months or less.

Derecognition

Financial assets are derecognised where the contractual rights to receipt of cash flows expires or the asset is transferred to another party whereby the College no longer has any significant continuing involvement in the risks and benefits associated with the asset. Financial liabilities are derecognised where the related obligations are either discharged, cancelled or expired.

Impairment of Assets

At the end of each reporting period, the College reviews the carrying values of its tangible and intangible assets to determine whether there is any indication that those assets have been impaired. If such an indication exists, the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, is compared to the asset's carrying value. Any excess of the asset's carrying value over its recoverable amount is recognised in profit or loss.

At the end of each reporting period, the company assesses whether there is objective evidence that a financial asset has been impaired. A financial asset or a group of financial assets will be deemed to be impaired if, and only if, there is objective evidence of impairment as a result of the occurrence of one or more events (a "loss event"), which has an impact on the estimated future cash flows of the financial asset(s).

Goods and Services Tax (GST)

Revenues, expenses and assets are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Australian Taxation Office (ATO).

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the ATO is included with other receivables or payables in the statement of financial position.

Cash flows are presented on a gross basis. The GST components of cash flows arising from investing or financing activities, which are recoverable from or payable to the ATO, are presented as operating cash flows included in receipts from customers or payments to suppliers.

Provisions

Provisions are recognised when the College has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result and that outflow can be reliably measured. Provisions recognised represent the best estimate of the amounts required to settle the obligation at the end of the reporting period.

New Accounting Standards for Application in Future Periods

Accounting Standards issued by the AASB that are not yet mandatorily applicable to the company, together with an assessment of the potential impact of such pronouncements on the company when adopted in future periods, are discussed below:

- *AASB 9: Financial Instruments and associated Amending Standards (applicable to annual reporting periods beginning on and after 1 January 2018).*

  The Standard will be applicable retrospectively (subject to the provisions on hedge accounting outlined below) and includes revised requirements for the classification and measurement of financial instruments, revised recognition and derecognition requirements for financial instruments, and simplified requirements for hedge accounting.

  The key changes that may affect the company on initial application include certain simplifications to the classification of financial assets, simplifications to the accounting of embedded derivatives, upfront accounting for expected credit loss, and the irrevocable election to recognise gains and losses on investments in equity instruments in equity instruments that are not held for trading in other comprehensive income. AASB 9 also introduces a new model for hedge accounting that will allow greater flexibility in the ability to hedge risk, particularly with respect to hedges of non-financial items. Should the entity elect to change its hedge policies in line with the new hedge accounting requirements of the Standard, the application of such accounting would be largely prospective.

  The College is in the process of completing its impact assessment of AASB 9. Based on a preliminary assessment performed over each line of business, the effects of AASB 9 are not expected to have a material effect on the College.

- *AASB 15: Review from Contracts with Customers (applicable to annual reporting periods beginning on or after 1 January 2019*.

When effective, this Standard will replace with current accounting requirements applicable to revenue with a single, principles-based model. Apart from a limited number of exceptions, including leases, the new revenue model in AASB 15 will apply to all contracts with customers as well as non-monetary exchanges between entities in the same line of business to facilitate sales to customers and potential customers.

The core principle of the Standard is that an entity will recognise revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for the goods or services. To achieve this objective, AASB 15 provides the following five-step process:

- identify the contracts(s) with a customer;
- identify the performance obligations in the contract(s);
- determine the transaction price;
- allocate the transaction price to the performance obligations in the contract(s); and
- recognise revenue when (or as) the performance obligations are satisfied.

The transitional provisions of this Standard permit an entity to either: restate the contracts that existed in each prior period presented per *AASB 108: Accounting Policies, Changes in Accounting Estimates and Errors* (subject to certain practical expedients in AASB 15); or recognise the cumulative effect of retrospective application to incomplete contracts on the date of initial application. There are also enhanced disclosure requirements.

The College is in the process of completing its impact assessment of AASB 15. Based on a preliminary assessment performed over each line of business and revenue type, the effects of AASB 15 are not expected to have a material effect on the College.

- *AASB 16: Leases (applicable to annual reporting periods beginning on or after 1 January 2019).*

When effective, this Standard will replace the current accounting requirements applicable to leases in *AASB 117: Leases and related Interpretations*. AASB 16 introduces a single lessee accounting model that eliminates the requirement for leases to be classified as operating or finance leases.

The main changes introduced by the new Standard are as follows:

- Recognition of a right-of-use asset and liability for all leases (excluding short-term leases with less than 12 months of tenure and leases relating to low-value assets);
- Depreciation of right-of-use assets in line with *AASB 116: Property, Plant and Equipment in profit or loss and unwinding of the liability in principal and interest components*;
- Inclusion of variable lease payments that depend on an index or a rate in the initial measurement of the lease liability using the index or rate at the commencement date;
- Application of a practical expedient to permit a lessee to elect not to separate non-lease components and instead account for all components as a lease; and
- Inclusion of additional disclosure requirements.

The transitional provisions of AASB 16 allow a lessee to either retrospectively apply the Standard to comparatives in line with *AASB 108: Accounting Policies, Changes in Accounting Estimates and Errors* or recognise the cumulative effect of retrospective application as an adjustment to opening equity on the date of initial application.

Although the directors anticipate that the adoption of AASB 16 will impact the company's financial statements, it is not expected to have a material effect on the College. It is impracticable at this stage to provide a reasonable estimate of the impact.

Fair Value Disclosures

The company does not measure any other assets or liabilities at fair value on a recurring basis after initial recognition. The carrying amount of financial assets and financial liabilities as disclosed in the statement of financial position and notes to the financial statements approximates their fair value.

Comparative Figures

Where necessary, comparative information has been adjusted to be consistent with current year disclosures.

In prior year, Trade Receivables and Unearned Income were shown as on a net basis, however in current year these have been shown as gross with the comparative restated. This has had no change or impact on Net Assets or Profit.

2. REVENUES FROM ORDINARY ACTIVITIES	2018 $	2017 $
Operating Revenue		
Rendering of Services	9,262,274	9,149,196
Grant Income	2,798,743	5,019,380
Sponsorship	294,500	769,248
Sundry Income	8,557	10,288
Non Operating Revenue		
Interest	187,083	186,063
	12,551,157	**15,134,175**

3. EXPENSES FROM ORDINARY ACTIVITIES	2018 $	2017 $
Classification of Expenses by Function		
College Services & Admin Expenses	9,496,091	9,502,973
John Flynn Scholarship Scheme Grant Expenses	-	2,560,200
Bi-College Grant Expenses	169,730	153,258
GP Procedural Grant Expenses	327,433	271,079
Domestic Violence Grant Expenses	133,383	109,088
Chronic E-Health Grant Expenses	-	612,606
GP Anaesthetic Grant Expenses	538,156	552,311
Telehealth Grant Expenses (RHOF)	384,441	432,581
AGPT Selection Grant Expenses	333,598	118,147
jDocs Grant Expenses	171,264	4,928
GP Training Grant Expenses	528,783	205,181
Lung Foundation Grant Expenses	16,708	-
Yellow Fever Grant Expenses	40,212	-
Codeine Rescheduling Grant Expenses	93,416	-
Black Dog Institute Grant Expenses	61,623	-
	12,294,838	**14,522,352**
Other Expenses		
Non Program Related Employee Benefits Expense	4,001,979	3,361,717
Program Related Employee Benefits Expense	1,052,877	1,136,187
Amortisation and Depreciation Expense	357,202	340,316

4. SURPLUS/(DEFICIT) FROM ORDINARY ACTIVITIES	2018 $	2017 $
Surplus/(Deficit) from Ordinary Activities includes:		
Net (Gain)/Loss from sale of Plant and Equipment	1,067	1,511
Rental expense from operating leases	268,761	234,710
Superannuation contributions	327,557	285,843

5. CASH AND CASH EQUIVALENTS	2018 $	2017 $
Cash on Hand	200	200
Cash at Bank	5,072,020	4,205,439
Cash on Deposit	8,091,908	7,943,692
	13,164,128	12,149,331

6. TRADE AND OTHER RECEIVABLES	2018 $	2017 $
Trade Receivable	1,666,077	1,758,007
	1,666,077	1,758,007

Included in the above, are aggregate amounts receivable from the following related parties:

Directors (other than loans to directors)	-	-

7. OTHER ASSETS	2018 $	2017 $
Prepayments	383,376	298,073
Accrued Income	32,076	17,438
	415,452	315,511

8. INTANGIBLE ASSETS	2018 $	2017 $
CRM & LMS Development (at cost)	1,684,882	1,372,861
Accumulated Amortisation	(778,338)	(488,378)
	906,544	884,483
Movement in Intangible Assets		
Opening Balance	884,483	1,159,055
Transferred from Capital Work-In-Progress	-	-
Additions	312,021	-
Disposals at Written Down Value	-	-
Amortisation	(289,960)	(274,572)
Closing Balance	**906,544**	**884,483**

9. PROPERTY PLANT AND EQUIPMENT	2018 $	2017 $
Office Equipment (at cost)	571,234	338,392
Accumulated Depreciation	(392,158)	(234,329)
	179,076	104,063
Movement in Plant and Equipment		
Opening Balance	104,063	99,593
Additions	143,322	57,055
Disposals at Written Down Value	(1,067)	(1,511)
Depreciation Expense	(67,242)	(51,074)
Closing Balance	**179,076**	**104,063**
Leasehold Improvements (at cost)	125,744	125,744
Accumulated Depreciation	(125,744)	(125,744)
	-	-
Movement in Leasehold Improvements		
Opening Balance	-	14,670
Additions	-	-
Depreciation Expense	-	(14,670)
Closing Balance	**-**	**-**
Total Property Plant and Equipment	**179,076**	**104,063**

10. TRADE AND OTHER PAYABLES	2018 $	2017 $
(i) Current		
Trade and Sundry Creditors	460,951	547,109
Unearned Income	8,836,124	8,069,680
Accruals	299,268	356,499
Employee Benefits (annual leave, salaries and PAYG)	326,696	325,402
GST Payable	397,550	171,252
	10,320,589	**9,469,942**
Included in unearned income, are amounts from directors for memberships paid in advance:	7,464	7,250

11. PROVISIONS	2018 $	2017 $
Current		
Long Service Leave	283,241	290,075
Non-Current		
Long Service Leave	51,887	43,437
Provision for "Make Good"	146,450	146,450
	198,337	189,887
Analysis of Total Provisions		
Current	283,241	290,075
Non-current	198,337	189,887
Total Provisions	**481,578**	**479,962**

The movement in the provision during the 2018 financial year is as follows:

	Provision for 'Make Good' $	Long Service Leave $
Opening balance at 1 July 2017	146,450	333,512
Additional provisions raised during the year	-	42,438
Amounts used	-	(40,822)
Balance as at 30 June 2018	**146,450**	**335,128**

Provision for "Make Good"

A provision has been recognised for the requirement to restore the leased premises to their original condition at the conclusion of the lease term. The provision has been estimated using actual past experience with comparisons made to the experience of other similar organisations which generally fall between 30% to 50% of the annual rental expense. Management review the provision annually.

Provision for Non-current Employee Benefits

A provision has been recognised for employee entitlements relating to long service leave. In calculating the present value of future cash flows in respect of long service leave, the probability of long service leave being taken is based on historical data. The measurement and recognition criteria relating to employee benefits have been included in Note 1 to these financial statements.

12. OTHER LIABILITIES	2018 $	2017 $
Current		
Deferred lease incentive	55,920	44,620
Non-Current		
Deferred lease incentive	-	-
	55,920	**44,620**

13. RETAINED EARNINGS	2018 $	2017 $
Retained Earnings at the beginning of year	5,216,871	4,605,048
Net Surplus/(Deficit)	256,319	611,823
Retained Earnings at the end of year	**5,473,190**	**5,216,871**

14. AUDITOR'S REMUNERATION	2018 $	2017 $
Audit and review of Financial Statements	18,500	17,000
Other Project Audit Services	5,500	5,500
	24,000	**22,500**

15. COMMITMENTS FOR EXPENDITURE	2018 $	2017 $
Operating Expenditure		
Noncancellable operating lease for lease of premises with a term of more than one year.		
Commitments not provided for:		
No later than 1 year	270,957	268,761
Later than 1 year but no later than 5 years	613,302	806,283
Later than 5 years	-	-
	884,259	**1,075,044**

The property lease commitments are non-cancellable operating leases contracted for but not recognised in the financial statements with a five-year term. Increase in lease commitments may occur in line with the Consumer Price Index (CPI).

16. MEMBERS' GUARANTEE

The company is limited by guarantee. If the company is wound up, the Articles of Association state that each member is required to contribute a maximum of $10 each towards meeting any obligations of the company.

17. CORPORATE INFORMATION

Australian College of Rural and Remote Medicine Limited is an Australian company incorporated and domiciled in Australia. Its principal activities are the provision of medical education and training services. The principal place of business and registered office of the Australian College of Rural and Remote Medicine Limited is Level 2, 410 Queen Street, Brisbane, Queensland. There are 54 employees (2017: 54) at the end of the reporting period.

18. SEGMENT INFORMATION

The company's sole business segment is the provision of medical, education and training services to rural and remote areas in Australia.

19. ECONOMIC DEPENDENCY

The project operations of the Australian College of Rural and Remote Medicine are dependent upon ongoing funding, which, to date, has been predominantly through agreements with the Department of Health.

20. RELATED PARTY TRANSACTIONS

Key management personnel comprises the directors and senior executive management team who have authority and responsibility for planning, directing and controlling the activities of the company.

The aggregate compensation of key management personnel is as follows:

	2018 $	2017 $
Key management personnel compensation		
• short-term benefits	996,000	949,539
• post-employment benefits	80,885	78,130
• other long-term benefits	6,827	5,470
Total	**1,083,712**	**1,033,139**

Of the above short-term benefits $62,377 (2017: $79,481) relates to payments to directors for transactions made at arm's length.

Other than those disclosed above and in note 10, there are no other related party transactions that occurred during the 30 June 2018 financial year (2017: nil).

21. NOTES TO THE STATEMENT OF CASHFLOWS

i) Reconciliation of Surplus/ (Deficit) from Ordinary Activities after Income Tax to Net Cash Provided by Operating Activities

ACTIVITIES	2018 $	2017 $
Surplus/(Deficit) from ordinary activities after income tax	256,319	611,823
Depreciation	67,242	65,744
Amortisation	289,960	274,572
Employee Entitlements	1,616	39,478
Loss/(Gain) on Disposal of Assets	1,067	1,511
(Increase)/Decrease in Receivables	77,292	(1,059,435)
Increase/(Decrease) Prepayments	(85,303)	12,847
Increase/(Decrease) Creditors & Borrowings	861,947	2,353,129
Net Cash Provided by Operating Activities	**1,470,140**	**2,299,669**

For the purposes of the Statement of Cashflows, cash includes cash on hand and in banks and investments in money markets, net of bank overdrafts.

ii) Reconciliation of Cash

	2018 $	2017 $
Cash on Hand	200	200
Cash at Bank	5,072,020	4,205,439
Cash on Deposit	8,091,908	7,943,692
	13,164,128	**12,149,331**

iii) Undrawn Credit Card Facilities

	2018 $	2017 $
Facility Limits at reporting date	157,000	255,000
Less: drawn at balance date	(91,835)	(84,729)
Undrawn facilities at reporting date	**65,165**	**170,271**

22. EVENTS AFTER THE BALANCE SHEET DATE

There have been no material events that have occurred since the end of the financial year.

23. FINANCIAL INSTRUMENTS

Financial Risk Management Policies

The Company's financial instruments consist mainly of deposits with the banks, accounts receivable and accounts payable.

The Company does not have any derivative instruments at 30 June 2018.

i) Treasury Risk Management

A finance committee meet on a regular basis to analyse financial risk exposure and to evaluate treasury management strategies in the context of the most recent economic conditions and forecasts.

The committee's overall risk management strategy seeks to assist the Company in meeting its financial targets whilst minimising potential adverse effects on financial performance.

The finance committee operates under policies approved by the board of directors. Risk management policies are approved and reviewed by the Board on a regular basis. These include credit risk policies and future cash flow requirements.

ii) Financial Risk Exposures and Management

The main risks the Company is exposed to through its financial instruments are cash flow, interest rate risk, liquidity risk and credit risk.

Interest rate risk

No assets or liabilities of the company bear interest except for cash and cash equivalents. The interest rate (market) risk regarding these assets is monitored by the directors to ensure the best possible financial returns.

At 30 June 2018 the weighted average effective interest rate in relation to cash and cash equivalents was 0.87% (2017 – 0.917%) with the interest rate being entirely represented by floating rates. In terms of interest rate sensitivity analysis, a 2% increase/decrease in interest rates would cause the net profit before tax and equity of the company to increase/decrease by $182,000 annually assuming all other variables remain constant.

Foreign currency risk

The company is not exposed to fluctuations in foreign currencies.

Liquidity risk

The company manages liquidity risk by monitoring forecast cash flows and ensuring that spending remains within approved project budgets for which funds are received in advance.

Credit Risk

The maximum exposure to credit risk, excluding the value of any collateral or other security, at balance date to recognised financial assets, is the carrying amount, net of any provisions for impairment of those assets, as disclosed in the balance sheet and notes to the financial statements.

There are no amounts of collateral held as security at 30 June 2018.

Credit risk arising from deposits with financial institutions is managed by the deposit of funds with authorised deposit taking institutions in Australia. The company is not exposed to any significant credit risk as its receivables are principally from commonwealth government grant funding or from members in respect of subscription and other assessment course services.

(iii) Carrying Amount of Financial Instruments by Category

The carrying amounts for each category of financial instruments, measured in accordance with AASB 139 as detailed in the accounting policies to these financial statements, are as follows:

	2018 $	2017 $
Financial Assets		
Cash and cash equivalents	13,164,128	12,149,331
Accounts receivable and other debtors	1,666,077	1,758,007
Total Financial Assets	14,830,205	13,907,338
Financial Liabilities		
Financial liabilities at amortised cost		
Accounts payable and other payables	460,951	547,109
Total Financial Liabilities	460,951	547,109

(iv) Financial liability and financial asset maturity analysis:

- Trade receivables represent the principal amounts outstanding at balance date, are non-interest bearing and are usually settled within 30 days.
- All other receivables are due to be received within one year.
- Trade payables represent the principal amounts outstanding at balance date, are non-interest bearing and are usually settled within 30 days.
- All other payables are due for payment within one year.

(v) Net Fair Value of Financial Instruments is equal to or approximately equal to their carrying amount.

24. CONTINGENT LIABILITIES

The College has no contingent liabilities at 30 June 2018 (2017: nil).

DIRECTORS DECLARATION

In accordance with a resolution of the Directors of the Australian College of Rural and Remote Medicine Limited, the Directors declare that:

1. The financial statements and notes as set out on pages 7 to 24 are in accordance with the *Corporations Act 2001* and the *Australian Charities and Not-for-Profit Commission Act 2012* and:

   a) comply with Australian Accounting Standards; and

   b) give a true and fair view of the company's financial position as at 30 June 2018 and of its performance for the year ended on that date.

2. In the Directors' opinion, there are reasonable grounds to believe that the company will be able to pay its debts as and when they become due and payable.

Signed in accordance with a resolution of the Directors.

Director
Dated at Adelaide , this 18th day of September, 2018

INDEPENDENT AUDITOR'S REPORT
TO THE MEMBERS OF AUSTRALIAN COLLEGE OF RURAL AND REMOTE MEDICINE LIMITED

Report on the Audit of the Financial Report

Opinion

We have audited the financial report of the Australian College of Rural and Remote Medicine Limited (the "Company"), which comprises the Balance Sheet as at 30 June 2018 and the statement of profit and loss and other comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and the director's declaration.

In our opinion the financial report of the Company is in accordance with Division 60 of the *Australian Charities and Not-for-Profit Commission Act 2012*, including:

(i) giving a true and fair view of the Company's financial position as at 30 June 2018 and of its performance for the year then ended; and
(ii) complying with Australian Accounting Standards and Division 60 of the *Australian Charities and Not-for-Profits Commission Regulations 2013*.

Basis for Opinion

We conducted our audit in accordance with Australian Auditing Standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of our report. We are independent of the Company in accordance with the ethical requirements of the Australian Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to our audit of the financial report in Australia. We have also fulfilled our other ethical responsibilities in accordance with the Code.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of the Directors for the Financial Report

The directors of the Company are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Australian Charities and Non-for-Profits Commission Act 2012* and for such internal control as the directors determine is necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

In preparing the financial report, the directors are responsible for assessing the ability of the Company to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Company or to cease operations, or has no realistic alternative but to do so.

The directors are responsible for overseeing the company's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Report

Our objectives are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists.

Auditor's Responsibilities for the Audit of the Financial Report (Continued)

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with Australian Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 Company's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the directors.
- Conclude on the appropriateness of the directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Company's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Company to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Bentleys Brisbane (Audit) Pty Ltd
Chartered Accountants

Stewart Douglas
Director
Brisbane
21 September 2018

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