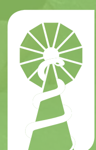
ANNUAL REPORT

2019-2020



Australian College of Rural & Remote Medicine

WORLD LEADERS IN RURAL PRACTICE

ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the traditional owners of lands across Australia in which our members and staff work and live, and pay respect to their elders past present and future.

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PRESIDENT'S REPORT

It's been a year of 'unprecedenteds' and I want to acknowledge the work that our members are doing and the distress that the year has continued to bring to so many of us and our communities.

Meeting unforeseen challenges intelligently and responsibly, is however, what we as rural doctors and Rural Generalists are trained to do, and the year has not deterred the College from getting on with business.

The crises have drawn national attention to our College's expertise in areas such as telehealth, online services delivery and secondary and emergent care in low resource settings. Government and other colleges have been looking to the Australian College of Rural and Remote Medicine (ACRRM) to draw on their experience in these areas.

The bushfires, COVID, the associated lockdown and border restrictions have all shone a light on how critical ACRRM doctors are for remote and rurally based people. Doctors living locally, with primary care capacity and skills extending from airways management, to population health and mental health, that is Rural Generalists, have provided their communities with required services, and the assurance that needed care will be available.

The College has had a constant line of communication with the Minister for Regional Health and the Chief Medical Officer, meeting weekly at the height of the COVID pandemic. There has also been regular dialogue with the Federal Health Minister and key department officials at both Commonwealth and jurisdictional levels. We have been able to continuously inform the government's tactical response with the perspectives and unfolding circumstances in remote and rural communities.

ACRRM RURAL GENERALIST TRAINING

The College continues to go from strength to strength in building fit-for-purpose, FACRRM training across the country. The Government's commitment to new nationally supported ACRRM training places over four years is a watershed for our College. It will enable an expansion of capacity and economies of scope and scale for our registrars and our supervisors and still allow them to maintain their strong, direct relationship to their College. There have been delays in the program roll-out but we hope to see it kickstarted by the end of the year. Strengthening this development, is the injection of Commonwealth funding in all jurisdictions to establish or expand RG support and the College has been working in all states and Territories with the emerging RG Coordinating Unit and other initiatives. The College also continues to progress its joint-application for Specialty Recognition of Rural Generalist Medicine.

COVID RESPONSE

In addition to its individual efforts, the College has joined forces with the Rural Doctors Association of Australia (RDAA) to pool resources to provide the strongest possible response for our members. Special thanks to Dr Adam Coltzau who on behalf of both organisations has led the delivery of our COVID Response to members. It has included a series of national webinars engaging hundreds of our members, information and clinical resources, regular newsletters, joint media releases and special initiatives such as our project to distribute PPE packs to our members.

DIGITAL HEALTH

A major breakthrough for our College has been the introduction of telehealth item numbers for rural general practitioners. This is a long-standing policy goal of our College, for which last year's introduction of limited telehealth item numbers for rural General Practitioners, instigated by a joint ACRRM-RDAA Submission provided the policy foundation. There is still fine-tuning to be done, if telehealth is to improve rather than compromise, rural healthcare, must be funded in a manner which values in-person, local, continuous care. This is a maxim of ACRRM Telehealth Standards written over a decade ago, and the College will continue to work to ensure intelligent policy enables, government supported digital healthcare services to become a permanent part of rural healthcare.

CONNECTING WITH MEMBERS

In such turbulent times, our new online discussion forum, has been a really important resource to enable our members to engage with all the issues of the year. Personally, I have found it invaluable in enabling me to keep a finger on the pulse of member concerns, and to speak directly with members and to their issues. Over the lockdown, Board and College Council have also been having informal fortnightly meetings to help keep informed of our members' perspectives, with representatives reporting on emerging issues from our rural communities, registrars, junior doctors, our Aboriginal and Torres Strait Islander members and each state and Territory.

POLICY REFORM

The COVID crisis has forestalled the Government's progress on its reform agenda particularly on Primary Health Care and Rural Medical Workforce Development. The crisis has however, shone a light on the value proposition of our doctors and their work, and ACRRM is well positioned to use its membership on all the key national reform forums to progress the College's vision for rural healthcare over the forthcoming months as these forums restart.

BUILDING RURAL WORKFORCE

Strengthening the rural workforce has never been more prescient and our College continues to stand alone in delivering workforce outcomes. This has been evidenced by the latest research arising from the MABEL dataset, as well outcomes of the national registrar surveys conducted this year by the Department of Health and the Medical Board of Australia. Fellowship with ACRRM remains by far the best predictor of a doctor who will practice rurally, remotely, and who will provide Rural Generalist advanced skilled services. Importantly the new MABEL research has found this to be true even by

PRESIDENT'S REPORT

> **Our College was formed out of a belief that there is a model of practice that is necessary to deliver excellent healthcare to remote and rural communities.**

comparison to doctors with FARGP and holds for the new generation of doctors trained by ACRRM as well as for our founding members. National surveys have have also shown that ACRRM registrars continue to be the GP trainees most likely to be planning a long-term career in Aboriginal and Torres Strait Islander peoples' health care.

As the end of my term as President approaches, I acknowledge the incomparable privilege it has been to represent the almost 5000 remote and rural doctors that make up our College and the work that you do. Our founding members and their work has inspired an outstanding new generation, and as College enrolments continue to expand, and committed and capable new Fellows continue to emerge, I see a bright future for our College and for remote, rural and Indigenous peoples' healthcare. I would like to thank the College Board and staff for their support throughout my term as President. Their committment always remains unwavering.

Our College was formed out of a belief that there is a model of practice that is necessary to deliver excellent healthcare to remote and rural communities and the year's events have been stark testament to how critical the Rural Generalist skill set is for rural people. For a quarter of a century our College has worked relentlessly toward full recognition and support within our health systems of rural doctors and Rural Generalist practice. As we move ever closer to our goals, its timely to reflect that our College has never lost sight of this vision for our members and our communities, and, no matter what the new year brings, bushfires, floods, cyclones, or pandemics - we'll stay the course.

Dr Ewen McPhee
President

[1]McGrail M, O'Sullivan B. (2020) *Faculties to Support General Practitioners Working Rurally at Broader Scope: A National Cross-Sectional Study of Their Value.* International Journal of Environment Research and Public Health

[2]Taylor et al. ACER (2020) *AGPT National Registrar Survey, Australian General Practice Registrars (ACRRM)* 2019.

IMAGE OF DR ALY KNELL, COURTESY OF NTGPE

CHIEF EXECUTIVE OFFICER'S REPORT

It's been a year of business as not-so-usual. Bushfires and pandemics notwithstanding, the year has seen major steps forward for our College in progressing our strategic goal of a strong, fit-for-purpose ACRRM Training Program. The year's challenges have also brought us forward in innovating systems and resources for the new normal.

CONTINUITY IN COVID

Resilience is something that health systems demand in abundance of our members. While we continue to be in awe of our doctors and their tenacity, my sincere hope is that our staff and services can lessen this load. To this end, a resilient management approach, accepting uncertainty and rapidly adapting to challenges, has always been the ACRRM way. This year, I am grateful to the Board and Council, who have provided the leadership imprimatur for our teams to be bold and deliver for our members, even when this has meant rapid systems development and implementation. The approach has enabled the continuity of all our key services over the year and led to ranging innovations.

We committed to providing registrars with every opportunity to continue their journey to Fellowship and were proud to be the only medical College in Australia to deliver all assessments as scheduled. With the hard work to deliver this in place, we were particularly thrilled to see almost 100 registrars graduate this year.

With many of our members' professional development opportunities cancelled in response to COVID-19, we continued to be innovative with developing new

online options, starting with staging the Independent Pathway onboarding workshop virtually. This new format proved a success, enabling participants to remain in their communities where they are needed, while engaging with their peers in workshops, plenary sessions and social events.

We have also been able to deliver significant skills education and training workshops entirely online and to revise our StAMPS, PESCI interviews and training selection processes to convert them to entirely remote based delivery, including training and support for examiners in the new delivery models.

We continued the revision of the PDP guidelines to accommodate the Medical Board's Professional Performance Framework and support members to work under the new arrangements with minimal complexity. The College successfully advocated

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to enable our doctors to undertake online options to meet their requirements under the Procedural Grants Program during COVID. New systems have been established to enable these as well as to provide end-to-end support for participants in this program, from eligibility, to accreditation of activities, and administration of claims and payments directly to members.

This was all achieved while increasing engagement with advisory groups, liaising with a range of government departments and stakeholder organisations, and providing regular and relevant information and resources to members. In addition to the immediate response, we remained committed to supporting members and their communities in dealing with the longer-term mental, social and economic impacts of these events. The need for a strong and immediate health response to the challenges resulting from the COVID-19 pandemic has resulted in '10 years of policy reform in 10 days'. With much gained in a short time, we look forward to taking the learnings from these decisions and refining the reforms into ongoing, sustainable programs.

STRENGTHENED RG TRAINING

The College's progress toward a fully fit-for-purpose national Fellowship program is moving apace at multiple levels. The College has been meeting weekly with the Department of Health to progress these. The Commonwealth Governments' commitment to establish an extra hundred ACRRM RG places over the next four years, has required development of a purpose-built program structure and funding model to support registrars and participating remote and rural training practices. Planning is well advanced and the College expects to be underway in the forthcoming months. Transition of the management functions previously held by the Commonwealth Department of Health for the national GP Training framework is now in place. The College manages all central administrative functions for its registrars on AGPT and RVTS, including recruitment, enrolment, training policies, and research grants.

EXPANDED EDUCATION PROGRAMS

In tandem with these developments, our teams have been growing our delivery systems, resources and personnel to expand the scope, structure and regionalisation of our education services. The College now has bespoke technologies to manage enrolments, selection, MBS reporting which can interact seamlessly across training pathways and across members' career journey. The College has formalised key education delivery roles, such as its Lead Examiners,

CHIEF EXECUTIVE OFFICER'S REPORT

and Leads for each assessment modality. The number of medical educators supporting our registrars and supervisor has continued to expand.

Our teams now deliver IP registrars a comprehensive education program built entirely around the ACRRM Rural Generalist curriculum and assessment program. This comprises a series of curriculum modules, delivered through online courses supported by activities, assessments, medical educator facilitated discussions and a week of group workshop activities. It also includes online courses on preparing for ACRRM assessments.

Summer bushfires and a world-wide COVID-19 pandemic certainly provided members with unique challenges this year and the College responded quickly to resource and support members to meet the needs of their communities, colleagues and selves.

We know the difficult times that so many of our members and their patients have been experiencing and on behalf of our ACRRM team we want to assure you, we have not stopped delivering on our core services nor progressing our bigger picture goals, and, we remain ready and willing to find a way to meet our members' needs, whatever the new year brings.

Ms Marita Cowie
Chief Executive Officer

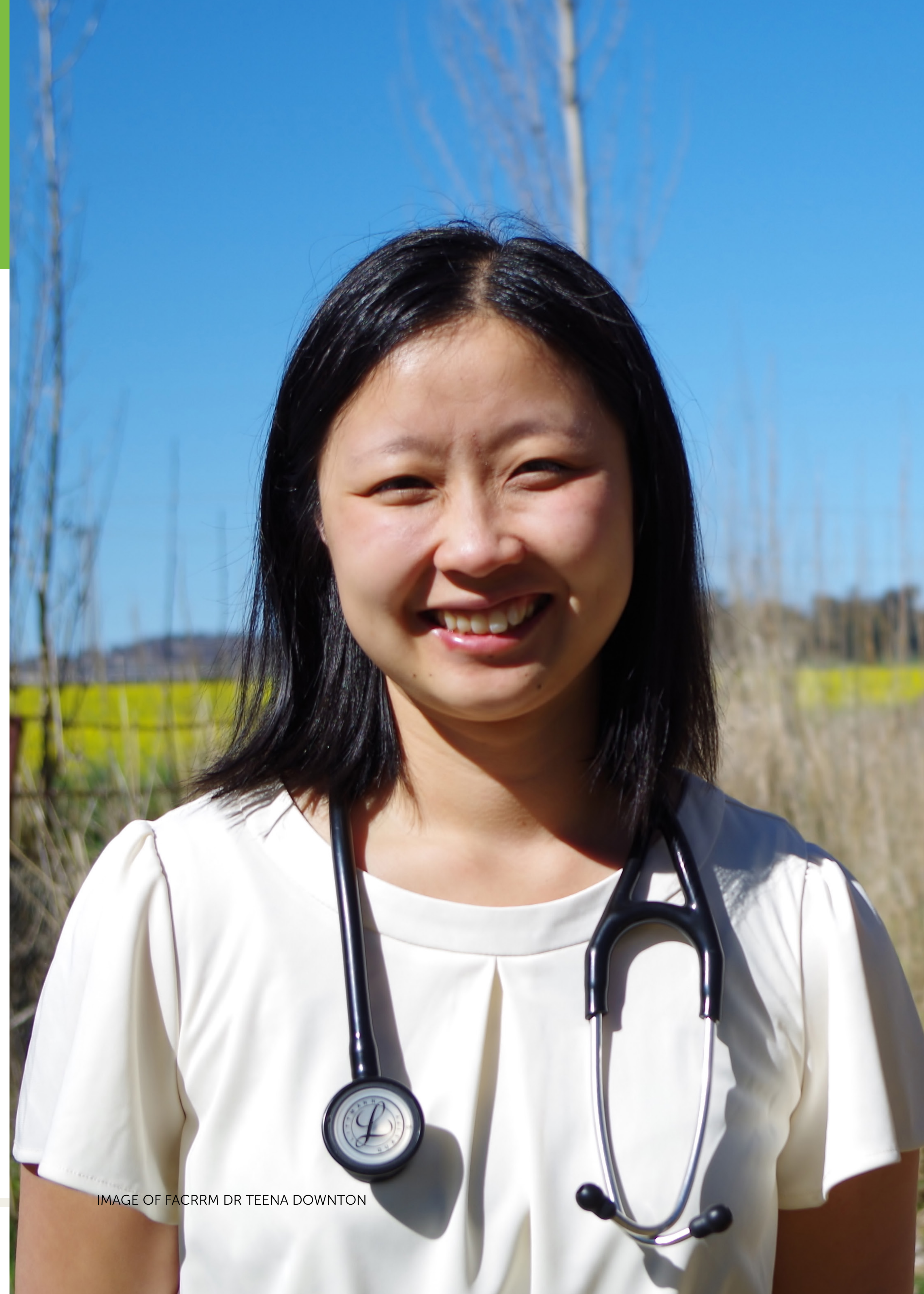


IMAGE OF FACRRM DR TEENA DOWNTON

CENSOR-IN-CHIEF'S REPORT

COVIDITY. n. The state of anxiety associated with the disruption to health, society and the economy caused by a global pandemic.

It shouldn't be left to the tech-nerds and IT programmers locked up in the Californian internet sweat-shops to be solely responsible for the creation of new words and "evolution" of the English language. This state of COVIDITY has affected just about every facet of human existence and will be remembered for generations to come.

In Eastern Australia the pandemic was preceded by devastating bushfires, which affected many rural doctors, some of whom lost their homes. The financial and mental health impact of the fires on rural communities was initially masked by the emergence of the pandemic; the burden of mental and physical ill-health exacerbated by the pandemic is now only coming to light and increasing the work-load of rural doctors.

This disruption has brought about rapid and long-lasting changes in health care and medical education. MBS item numbers for telehealth consultations are hopefully here to stay, and e-prescribing will provide streamlined access to medications and perhaps reduce medication errors.

ACRRM has led the way amongst medical colleges in maintaining delivery of our education program and our assessments.

Our knowledge of how to overcome the "tyranny of distance" with the previous establishment of internet-based education and assessment delivery programs has meant that in 2020 ACRRM has been able to offer MCQ assessment on-line, and conduct

Case-Based Discussion and StAMPS assessments via videoconference, with no major disruption. As a result, other colleges have engaged actively with ACRRM education staff to learn about our methods of delivery.

To complement this, the review of ACRRM's assessment program over the past decade was published earlier this year, led by Professor Tarun Sen Gupta, Chair of the ACRRM Assessment Committee.

ACRRM's Selection Program has also continued without interruption, with multiple mini interviews (MMIs) of applicants for both the Independent Pathway and the Australian General Practice Training program conducted by videoconference.

We have maintained a close watch on trainee progress since the outbreak of the pandemic in Australia, including fortnightly meetings with Regional Training Organisation senior staff to manage trainee progression issues, as well as regular communication with the ACRRM Registrar Committee.

The experience of trainees in 2020 will certainly be remembered as unique.

Not only have our Registrars, the future Rural Generalist workforce in Australia, gained detailed knowledge of public health principles around the management of a pandemic, but they have also experienced caring for rural patients and rural communities affected by COVIDITY – with a growing understanding of the implications of this for healthcare delivery and the sustainability of rural communities in the future. The impressive qualities of our Registrar cohort leave us in no doubt that they are up for the challenge.

Associate Professor David Campbell
Censor-in-Chief

ACRRM has led the way amongst medical colleges in maintaining delivery of our education program and our assessments.

SPECIALIST RECOGNITION

The Application to have Rural Generalist Medicine recognised as a specialist field within general practice was submitted to the Medical Board of Australia in December 2019.

This was submitted jointly by our College and the Royal Australian College of General Practitioners (RACGP).

To progress the application a Rural Generalist Recognition Taskforce was formed comprising ACRRM President and CEO, RACGP Vice President and CEO and one additional Fellow from each College. The Colleges invited the National Rural Health Commissioner to chair the Taskforce. The group has continued to meet regularly and further develop and support the application.

Should it be successful the colleges will be required to submit a more detailed application as part of a second stage assessment which will include a national consultation. In parallel with this assessment the application process may also require an assessment of the proposal by the Commonwealth Government's Office of Best Practice Regulation. The assessment timeframe is difficult to predict however it is hoped that the process may be able to be completed over the next two years.

NATIONAL RURAL GENERAL PRACTICE IMPLEMENTATION

The College is part of the leadership steering group formed to progress the broader agenda set out in the National Rural Health Commissioner Report Recommendations in 2018. The group includes the College, the National Rural Health Commissioner, the Royal Australian College of General Practitioners, the Rural Doctors Association of Australia, and, the Australian Medical Association. The group has detailed a comprehensive draft work plan for implementation of the Report Recommendations. It will address a range of issues from vertically-integrated training, to specialty recognition and facilitated clinical credentialing, to practitioner employment and remuneration.

JURISDICTIONAL DEVELOPMENTS

Australian states and territories have received federal Government grants to either establish or expand their programs and activities to support Rural Generalist training in their respective jurisdictions. From these, by 2020 there should be a Rural Generalist Coordinating Unit within each state and territory (excluding Australian Capital Territory) and a Governance structure with the General Practice Colleges to provide a forum for collaboration. The College is working closely with all seven jurisdictions in these developments.

NEW RURAL GENERALIST TRAINING PLACES

The Minister for Rural Health, Mark Coulton announced that the Commonwealth Government's commitment to establish 100 new ACRRM RG places over four years from 2021. This initiative will establish government-funded training for our registrars, supervisors and training practices entirely fit-for-purpose to the ACRRM Fellowship and Rural Generalist Curriculum. The College has developed a comprehensive proposal for recruiting and training these doctors in all states and territories. The proposal will allow the College to build a critical mass of training registrars and resources to enable economies of scale and underpin a strong national program.

IMAGE OF PARKES, COURTESY OF DESTINATION NSW

EDUCATION SERVICES

SELECTION

Despite the year's many unexpected turns, the Education Services team has delivered all training and assessment activities and further expanded the program. This year also saw the College take responsibility for the AGPT application and selection process, using a custom-designed ACRRM Training Application Management System.

The complete Registrar eligibility and selection process is now embedded within the College and a new ACRRM Training Application Management System housed on the ACRRM website. There is further work underway for the alignment of Australian General Practice Training (AGPT) and Independent Pathway (IP) selection processes in this area.

TRAINING SUPPORT

Supporting our registrars to continue their progressiong towards Fellowship during COVID-19 was an overriding priority. The College worked to maintain open and regular communication on training plans and provide access to additional welfare supports.

All training policies were reviewed to be flexible and fit for purpose, enabling training and exams to proceed on schedule.

Work was also undertaken to align College processes for the delivery and administration of the AGPT program.

The College met a number of milestones in the transition to College-led training, enabling ACRRM to fully operationalise our vision to deliver a structured, supported national training program for our Registrars.

We successfully conducted regular study groups for the Primary Curriculum and Emergency Medicine StAMPS exams, along with a two-day intensive workshop for Registrars with multiple unsuccessful exam attempts. These programs provided Registrars with regular individual feedback and guidance on the standard of expectation of the exams. A focus on structured remediation support has been undertaken this year to improve assessment outcomes and earlier identify Registrars at risk of non progression.

CURRICULUM REVIEW

2020 has seen the embedding of the new and revised ACRRM Rural Generalist Curriculum within the training framework. Work undertaken to map this new curriculum across course material, assessment requirements and training resources has involved extensive consultation with ACRRM members and stakeholders.

The reviewed Curriculum reflects the skills and competencies required to deliver internationally-recognised, high-standard training, preparing doctors to practice independently and safely in a wide range of rural and remote contexts. Further review is underway on the components of the curricula relating to Indigenous health and Advanced Specialised Training Curricula.

ASSESSMENT

ACRRM continued to deliver a robust assessment program this year and has overcome a number of hurdles in delivery during the recent COVID-19 developments by moving all modalities to online delivery and ensuring support of ongoing Registrar progression. As the only College in Australia to continue the delivery of standardised assessments during this time, this has been a great success for the College.

The program continues to embrace a programmatic approach to assessment in conjunction with the Registrar Committee and other key stakeholders, with a focus on improving Registrar preparation, readiness and remediation for all modalities.

The College introduced new pre-requisites for some assessment modalities in 2020. These decisions were based on evidence that completion of certain training, preparation activities and or success in particular assessments led to greater likelihood of success in certain exams. These changes will continue to be monitored and evaluated closely. More information is available on our website (acrrm.org.au).

The College also undertook a strategic approach to succession planning for Lead Examiner roles incorporating governance measures on diversity and tenure.

Key developments in assessment include:

- MCQ requirement introduced as pre-requisite for PC StAMPS eligibility.
- Revised criteria for CBD assessments implemented under COVID-19 terms.
- Revised criteria for StAMPS preparation activity.
- Introduction to CBD, MCQ and StAMPS online courses published.
- CBD refinements including allowing enrolment throughout the year, one assessor reviewing all cases and choosing cases for the assessment, criteria around undertaking CBD in ED and RFDS settings.
- AST in Palliative Care introduced using CBD as main summative assessment.

We would like to thank the following Fellows for their contribution to the management and implementation of the various ACRRM assessment modalities:

Drs Raymond Lewandowski, Peter Arvier, Angela Stratton, Johanna Mostofizadeh, John Togno, Stephen Margolis, Chris Carroll, Ralph Chapman, and Katie Goot, along with all scenario writers and contributors.

AUSTRALIAN GENERAL PRACTICE TRAINING

Round Two applications for AGPT 2020 was the final intake managed entirely by the Department of Health.

The College assumed responsibility for the full application and selection process for Round One applications for ACRRM training in 2021 , and with the benefit of a custom-designed ACRRM Training Application Management System it was a faster, more efficient application process, which provided greater transparency and data on the profile and engagement of candidates at all stages.

ACRRM worked very closely with Regional Training Organisations (RTOs) and the Department of Health throughout the application and selection process, particularly regarding marketing, recruitment and selection logistics.

The College continues to convenes fortnightly meetings with RVTS and all AGPT RTOs to monitor implementation of training policies and processes, share COVID-19 related impacts, experience and responses, and to exchange views and ideas.

INDEPENDENT PATHWAY

This Fellowship pathway currently has 300 Registrars actively training across rural and remote Australia. Independent Pathway (IP) is supported by a team of Training Officers and Medical Educators. There is a quarterly application round and an average of 25 registrars each intake, but numbers are not restricted by a quota.

The second half of the brand new ACRRM Independent Pathway Education program was run at the beginning of this financial year with 48 registrars all completing the program. The new program consists of 10 topics delivered in four-week blocks over a 12-month period. Each online topic consists

EDUCATION SERVICES

of four weeks of education including self-directed learning, online case discussions, capstone webinar and a final assessment activity.

In the second half of the financial year the Education Development team reviewed, improved and re-ran the first six months (five topics) of the new program for 74 registrars - with 73 completing the program. During this period, work also began on additional self-directive topics planned to roll out in the next financial year.

EDUCATION DEVELOPMENT

DRUG AND ALCOHOL ADDICTION EDUCATION (DAAE) PROGRAM

The College has been funded by the Department of Health to design and deliver a suite of incentivised training activities to strengthen the capacity of General Practitioners to address drug and alcohol addiction in their communities. Our commitment has been to ensure that these programs address the issues pertinent to doctors in rural and remote areas, remote Aboriginal and Torres Strait Islander communities, and are able to be accessed from even the remotest of practice locations.

Delivery of the program activities has begun with the launch of the Alcohol and Other Drugs – Driving Change in Communities online course, along with accompanying satellite courses that provide complimentary educational content.

In response to the impacts of COVID-19, the program workshop, originally planned for face-to-face delivery, has been adapted to a virtual format.

On successful completion of each training activity, eligible ACRRM members can apply to claim an incentive grant, in accordance with the following:

- Online Learning Course - $1,300 (Excl. GST)
- Workshop - $2,700 (Excl. GST)
- Webinar - $200 (Excl. GST)

Participants also have access to the DAAE Program Hub where additional Alcohol and Other Drugs resources are provided. These are listed nationally, by state, and by PHN. Participants are also able to engage in moderated case studies presented by experienced ACRRM fellows. These cases are designed to encourage critical thinking and peer-to-peer communication.

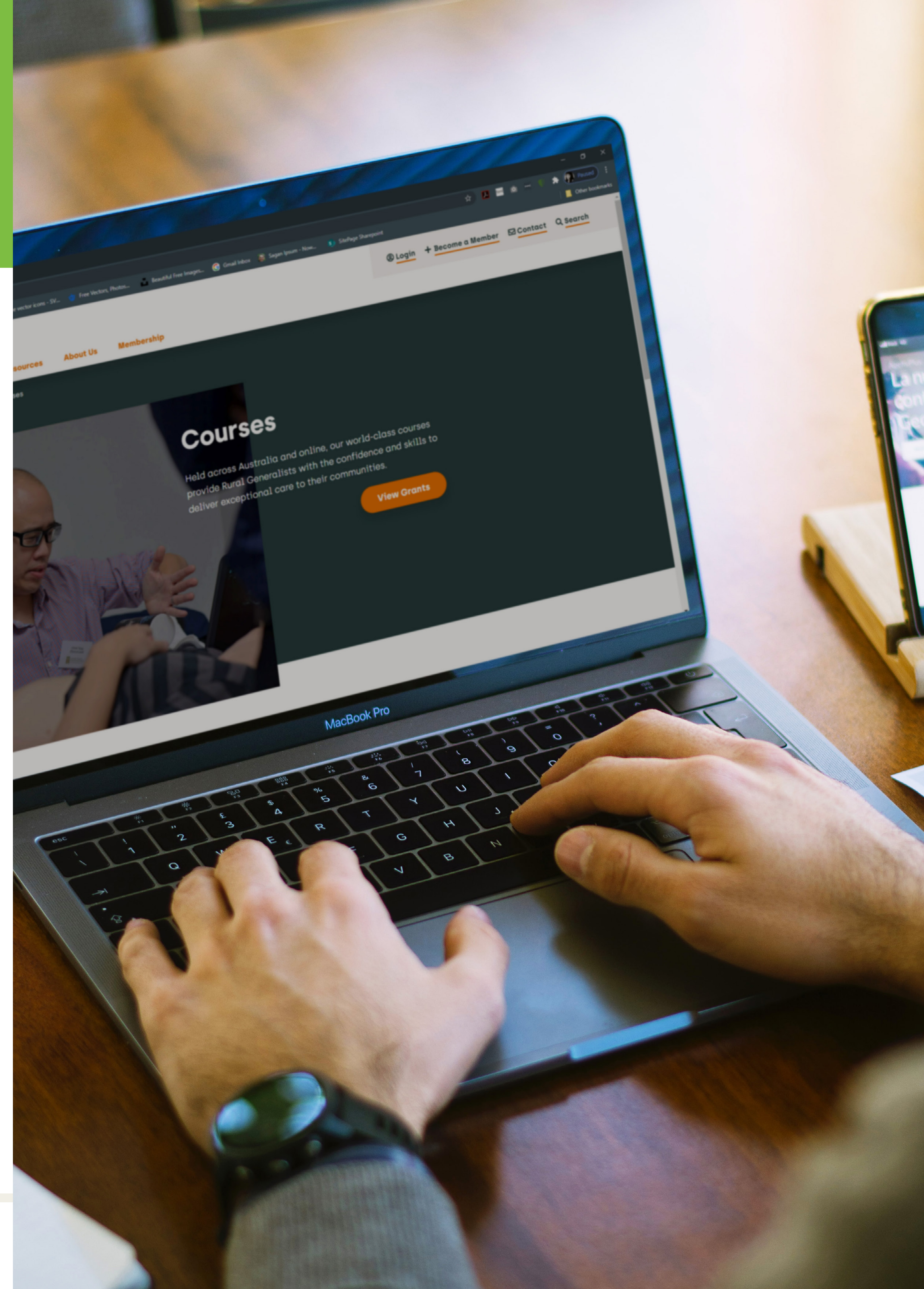
The program has received an extension due to the circumstances surrounding COVID-19, until 31 December 2021.

IMPLANON

The Education Development team worked with MSD to develop the Implanon insertion training for rural and remote practitioners online course.

This consists of online training and assessment - followed by a live Zoom session for further training and observational assessment using placebo devices sent to remote participants. This format allows ACRRM members from any location in Australia to access Implanon training.

The course has been developed and trialed and will be rolled out further next year.



MEMBER STORY:
DR TREVOR BURCHALL

Dr Trevor Burchall has been a Rural Generalist (RG) for over 30 years, including ten years spent purely as an ED Director in his home city of Mt Gambier, SA. He is currently working as rural ED and GP locum, part time FIFO for RFDS in Mt Isa, a deputy CMO SA Ambulance Service and Medical Educator for ACRRM. Along with all of his work commitments, Trevor also keeps busy with his three (adult) children, two grandchildren, and three stepchildren aged 9, 7 and 4.

What challenges have you faced in addressing drug and alcohol addiction in your community?

I have always worked in a rural setting and the main problem has always been accessing drug and alcohol allied health resources to assist with the management of these patients. I'm sure that this is the same in most rural and remote communities across Australia.

What prompted you to undertake the ACRRM Drug and Alcohol Addiction Education (DAAE) Program? How will you use these learnings and apply it to your local community?

I thought that if I could learn more about this field then it would be of benefit to myself and, of course, to the patients and communities that I am involved with especially with the lack of resources, as mentioned above.

As a Medical Educator for ACRRM's Independent Pathway why do you think the DAAE program is important for FACRRMs and rural doctors in training?

Drug and alcohol addiction makes up a significant part of any GP's workload but the impact of it on family, friends and community is huge, especially in smaller rural communities. I think it's imperative that we, as FACRRM's and rural doctors in training, all strive to be as informed as we can on these topics so that we can provide maximal care and assistance to all involved. It also appears to be a growing issue in our communities which is another reason to complete the DAAE program.

What takeaways have you had following completion of the ACRRM DAAE Program?

My main takeaway would be that whilst it is a huge issue, there are some major points that we need to know including assessment tools and management tips - all of which are covered in the course. The DAAE course provides the information that one needs to know in an easy to follow and clinically based format. Also, there are some great links to other resources which look to be very informative and useful.

What would you say to anyone thinking of enrolling in the program?

Take the time and do it and you won't regret it. Even if it's not a particular area of interest for you still do it as it is essential knowledge.

> **Drug and alcohol addiction makes up a significant part of any GP's workload but the impact of it on family, friends and community is huge.**

QUALITY & SAFETY REPORT

With the advent of bushfires and COVID-19 in 2020, the College focused on providing resources to assist Registrars and Fellows to support their communities with the healthcare challenges they faced.

The rapid onset of fires across the nation in the first weeks of the year prompted the College to review and further develop its national disaster resources, specifically in relation to mental health supports. These were widely promoted to Rural Generalists and their communities via the weekly Country Watch newsletter, Connect@ACRRM member platform, regular emails, and website updates.

COVID-19 is a new challenge for the College , ACRRM and RDAA obtained funding from the Department of Health to collaborate on the COVID-19 Response for Rural and Remote Communities project, which was purposed with providing rural and remote doctors with:

- Relevant clinical resources
- Practice support resources
- Response preparedness resources
- Updates and information though a regular newsletter
- Representation and advocacy

The College was also a member of the National COVID-19 Clinical Evidence Taskforce, providing input into creating responsive and relevant resources to support rural and remote doctors.

This is an ongoing project, which includes regular newsletters and media releases to not only provide members with resources to benefit their practice and communities, but also advocate on their behalf for necessary changes, such as increased funding for Telehealth.

THE IMPACT OF COVID ON DIGITAL HEALTH

This has been, for all the obvious reasons, a big year for digital health. The surprise story has been the creation of telehealth item numbers on Medicare. Long requested and lobbied for, it took the requirements of social distancing in the SARS-CoV-2 pandemic for government to realise that funding only face-to-face consultations was no longer acceptable in the 21st Century. Prior to this, telehealth had been confined to either state level initiatives, often around specific fields (such as stroke, mental health and ophthalmology), or quite restrictive limitations around rurality and specialist involvement.

Rural practitioners have always undertaken telehealth, just never had it remunerated before. A telephone was always more efficient when the farmer lives an hour away from the practice. For this reason, rural practice was faster than urban practice to adopt telehealth. At the time of writing this, half of all consults are now done by telehealth across the country. Alas, the majority of activity is by telephone. Despite the benefits of video consultation in improving the assessment of patients, and in facilitating communication, video consultation remains at less than one per cent of all consultations.

The difficulties of the various platforms, concerns about security, and usability all conspire to make adoption difficult to implement and difficult to integrate into workflow. All this means that practitioners vary from using FaceTime/Google Meet/WhatsApp, to bespoke clients such as ZoomHealth, etc. Promoting standards and facilitating adoption of integrated video consultations will be a priority of the ACRRM Digital Health committee over the coming years.

It hasn't all been about telehealth though. Another welcome effect of the pandemic has been the acceleration of electronic prescribing. By the time you read this, you will be able to transmit an electronic prescription token by email or SMS to the patient, who can then fill it at any pharmacy. This will greatly improve our ability to care for remote patients. The next step that the digital health committee will be advocating for is the completion of the digital care loops – adding electronic ordering and referrals to the mix.

In addition to the above, the committee and the College has been active in a number of other areas. The CSIRO has been undertaking a long-term project to look at the standards for GP electronic medical records, with ACRRM 's involvement. In addition, we have had some input into the development of the Practice Incentive Program – Quality Improvement (PIP-QI). The College has had several webinars over the year on the My Health Record, using digital data to improve care, and on the PIP-QI.

As the increasing digitising of the medical world continues apace, the College and the Digital Health Committee will continue to be active in driving the agenda for the benefit of members.

By Associate Professor Chris Pearce, Digital Health Committee Chair

NEW PROFESSIONAL DEVELOPMENT PROGRAM

The 2019-2020 financial year signaled the commencement of the College's revised Professional Development Program which has been adjusted to meet the requirements of the Medical Board of Australia's (MBA) upcoming Professional Performance Framework (PPF). The College has worked tirelessly to ensure the program can enable our members to maintain compliance while minimizing their administrative requirements. Rolling out the new systems has involved extensive and ongoing interaction with members.

In the new CPD Framework, most activities are approved instantly (apart from Life Support and MOPs activities) and we have enabled effective options for demonstrating acceptable evidence. The College is working to evolve the PD portfolio to be a more versatile virtual space that not only supports and enables member CPD relevant to their personal scope of practice, but intuitively delivers content and opportunities based on their individual needs.

Additionally, we have identified that peer engagement is a significant desire from our members, and ACRRM continues to drive and develop member platforms to discuss, learn and share ideas with each other, through interactive webinars and forums, including the new Connect@ACRRM platform.

The College thanks the Chair of the Professional Development Committee, Dr Ian Kammerman for his untiring commitment to helping members navigate the new professional development program arrangements.

QUALITY & SAFETY REPORT

PROGRESS TO DATE

The ACRRM website has been updated to provide a range of resources to help members understand the new framework with a breakdown of requirements, categories and activities. We have developed a webinar explaining the framework, including practice-based user case studies, a new handbook, as well as a timeline showing how the framework has evolved. These are supported by ever evolving FAQs which is driven by our ongoing engagement with members.

A new library of CDP resources has been published within the PD portfolio including templates and guidelines on peer review, clinical audit, peer observation of teaching, Significant Event Analysis, PUNs and DENs , patient feedback, and medical record review. Furthermore, a detailed webinar from Dr Tony Lembke and A/Prof Chris Pearce demonstrating how to use your practice systems and data for performance review and outcome measurement is now available.

The program has attracted 323 new participants in the 2019-2020 financial year and 2246 activities (classes) have been accredited so far for the current triennium.

STILL TO COME

The College will continue to improve and update the PD portfolio and modify the framework throughout this triennium as members engage with the program and provide feedback on how we can better improve the service we deliver to them.

Resources currently under development include guidelines on how to use practice analytics for quality improvement and CPD, case-based discussion capability in Connect@ACRRM, locum-specific resources and a list of reliable best-practice benchmarks.

The 2020-2022 framework will continue to enhance a wide variety of practice types, catering for basic reporting requirements including Vocationally Registered and FACRRM maintenance, as well as advanced skillset reporting in procedural, emergency and mental health areas.

RURAL PROCEDURAL GRANTS PROGRAM

The Rural Procedural Grants Program (RPGP) is a cornerstone of Rural Generalist workforce sustainability. It 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. Additional Emergency Mental Health funding will enable eligible registrants to access to a further $6000 per financial year from July 2020.

The 2019-2020 financial year has seen increased flexibility in the program with the ability to claim $1000 per day for online activities for the remainder of 2020, in response to COVID-19 and the cancellation of many face-to-face events.

ACRRM advocated strongly for these measures to support rural medicine and has proactively identified eligible activities and published a list on the College website. The College has effectively communicated these changes, ensuring that the program is promoted to the widest possible audience of rural practitioners. The College has taken over payment processing from July 2020, for those registered in the program with ACRRM and has ensured a seamless handover from Services Australia, with no disruption in payment services.

During the 2019-2020 financial year there were 113 new registrations to access the program bringing the total as at 30 June to 2300.

The 1843 claims for grant funding processed by ACRRM this financial year has supported Rural Generalists by offsetting some of the costs of training to maintain the skills and knowledge necessary for safe rural practice.

DIGITAL HEALTH

There are real opportunities to achieve higher standards of healthcare in rural and remote Australia through the increased and integrated use of digital health solutions.

Digital health can improve equitable access to health services and support patients in the prevention, diagnosis, treatment and management of their health and wellbeing. It also supports rural doctors in accessing education, training and peer support in what can be an isolated profession

The digital health team supports members in their knowledge, skills and confidence in using digital technologies in everyday practice. We work at a local, state and national level to ensure quality healthcare is delivered safely when new technology systems and processes are introduced. Through collaboration and co-design, the College advocates for the information technology and information management needs of rural and remote communities to ensure the sustainable, safe and appropriate use of technology.

This year saw the College engaging in several national and local projects:

The digital health team supports members in their knowledge, skills and confidence in using digital technologies in everyday practice.

- MBS Telehealth Item numbers for GP to Patients, with two releases this year. Firstly, for patients in MMM6 and 7 and the temporary arrangements to support the COVID-19 health action plan
- College Telehealth Resources. The review and update of the suite of telehealth resources which the College has nationally and internationally since 2012.
- Electronic Prescribing. Changes to Commonwealth legislation on 31 October 2019 recognised an electronic prescription as an alternative legal form by which medicines can be supplied under the Pharmaceutical Benefits Scheme (PBS).
- The Australian Digital Health Agency's Communities of Excellence program in Emerald, QLD and Hedland WA. Developing tools and resources to assist the providers in the

QUALITY & SAFETY REPORT

Communities improve their technology skills and knowledge to improve health services and healthcare knowledge at a community level.

- My Health Record provider knowledge and awareness developed an online education module 'digital health in rural and remote Australia' authored by GP Dr Tony Lembke.
- The development of the National Child Health Record system which will be trialled in 2020-21. The College participated in the design of the clinical information held in the system and presented to parents though the app.
- Department of Health and CSIRO Primary Care Data Quality, seeking to establish minimum datasets for the transfer of care and health assessments and provide education to rural doctors.
- National Tele-Derm service hosted by the College and made available to all Australian Rural Doctors. Supporting over 3000 doctors and providing dermatology advice to over 600 cases to support early intervention and reduce the need to travel.
- Rural and Remote Digital Innovation Group, a national collaboration, hosted by the College to give key rural organisations access to shared knowledge and advice to support the implementation and meaningful use of digital health technologies, with an emphasis on improving access to health care in rural, remote and ATSI communities across the primary and secondary care continuum using telehealth.

COURSES REPORT

2019-2020 was on track to be a stellar year for ACRRM courses with full attendance at RMA19 workshops, the debut of Emergency Week and with the biggest courses in Rural Emergency Medicine booked for the second half of the year.

ACRRM was on a trajectory to exceed the previous year's delivery schedule and deliver more than 70 courses to over 1400 members until the onset of COVID-19. Despite the impact of the pandemic, the College managed to deliver more than 50 courses face to face and virtually across 13 different locations to more than 840 participants over nine months. In order to ensure the health and safety of all staff and participants, the College cancelled 23 courses in the last three months of the financial year. These included courses which were scheduled in conjunction with major events including RDAV, RDAQ and RADU. We have rebooked with these events in the next year.

With success in delivering virtual events such as Mental Health Skills Training and Drug and Alcohol Addiction Education, the team strategised to move ACRRM's flagship courses to virtual platforms to provide members with the opportunity to continue their professional development and gain the skills required to provide rural and remote communities with exceptional health care.

COURSE	TOTAL COURSES	TOTAL REGISTRATION
REST	20	364
REOT	5	93
ALS	11	180
Ultrasound	3	39
Mental health	5	45
RACM	4	68
PHaRM	3	47
TOTAL	**52**	**844**

RMA19

The college offered 10 courses, including two ALS and two REST courses, to more than 180 participants who took advantage of combining their learning experiences with attendance at RMA19.

A highlight of the week was launching REST version 2.0 with much success. The College thanks the REST 2.0 working party and the Standards and Development committee for their assistance with this upgraded version.

NUMBERS:

COURSE	NUMBER
x2 ALS	39
x2 REST	37
REOT	20
PHaRM	20
RACM	24
US	19
MHST	10
Dermatology	11

QUALITY & SAFETY REPORT

EMERGENCY WEEK

The College's inaugural Emergency Week was held in Brisbane 2-8 December 2019, featuring seven of ACRRM's most popular courses.

Emergency Week was an opportunity for members to attend courses presented by leading authorities in their areas of specialty using state-of-the-art equipment. Each course was designed to provide Rural Generalists with the confidence and skills to deliver exceptional care to their communities.

Emergency Week's debut saw an outstanding 95 members come together to learn, share and grow, and gain access to last minute CPD points before the end of the triennium.

NUMBERS:

COURSE	NUMBER
ALS	15
REST	19
REOT	19
PHaRM	10
RACM	18
US	10
MHST	4

MEMBER STORY:
DR RACHEL JAMES

Dr Rachel James is a rural general practice obstetrician registrar with an unlikely journey into medicine. Dr James shares her story and rural generalism experiences.

Tell us about your journey into medicine. What made you want to pursue a career as a Rural Generalist?

I come from a non-medical family in the capital city of Perth WA. When I left high school, medicine was the furthest thing from my mind. My dream was to be the general manager of the Australian Ballet Company. By the age of 23 I've ended up as a GP obstetrician in the rural town of Deniliquin, NSW. Life certainly throws some curve balls to make things interesting!

Well I started my arts degree and I hated it. I was bored and I quickly realised I had no passion for excel spreadsheets even when they were linked to tutus and pointe shoes. I moved to a science degree and liked it but once again, spending hours alone in a lab did not suit me either. I had to blend the two. Medicine, a science based on a subtle artform appealed to me. I always wanted a career which would contribute to the world and where I felt I could make a difference so medicine seemed a nature progression.

Studying medicine at Flinders University gave me the opportunity to explore. Medicine is so special in the way you can travel off the beaten path and be so accepted by different communities. I found myself choosing rural rotation after rural rotation because I liked the variety, locations and the communities.

My journey to a career in Rural Generalism was a slow but considered path. I remember having breakfast with my boyfriend, now husband, we were both so tired between him working ED and me working O&G shifts. We were seeing so many patients and yet felt we were not making a difference to the communities. We felt like we were on conveyor belts, creating no actual meaningful change. We missed the variety, we missed nature, and we missed the sense of community we had in our rural experiences. We both had positive rural experiences but are both from major cities, so it felt like a risk. In the end we just thought "let's give it a go" and we took the plunge to move rural and give it our best shot. What we have found is a very rewarding and fulfilling career which we are able to achieve together.

What does rural generalism mean to you?

To me a Rural Generalist is a doctor who can walk into any clinical situation and has the skills to contribute to the wellbeing of the patient. This doesn't mean being an expert in every field but means knowing how to assess, triage, ask for help, plan logistics and manage a team. It is the feeling of being capable in a range of different clinical settings from primary care to the emergency room to retrievals and everything in between.

> **To me a Rural Generalist is a doctor who can walk into any clinical situation and has the skills to contribute to the wellbeing of the patient.**

What does a typical workday or week look like for you?

The word "typical" needs to be removed from the vocabulary when talking about rural generalism because there is no such thing. On occasion I have a week when I solely do general practice which I love. Other times I am doing my GP clinics, being on call for the local ED, handling hospital inpatients or managing the obstetric unit. It can go from calm to very busy very quickly. I usually describe it as having multiple hats but I love each one of my hats so it is always a good day, even though sometimes it is a long day.

Do you have any career highlights so far?

I have so many highlights. Being a female rural GP in itself is a highlight. The number of female rural GPs is very low and there is such a high percentage of women who unfortunately feel uncomfortable discussing certain matters with male GPs. I have had so many conversations to young adults about contraception, STIs and periods, I have completed so many cervical screens that have been very much overdue, and have started the conversation around urinary continence for many older woman who have been suffering in silence. These things equal long-term benefits and it's a privilege to be a part of.

I also provide termination services which is not my favourite aspect of medicine, but I feel it is vitally important for woman to have control over their bodies and futures. Currently, rural women have

MEMBER STORY: DR RACHEL JAMES CONT.

very limited services for termination which results in needing to travel long distance at a high financial cost meaning some are excluded from having a choice. I am happy to say I am forming a very small part of the solution to this problem and I can follow up with better contraception options thereafter.

On a lighter note, I diagnosed a STEMI as it was happening in ED. I was watching the telemetry of an Aboriginal women who came in with nausea. I was looking at the screen as the ST elevation started and said, "that looks like a STEMI!". The printout confirmed I was right. We managed to thrombolysis shortly after leading to a very small amount of time with lack of perfusion.

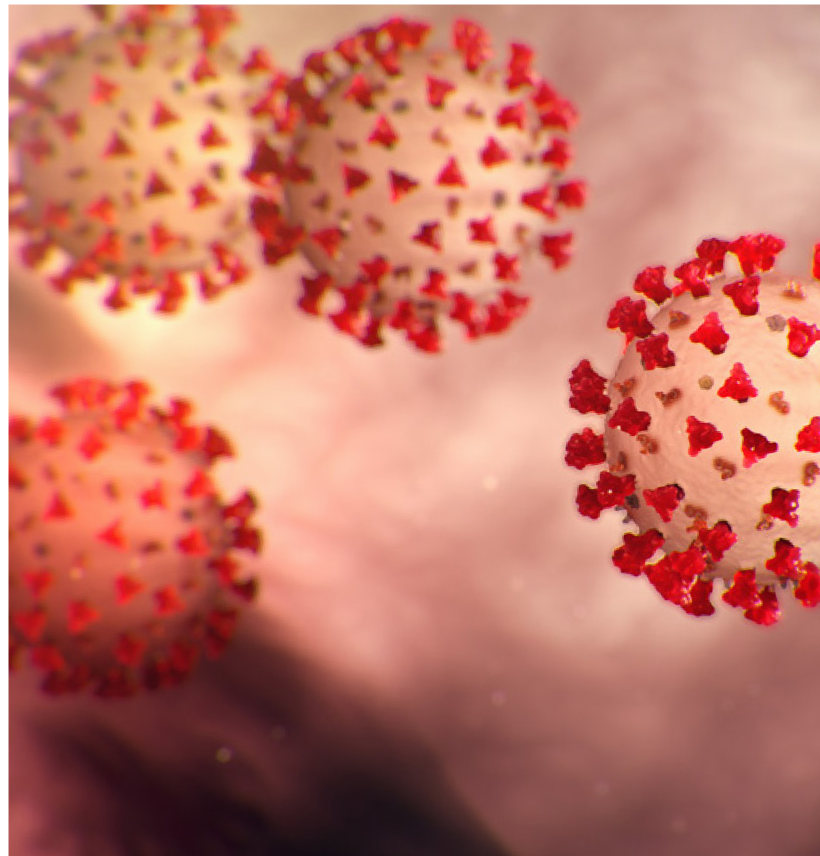
Regarding obstetrics, I have had so many. I have had women who have very few supports and by being able to deliver close to home it means they can stay close to family and friends during such an important part of their lives. Then getting to take care of growing families after the delivery is very special. Some of the babies I have delivered are now turning two!

As a recent Fellow, do you have any tips for medical students and junior doctors who are thinking about choosing a career in rural medicine?

Take the plunge. When you have lived city your whole life it can be challenge because it is a different lifestyle and location as well as a job but life is about having an adventure and taking risks. Moving rural can be amazing.

POLICY & ADVOCACY REPORT

While the College policy and advocacy agenda has expanded to include support for members and communities affected by a spate of natural disasters and the response to the COVID-19 pandemic, our regular program of advocacy and policy development has continued.



POLICY HIGHLIGHTS:

- Working toward implementation of the **National Rural Generalist Pathway** including progressing the national immigration plan; joint application to the Medical Board for specialist recognition and working with the Commonwealth, states and territories to establish the Rural Generalist Coordination Units.
- **New position statements** on pill testing; pharmacy prescribing; climate change and human health; rural maternity services; minimum standards for rural emergency departments.
- 22 formal **submissions**, including to the Senate Select Committee COVID-19 inquiry; Rural Generalist Coordinating Unit operations; National Rural Generalist Pathway for Allied Health; Natural Disaster Royal Commission health issues paper; Medical Benefits Schedule Taskforce.
- **Policy support for** the College response to the Medical Board of Australia consultations on mandatory reporting; professional development frameworks and a range of other issues.

ADVOCACY AND ENGAGEMENT

- ***Participation in over 60 Advisory Committees and Working Groups*** at both the Commonwealth and jurisdictional levels, including the Practice Incentive Program Advisory Group; National Workforce Reform Advisory Committee; Primary Health Care Reform Advisory Committee; Rural Health Roundtable; State Rural Generalist Coordination Units.
- ***Disaster planning and response,*** and involving Rural Generalists and the primary health sector in planning and response at the Commonwealth, jurisdictional and community levels.

> **Participation in over 60 Advisory Committees and Working Groups at both the Commonwealth and jurisdictional levels.**

- ***Health impacts of climate change,*** including College recognition of climate change as a health emergency; and endorsement of global and national appeals to address the health impacts of climate change as part of ongoing disaster response and planning.
- ***Ongoing partnerships with the Rural Doctors Association of Australia (RDAA),*** including a Rural and Remote COVID-19 communications project and Reducing Opioid Harm project.
- ***Formalised working relationships*** with RDAA, the National Rural Health Alliance, and a number of rurally-based Primary Health Networks.
- ***Stakeholder and rural community engagement,*** with the College consolidating relationships with rural community organisations as well as with other medical and rural stakeholders.
- ***Supporting reconciliation*** in consultation with the Aboriginal and Torres Strait Islander Members' Group through advocacy, engagement with Aboriginal and Torres Strait Islander business and community groups, and the Closing the Gap Steering Committee.
- ***Supporting the College Respectful Workplaces Working Group,*** including initiatives to foster diversity and respectful workplace culture; and support practitioner health and wellbeing.
- ***Advancing international relationships***, through ongoing development of a Memorandum of Understanding with the Japan Rural Generalist Program and engaging with international organisations, Colleges and associations, including Rural WONCA, which is chaired by Dr Alan Bruce Chater, (FACRRM).

MEMBERSHIP REPORT

The College's membership reached the significant milestone of over 5000 members, this growth is a testament to our dedication to the training of current and future Rural Generalists and advocacy for rural and remote communities.

College membership has sustained continuing annual growth, to increase by over 25 per cent over the past five years. This partially reflects increasing training enrolments, but also growth in our junior doctors, medical students and Fellowed members categories. This is also exhibited by the College's assistance through the bushfires at the beginning of 2020, the procurement of Personal Protective Equipment throughout the COVID-19 pandemic and providing all members access to an Employee Assistance Program, another level of support in uncertain times. An example of the College's ability to adapt to member need has been providing assessments online, which has allowed them to continue their education and pursuit of Fellowship while remaining in their communities.

The ACRRM Mentoring program has continued to thrive with an increased number of mentors and mentees connected allowing mentors to provide pastoral guidance to the next generation of rural and remote practitioners. Collegial support has also been provided through the recently launched Connect@ ACRRM, a College community where members can gain advice and discuss current topics that affect a rural practitioner in real time.

This year saw the Marketing and Communications team work on the College's biggest conference to date, support members through bushfires, COVID-19, changes to the Professional Development Program, taking ownership of selection and assessment for the Australian General Practice Training program, advocate for recognition of Rural Generalism and undertake activities to prepare for College-led training.

To ensure this could all happen in an engaging, timely and effective manner, ACRRM invested in resources and systems, which positions us well for future Marketing and Communications requirements.

These activities also provided stimulus to increase media and stakeholder engagement, which in turn strengthened the College brand and reputation.

MEDIA

The College is committed to increasing media presence and the Marketing and Communications team has proactively established relationships with key media stakeholders, as well as organisations which promote and support rural generalism.

This year, ACRRM President Dr Ewen McPhee was interviewed across broadcast, print and online media on topics as diverse as COVID-19, rural workforce requirements, and College-led training.

The College joined with the Rural Doctors Association of Australia (RDAA) to form the COVID-19 Rural and Remote Response team, headed by ACRRM's Dr Ewen McPhee, RDAA's Dr John Hall and Dr Adam Caltzou. As well as media releases, this collaborative effort provided members of both organisations with information through newsletters, webinars and practical resources.

SOCIAL MEDIA

What a year it has been for social. We have not only increased engagement across Facebook, Twitter and Linked-In, but reinvigorated Instagram and introduced a new platform specifically for members – Connect@ACRRM.

Our primary aim with social media this year was to boost our engagement and reach with generic and paid digital campaigns and improve our efficiencies through better use of data and platforms.

The results improved marketing campaigns across all pathways and led to higher traffic on the website.

MEMBER COMMUNICATIONS

ACRRM has further developed its member communication platforms with a new newsletter and email system which has the capability to provide members with information that is specific to their interests and requirements.

COUNTRY WATCH

The ACRRM weekly newsletter to all stakeholders, Country Watch, which is delivered to more than 20,000 people, regularly sees open and engagement rates at around 30 percent, higher than the industry average rate of 20 per cent (https://www.privy.com/blog/2020-email-marketing-benchmarks-guide)

COLLEGE TRAINING CONNECTIONS

College Training Connections is targeted to members undertaking and supporting Fellowship training, including registrars, medical educators, supervisors and stakeholders including Regional Training Organisations, Primary Health Networks, Rural Workforce Agencies, Rural Clinical Schools and key Government representatives.

WEBSITE

The new-look ACRRM website was launched in December 2019. The Marketing and Communications team worked with the Business Systems and Integration team, to oversee the restructure.

College membership has sustained continuing annual growth, to increase by over 25 per cent over the past five years.

All business units contributed content specific to their area of interest.

The primary purpose of developing the new website was to offer an enhanced user experience, with improved navigation and content. Feedback has largely been positive and is resulting in further work to improve the navigation menu, search functions and SEO capabilities.

CONNECT@ACRRM

Connect@ACRRM is an online community that allows ACRRM members to engage, network and collaborate across Australia and beyond.

Launched in December 2019, this online tool was created with the purpose of providing a community and to increase member engagement. The platform has been well received with high member engagement in discussions, profiles, and meaningful connections being fostered between members.

With access to open forum discussions, resource libraries and dedicated communities (e.g. Registrar

MEMBERSHIP REPORT

Community, Future Generalists) members are able to communicate across a wide range of functions. Members create their profile by adding a bio and photo, and can add friends and connections by searching the member base.

Daily activity is seen on discussions posts which are topical and include great advice and information shared through comments.

Connect@ACRRM allows for;

- Talking to members in real-time.
- Sharing clinical learnings.
- Asking questions about life as a rural doctor.
- Listening and learning from other members facing the same/ similar problems .
- Sharing insights and experience in peer-to-peer discussion forums.
- Sharing industry thoughts on specific topics or issues.
- Personalised delivery methods to suit the individual; real time, daily digest, weekly digest.

Connect@ACRRM has become the go-to place to network, share insights and experiences, and gain knowledge from peers that are connected through a commitment to providing rural and remote communities with excellent health care.

The platform has proven to be a useful tool during COVID-19, with RGs sharing advice and information.

MEMBER ENGAGEMENT

Despite COVID-19, ACRRM has been well represented across the country with attendance at a number of face-to-face events. Highlights include the Member Services team inspiring students at the Australian Medical Students Association (AMSA) National Conference and AMSA Rural Health Summit, Education Services waving the green and orange flag at GPTEC 19, and sponsorship of annual events for the Australasian Military Medicine Association, the Australian Indigenous Doctors' Association and state-based rural doctors networks and associations.

While many planned events were initially cancelled when the pandemic hit Australia in March, creative event planners quickly pivoted to virtual events and activities. This online engagement suited ACRRM well and allowed for increased representation from FACRRMs and Registrars at university careers expos, hospital forums and information sessions, and Regional Training Organisations' orientation workshops – far more than would have been possible for Rural Generalists usually unable to travel to face-to-face events due to geography and commitments in their communities.

RECONCILIATION ACTION PLAN REPORT

Priority given to continuing the reconciliation journey

The College's reconciliation journey continues to be a priority for the College Board, Council, staff and members. During the year we have been implementing the actions and activities documented in our 'Innovate' Reconciliation Action Plan, which was launched in April 2019.

Implementation of the RAP is coordinated by a Steering Committee which meets regularly to monitor progress. This Committee is composed predominantly of College staff with the meeting outcomes being tabled with the College Indigenous Members' group who provide ongoing feedback and guidance. The Committee also reports to the College Board and Council.

As part of the RAP, we have finalised a list of dates of national significance and these are acknowledged through member and staff communication. We have also been active in ensuring content, art and images relevant to Aboriginal and Torres Strait Islander peoples are incorporated into College events, website, publications and facilities.

The Aboriginal and Torres Strait Islander Members Group and the Respectful Workplaces Working Group have both been active in promoting respectful workplaces where diversity and inclusiveness is valued and our Indigenous members are supported.

ACRRM INDIGENOUS MEMBERS' GROUP

The ACRRM Indigenous Members' Group is the College's key representative body for its Indigenous Members. It provides a mentoring and networking forum open to all Aboriginal or Torres Strait Islander College members, from students through to Fellows. It also acts as a reference group for the College, providing advice and guidance on issues of importance to Aboriginal and Torres Strait Islander peoples' health and doctor training.

Over the year, the group, chaired by Dr Sarah Jane McEwan, has formalised its structures to strengthen its links to College governance. Dr Regina Phillip has joined ACRRM College Council as the group's nominee and provides a conduit between the two forums and Dr Danielle Dries is the Group's nominated representative on the Respectful Workplaces Working Group. The Group is also looking to facilitate representation on the Registrar Committee. The Group provides guidance to the RAP Steering Committee and receives reports on the Committee's activities.

Over the year the group has also assisted with the College's curriculum development in the area of Aboriginal and Torres Strait Islander peoples' health, it held a networking event for members at RMA19, and has established a dedicated Indigenous Members Forum on ACRRM Connect.

RMA19

RURAL MEDICINE AUSTRALIA 2019

The 2019 Rural Medicine Australia conference (RMA19) continued to live up to its name as the peak national event for rural and remote doctors in Australia by attracting a diverse community of students, junior doctors, educators, academics and Rural Generalists.

RMA19 was the largest conference ACRRM has co-hosted with RDAA to date. More than 1000 delegates attended to listen to 149 presentations, six keynotes and engage with 60 sponsors and exhibitors. There were standing ovations in plenary sessions and the #RMA19 hashtag trended at number one on Twitter in Australia. Over 4,000 tweets were sent and 11,000 interactions with Facebook.

Gold Coast University Hospital local, and Queensland's first quadriplegic medical intern, Dr Dinesh Palipana OAM, inspired ACRRM's newest Rural Generalists at their Fellowship Ceremony. Delegates also heard from prominent government representatives including Minister for Regional Services Mark Coulton MP, Queensland Health Minister Dr Steven Miles, Shadow Minister for Health Chris Bowen MP, and Digital Health Agency CEO Tim Kelsey. The ever-popular Ita Buttrose closed the conference with an engaging and thought provoking address. As conference MC, Dr Norman Swan facilitated questions and led discussions.

1000+ DELEGATES

149 PRESENTATIONS

11,000 FB RMA INTERACTIONS

NUMBER 1 ON TWITTER

60 SPONSORS AND EXHIBITORS SUPPORTING THE EVENT

MEMBER STORY:
DR ROBERT (BOB) WORSWICK

Tell us about your decision to become a doctor?

I am a late comer to medicine, and it's probably fair to say that I arrived at my medical career by accident, rather than by design. I joined the Army straight out of high school and completed officer training at ADFA (Australian Defence Force Academy) and the Royal Military College Duntroon. I then spent 20 years as an infantry officer, during which time I had the privilege of commanding young Australian men and women, and serving in the far flung (and not so nice) corners of the globe – Somalia, Syria, South Lebanon, East Timor, Iraq and Afghanistan.

After twenty odd years I decided to take 'the road less travelled' – to follow a different career path in the Army. Medicine was not my first choice. I wanted to become a linguist, and after completing language aptitude testing, I suggested to the Army that I should undertake a year of intensive Arabic or Dari language training. The Army, in its wisdom, said that it had no need for me to become a linguist. 18 months later I was serving in Afghanistan (where the national language is Dari). Shortly after arriving in Afghanistan I received my GAMSAT result and was invited to interview at Sydney University. I came back to Australia for the interview, returned to Afghanistan to complete my tour of duty, and shortly after I came home, I was a medical student. Looking back, it was a surreal experience.

What made you want to pursue a career as a rural GP?

Before I started my medical training, I knew I was going to become a rural generalist. Actually, that's not quite true. I knew the Army expected me to become a GP, and I knew that I was going to train through ACRRM. As a high school student, I read the book To Kill a Mockingbird, in which Atticus Finch says that '...you never really understand a person until you climb into their skin and walk around in it.' This is often misquoted as 'to walk a mile in another person's shoes'. I've literally walked many miles in my patients' shoes, and before I started medicine I had a very clear understanding of what was expected of me as an Army doctor – because it was what I expected from the |Army doctor when I was an infantry officer. I was duty bound to train with ACRRM to become a rural generalist.

How is Fellowship training different for ADF registrars?

Undertaking GP training as an Army medical officer is challenging. On a day-to-day basis, the Army needs you in the barracks working as a GP, or providing medical support to troops during field exercises in Australia, or supporting troops deployed overseas on military operations. Sometimes this can be at very short notice – we had a number of ADF doctors who were recalled from leave to provide support to people affected by bushfires for example. Army GPs also spend a couple of days a week (when Army commitments allow) working in a civilian GP practice, so that we get to see paediatric and geriatric patients, and chronic disease (i.e. things you don't see in Army patients) – to achieve the 'comprehensive general practice' experience required by GP registrars. The exigencies of military service mean that the pathway to fellowship is a meandering route and the ADF registrar is a 'hunter and gatherer' – we undertake training and gather experiences and competencies in a disjointed manner. Consequently, it takes us a bit longer to get through training. But that's ok – becoming a rural generalist is as much about the journey as it is about the destination.

In a lot of respects, working as an Army GP is like working in a small country town. The barracks – our town – has about 4000 people. Although most barracks are located in metropolitan or regional

> **Do it. Having started medicine quite late in life, my single piece of advice to medical students and junior doctors is not to rush.**

locations, the 'patients' routinely go into rural and remote locations (field exercises and deployments), and their doctor goes with them. This is one of the unique aspects of being a military doctor – we routinely provide 'comprehensive general practice and emergency (pre-hospital) care' in a tent, at sea on a ship, in the back of a helicopter or fixed wing aircraft, or in a deployable field hospital. When we do so, we deploy as a team – usually with a few medics and a nurse. This is another unique aspect of military medicine – as a registrar you are expected to lead a team, and you are required to provide training for the members of the team.

What do you enjoy most about being an Army doctor?

Being an Army doctor can be incredibly frustrating at times, but it is also really rewarding. The best part is the people – my patients are the young women and men who have volunteered to serve their country, and

MEMBER'S STORY:

DR ROBERT (BOB) WORSWICK CONT.

it is a privilege to care for them. You also get unique opportunities and experiences that are not available to your non-military medical peers. Flying at tree-top level in military helicopters, sailing on a patrol boat through the Kimberley Coast, training in chemical warfare, providing support to humanitarian activities, etc. As an Army doctor you are guaranteed 'a life less ordinary'.

What advice would you give to medical students and junior doctors who are thinking about training as a Rural Generalist?

Do it. Having started medicine quite late in life, my single piece of advice to medical students and junior doctors is not to rush. You don't need to be the first person in your cohort to become a specialist – you'll end up spending longer doing the same thing. The foundation of medicine is primary care and I think all doctors should spend some time in primary care. And the best way to do this is as a rural generalist. The advantage of being a rural generalist is that you can be anything and everything. By that I mean it takes about six to eight years (sometimes more) to specialise in a single discipline. However, as a rural generalist, in the time that it takes your colleagues to specialise, you can complete procedural skills training in a few disciplines, underpinned by a strong foundation in general practice. This is your ticket to anywhere.

AUSTRALIAN COLLEGE OF RURAL AND REMOTE MEDICINE LIMITED
A.C.N 078 081 848

FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2020

DIRECTORS' REPORT

The Directors submit the following report for the year ended 30 June 2020 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 Michael Beckoff

Ms Annabelle Brayley

Dr Sarah Chalmers

Dr Daniel Halliday

Dr Michelle Hannan

Dr Suzanne Harrison

Dr Anthony Hobbs

Dr Ewen McPhee

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 Council) 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 2020 amounted to $758,583 (2019 profit: $333,416).

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 they cease to be a member, for payment of the debts and liabilities of the Company contracted before they 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 Michael Beckoff

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

Dr Beckoff is a practicing 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.

Ms Annabelle Brayley

Ms Annabelle Brayley trained as a registered nurse before moving to live on an isolated sheep/cattle station in South West Queensland. After her second child went to boarding school, she re-entered the rural/remote health workforce utilising satellite technology to work from a home office. She now lives in a small South West Queensland community from where she pursues her passion for storytelling.

Dr Sarah Chalmers

BSc(Hon), PG, DipEd, MBBS, FRACGP, FACRRM

Sarah is currently a senior lecturer in general practice and rural medicine at James Cook University in Townsville and a Rural Generalist in Winton. Prior to this, she spent 15 years as Rural Generalist and educator in North East Arnhem Land in the NT.

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 was recently appointed a Member of the Order of Australia for significant service to community health in rural and remote areas.

Dr Daniel Halliday

MBBS, FACRRM, DRANZCOG (Adv), FRACGP, B.BioMed.Sc, GAICD, GCAHM, AFRACMA

Dr Dan Halliday is a Rural Generalist with special interest in Obstetrics and is Medical Superintendent of Stanthorpe Hospital, Queensland. Dan is a Past-President of Rural Doctors Australia of Queensland (RDAQ) and current Chair of the RDAQ Foundation. Dan was the inaugural ACRRM Chair of College Council and is a member of the QLD Branch of ASMOF.

Dr Michelle Hannan

BMedSc(Hons I), MBBS, DCH, MPH&TM, FACRRM, AFRACMA, GAICD

Dr Michelle Hannan became a FACRRM in 2017 with an AST in Emergency Medicine. She has worked as a Rural Generalist across diverse rural and remote areas, including Wagga Wagga, Broken Hill, Wilcannia, and Tasmania. She currently works with the Royal

DIRECTORS' REPORT CONT.

Flying Doctor Service in Mt Isa in both aeromedical retrieval and primary care. Her experience as an ACRRM registrar and now FACRRM provides her with the drive to advocate for the development of a true Rural Generalist Pathway with suitable employment options for Fellows and support for ACRRM registrars in all jurisdictions.

Michelle also sits on the boards of the Children's Hospital Foundation and the Children's Health Research Alliance, and previously served on the boards of the Rural Doctors Association of Tasmania and the Rural Doctors Association of Australia.

Dr Suzanne Harrison

MBBS, DA, FACRRM, Masters Sports 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 Anthony Hobbs

MBBS (1st Hons), FACRRM, DRANZCOG (Adv), DTM&H, DCH, GAICD

Dr Anthony (Tony) Hobbs is a former Deputy Chief Medical Officer of the Commonwealth Department of Health. He was previously the Principal Medical Adviser at the Therapeutic Goods Administration and was a General Practitioner in rural New South Wales for nearly 20 years. Tony is currently the Chief Medical Adviser at Calvary Health Care and continues to undertake part-time General Practice.

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. Dr McPhee has had recent involvement in government health policy through membership of the Primary Health Reform Steering Group.

MEETINGS OF DIRECTORS

During the 2019-2020 financial year, seven meetings of Directors were held with attendance as follows:

DIRECTORS	DIRECTORS MEETINGS	
	Eligible to attend	Attended
Dr Michael Beckoff	7	7
Ms Annabelle Brayley	7	6
Dr Sarah Chalmers	7	7
Dr Dan Halliday	7	7
Dr Michelle Hannan	7	7
Dr Suzanne Harrison	7	6
Dr Anthony Hobbs	7	7
Dr Ewen McPhee	7	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	7	6
Ms Marita Cowie, Chief Executive Officer	7	7
Associate Professor Ruth Stewart, Immediate Past President	7	6

DIRECTORS' REPORT CONT.

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

COUNCIL MEMBERS	COUNCIL MEETINGS	
	Eligible to attend	Attended
Dr Michael Beckoff	6	6
Ms Annabelle Brayley	6	5
Associate Professor David Campbell	6	5
Dr Sarah Chalmers	6	5
Ms Marita Cowie	6	5
Dr Daniel Halliday	6	5
Dr Michelle Hannan	6	3
Dr Suzanne Harrison	6	5
Dr Allison Hempenstall	6	5
Dr Anthony Hobbs	6	4
Dr Stephen Holmes	4	2
Dr Viney Joshi	3	1
Dr Rod Martin	6	6
Dr Eve Merfield	6	5
Dr Andrew Miller	2	2
Dr Antoinette Mowbray	6	4
Dr Ewen McPhee	6	6
Dr Regina Philip	4	3
Dr Francois Pretorius	6	4
Associate Professor Ruth Stewart	6	6
Ms Suzanne Tegen	6	5
Ms Megan Telford	6	5
Professor Lucie Walters	6	3
Dr Greer Weaver	4	2

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

FINANCE AUDIT AND RISK MANAGEMENT COUNCIL MEMBERS	FINANCE AUDIT AND RISK MANAGEMENT COUNCIL MEMBERS	
	Eligible to attend	Attended
Dr Michael Beckoff	6	6
Dr Sarah Chalmers	6	5
Ms Marita Cowie	6	5
Mr Will Fellowes	6	5
Dr Dan Halliday	3	2
Dr Suzanne Harrison	3	3
Dr Viney Joshi	4	3
Dr Rod Martin	6	5
Dr Francois Pretorius	2	2
Dr Susi Tegen	3	3

AUDITOR'S INDEPENDENCE DECLARATION

The lead auditor's independence declaration under section 307C of the Corporations Act 2001 for the year ended 30 June 2020 has been received by the directors.

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

Director

Dated at Adelaide, this 29th day of September, 2020

DIRECTORS' REPORT CONT.

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 2020 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
Chartered Accountants

Stewart Douglas
Director
Brisbane
29 September 2020

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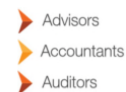

FINANCIAL STATEMENTS

STATEMENT OF PROFIT AND LOSS AND OTHER COMPREHENSIVE INCOME FOR THE YEAR ENDED 30 JUNE 2020

	Notes	2020 $	2019 $
Revenues from Ordinary Activities	2	18,917,063	16,830,436
Expenses from Ordinary Activities	3	(18,158,480)	(16,497,020)
Surplus/(Deficit) from Ordinary Activities		758,583	333,416
Income Tax Expense		-	-
Surplus/(Deficit)	4	758,583	333,416
Other comprehensive income		-	-
Total comprehensive income for the year		758,583	333,416

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

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2020

	Notes	2020 $	2019 $
CURRENT ASSETS			
Cash and Cash Equivalents	5	21,435,542	20,944,112
Investments	6	3,458,865	-
Trade and Other Receivables	7	1,949,279	2,014,428
Other Assets	8	555,031	542,626
TOTAL CURRENT ASSETS		27,398,717	23,501,166
NON-CURRENT ASSETS			
Intangible Assets	9	232,592	569,568
Right-of-use Assets	10	378,856	-
Plant and Equipment	11	228,630	174,179
TOTAL NON-CURRENT ASSETS		840,078	743,747
TOTAL ASSETS		28,238,795	24,244,913
CURRENT LIABILITIES			
Trade and Other Payables	12	20,753,091	17,850,112
Provisions	13	349,995	335,214
Lease Liabilities	14	326,570	-
Other Liabilities	15	-	17,393
TOTAL CURRENT LIABILITIES		21,429,656	18,202,719
NON-CURRENT LIABILITIES			
Provisions	13	216,392	199,598
Lease Liabilities	14	27,558	-
Other Liabilities	15	-	35,990
TOTAL NON-CURRENT LIABILITIES		243,950	235,588
TOTAL LIABILITIES		21,673,606	18,438,307
NET ASSETS		6,565,189	5,806,606
EQUITY			
Retained Earnings	16	6,565,189	5,806,606
TOTAL EQUITY		6,565,189	5,806,606

The above Statement of Financial Position should be read in conjunction with the attached notes

FINANCIAL STATEMENTS CONT.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2020

	Notes	2020 $	2019 $
Cash Flows from Operating Activities			
Receipts from Members & Other Consultancies		12,366,345	12,752,986
Interest Received		147,261	211,976
Grants Received		11,836,314	13,054,466
Payments to Suppliers and Employees		(19,935,746)	(18,188,977)
Net Cash (used in)/provided by Operating Activities	23(i)	4,414,174	7,830,451
Cash Flows from Financing Activities			
Lease Repayment		(342,140)	-
Net Cash (used in)/provided by Financing Activities		(342,140)	-
Cash Flows from Investing Activities			
Payments for Property, Plant, Equipment and Capital WIP		(149,358)	(50,467)
Payments for Investments		(3,458,865)	-
Dividends and Distributions Received		27,618	-
Net Cash (used in) Investing Activities		(3,580,605)	(50,467)
Net Increase (Decrease) in Cash held		491,430	7,779,984
Cash at the beginning of the Financial Year		20,944,112	13,164,128
Cash at the end of the Financial Year	23(ii)	21,435,542	20,944,112

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 2020

	Retained Earnings $	Total $
Balance at 30 June 2018	**5,473,190**	**5,473,190**
Comprehensive Income		
Net Surplus/(Deficit)	333,416	333,416
Other Comprehensive Income	-	-
Total Comprehensive Income	333,416	333,416
Balance at 30 June 2019	**5,806,606**	**5,806,606**
Comprehensive Income		
Net Surplus/(Deficit)	758,583	758,583
Other Comprehensive Income	-	-
Total Comprehensive Income	758,583	758,583
Balance at 30 June 2020	6,565,189	6,565,189

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

NOTES TO FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2020

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 amortisation 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 13.

New and Amended Accounting Policies Adopted by the College

Initial application of AASB 15: *Revenues from Contracts with Customers and AASB 1058: Income for Not-for-Profit Entities*

The College has adopted AASB 15: Revenue from Contracts with Customers and AASB 1058: Income for Not-for-Profit Entities with a date of initial application of 1 July 2019. As a result, the College has changed its accounting policy for revenue recognition as detailed in Note 1.

Based on the assessment undertaken by the College there has been no change to the existing accounting treatment adopted by the College and therefore no adjustment to the opening balance of equity is required. Therefore, the comparative information has not been restated.

Initial application of AASB 16: *Leases*

The College has adopted AASB 16: Leases with a date of initial application of 1 July 2019. As a result, the College has changed its accounting policy for leases as detailed in this note.

The College has applied AASB 16 using the modified retrospective method; which requires measuring the lease liability at the present value of the remaining lease payments at the date of initial application. Under this method, the right-of-use asset is measured at an amount equal to the lease liability, adjusted by the amount of any prepaid or accrued lease payments relating to that lease, recognised in the statement of financial position immediately before the date of initial application. No adjustment to the opening balance of equity is required. Therefore, the comparative information has not been restated.

Impact on assets, liabilities and equity as at 1 July 2019	**$**
Right of use of assets	568,285
Net impact on total assets	**568,285**
Lease liabilities	(621,668)
Deferred lease incentive	53,383
Net impact on total liabilities	**(568,285)**
Retained earnings	-
Operating lease commitment at 30 June 2019	742,070
Less: Discounting using incremental borrowing rate at 1 July 2019	120,402
Lease liability recognised at 1 July 2019	**621,668**

Revenue Recognition

The College has applied AASB 15: Revenue from Contracts with Customers and AASB 1058: Income of Not-for-Profit Entities using the cumulative effective method of initially applying AASB 15 and AASB 1058 as an adjustment to the opening balance of equity at 1 July 2019. Therefore, the comparative information has not been restated and continues to be presented under AASB 118: Revenue and AASB 1004: Contributions. The details of accounting policies under AASB 118 and AASB 1004 are disclosed separately since they are different from those under AASB 15 and AASB 1058, and the impact of changes is disclosed in Note 1.

NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2020

In the current period

Grants

When the College receives grant revenue, it assesses whether the contract is enforceable and has sufficiently specific performance obligations in accordance to AASB 15.

When both these conditions are satisfied, The College:

- identifies each performance obligation relating to the grant
- recognises a contract liability for its obligations under the agreement
- recognises revenue as it satisfies its performance obligations.

Where the contract is not enforceable or does not have sufficiently specific performance obligations, the College:

- recognises the asset received in accordance with the recognition requirements of other applicable accounting standards (e.g. AASB 9, AASB 16, AASB 116 and AASB 138)
- recognises related amounts (being contributions by owners, lease liability, financial instruments, provisions, revenue or contract liability arising from a contract with a customer)
- recognises income immediately in profit or loss as the difference between the initial carrying amount of the asset and the related amount.

If a contract liability is recognised as a related amount above, the College recognises income in profit or loss when or as it satisfies its obligations under the contract.

Subscription Income

Subscription revenue is recognised only when the College's right to receive payment of the subscriptions is established.

Interest

Interest revenue is recognised using the effective interest method, which for floating rate financial assets is the rate inherent in the instrument.

Dividend Income

The College recognises dividends in profit or loss only when the College's right to receive payment of the dividend is established.

All revenue is stated net of the amount of goods and services tax.

In the comparative period

(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 a 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.

Leases

The College as lessee

At inception of a contract, the College assesses if the contract contains or is a lease. If there is a lease present, a right-of-use asset and a corresponding lease liability is recognised by the College where the College is a lessee. However, all contracts that are classified as short-term leases (lease with remaining lease term of 12 months of less) and leases of low value assets are recognised as an operating expense on a straight-line basis over the term of the lease.

Initially the lease liability is measured at the present value of the lease payments still to be paid at commencement date. The lease payments are discounted at the interest rate implicit in the lease. If this rate cannot be readily determined, the College uses the incremental borrowing rate.

Lease payments included in the measurement of the lease liability are as follows:

- fixed lease payments less any lease incentives;
- variable lease payments that depend on an index or rate, initially measured using the index or rate at the commencement date;
- the amount expected to be payable by the lessee under residual value guarantees;
- the exercise price of purchase options, if the lessee is reasonably certain to exercise the options;
- lease payments under extension options if lessee is reasonably certain to exercise the options; and
- payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease

The right-of-use assets comprise the initial measurement of the corresponding lease liability as mentioned above, any lease payments made at or before the commencement date as well as any initial direct costs. The subsequent measurement of the right-of-use assets is at cost less accumulated depreciation and impairment losses.

Right-of-use assets are depreciated over the lease term or useful life of the underlying asset whichever is the shortest.

Where a lease transfers ownership of the underlying asset or the cost of the right-of-use asset reflects that the College anticipates to exercise a purchase option, the specific asset is depreciated over the useful life of the underlying asset.

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	Straight Line	10%-33%
Right of Use Assets	Straight Line	Over the life of the lease
Leasehold Improvements	Straight Line	20%

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.

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.

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 the date that the College commits itself to either the purchase or sale of the asset (i.e. trade date accounting is adopted).

Financial instruments (except for trade receivables) 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 expensed to profit or loss immediately. Where available, quoted prices in an active market are used to determine fair value. In other circumstances, valuation techniques are adopted.

Classification and subsequent measurement

Financial Liabilities:

Financial liabilities are subsequently measured at:

- Amortised cost; or
- Fair value through profit or loss.

A financial liability is measured at fair value through profit and loss if the financial liability is:

- A contingent consideration of an acquirer in a business combination to which AASB 3: Business Combinations applies;
- Held for trading; or
- Initially designated at fair value through profit or loss.

All other financial liabilities are subsequently measured at amortised cost using the effective interest method.

The effective interest method is a method of calculating the amortised cost of a debt instrument and of allocating interest expense in profit or loss over the relevant period. The effective interest rate is the internal rate of return of the financial asset or liability. That is, it is the rate that exactly discounts the estimated future cash flows through the expected life of the instrument to the net carrying amount at initial recognition.

A financial liability is held for trading if:

- It is incurred for the purpose of repurchasing or repaying in the near term;
- Part of a portfolio where there is an actual pattern of short-term profit taking; or
- A derivative financial instrument (except for a derivative that is in a financial guarantee contract or a derivative that is in an effective hedging relationship).

The College currently does not recognise any financial liabilities at fair value through profit or loss, with all financial liabilities being recognised at amortised cost.

Financial Assets:

Financial assets are subsequently measured at:

- Amortised cost;
- Fair value through other comprehensive income; or
- Fair value through profit or loss.

Measurement is on the basis of two primary criteria:

- The contractual cash flow characteristics of the financial asset; and
- The business model for managing financial assets.

A financial asset that meets the following conditions is subsequently measured at amortised cost:

- The financial asset is managed solely to collect contractual cashflows; and
- The contractual terms within the financial asset give rise to cashflows that are solely payments of principal and interest on the principal amount outstanding on specified dates.

A financial asset that meets the following conditions is subsequently measured at fair value through other comprehensive income:

- The contractual terms within the financial asset give rise to cashflows that are solely payments of principal and interest on the principal amount outstanding on specified dates;
- The business model for managing the financial assets comprises both contractual cashflows and the selling of the financial asset.

By default, all other financial assets that do not meet the measurement conditions of amortised cost and fair value through other comprehensive income are subsequently measured at fair value through profit or loss.

The College currently recognises investments in market securities at fair value through profit or loss with all other financial assets being recognised at amortised cost.

Derecognition
Derecognition refers to the removal of a previously recognised financial assets or financial liabilities from the statement of financial position.

Derecognition of Financial Liabilities:
A liability is derecognised when it is extinguished (i.e. when the obligation in the contract is discharged, cancelled or expires). An exchange of an existing financial liability for a new one with substantially modified terms, or a substantial modification to the terms of a financial liability is treated as an extinguishment of the existing liability and recognition of a new financial liability.

The difference between the carrying amount of the financial liability derecognised and the consideration paid and payable including any non-cash assets transferred or liabilities assumed, is recognised in profit or loss.

Derecognition of Financial Assets:
A financial asset is derecognised when the holder's contractual rights to its cash flows expire, or the asset is transferred in such a way that all the risks and rewards of ownership are substantially transferred.

All of the following criteria need to be satisfied for Derecognition of financial asset:

- The right to receive cash flows from the asset has been expired or been transferred;
- All risk and rewards of ownership of the asset have been substantially transferred; and
- The College no longer controls the asset.

On derecognition of a financial asset measured at amortised cost, the difference between the asset's carrying amount and the sum of the consideration received and receivable is recognised in profit or loss.

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.

NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2020

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.

Fair Value Disclosures

With the exception of investments, the College 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.

2. REVENUES FROM ORDINARY ACTIVITIES

	2020 $	2019 $
Operating Revenue		
Rendering of Services	10,630,531	9,696,019
Grant Income	7,127,250	6,457,155
Sponsorship	552,936	465,286
Sundry Income	-	-
Non Operating Revenue		
Government Subsidies	428,000	-
Interest	147,261	211,976
Investment Income	31,085	-
	18,917,063	16,830,436

3. EXPENSES FROM ORDINARY ACTIVITIES

	2020 $	2019 $
Classification of Expenses by Function:		
College Services & Admin Expenses	11,031,230	10,039,865
Drug & Alcohol Addiction Grant Expenses	739,123	86,520
Bi-College Grant Expenses	-	69,290
GP Procedural Grant Expenses	378,866	270,542
Chronic E-Health Grant Expenses	-	62,972
GP Anaesthetic Grant Expenses	265,045	118,016
Telehealth Grant Expenses (RHOF)	398,780	410,806
GP Training Grant Expenses	375,533	468,096
Lung Foundation Grant Expenses	-	12,245
Yellow Fever Grant Expenses	28,181	30,073
Codeine Rescheduling Grant Expenses	-	33,188
Black Dog Institute Grant Expenses	-	37,503
Non-VR Fellowship Support Grant Expenses	2,628,224	3,676,823
AGPT Transition Grant Expenses	1,780,595	1,144,738
Digital Health Grant Expenses	286,001	36,343
CSIRO Grant Expenses	48,968	-
Rural Generalist Recognition Grant Expenses	78,948	-
COVID 19 Communications Grant Expenses	101,860	-
Opioid Harm (TGA) Grant Expenses	17,126	-
	18,158,480	16,497,020
Other Expenses:		
Non Program Related Employee Benefits Expense	4,771,082	4,069,002
Program Related Employee Benefits Expense	2,515,923	1,896,958
Amortisation and Depreciation Expense	620,610	392,066

NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2020

4. SURPLUS/(DEFICIT) FROM ORDINARY ACTIVITIES

	2020 $	2019 $
ACTIVITIES		
Surplus/(Deficit) from Ordinary Activities includes:		
Net (Gain)/Loss from sale of Plant and Equipment	701	274
Superannuation contributions	374,220	334,446
Rental expense from operating leases	-	268,761

5. CASH AND CASH EQUIVALENTS

	2020 $	2019 $
Cash on Hand	200	200
Cash at Bank	15,205,098	11,753,094
Cash on Deposit	6,230,244	9,190,818
	21,435,542	20,944,112

6. INVESTMENTS

	2020 $	2019 $
Listed Securities	1,099,410	-
Managed Investments	2,359,454	-
	3,458,865	-

7. TRADE AND OTHER RECEIVABLES

	2020 $	2019 $
Trade Receivable	1,939,634	2,014,428
Other Receivables	9,645	-
	1,949,279	2,014,428

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

	2020 $	2019 $
Directors (other than loans to directors)	-	1,145

8. OTHER ASSETS

	2020 $	2019 $
Prepayments	547,277	520,339
Accrued Income	7,754	22,287
	555,031	542,626

9. INTANGIBLE ASSETS

	2020 $	2019 $
CRM & LMS Development (at cost)	1,684,882	1,684,882
Accumulated Amortisation	(1,452,290)	(1,115,315)
	232,592	569,568
Movement in Intangible Assets		
Opening Balance	569,568	906,544
Transferred from Capital Work-In-Progress	-	-
Additions	-	-
Disposals at Written Down Value	-	-
Amortisation	(336,976)	(336,976)
Closing Balance	232,592	569,568

NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2020

10. RIGHT OF USE ASSETS

The College's lease portfolio includes buildings. These leases have lease terms of ranging between 3 and 5 years.

The option to extend or terminate are contained in the property leases of the College. These clauses provide the College opportunities to manage leases in order to align with its strategies. All of the extension or termination options are only exercisable by the College. The extension options termination options which are probable to be exercised have been included in the calculation of the Right of Use Asset.

Amounts recognised in the statement of the financial position	**Leased Buildings $**	**Total $**
Cost		
Balance at 1 July 2019	-	-
Recognised on initial application of AASB 16	568,285	568,285
Acquisitions	-	-
Disposals	-	-
Balance at 30 June 2020	568,285	568,285
Amortisation		
Balance at 1 July 2019	-	-
Amortisation expense	189,429	189,429
Disposals	-	-
Balance at 30 June 2020	189,429	189,429
Carrying amounts		
Balance at 30 June 2020	378,856	378,856

Amounts recognised in the statement of profit or loss	**2020 $**
Amortisation expense related to right-of-use-assets	189,429
Interest expense on lease liabilities	74,600
Short term leases expense	-
Low value asset lease expense	-
	264,029

11. PROPERTY PLANT AND EQUIPMENT

	2020 $	**2019 $**
Office Equipment (at cost)	708,014	568,773
Accumulated Depreciation	(479,384)	(394,594)
	228,630	174,179
Movement in Plant and Equipment		
Opening Balance	174,179	179,076
Additions	149,358	50,467
Disposals at Written Down Value	(701)	(274)
Depreciation Expense	(94,206)	(55,090)
Closing Balance	228,630	174,179
Leasehold Improvements (at cost)	125,744	125,744
Accumulated Depreciation	(125,744)	(125,744)
	-	-
Movement in Leasehold Improvements		
Opening Balance	-	-
Additions	-	-
Depreciation Expense	-	-
Closing Balance	-	-
Total Property Plant and Equipment	228,630	174,179

NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2020

12. TRADE AND OTHER PAYABLES

	2020 $	2019 $
(i) Current		
Trade and Sundry Creditors	582,133	517,579
Unearned Income	18,477,539	15,252,722
Non-VR Subsidy Received in Advance	407,123	764,825
Accruals	474.910	285,213
Employee Benefits (annual leave, salaries and PAYG)	501,967	394,454
GST Payable	309,419	635,319
	20,753,091	17,850,112
Included in unearned income, are amounts from directors for memberships paid in advance:	7,927	7,682

13. PROVISIONS

	2020 $	2019 $
Current		
Long Service Leave	349,995	335,214
Non-Current		
Long Service Leave	56,898	53,148
Provision for "Make Good"	159,494	146,450
	216,392	199,598

Analysis of Total Provisions	2020 $	2019 $
Current	349,995	335,214
Non-current	216,392	199,598
Total Provisions	566,387	534,812

The movement in the provision during the 2019 financial year is as follows:

	Provsion for "Make Good" $	Long Service Leave $
Opening balance at 1 July 2019	146,450	388,362
Additional provisions raised during the year	13,044-	44,504
Amounts used	-	(25,973)
Balance as at 30 June 2019	159,494	406,893

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.

14. LEASES

Lease liabilities are presented in the statement of financial position as follows:	2020 $	2019 $
Current	326,570	-
Non-current	27,558	-
	354,128	-

NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2020

The lease liabilities are secured by the related underlying assets. The undiscounted maturity analysis of lease liabilities at 30 June 2020 is as follows:

30 June 2020	**Within 1 year $**	**1-5 years $**	**5-10 years $**	**Total $**
Lease payments	342,140	399,930	-	-
Finance charges	74,600	45,802	-	-
Net present values	267,540	354,128	-	-

15. OTHER LIABILITIES

Other liabilities are presented in the statement of financial position as follows:	**2020 $**	**2019 $**
Current		
Deferred lease incentive	-	17,393
Non-Current		
Deferred lease incentive	-	35,990
	-	53,383

16. RETAINED EARNINGS

	2020 $	**2019 $**
Retained Earnings at the beginning of year	5,806,606	5,473,190
Net Surplus/(Deficit)	758,583	333,416
Retained Earnings at the end of year	6,565,189	5,806,606

17. AUDITOR'S REMUNERATION

	2020 $	**2019 $**
Audit and review of Financial Statements	18,500	18,500
Other Project Audit Services	14,000	7,500
	32,500	26,000

18. MEMBERS' GUARANTEE

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

19. 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 77 employees (2019: 68) at the end of the reporting period.

20. SEGMENT INFORMATION

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

21 . 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

NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2020

22 . RELATED PARTY TRANSACTIONS

Key management personnel comprise of 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:

	2020 $	2019 $
Key management personnel compensation		
Short-term benefits	932,882	1,018,239
Post-employment benefits	76,002	86,232
Other long-term benefits	7,107	7,106
Total	1,015,991	1,111,577

Of the above short-term benefits $64,749 (2019: $37,966) relates to payments to directors for transactions made at arm's length.

Other than those disclosed above and in note 6 and note 10, there are no other related party transactions that occurred during the 30 June 2020 financial year (2019: nil).

23 . 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	2020 $	2019 $
Surplus/(Deficit) from ordinary activities after income tax	740,789	333,416
Depreciation	283,634	55,090
Amortisation	336,976	336,976
Loss/(Gain) on Disposal of Assets	701	274
(Increase)/Decrease in Receivables	52,064	(338,562)
(Increase)/Decrease in Prepayments	(26,938)	(136,963)
Increase/(Decrease) in Employee Entitlements	31,575	53,234
Increase/(Decrease) in Creditors & Borrowings	2,977,579	7,526,986
Net Cash Provided by Operating Activities	4,414,174	7,830,451

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	2020 $	2019 $
Cash on Hand	200	200
Cash at Bank	15,205,098	11,753,094
Cash on Deposit	6,230,244	9,190,818
	21,435,542	20,944,112

ii) Undrawn Credit Card Facilities	2020 $	2019 $
Facility Limits at reporting date	165,500	163,500
Less: drawn at balance date	(17,961)	(99,934)
Undrawn facilities at reporting date	147,539	63,566

ii) Changes in Liabilities arising from Financing Activities

	1 July 2019 $	Cash flows $	Non-cash changes Initial application of AASB16 $	Acquisition $	30 June 2020 $
Lease Liabilities	621,668	(342,140)	74,600	-	354,128
Total	**621,668**	**(342,140)**	**74,600**	**-**	**354,128**

24 . EVENTS AFTER THE BALANCE SHEET DATE

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

NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2020

25. 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 2020.

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 2020 the weighted average effective interest rate in relation to cash and cash equivalents was 1.12% (2019 – 0.86%) 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 $267,000 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 2020.

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:

FINANCIAL ASSETS

	2020 $	2019 $
Cash and cash equivalents	21,435,542	20,944,112
Accounts receivable and other debtors	1,949,279	2,014,428
Investments	3,458,865	-
Total Financial Assets	26,843,686	22,958,540

FINANCIAL LIABILITIES

	2020 $	2019 $
Financial liabilities at amortised cost	-	-
Accounts payable and other payables	582,113	517,579
Total Financial Liabilities	582,113	517,579

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.

26. CONTINGENT LIABITLITES

The College has no contingent liabilities at 30 June 2020 (2019: nil).

DIRECTOR'S 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 27 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 2020 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 29th day of September, 2020

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 2020 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 2020 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.

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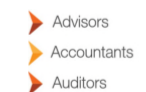

NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2020

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

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
29 September 2020

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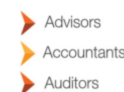

Fellow