Accreditation Report: Charles Darwin University, Faculty of Health, School of Medicine, CDU Menzies medical program

Medical School Accreditation Committee

November 2024

Australian Medical Council Limited

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Acknowledgement of Country

The AMC acknowledges the Aboriginal and/or Torres Strait Islander peoples as the original Australians, and the Māori as the original people of Aotearoa New Zealand.

We acknowledge and pay our respects to the Traditional Custodians of all the lands on which we live and work, and their ongoing connection to the land, water and sky. The Australian Medical Council offices are on the land of the Ngunnawal and Ngambri Peoples. The Charles Darwin University campus is located on the lands of the Larrakia people and operates across many lands across the Northern Territory.

We recognise the Elders of all these Nations past, present and emerging, and honour them as the Traditional Custodians of knowledge for these lands.

Executive Summary

Accreditation process

The *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2024* describe a two-stage process for medical education providers to seek accreditation of proposed new medical programs:

- Stage 1 - Initial assessment to review readiness for assessment based on a written submission, addressing accreditation standards and outlining the resources and curriculum necessary to deliver the medical program. Based on the AMC's assessment, the provider may be invited to proceed to Stage 2.
- Stage 2- Set an accreditation assessment, providing full details of full program of study for the first two years as well as implementation plans. The provider must also complete an accreditation submission against the standards and identify strengths and weakness related to this development.

Appendix 1 provides an overview of the AMC's accreditation process in Australia.

The CDU School of Medicine (the School) was established in January 2022 and is proposing a five year undergraduate medical program, aiming to commence in Semester 1, 2025. The School's underlying philosophy for commencement is to *"celebrate the value of general practice and rural generalism and encourage students along the pathway to building the medical workforce the Northern Territory (NT) needs now and into the future"*. The School is partnering with the Western Sydney University (WSU), utilising WSU's five-year BClinSci(Med) MD Program as a basis for developing the CDU Medical Program.

The AMC assessed the Stage 1 submission in February 2024 and invited the School to provide a Stage 2 submission. To review the Stage 2 submission, an AMC team (the team), chaired by Professor Jane Dahlstrom OAM, was constituted - the composition of the team can be seen in Appendix 2. The team reviewed the School's written submissions and visited the School and a number of proposed clinical teaching sites in the week of Monday 15 to Friday 19 July 2024. The activities undertaken are listed in Appendix 3.

Following the assessment visit, the team requested additional information in a number of key areas to ensure that sufficient information was available to the team to make an assessment against the accreditation standards and provide advice to the Medical School Accreditation Committee. The School provided this information in September 2024 and the draft report of the team's findings was prepared and provided to CDU for review of factual accuracy on Wednesday 23 October 2024. Having reviewed CDU's feedback, the team's report was submitted for the Committee's consideration on Monday 4 November 2024.

This report outlines the Stage 2 assessment of the CDU MD program.

Decision on accreditation

Under the Health Practitioner Regulation National Law, the AMC may grant accreditation if it is reasonably satisfied that a program of study, and the education provider that provides it, meet the approved accreditation standards. It may also grant accreditation if it is reasonably satisfied that the provider and the

program of study substantially meet the approved accreditation standards and the imposition of conditions will ensure the program meets the standards within a reasonable time.

Having made a decision, the AMC reports its accreditation decision to the Medical Board of Australia to enable the Board to make a decision on the approval of the program of study for registration purposes.

At its Friday 29 November 2024 meeting, AMC Directors resolved:

i. that the Charles Darwin University, Faculty of Health, School of Medicine CDU Menzies Medical Program substantially meets the accreditation standards;

ii. that accreditation of five-year Bachelor of Clinical Sciences / Doctor of Medicine (BClinSci/MD) Charles Darwin University, Faculty of Health, School of Medicine CDU Menzies Medical Program be granted, to 31 March 2031;

iii. that accreditation of the program is subject to the condition that students do not commence before 1 January 2026 AND satisfying condition 2 (relating to the program's sustainability) and condition 6 (relating to confirmation of a plan for clinical placements for the duration of the program);

iv. that accreditation of the program is subject the other conditions contained in the report, to a follow-up assessment, and to the School and the program meeting the future accreditation and monitoring requirements of the AMC.

Conditions on accreditation

Where a month is not specified in the deadline for the condition the School is expected to demonstrate that it has satisfied the condition within the monitoring submission scheduled for that year.

Condition		To be met by
Standard 1: Purpose, context and accountability		
1	Provide evidence that the documented governance structure and its committees are working as intended, this involves: (Standard 1.3.1) a. Confirming the approach to student representation in decision-making about the program one year after program commencement. (Standard 1.3.4) b. Confirming the participation of Aboriginal and/or Torres Strait Islander peoples (academic staff, community groups/health services and clinical supervisors) in the program's governance and decision-making structures. (Standard 1.3.5)	2027
2	Provide written assurance that the University will continue to support the program in the event that no additional student numbers are agreed for the medical program. (Standard 1.4.1)	May 2025
3	Provide evidence of successful recruitment of additional academic expertise to oversee evaluation, assessment, and admissions, to ensure academic oversight. (Standard 1.4.3)	July 2025
4	Demonstrate academic and professional staff capacity (and supporting development) to undertake the engagement and curriculum and assessment content development, review and refinement in relation to Aboriginal and/or Torres Strait Islander people's health. (Standard 1.4.4)	July 2025
Standard 2: Curriculum		
5	Confirm the contextualisation of the curriculum and aligned teaching and learning methods for the last three years of the program, including: a. Documentation of alignment of the last three years of the program to the full set of current AMC graduate outcomes one year after program commencement. (Standard 2.1)	2027

Condition		To be met by
	b. Evidence of the development of the First Nations Culture and Health Curriculum in line with the accreditation standards, led by Aboriginal and/or Torres Strait Islander experts. one year after program commencement. (Standard 2.2.3, 2.2.4, 2.3.6, 2.3.7) c. Confirming the arrangements for interprofessional learning to foster collaborative practice. (Standard 2.3.3)	
6	Work with Flinders University and Northern Territory Health services to develop a model for the distribution of students from both programs across Northern Territory health services. With respect to the CDU program: a. Provide a plan that describes the clinical experiences across medical disciplines for the intended cohort across the five years of the curriculum (noting plans for three years of fulltime learning in clinical placements), across Northern Territory Health services and demonstrate commitment from key health service to the forecast time for training. (Standards 2.3.8, 5.4.1, 5.4.3, 5.5.4)	May 2025
Standard 3: Assessment		
7	Confirm the system of assessment by providing: a. A plan for quality assurance processes and validity evidence for assessments in the first two years of the program. (Standard 3.1.4, 3.1.5) b. Details of assessments for clinical skills and workplace-based assessments, demonstrating sufficient sampling and defensible decision making related to competence. (Standard 3.1.2) c. A mapping of assessment requirements against University policies to ensure competence at progression points. (Standard 3.1.2) d. Provide the outcome of evaluation of whether the formative assessment in the bridging course meets the needs of ensuring students are prepared for the medical program and confirm any refinements. (Standard 3.1.4)	a. July 2025 b. 2027 c. 2026 d. 2027
8	Confirm the plan for feedback reports to support student learning, beyond score reporting. (Standard 3.2.1)	2027
9	Clarify the plans for the evaluation of assessment data at a cohort level, sub-quota level (e.g. Aboriginal and/or Torres Strait Islander student, students at different clinical sites), and examination level. (Standard 3.2.3)	2026
10	Demonstrate that assessment quality will be maintained through: a. Confirming how assessment for the program will be systematically reviewed and evaluated. (Standard 3.3.1) b. Providing detailed documentation to support the management of essential assessment quality assurance processes (such as process map and standard operating procedures) is in place. (Standard 3.3.1) c. Providing evidence of blueprinting and population of blueprinting for high-stakes assessments linked to progression decisions (e.g. knowledge-based examinations, OSCE, clinical skills assessments). (Standard 3.3.1)	a. July 2025 b. 2026 c. 2027
Standard 4: Students		
11	Confirm the starting cohort, the selection processes used and supports put in place, and describe any learning or consequential refinement of policy and process. (Standard 4.1)	2026

Condition		To be met by
12	Demonstrate the effectiveness of student wellbeing policies, processes and timely support for medical students requiring additional support, reasonable adjustments/accommodations, including implementation of flexible study policies: a. in the first two years of the program, and b. the final three years of the program. (Standard 4.1, 4.23, 4.2.5)	a. 2028 b. 2029
13	Develop a policy and procedure for identifying, managing and/or supporting medical students whose professional behaviour raises concerns, in a timely way. (Standard 4.3.2)	2025
14	Demonstrate the effectiveness of procedures for managing medical students when their impairment raises concerns about their fitness to practise medicine or their ability to interact with patients, including in a culturally safe way: a. in the first two years of the program, and b. in the final three years of the program. (Standard 4.3.1, 4.3.2)	a. 2028 b. 2029
Standard 5: Learning environment		
15	Demonstrate that there are appropriate facilities to deliver the program with the planned student numbers across the full five years of the program. (Standards 5.1.1, 5.1.2)	2027
16	Demonstrate that there is access to amenities that support learning and wellbeing for students on clinical placements by: a. Providing evidence that that planning is underway and there is health service and stakeholder commitment to address a long-term needs analysis for education infrastructure and student accommodation across all clinical placement sites by July 2025. (Standards 5.1.1, 5.4.3) b. Providing evidence that there is appropriate infrastructure for education and student accommodation in at regional and rural placement sites. (Standard5.1.3)	a. May 2025 b. 2027
17	Demonstrate that there are sufficient academic staff to deliver, evaluate and refine the curriculum and assessment program, progressively from 2026 onward. (Standard 5.2.1)	2029
18	Describe how staff development and promotion will be delivered for the medical program by time of program commencement and demonstrate the implementation of this in line with the accreditation standards within one year of program delivery. (Standard 5.3)	2027
Standard 6: Evaluation and continuous improvement		
19	Demonstrate that the plans, processes, technology and staffing for monitoring, evaluation and continuous improvement have been implemented for the commencement of the program by 30 July 2025. Please provide evidence of: a. The implementation of an evaluation plan and processes that assesses the alignment of curriculum content with graduate outcomes and review the curriculum, teaching and learning, and assessment quality. (Standard 6.1.1) b. Timely feedback from students, staff and health services and demonstrate responsiveness to that feedback. (Standard 6.1.1, 6.1.2) c. How the planned memberships of national groups and the consideration of national and international developments in medicine and medical education are informing program development. (Standard 6.1.3)	July 2025

Condition		To be met by
	d. Consultation with Aboriginal and/or Torres Strait Islander education experts on how they will engage with evaluation processes. (Standard 6.2.4)	
20	Demonstrate the effectiveness of the evaluation framework after one year of program delivery through: a. Providing evidence of refinements in the curriculum and assessment content, timetable, teaching and learning methods in response to feedback from staff, students and stakeholders. (Standard 6.1.1) b. Demonstrating how progress and outcomes for student cohorts are monitored, evaluated and responded to, including the approach for assessing whether the bridging course is fit for purpose. (Standard 6.2.1. 6.2.2, 6.2.3, 6.2.4) c. Demonstrating the involvement of Aboriginal and/or Torres Strait Islander education experts in the evaluation processes. (Standard 6.2.4) d. Providing evidence of reporting of evaluation through governance processes and to students and those delivering the program. (Standard 6.3.1)	2027

Commendations

A	The consideration of, and commitment to the place-based needs of the communities CDU serves.
B	The engagement with Aboriginal and/or Torres Strait Islander communities and the co-production of a First Nations engagement plan.
C	The tremendous commitment and impressive work of the small leadership team to the preparations for and success of the Program.
D	The commitment of the University to enable expedited processes, including fast tracking recruitment, to support the development of the Program.
E	The purchase of the Western Sydney University curriculum and assessment system provides a sound basis for a medical program that is responsive to the needs of the communities of the NT.
F	There have been good foundations built to support the development of the First Nations Culture and Health curriculum content with a strengths-based approach evident in early contextualisation of the first two years.
G	The work with the highly engaged central University student services to establish a range of supports for medical program students.
H	The commitment of the academic leadership team in restructuring the early years of the Program into semesters to better enable flexible learning options.
I	The physical facilities at the Royal Darwin Hospital site.
J	There is good support by central University IT services to the medical program.
K	The defined strategy for recruiting and retaining Aboriginal and/ or Torres Strait Islander with First Nations identified positions and a strong relationship with Aboriginal Medical Services
L	CDU's strong relationship with the Aboriginal Medical Services.

Recommendations for improvement

AA	Resource the development and implementation of framework for engagement in secondary schools and other key community groups to encourage and support local student enrolment in the Program. (Standard 1.1.4)

BB	Include community stakeholder membership on the Accreditation and Evaluation Committee. (Standard 6.1.1)

Monitoring and next steps

Following an accreditation decision by AMC Directors, the AMC will monitor that it remains satisfied the education provider is meeting the standards and addressing conditions on its accreditation through annual monitoring submissions. This will require the education provider to make a written submission and may also include accreditation activities such as meetings with the education provider. The monitoring process is described in Section 4 of the accreditation procedures.

As set out in Section 3.1 of the accreditation procedures, in cases where conditions on accreditation or reaccreditation require it, the AMC also conducts follow-up accreditation assessments. It may conduct a follow-up assessment when an education provider and its programs are found to only substantially meet the accreditation standards, when it has granted an education provider a limited period of accreditation, placed conditions on accreditation, or when it wishes to review plans for later stages of new program development.

Appreciation

The AMC thanks the University, School and staff for the detailed planning and the comprehensive material provided for the team. The AMC acknowledges the staff, clinicians, students and others who met members of the team for their hospitality, collegiality and assistance during the assessment process.

Assessment against the Accreditation Standards

Key Findings

Work has been undertaken by the small highly committed program team to plan and develop foundational program documents. Charles Darwin University (CDU) has a demonstrable history in supporting health programs that result in health practitioners who serve the Northern Territory and there is a clear commitment from Northern Territory Health (NT Health) to support the program in its ambitions to develop medical practitioners from the region as a response to challenges in recruiting and retaining medical staff.

Standard 1: Purpose, context and accountability			
1.1	Purpose	Substantially Met	This Standard is Substantially Met
1.2	Partnerships with communities and engagement with stakeholders	Substantially Met	
1.3	Governance	Substantially Met	
1.4	Medical program leadership and management	Substantially Met	

Standard 2: Curriculum			
2.1	Medical program outcomes and structure	Substantially Met	This Standard is Substantially Met
2.2	Curriculum design	Substantially Met	
2.3	Learning and teaching	Substantially Met	

Standard 3: Assessment			
3.1	Assessment design	Substantially Met	This Standard is Substantially Met
3.2	Assessment feedback	Substantially Met	
3.3	Assessment quality	Substantially Met	

Standard 4: Students			
4.1	Student cohort and selection policies	Substantially Met	This Standard is Substantially Met
4.2	Student wellbeing	Substantially Met	
4.3	Professionalism and fitness to practise	Substantially Met	
4.4	Student indemnification and insurance	Met	

Standard 5: Learning Environment			
5.1	Facilities	Substantially Met	This Standard is Substantially Met
5.2	Staff resources	Substantially Met	
5.3	Staff appointment, promotion and development	Substantially Met	
5.4	Clinical learning environment	Substantially Met	
5.5	Clinical supervision	Substantially Met	

Standard 6: Evaluation and continuous improvement			
6.1	Audit Activity	Substantially Met	This Standard is Substantially Met
6.2	Compliance reporting	Substantially Met	
6.3	AMC Feedback and reporting	Substantially Met	

ITEMISED OUTCOME OF ACCREDITATION ASSESSMENT

ONE	M	SM	SM	SM	SM	SM	SM	M	M	SM	ND	SM	M	SM	M	SM	M	M	SM
	1.1.1	1.1.2	1.1.3	1.1.4	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	1.3.6	1.4.1	1.4.2	1.4.3	1.4.4	1.4.5	1.4.6

TWO	SM	ND	M	SM	SM	SM	SM	SM	SM	M	M	SM	M	M	SM	ND	ND	SM	SM	NM	ND
	2.1.1	2.1.2	2.2.1	2.2.2	2.2.3	2.2.4	2.2.5	2.2.6	2.2.7	2.2.8	2.2.9	2.2.10	2.3.1	2.3.2	2.3.3	2.3.4	2.3.5	2.3.6	2.3.7	2.3.8	2.3.9

THREE	SM	SM	SM	SM	SM	SM	ND	SM	ND	SM	ND
	3.1.1	3.1.2	3.1.3	3.1.4	3.1.5	3.1.6	3.2.1	3.2.2	3.2.3	3.3.1	3.3.2

FOUR	SM	M	SM	SM	SM	SM	M	SM	SM	SM	SM	M	ND	SM	M
	4.1.1	4.1.2	4.1.3	4.1.4	4.1.5	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6	4.2.7	4.3.1	4.3.2	4.4.1

FIVE	SM	SM	NM	SM	SM	ND	SM	SM	SM	SM	ND	M	SM	ND	ND	SM	NM	SM	NM	ND	ND	ND	SM	SM
	5.1.1	5.1.2	5.1.3	5.1.4	5.1.5	5.1.6	5.2.1	5.2.2	5.2.3	5.2.4	5.2.5	5.2.6	5.3.1	5.3.2	5.3.3	5.3.4	5.4.1	5.4.2	5.4.3	5.5.1	5.5.2	5.5.3	5.5.4	5.5.5

SIX	SM	SM	SM	SM	SM	SM	SM	SM	SM
	6.1.1	6.1.2	6.1.3	6.2.1	6.2.2	6.2.3	6.2.4	6.3.1	6.3.2

Key:
Met
Substantially Met
Not Met
Not Yet Determined

STANDARD 1: Purpose, context and accountability

The team identified the following:

- There is a clear purpose for the program in the context of medical workforce pressures in the Northern Territory and strong engagement with and commitment from stakeholders to the program, particularly those from the health service.
- There is documented support from Aboriginal and/or Torres Strait Islander health services and plans demonstrating a commitment to supporting First Nations staff and students to participate in the program, although it was not clear that the resources matched the ambitions.
- The proposed governance arrangements appear sound, although Aboriginal and/or Torres Islander people's participation in the arrangements need to be clarified.

While the School demonstrated financial modelling that predicted positive financial footing by 2030, this included various assumptions. There is concern about the ongoing financial viability of the program in the longer term, given only 40 medical Commonwealth Supported Places (CSPs) have been confirmed (subject to AMC accreditation) and other anticipated income includes 20 additional medical CSPs (which are not yet guaranteed) or international students (which might not be able to be realised).

1.1 Purpose	
1.1.1	The medical education provider has defined its purpose, which includes learning, teaching, research, social and community responsibilities.
1.1.2	The medical education provider contributes to meeting healthcare needs, including the place-based needs of the communities it serves, and advancing health equity through its teaching and research activities.
1.1.3	The medical education provider commits to developing doctors who are competent to practice safely and effectively under supervision as interns in Australia or Aotearoa New Zealand, and who have the foundations for lifelong learning and further training in any branch of medicine.
1.1.4	The medical education provider commits to furthering Aboriginal and/or Torres Strait Islander and Māori people's health equity and participation in the program as staff, leaders and students.

In 2003, the merger of the Northern Territory University (including the Centralian College of Alice Springs, Katherine Rural College, and the University College of NT), and the Menzies School of Health Research resulted in the establishment of Charles Darwin University (CDU; the University), which reaches to all parts of the Territory as a partner in the Territory's development across the social, cultural and economic spheres.

CDU offers vocational and higher education opportunities in the trades, vocations and professions of direct relevance to the Northern Australia workforce to over 24,000 students each year. The University has three faculties—Health; Science and Technology; and Arts and Society—and CDU TAFE, overseen by Pro Vice-Chancellors who report directly to the Vice-Chancellor. The University states that course offerings are influenced by community needs, and collaboration with local industry partners and First Nations community leaders is highly valued in the evaluation of business cases for new courses.

The Faculty of Health already works in strong partnership with local communities, NT Health, and the Aboriginal Community Controlled Health Organisations (ACCHOs) sector to support the broader health workforce needs across acute and primary health care sectors. The Faculty has courses in nursing, midwifery, occupational therapy, audiology, physiotherapy, pharmacy, speech pathology, dietetics, paramedicine, biomedical science, medical laboratory science, psychology and social work. It also delivers the Bachelor of Clinical Sciences pathway into the Northern Territory Medical Program (NTMP).

CDU has clearly defined the purpose of the CDU Menzies Medical Program (the Program) as addressing the critical medical workforce needs that have been steadily worsening. The Program was developed in response to NT Government and health service desire to support the development of doctors from and strongly

connected to local communities. It therefore aims to graduate doctors with the knowledge, skills, behaviours and experience to practise safely and effectively in NT health services, and the intention to remain in NT communities. The planned program focuses on First Nations health and wellbeing, remote and rural medicine, rural generalism, and skills needed for the provision of high-quality interdisciplinary team-based regional and remote health services. There is a clear commitment to graduating doctors who will be safe and effective interns, and a particular focus on articulating what the requirements are for safe and effective practice in the Northern Territory.

There is strong engagement from stakeholders, and commitment to the purpose was clearly evident across a range of stakeholders, internal and external to the University. The team notes the Program has considered the healthcare needs and the place-based needs of NT communities in its planning of the program and contextualisation of the purchased curriculum and assessment framework. It was also observed that CDU staff and stakeholders consistently expressed their deep commitment to improving and advocating for First Nations health equity.

During the assessment, CDU's aims to support First Nations leadership and increase participation of Aboriginal and/or Torres Strait Islander staff in the Program was evident. While the team notes employment of First Nations people on staff has commenced, their participation in governance and decision making is yet to be well-articulated. The participation of First Nations students is also yet to be determined as enrolment has not commenced. The team also notes that, to date, there has been limited time and resources given to support structured community engagement in secondary schools and other key community groups to encourage First Nations students to join the direct-entry medical program.

1.2 Partnerships with communities and engagement with stakeholders	
1.2.1	The medical education provider engages with stakeholders, including community groups who experience health inequities and Aboriginal and/or Torres Strait Islander and Māori people and organisations, to: • define the purpose and medical program outcomes • design and implement the curriculum and assessment system • evaluate the medical program and outcomes of the medical program.
1.2.2	The medical education provider has effective partnerships to support the education and training of medical students. These partnerships are supported by formal agreements and are entered into with: • community organisations • health service providers • local prevocational training providers • health and related human service organisations and sectors of government.
1.2.3	The medical education provider has mutually beneficial partnerships with relevant Aboriginal and/or Torres Strait Islander and Māori people and organisations. These partnerships: • define the expectations of partners • promote community sustainability of health services.

The team heard a consistent message from CDU stakeholders of the commitment to partnering with the Program to implement a medical school that meets the future needs of the Northern Territory. CDU partnership organisations, including community organisations, health service providers, local prevocational training providers and other sectors were consistent in their support for the Program. However, formal agreements describing funding, how the partnerships will work, and other requirements were largely not yet in place at the time of the team's visit. A briefing paper has been developed as an initial step in the consultation with partners about clinical placements, which students will enter from Year 3 of the program.

The Program has strong support from local ACCHOs, Danila Dilba (Darwin) and Central Australia Aboriginal Congress (Alice Springs), who expressed their commitment to supervising CDU Year 3, 4 and 5 medical students on clinical placement. The Program has committed to paying backfill of salaries for practitioners that supervise CDU medical students. Agreements with ACCHOs were provided to the team by CDU, some of which require renewal.

A CDU Menzies Medical Program First Nations Working Group has been established to work with key NT First Nations stakeholders with the aspiration to develop the program into a locally led one that inspires and supports First Nations students to study medicine in the Northern Territory. A CDU First Nations Engagement Plan 2024–2026 has been developed, following results of a First Nations Working Group survey of community stakeholders.

The Program's Strategic Board will include a minimum of three First Nations/ACCHO members and will assist with community engagement. However, it remains unclear who has the role for undertaking community engagement and currently there appears insufficient capacity for existing staff to undertake this work within their role.

1.3 Governance	
1.3.1	The medical education provider has a documented governance structure that supports the participation of organisational units, staff and people delivering the medical program in its engagement and decision-making processes.
1.3.2	The medical education provider's governance structure provides the authority and capacity to plan, implement, review and improve the program, so as to achieve the medical program outcomes and the purpose of the medical education provider.
1.3.3	The medical education provider's governance structure achieves effective academic oversight of the medical program.
1.3.4	Students are supported to participate in the governance and decision making of their program through documented processes that require their representation.
1.3.5	Aboriginal and/or Torres Strait Islander and Māori academic staff and clinical supervisors participate at all levels in the medical education provider's governance structure and in medical program decision-making processes.
1.3.6	The medical education provider applies defined policies and processes to identify and manage interests of staff and others participating in decision-making processes that may conflict with their responsibilities to the medical program.

The University has supported the development of necessary governance approval processes and the team notes the high level of governance work to date completed by a small group of dedicated staff.

The governance structure for the Program is documented and describes seven committees/working groups.

The Medical Program Leadership Committee has oversight and responsibility for the program, and is reported to by the six other committees:

- Medical Program Accreditation and Evaluation Committee
- Medical Program Admissions Committee
- Medical Program Progression Committee
- Medical Program Assessment Committee
- Medical Program Curriculum Working Group
- Medical Program First Nations Working Group.

From the Terms of Reference, the team observed the program's committees/working groups have a very high level of overlap in representation. For example, all are chaired by the Dean, and the Course Coordinator

and the First Nations Lead sit on all committees. In addition, professional staff such as the Medical Program Manager, Medical Program Support Officer, and Accreditation and Admissions Manager sit on all or almost all committees. This presents a high load for those roles related to internal committee representation.

The team considers the membership should be reviewed to ensure sustainability, diversity, workload and consideration of lead portfolios for different academic staff. For example, the Program may consider academic staff with an admissions portfolio, academic staff with an assessment portfolio, and academic staff with an evaluation portfolio to be leading the respective work functions and thus chairing the relevant committee.

Recognising the structure reflects the current limitations of the number and capacity of the academic team, greater academic representation would assist in safeguarding academic quality and competency requirements for medicine across the five years of the Program.

There is medical student representation on some School governance committees and plans for establishing a medical student society. Confirmation of this during the early months of the first year is expected.

It not yet evident how the Medical Program Leadership Committee supports and takes advice from the First Nations Lead and other First Nations staff regarding input into leadership and design of the Program.

CDU has an appropriate policy and procedure for conflicts of interest that informs staff and others participating in decision-making processes about what constitutes a conflict of interest. An electronic reporting form is used to record conflicts of interest. However, CDU acknowledged that the development of a management plan specific to the medical program is required to demonstrate that the person with the conflict and the University have carefully considered the situation, recognised the issues involved and taken steps to prevent future problems.

1.4 Medical program leadership and management	
1.4.1	The medical education provider has the financial resources to sustain its medical program and these resources are directed to achieve the provider's purpose and the medical program's requirements.
1.4.2	There is a dedicated and clearly defined academic head of the medical program who has the authority and responsibility for managing the medical program.
1.4.3	The head of the medical program is supported by a leadership team with dedicated and defined roles who have appropriate authority, resources and expertise.
1.4.4	The medical program leadership team includes senior leadership role/s covering responsibility for Aboriginal and/or Torres Strait Islander and Māori health with defined responsibilities, and appropriate authority, resources and expertise.
1.4.5	The medical education provider assesses the level of qualification offered against any national standards.
1.4.6	The medical education provider ensures that accurate, relevant information about the medical program, its policies and its requirements is available and accessible to the public, applicants, students, staff and clinical supervisors. This includes information necessary to support delivery of the program.

Financial viability

In the May 2024 budget, the Commonwealth Government committed $24.6 million to CDU to establish a new medical school for the Northern Territory with 40 new commencing medical students per year from 1 January 2026. This is a combined Commonwealth Department of Health and Aged Care and Commonwealth Department of Education funding allocation. The education component will equal $6.4 million to cover the costs of CSPs, while the health component will equal $18.2 million over four years to cover establishment, capital and recurrent funding allocations. The funding will be released when CDU achieves AMC accreditation, as this was the requirement for the existing Commonwealth Department of Health and Aged

Care grant of $2.8 million. Financial assumptions that underpin budget planning related to international student numbers, and confirmed materialisation of Commonwealth to reach full-strength student numbers of 80 in the Program may not be realised.

The team has concerns that if additional Commonwealth support does not materialise and/or desired international student numbers are not achieved for total student numbers (at full strength the of expected 60 places) CDU would need to provide partial funding of the program in the long term, which creates significant risk to its viability, sustainability and quality. The team was assured that the University council had completed a range of financial modelling, including worst-case scenario modelling, and was prepared to accept the financial risk. The modelling of 60 students from 2028 has the program on a positive financial footing from 2030 with only the current committed Commonwealth funding included in this model. The University's Annual Report for 2023 notes that in the financial year ended 31 December 2023, 'the University's net result from continuing operations was $18.3 million in deficit for 2023. This is a deterioration in financial outcome compared to the surplus of $22.2 million in the previous year.'

The plan for capital expenditure associated with the Program was not available as part of budgetary information provided to the assessment team. For example, detailed plans about student accommodation and teaching facilities in rural/remote clinical sites were not available.

The proposed growth plan in terms of student numbers and associated staffing increase expected when at full strength needs to be further developed to ensure sufficient staffing and succession/cover planning and necessary academic expertise across all areas of medical education (e.g. assessment, staff development, research, evaluation and pastoral support for students). Casual staff provisions that can be anticipated as needed during the growth and development phase of the Program were not clear to the team.

Further, in respect of clinical placement planning, funding agreements/contracts that support costs of clinical placements and clinical supervision for medical students across the Program are not yet in place. In addition, signed agreements/contracts that detail the agreed model for co-funding between CDU and clinical education sites for shared/conjoint clinical positions are not yet in place.

Program leadership

The academic head, the leadership team, and the Faculty and University are clearly committed to the success of the Program and demonstrate highly responsive and adaptive processes to navigate the complexities of setting up a new medical program. The volume of work completed to date, under accelerated timelines by a small team, is very impressive.

There is a defined academic head (the Dean) who carries responsibility for the program, and the team was impressed by the dedication, commitment, depth and breadth of leadership, management, and development activities undertaken by this key role.

The Dean is intended to be supported by a small leadership team of academic and professional staff, a few of whom are yet to be recruited, or in the process of recruitment. There are three academic roles in the leadership team including the Dean, a Course Coordinator and First Nations Lead. Other key portfolios do not have permanent academic oversight in place (i.e. admissions, evaluation, assessment), but the University's commitment to staff recruitment, including fast tracking processes, is acknowledged. The size of the team has, however, inevitably limited the ability of the program to allocate sufficient resources towards the development of whole-of-program strategy and approaches in areas such as assessment and evaluation. There are also limitations on time to produce concrete plans and documented implementation specifics required for the rollout of the early years. The team therefore has concerns about sustainability and continuity associated with key person risks.

CDU has employed a very knowledgeable Larrakia Elder as the Medical Program First Nations Lead who has a great passion to see Aboriginal and/or Torres Strait Islander medical students succeed, not only in study, but in their pursuit of employment and gaining greater health outcomes for Aboriginal and/or Torres Strait Islander communities.

The work of the Medical Program First Nations Lead in preparing the program is impressive. The recent employment of a First Nations Medical Student Advisor is also a positive first step given the need for

community and stakeholder engagement, and student wellbeing and support. The two medical program roles will be supported by the Faculty of Health First Nations Health and Culture Specialist, the CDU Larrakia Elder in-Residence Aunty Dr Bilawara Lee and the CDU First Nations Leadership group. Given the ambitions of CDU and the program for supporting participation and making a positive contribution to Aboriginal and/or Torres Strait Islander health, it was clear that at the time of the visit, there were insufficient academic/community and support staff to support the Medical Program First Nations Lead in achieving the stated goals. The startup of a medical program requires extensive development, review and refinement of curriculum and assessment content related to First Nations health, which must be undertaken with strong engagement with local communities if it is to graduate doctors who are responsive to their needs.

The Program should also ensure the Aboriginal and/or Torres Strait Islander leadership roles contribute strategic input at the executive and program leadership levels, including supporting development of staff's capacity for culturally safe delivery of the program.

Program management

The Program articulates a three-year Bachelor Degree (Australian Qualifications Framework [AQF] Level 7) with a two-year Masters Degree (Extended) (AQF Level 9E). CDU is registered as an Australian university and has self-accrediting authority by TEQSA (Tertiary Education Quality and Standards Agency) to accredit its higher education courses. Academic approval processes for the program through CDU have been completed.

Some information related to the Program is available and accessible on the University's website (or will soon be); for example, admissions information, high-level curriculum descriptions and some students and staff guides. Other documents have recently been formulated in relation to curriculum trajectory across five years for students and staff; for example, a whole-of-program approach to assessment and an evaluation strategy and implementation plan, but they are yet to be enacted.

STANDARD 2: Curriculum

The effectiveness of the curriculum design and alignment of teaching and learning methods cannot be fully assessed until the implementation of the program. In considering the foundational documents and meetings with faculty and stakeholders, the team determined that:

- the medical program's outcomes are broadly consistent with the AMC graduate outcome statements, and the purchase of the Western Sydney University (WSU) curriculum and assessment framework provides a strong coherent foundation for the program
- good progress has been made with respect to contextualising the curriculum for Years 1 and 2; however, there is much work remaining to contextualise the full program to the NT setting. Opportunities to strengthen Aboriginal and/or Torres Strait Islander health content to ensure it is fit for the Northern Territory are likely to require additional time and resources than currently allocated.

2.1 Medical program outcomes and structure	
2.1.1	The medical program outcomes for graduates are consistent with: • the Australian Medical Council (AMC) graduate outcome statements • a safe transition to supervised practice in internship in Australia and Aotearoa New Zealand • the needs of the communities that the medical education provider serves, including community groups who experience health inequities and Aboriginal and/or Torres Strait Islander and Māori communities.
2.1.2	Students achieve assessment outcomes, supported by equitable access to learning and supervisory experiences of comparable quality, regardless of learning context. These outcomes are supported by appropriate resources in each learning environment.

CDU has six graduate attributes that aim to enact its vision to be 'Australia's most connected university through courageously making a difference in the Northern Territory, Australia and beyond.' By fulfilling these graduate attributes, students will be:

a. information literate;

b. imaginative and enduring innovators;

c. culturally responsive in their engagement with First Nations communities and issues;

d. impactful and influential leaders;

e. ethically and socially just; and

f. creative and courageous communicators.

The graduate outcomes, as determined by the CDU Curriculum Working Group of 28 health professionals drawn from acute and primary care, are to:

- Develop knowledge, skills and values required to work as an ethical medical professional.
- Apply comprehensive knowledge of the scientific basis of medical practice and clinical reasoning in inter-professional settings.
- Develop the skills to critically reflect on stereotypical thinking and institutional practices and policies to ensure clinicians deliver culturally safe care which centres the patient's priorities and beliefs.
- Apply an understanding of the impact of colonisation on First Nations traditional and contemporary history and ways to work effectively to strengthen First Nations health and wellbeing.
- Work effectively as a team member in an interprofessional team with the collective aim of improving patient outcomes in a primary healthcare model.

- Develop and practise effective and respectful communication which fosters trust and collaboration with patients, their families, and colleagues.
- Develop critical thinking and application of evidence-based medicine to improve quality of healthcare.

These are underpinned by learning outcomes that are derived from the AMC graduate outcomes across the four domains.

2.2 Curriculum design	
2.2.1	There is purposeful curriculum design based on a coherent set of educational principles and the nature of clinical practice.
2.2.2	Aboriginal and/or Torres Strait Islander and Māori health content is integrated throughout the curriculum, including clinical aspects related to Aboriginal and/or Torres Strait Islander and Māori health across all disciplines of medicine.
2.2.3	The Aboriginal and/or Torres Strait Islander and Māori health curriculum has an evidence-based design in a strengths-based framework and is led and authored by Aboriginal and/or Torres Strait Islander and Māori health experts.
2.2.4	The medical education provider is active in research and scholarship, including in medical education and Aboriginal and/or Torres Strait Islander and Māori health learning and teaching, and this research and scholarship informs learning, teaching and assessment.
2.2.5	There is alignment between the medical program outcomes, learning and teaching methods and assessments.
2.2.6	The curriculum enables students to apply and integrate knowledge, skills and professional behaviours to ensure a safe transition to subsequent stages of training.
2.2.7	The curriculum enables students to evaluate and take responsibility for their own learning, and prepares them for lifelong learning.
2.2.8	The curriculum design and duration enable graduates to demonstrate achievement of all medical program outcomes and AMC graduate outcome statements.
2.2.9	The curriculum outlines the specific learning outcomes expected of students at each stage of the medical program, and these are effectively communicated to staff and students.
2.2.10	There are opportunities for students to pursue studies of choice that promote breadth and variety of experience.

The Program has adopted the curriculum from the WSU medical program and is in the process of contextualising it to the NT setting. Contextualisation of the first two years of the program has been completed.

The program is a five-year direct entry program that provides a three-year Bachelor Degree (AQF Level 7) with a two-year Masters Degree (Extended) (AQF Level 9E) in Years 4 and 5 of the course. The units of study are completed in sequence, and each must be successfully completed before progressing to the next. Problem-based learning is the core of the Years 1–2 program and incorporates both horizontal integration (topics across all themes, and different disciplines such as anatomy and physiology being covered in each case) and vertical integration (authentic patient cases used to trigger learning and interest in the biomedical sciences, but leading to learning in the clinical sciences, such as patient communication and principles of diagnosis and treatment). The clinical phase of the program is three years of full-time learning in clinical and community settings across the Northern Territory. The purchased curriculum includes a 10-week pre-internship term at the end of the program, focusing on preparedness for internship.

The purchased curriculum includes a First Nations Culture and Health curriculum stream running across the five years of the program. The Leaders in Indigenous Medical Education (LIME) Indigenous Health Curriculum Mapping Tool (endorsed by Medical Deans Australia and New Zealand [MDANZ]) has been used to inform

the First Nations Culture and Health curriculum. The first two years of the curriculum sessions have been mapped against this tool in the guideline, although this tool was mapped to the 2012 AMC standards, rather than the current accreditation standards.

There are significant opportunities to strengthen the Aboriginal and/or Torres Strait Islander health content in a culturally safe way that is appropriate for the Northern Territory; however, this will require time and resources to undertake engagement with communities as well as curriculum development.

2.3 Learning and teaching	
2.3.1	The medical education provider employs a range of fit-for-purpose learning and teaching methods.
2.3.2	Learning and teaching methods promote safe, quality care in partnership with patients.
2.3.3	Students work with and learn from and about other health professionals, including through experience of interprofessional learning to foster collaborative practice.
2.3.4	Students develop and practise skills before applying them in a clinical setting.
2.3.5	Students have sufficient supervised involvement with patients to develop their clinical skills to the required level, and have an increasing level of participation in clinical care as they proceed through the medical program.
2.3.6	Students are provided with opportunities to learn about the differing needs of community groups who experience health inequities and Aboriginal and/or Torres Strait Islander and Māori communities. Students have opportunities to learn how to address systemic disadvantage, power differentials and historical injustices in their practice so as to increase the inclusivity of health services for these groups.
2.3.7	The medical education provider ensures that learning and teaching is culturally safe and informed by Aboriginal and/or Torres Strait Islander and Māori knowledge systems and medicines.
2.3.8	Students undertake an extensive range of face-to-face experiential learning experiences through the course of the medical program. Experiential learning is: • undertaken in a variety of clinical disciplines • relevant to care across the life cycle • situated in a range of settings that include health promotion, prevention and treatment, including community health settings • situated across metropolitan, regional, rural and, where possible, remote health settings.
2.3.9	Students undertake a pre-internship program.

The planned curriculum involves a broad range of teaching methods, including flipped classroom teaching, online modules, problem-based learning, immersive clinical simulation, clinical skills training, work-integrated learning placements, community-engaged learning, research training, reflective portfolios and mentorship.

There are plans for interactions with co-located health professional programs on the CDU Casuarina campus, and the program will need to ensure there are structured interprofessional learning opportunities implemented.

The First Nations curriculum is planned to focus on strong cultural connections instead of commencing from negative historical connotations. All clinical stories are planned to be based on real-life issues from a strengths-based perspective. The curriculum is being developed from the beginning by the Medical Program First Nations Lead and there is some collaboration across the Faculty of Health disciplines. The Faculty of Health has a cultural safety framework that will assist with the provision of culturally safe practice for Faculty staff and students.

There are working plans for a pre-internship program in the final year that seem fit for purpose. The Program should provide the AMC updates to its planning through annual monitoring, and evidence of delivery and outcomes in 2028.

STANDARD 3: Assessment

The team established that:

- the purchased program of assessment is being adapted appropriately with support from a qualified consultant. However, there is further work to do on the overall system of assessment and on culturally safe assessment for Aboriginal and/or Torres Strait Islander health, and the recruitment of a qualified assessment lead should be a priority.
- some further work is needed to clarify unprofessional student behaviours and the impact of these on progression
- significant further work is required to document the detail of how assessment quality will be controlled and student performance and progression analysed.

3.1 Assessment design	
3.1.1	Students are assessed throughout the medical program through a documented system of assessment that is: consistent with the principles of fairness, flexibility, equity, validity and reliability; supported by research and evaluation information evidence.
3.1.2	The system of assessment enables students to demonstrate progress towards achieving the medical program outcomes, including described professional behaviours, over the length of the program.
3.1.3	The system of assessment is blueprinted across the medical program to learning and teaching activities and to the medical program outcomes. Detailed curriculum mapping and assessment blueprinting is undertaken for each stage of the medical program.
3.1.4	The system of assessment includes a variety of assessment methods and formats which are fit for purpose.
3.1.5	The medical education provider uses validated methods of standard setting.
3.1.6	Assessment in Aboriginal and/or Torres Strait Islander and Māori health and culturally safe practice is integrated across the program and informed by Aboriginal and/or Torres Strait Islander and Māori health experts.

The assessment framework of the WSU Bachelor of Clinical Science (Medicine)/Doctor of Medicine (MD) has been adopted by the program and is undergoing some modification for the NT context. WSU expertise is available to support modification and implementation. CDU will include WSU academics in the assessment process to support external validity, quality assurance and benchmarking of its processes.

The approach to assessment at program level has been recently developed in an assessment guideline document. This will need to be refined to reflect contemporary evidence-based understanding and approaches in some areas (e.g. validity, sampling in objective structured clinical examinations [OSCEs], feedback reporting, technical calculation of 'adjustment', and sampling approaches for hurdle assessments).

An assessment summary has been provided in unit outlines with an approach to compensation/non-compensation within a unit. Further work should be undertaken on the assessment system across the whole program, ensuring it meets validity evidence requirements and graduate outcome competency requirements, as well as managing any issues with tensions between medical program requirements and CDU policies in the context of ensuring competence and safe practice.

How analysis and monitoring of single assessments and the system of assessment will occur longitudinally along the continuum of the program is yet to be documented. A description of how assessment in Aboriginal and/or Torres Strait Islander health and culturally safe practice is integrated across the program has been included. Information about assessments that support First Nations knowledges and development of cultural safety skills was provided. As these roll out, validity evidence and details of quality assurance processes

should be provided. The team suggests the approach to hurdle assessments in Aboriginal and/or Torres Strait Islander health be reviewed as part of consideration of sampling approaches for hurdle assessments.

The team notes the selective inclusion of individual assessments adopted from the WSU medical program, and changes due to single semester design for the Program. Validity evidence for each of the assessment formats, to demonstrate that students can achieve competencies in knowledge, skills and behaviours as they progress along the continuum of the program, must be provided as the program rolls out.

Some information about workplace-based assessments (WBAs) in the clinical years was provided, and a further detailed description of how these will be combined in holistically determining a student's overall performance will be needed within the next 12 months. WBA form design should be developed well in advance of students entering clinical placements. A plan for engaging clinical supervisors in this development and design should be developed.

The assessment lead position has been advertised. The assessment lead will Chair the Medical Program Assessment Committee and be a member of the Medical Program Progression Committee. In the interim the Program has employed a suitably qualified consultant.

An assessment approach for the bridging course was provided, and outlined use of formative assessments only. The team is concerned this does not provide evidence that students are appropriately prepared for entry into, and success in, the Program. Embedding consideration of a student's achievement level in the assessment design is needed. An evaluation of the relationship between assessment outcomes for the bridging course and the Program progression should be planned and implemented.

3.2 Assessment feedback	
3.2.1	Opportunities for students to seek, discuss and be provided with feedback on their performance are regular, timely, clearly outlined and serve to guide student learning.
3.2.2	Students who are not performing to the expected level are identified and provided with support and performance improvement programs in a timely manner.
3.2.3	The medical education provider gives feedback to academic staff and clinical supervisors on student cohort performance.

The Fitness to Practise Policy and Procedure underscore the expertise of the Faculty in dealing with health professional students. This policy and procedure seem appropriate for application to MD program students as intended.

Although the assessment schedule has been provided, it is unclear how feedback from formative assessments link with summative assessments across knowledge, skills and professional behaviours. Planning should include design of feedback reports suitable for a medical school context which balance score reporting (marks, grades) and provision of narrative forms of feedback that inform students on how to improve learning.

Noting the large number of hurdle assessments, details are required relating to how the system of assessment designs progression that ensures competence, and non-compensation between knowledge, skills and professional behaviours. Information about how the system of assessment relates to the program's four curriculum themes is needed.

Given CDU's intention to include international students as part of the Program cohort, the team expects documentation confirming that progression rules for the medical program meet CRICOS (Commonwealth Register of Institutions and Courses for Overseas Students) regulations. Documentation that there is no impact of progression rules on Aboriginal and/or Torres Strait Islander students' access to funding supports will also need to be provided.

Information about provision of remediation opportunities during progression rules-mandated breaks in study was provided. Information about progression of students who fail particular assessments within a unit (hurdle or non-hurdle, e.g. first semester OSCE) was provided. How this approach aligns with and considers

competence as part of progression to meet medical school requirements needs to be considered by the School and if any adjustment/exemptions to University policies are necessary.

Assessment of professionalism/professional behaviours is yet to be defined across the system of assessment. The Code of Professional Conduct for Medical Students was provided, although further work on how student behaviours not aligned with the code and/or other unsatisfactory professional behaviours are managed will need to be undertaken.

3.3 Assessment quality	
3.3.1	The medical education provider regularly reviews its system of assessment, including assessment policies and practices such as blueprinting and standard setting, to evaluate the fairness, flexibility, equity, validity, reliability and fitness for purpose of the system. To do this, the provider employs a range of review methods using both quantitative and qualitative data.
3.3.2	Assessment practices and processes that may differ across teaching sites but address the same learning outcomes, are based on consistent expectations and result in comparable student assessment burdens.

Further detailed information about how the program will manage essential quality assurance processes is needed. Broad information about blueprinting and standard setting has been provided. Details about item banking and tagging, item review, post-hoc psychometric analyses, pass-threshold calculations and decision making is needed. Broad details about how student assessment data will be considered by the Medical Program Progression Committee have been provided in the Terms of Reference. As the program rolls out, details of decision making by the committee will be needed.

Processes for assessment item development for summative assessments (e.g. MCQ examinations, OSCEs) have been defined as a responsibility of the Medical Program Assessment Committee.

Provision of training and professional development opportunities for faculty involved in assessment is a responsibility of the Medical Program Assessment Committee. An elaborated training plan for ensuring that academic and clinical staff upskilling occurs, including timelines and learning objectives, has been provided, although details about facilitation personnel are in progress.

Plans for evaluation of assessment data at cohort level, subquota level (e.g. First Nations students, different clinical sites) and examination level have not been elucidated and need to be planned in advance of program rollout.

Rationale for test specification, sampling, blueprinting and population of blueprinting for high-stakes assessments linked to progression decisions (e.g. knowledge-based examinations, OSCEs, clinical skills assessments) has been provided. The team suggests technical input from a psychometric perspective is needed as part of planning to ensure adequate sampling and contemporary test level blueprinting processes.

STANDARD 4: Students

In assessing the preparation of the program, the team confirmed that:

- appropriate selection policies are in place, and there are clear plans to support students who may have a less solid academic foundation at entry. However, there is a lack of clarity about whether the student cohort size anticipated will be achieved, which makes planning (and AMC assessment of the program) difficult.
- there are existing resources and mechanisms to support health program students, including those on clinical placements, and medical program–specific policies have been drafted
- a comprehensive Fitness to Practise Policy exists, although there is still work to be done on the supporting mechanisms.

4.1 Student cohorts and selection policies	
4.1.1	The size of the student intake is defined in relation to the medical education provider's capacity to resource all stages of the medical program.
4.1.2	The medical education provider has defined the nature of the student cohort, including targets and strategies for recruiting Aboriginal and/or Torres Strait Islander and Māori students, students with rural backgrounds and students from equity groups to support increased participation of these students in medical programs.
4.1.3	The medical education provider complements targets and strategies for recruiting Aboriginal and/or Torres Strait Islander and Māori students, students with rural backgrounds and students from equity groups with infrastructure and supports for student retention and graduation.
4.1.4	The medical education provider supports inclusion of students with disabilities.
4.1.5	The selection policy and admission processes are transparent and fair, and prevent racism, discrimination and bias, other than explicit affirmative action, and support the achievement of student selection targets.

The Program is preparing for a cohort of 20 domestic students to begin in 2025. Confirmed in writing to CDU on 26 August 2024, the Commonwealth Department of Education has approved these 20 places to be considered as part of CDU's general CSP funding envelope. These 20 CSPs will not be considered designated medical CSPs. It this then planned that the cohort will increase to 40 places from 2026 and to 60 places from 2028. The 40 medical CSPs included in the May 2024 budget will commence in 2026 and will be ongoing if the AMC approves the program. The additional students planned for 2028 will rely on recruitment of international students and/or additional medical CSPs. The medium-term plan is to secure CSPs and to enrol international students, aiming for a total student intake of up to 80 each year, over the next five years. The team notes the benefit of starting with a small cohort who can be well supported and can start in existing campus facilities; however, it remains necessary to have academic staffing that can deliver (and monitor and refine) the full program in Year 1, and the team raises concerns (in Standard 5) about the sufficiency and capacity of the starting academic team.

CDU has outlined subquotas in the following categories, which are aligned with the mission of the School and will guide the admissions process:

- NT First Nations applicants
- NT resident applicants
- First Nations applicants—rest of Australia
- rural applicants from elsewhere in Australia.

A documented contingency is in place for the actions that will be taken by the Program if these quotas are not met.

Informed by various committees such as the Strategic Board, First Nations Working Group and Curriculum Working Group, the Program has developed an admission process that is aimed at supporting the successful entry of students from target demographics. At present, there are no prerequisite subjects of study or external tests required for application into the Program. This decision necessitates substantial support through cohesive academic and wellbeing support for students, particularly during the initial entry into the Program. The Program has mandated a short course in chemistry and biology for students who have not undertaken these subjects prior to admission. Further monitoring and evaluation is required upon the commencement of students to assess the success of current strategies and subsequently guide further development.

There are multiple opportunities for mentorship and tutoring planned for the first year of the Program to support student success. CDU has a strong level of support for First Nations students through the First Nations Student Support Team, which is part of the CDU First Nations Leadership and Engagement Department. Furthermore, a program-specific First Nations student retention plan has been recently provided. Evaluation of the overarching strategy driving the action that will be taken by the Program to ensure that students are course ready will be essential.

An audit of facilities that will be used by the School has been undertaken along with the development of contingency plans to guarantee equitable access.

4.2 Student wellbeing	
4.2.1	The medical education provider implements a strategy across the medical program to support student wellbeing and inclusion.
4.2.2	The medical education provider offers accessible services, which include counselling, health and learning support to address students' financial, social, cultural, spiritual, personal, physical and mental health needs.
4.2.3	Students who require additional health and learning support, or reasonable adjustments/accommodations, are identified and receive these in a timely manner.
4.2.4	The medical education provider: • implements a safe and confidential process for voluntary medical student self-disclosure of information required to facilitate additional support and make reasonable adjustments/ accommodations within the medical program • works with health services to facilitate medical student self-disclosure of this information through safe and confidential processes before and during the transition to internship. These processes are voluntary for medical students to participate in, unless required or authorised by law.
4.2.5	The medical education provider implements flexible study policies relevant to the students' individualised needs to support student success.
4.2.6	The provision of student support is separated from decision-making processes about academic progression.
4.2.7	There are clear policies to effectively identify, address and prevent bullying, harassment, racism and discrimination. The policies include safe, confidential and accessible reporting mechanisms for all learning environments, and processes for timely follow-up and support. The policies, reporting mechanisms and processes support the cultural safety of learning environments.

It was evident to the team that the staff at CDU are committed to the success of prospective students. The collaboration between the School and central services to provide students with a wide range of services, such as counselling and health and learning support, is noteworthy.

Early assessments, attendance review and access to the learning management system have been identified as tools that will be used by the unit coordinator to recognise students who may need further support.

Furthermore, efforts have been made to separate student support provision and decision making regarding academic progression through the employment of dedicated professional support staff. These services and processes must be closely evaluated after the commencement of the program.

Targeted wellbeing initiatives within the Program are in the early stages of development. An overarching wellbeing strategy guiding the development of these initiatives has recently been developed.

The Program has demonstrated its commitment to flexible study options throughout the degree with the decision to implement a semester system for the first two years. A student wellbeing and welfare guide has been developed. Further development of the requirements of students taking a leave of absence and the supports available for this cohort of students must be clearly established and documented for the final three years of the program. It is recommended that CDU develops further granularity regarding expectations of student attendance and maximum time periods available for students to complete the years primarily based on campus and the years of immersive clinical learning so that expectations are clear to students.

The team was reassured by the availability of safe and confidential avenues for student self-disclosure of information required to facilitate additional support. However, the team found a lack of familiarity among existing health program students with these processes. It is recommended that the School prioritises ensuring students are well-informed about the services available to them.

Policies regarding sharing of sensitive student information during the coordination of student placements in partnership with the NT Government, a prospective employer for medical students at CDU, have been developed. Policies regarding the effective recognition and prevention of bullying, harassment, racism and discrimination have been clearly identified. These policies reflect the values of CDU and the culture of the Program. In particular, it is noted that the faculty of health has established guidelines to ensure culturally safe clinical practices and placement.

4.3 Professionalism and fitness to practice	
4.3.1	The medical education provider implements policies and timely procedures for managing medical students with an impairment when their impairment raises concerns about their fitness to practise medicine or their ability to interact with patients, including in a culturally safe way.
4.3.2	The medical education provider implements policies and timely procedures for identifying, managing and/ or supporting medical students whose professional behaviour raises concerns about their fitness to practise medicine or their ability to interact with patients, including in a culturally safe way.

The team reviewed a comprehensive Fitness to Practise Policy. It is noted that the Program has plans to educate and inform students about the practicalities of this policy in the first weeks of the program, via the professionalism curriculum, to ensure students are aware of the fitness to practise requirements. In the first year of the program, the professionalism curriculum will centre around the CDU Code of Conduct, the Good Medical Practice Code of Conduct and the requirements and procedures relevant to disclosing impairments. Policies and procedures that outline methods for identifying, managing and/or supporting medical students whose professional behaviours raise concerns must be developed.

4.4 Student indemnification and insurance	
4.4.1	The medical education provider ensures that medical students are adequately indemnified and insured for all education activities.

Relevant indemnity insurance coverage is provided for students while on campus and/or engaging in University-related activities and/or approved unpaid placements, work experience or internships.

STANDARD 5: Learning environment

Some elements of this standard will not be able to be demonstrated until the program is being implemented. The team established that:

- the plans for new infrastructure in the form of the Centre for Better Health Futures appear excellent and, although slightly delayed, are on track to be available for June 2025. As a contingency arrangement, there are adequate facilities to support the first-year intake of 20 students at the existing CDU campus with appropriate technology and learning resources.
- as of October 2024, seven academic posts have been successfully appointed, as well as one consultant, with a further three FTE roles to be advertised in January 2025. This staffing level may present a challenge when customising, delivering, evaluating and refining the program in Year 1 if the planned recruitment in January 2025 is not successful. The professional staffing appeared adequate and well supported.
- there are overarching University policies for staff development and promotion, which would need to be tested in their application to the medical program
- while there is much goodwill and commitment, discussions with health services regarding clinical placements and time for teaching are in early stages. Many of the intended clinical placement sites already teach Flinders University students and there is no clear agreement about capacity for both programs or how students on different programs will be supported, appropriate to their experience and learning outcomes.

5.1 Facilities	
5.1.1	The medical education provider has the educational facilities and infrastructure to deliver the medical program and achieve the medical program outcomes.
5.1.2	Students and staff have access to safe and well-maintained physical facilities in all learning and teaching sites. The sites support the achievement of both the medical program outcomes and student and staff wellbeing, particularly for students and staff with additional needs.
5.1.3	The medical education provider works with training sites and other partners to provide or facilitate access to amenities that support learning and wellbeing for students on clinical placements. This includes accommodation near placement settings that require students to be away from their usual residence.
5.1.4	The medical education provider uses technologies effectively to support the medical program's learning, teaching, assessment and research.
5.1.5	The medical education provider ensures students have equitable access to the clinical and educational application software and digital health technologies to facilitate their learning and prepare them for practice.
5.1.6	Information services available to students and staff, including library and reference resources and support staff, are adequate to meet learning, teaching and research needs in all learning sites.

Construction of CDU's new $25.8 million Centre for Better Health Futures, a new health teaching and research facility, has been delayed. The completion date was extended from March 2025 to June 2025 to accommodate the medical program floor. This addition came after the Commonwealth funding announcement in the May 2024 budget, which included funds to proceed with this infrastructure. The Centre for Better Health Futures building is designed to provide students with immersive experiences including the use of digital health tools such as telehealth. The team reviewed the plans, which appeared to provide excellent modern and technology-enhanced teaching and learning spaces with a culturally safe space and fit-for purpose student areas. There was some uncertainty about the adequacy of meeting rooms for staff and

students; however, CDU did appear to have good capacity for meeting rooms capable of supporting additional students across the campus.

Contingency plans have been made to use existing infrastructure at CDU which appears adequate for the addition of a first-year intake of 20 students, although there is limited wheelchair access to some teaching areas.

Menzies School of Health Research has a facility on the Royal Darwin Hospital campus that has capacity to provide a hub for medical students on clinical placement, although it has limited space.

CDU has campuses in Alice Springs, Katherine and Nhulunbuy which will provide a hub for students on placement.

The team found the facilities at the Royal Darwin Hospital to be excellent. However, it heard of significant limitations in terms of accommodation and infrastructure at planned regional and rural clinical placement sites. It is important for the Program to address these concerns and demonstrate appropriate infrastructure is in place in advance of student clinical placements commencing in regional and rural sites (current plans are for these to commence in 2027–2028).

CDU provides students with access to a physical and virtual library and there are dedicated library staff for the Faculty of Health. The ClinicalKey clinical search engine from Elsevier featuring books, medical journals, images and videos has been purchased for staff and students. CDU has many established programs with supported online delivery across the Northern Territory and interstate. It has the capacity to support students in information technology with a central University team of 14. The CDU Portal provides a single point of access to the many applications available to CDU staff and students and is well supported by central IT services. Learnline, CDU's online learning platform, includes a virtual classroom called Collaborate.

5.2 Staff resources	
5.2.1	The medical education provider recruits and retains sufficient academic staff to deliver the medical program for the number of students and the provider's approach to learning, teaching and assessment.
5.2.2	The medical education provider has an appropriate profile of professional staff to achieve its purpose and implement and develop the medical program.
5.2.3	The medical education provider implements a defined strategy for recruiting and retaining Aboriginal and/or Torres Strait Islander and Māori staff. The staffing level is sufficient to facilitate the implementation and development of the Aboriginal and/or Torres Strait Islander and Māori health curriculum, with clear succession planning.
5.2.4	The medical education provider uses educational expertise, including that of Aboriginal and/or Torres Strait Islander and Māori people, in developing and managing the medical program.
5.2.5	The medical education provider recruits, supports and trains patients and community members who are formally engaged in planned learning and teaching activities. The provider has processes that are inclusive and appropriately resourced for recruiting patients and community members, ensuring the engagement of community groups who experience health inequities and Aboriginal and/or Torres Strait Islander and Māori communities.
5.2.6	The medical education provider ensures arrangements are in place for indemnification of staff with regard to their involvement in the development and delivery of the medical program.

An updated staffing list provided on 25 October 2024 indicates there are now seven academic staff employed by the Program, with three additional FTE roles currently advertised. Collectively, the currently appointed staff and upcoming recruits include:

- Dean
- Medical Program Course Coordinator

- Medical Program First Nations Lead
- Senior Lecturer Medical Clinical Sciences
- Senior Lecturer Anatomy and Physiology
- Senior Lecturer Biomedical Sciences (commenced 16 September 2024)
- Senior Lecturer Population Health (included in September response document)
- Senior Lecturer Clinical Medicine (appointed and commences January 2025)
- Senior Lecturer Clinical Sciences (appointed and commences January 2025)
- Senior Lecturer Medical Education and Assessment (appointed and commences January 2025).

Professor Neil Spikes has been employed as a consultant and is the current Medical Education Assessment Lead.

The staffing outlines the recruitment of three additional senior lecturers and casual tutors to commence in January 2025. There are an additional 16 0.2 FTE Clinical Professor positions (3.2 FTE) budgeted for 2025 and the recruitment process for these positions is underway.

Having reviewed the curriculum and assessment program and being mindful of the need to deliver, review and update the program in its first years of implementation, the team concluded the small group currently employed is not yet sufficient. CDU should prioritise the recruitment of additional academic staff. Currently, there is no assessment expert to support implementation, evaluation and refinement of the program, although it is noted that a consultant has commenced as an expert assessment lead.

At the time of the site visit, there were two professional staff working in the Program, with support from the wider Faculty of Health team. An update provided in October indicates three new staff commenced in September: a Medical Program Manager, a First Nations medical student advisor and an Accreditation and Admissions Manager. A technical support position for clinical skills, anatomy and learning technology will begin in January 2025 to support the commencing cohort.

The current professional staff feel well supported. They have large portfolios but work collaboratively. There is a professional development budget for the staff, and they can request additional support through the Career Development Plan. Internal training is also available.

CDU is joining with Australian Indigenous Doctors Association (AIDA) for a mentoring program and support of Aboriginal and/or Torres Strait Islander students. Students, before entering clinical spaces, are expected to be well set up for culturally safe practice. CDU will embed a First Nations Health and Culture curriculum in a yarning circle format for one hour every week for the first two years.

There is a defined strategy for recruiting and retaining Aboriginal and/or Torres Strait Islander staff, and the Program recently appointed an additional First Nations academic for future staff development and staff planning needs. However, there are currently capacity limitations in Aboriginal and/or Torres Strait Islander staff (both academic and professional) that impact on the responsibilities of the Medical Program First Nations Lead role. The stretch for these staff will only increase as the program commences.

The Faculty of Health already has a simulated patient volunteer program which commenced in 2023 and is administered by the Senior Simulation Technical Officer. Volunteers are provided with training and are given remuneration for their participation. The program is drawn from across the Darwin community and includes First Nations people. New simulation facilities are planned for the new building. The team did not investigate in detail how the medical program would engage with the patient volunteers during this assessment.

CDU has committed to indemnify staff for their involvement in the development and delivery of the medical program.

5.3 Staff appointment, promotion and development	
5.3.1	The medical education provider's appointment and promotion policies for academic staff address a balance of capacity for teaching, research and service functions. The appointment and promotion policies include a culturally safe system for measuring success of Aboriginal and/or Torres Strait Islander and Māori staff.
5.3.2	The medical education provider appraises and develops staff, including clinical title holders and staff who hold a joint appointment with another body.
5.3.3	The medical education provider provides Aboriginal and/or Torres Strait Islander and Māori staff with appropriate professional development opportunities and support. Aboriginal and/or Torres Strait Islander and Māori staff have formal opportunities to work together in teams and participate in mentoring programs across the medical program and higher education institution.
5.3.4	The medical education provider ensures that staff, clinical supervisors and students have training in cultural safety and participate in regular professional development activities to support ongoing learning in this area.

CDU provided an Academic Staff Promotions Policy and Procedure that recognises engagement, research, and teaching and learning as distinct categories. It does not address culturally safe approaches for First Nations staff. A University-level First Nations Workforce Policy and a First Nations Leadership Policy were also provided; however, it was not yet clear how these would be applied to the medical program. Given this is an assessment of preparedness, the focus was on recruitment. Implementation of development and promotional opportunities will be reviewed once the program is being implemented.

The Program has ensured that all students and staff will complete the level 1 and 2 Indigenous Allied Health Australia cultural competence courses. These courses cover truth-telling beyond cultural awareness. Level 3 is action based, and participants are given with an action plan from lecturers who have undertaken the training in the Faculty of Health.

5.4 Clinical learning environment	
5.4.1	The medical education provider works with health services and other partners to ensure that the clinical learning environments provide high-quality clinical experiences that enable students to achieve the medical program outcomes.
5.4.2	There are adequate and culturally safe opportunities for all students to have clinical experience in providing health care to Aboriginal and/or Torres Strait Islander and Māori people.
5.4.3	The medical education provider actively engages with co-located health profession education providers to ensure its medical program has adequate clinical facilities and teaching capacity.

There are four separate health provider groups in the Northern Territory with reported capacity to provide clinical training places for the medical students in the program:

- NT Health, through the five regional health services, including six hospitals and 74 primary care clinics
- Healthscope—Darwin Private Hospital
- urban general practice clinics
- ACCHOs.

Currently CDU has an overarching agreement with NT Health for clinical places, and contracts with Darwin Private Hospital, Palmerston GP Super Clinic and ACCHOs are now in place.

The (previous) Chief Minister of the Northern Territory provided written confirmation to CDU and the Federal Minister for Health and Aged Care that the government will work with NT Health to provide the required clinical placements to CDU's medical students, as well as employment to its graduates as interns. The team did not have clarity over how student placements will be allocated or the policy and procedures surrounding

this. It was indicated that the NT Government may undertake management of placement allocation for medical students from all medical education providers, but this is not confirmed.

There has been clear communication and discussion with the staff of the Royal Darwin Hospital. Arrangements are still in the formative stages, and there is an assumption that clinicians will be able to allocate 0.2 FTE non-clinical time to teach into the medical program. This 0.2 FTE time may be needed for non-clinical administrative work by clinicians and not necessarily to undertake academic/teaching work. Moreover, the Flinders University NTMP has existing arrangements to engage the same medical staff to teach in their program. Considering the nature of medical staffing recruitment and retention in the Northern Territory, not having a clear plan and staffing profile creates uncertainty about the engagement of academic and clinical staffing resources to teach into the medical program.

At the time of the visit, there had been no discussion with senior executives of the Flinders University programs about the plans for student clinical placements. A meeting is planned in October 2024 and a briefing plan has been developed. The senior hospital executives at all sites were supportive of their staff being involved in student teaching. Given most clinical supervisors are currently employed in the Flinders University program, further demonstration of commitment to CDU is required. The Flinders University program executive is currently concerned about their ability to provide enough placements for CDU students at Royal Darwin Hospital, First Nations sites and other rural sites. The Flinders University program is concerned about the quality of clinical learning experience for both CDU and Flinders University students in the future. The expectation that the same group of academic and clinical tutors and supervisors will be able to manage the requirements of two different medical school programs across NT health services needs to be worked through. There is potential for significant conflict and poor clinician and student experiences if the footprint of both programs is not planned with health services in a collaborative way that supports all students to achieve their learning outcomes.

CDU has several rural teaching sites for other schools in the Faculty of Health that it hopes to develop into medical student training sites. Flinders University has rural medical school training sites at many of these locations. There is no agreement with Flinders University for medical students to collocate at these training sites.

There is a strong relationship between the Aboriginal Medical Services and CDU and, although these placements are yet to be established with CDU, confidence can be taken from CDU's strong track record in Aboriginal and Torres Strait Islander engagement and letters of support.

5.5 Clinical supervision	
5.5.1	The medical education provider ensures that there is an effective system of clinical supervision to ensure safe involvement of students in clinical practice.
5.5.2	The medical education provider ensures that clinical supervisors are provided with orientation and have access to training in supervision, assessment and the use of relevant health education technologies.
5.5.3	The medical education provider monitors the performance of clinical supervisors.
5.5.4	The medical education provider works with healthcare facilities to ensure staff have time allocated for teaching within clinical service requirements.
5.5.5	The medical education provider has defined the responsibilities of hospital and community practitioners who contribute to delivering the medical program and the responsibilities of the medical education provider to these practitioners.

There is confidence across NT health service stakeholders that CDU students will also be provided with safe, scaffolded and positive supervisory experiences in clinical practice and a clear desire for the program to succeed. However, the discussions and negotiations with Royal Darwin Hospital staff, local health districts, general practices, Aboriginal Medical Services and other community health placements in relation to responsibilities, time allocations, orientation, training and monitoring of clinical supervisors are yet to

progress beyond early meetings. These discussions and negotiations will need to take place in conjunction with discussions about clinical placements. Monitoring to ensure staff have time allocated for teaching within clinical service requirements will be required.

It is noted that CDU currently delivers healthcare programs in which health practitioner supervisors require orientation, training and access to technologies, and for which monitoring of performance is in place.

STANDARD 6: Evaluation and continuous improvement

This standard will not be able to be demonstrated until the program is being implemented. The team established that there are good foundational plans being put in place to evaluate and continuously improve the program, once running. The development and implementation of these plans will need to be assessed by the Accreditation and Evaluation Committee as the program is rolled out and refined.

6.1 Continuous review, evaluation and improvement	
6.1.1	The medical education provider continuously evaluates and reviews its medical program to identify and respond to areas for improvement and evaluate the impact of educational innovations. Areas evaluated and reviewed include curriculum content, quality of teaching and supervision, assessment and student progress decisions. The medical education provider quickly and effectively manages concerns about, or risks to, the quality of any aspect of the medical program.
6.1.2	The medical education provider regularly and systematically seeks and analyses the feedback of students, staff, prevocational training providers, health services and communities, and uses this feedback to continuously evaluate and improve the program.
6.1.3	The medical education provider collaborates with other education providers in the continuous evaluation and review of its medical program outcomes, learning and teaching methods, and assessment. The provider also considers national and international developments in medicine and medical education.

The School has initially formed an Accreditation and Evaluation Committee, which will be supported by a program-based evaluation team. An evaluation framework for the Program is underway. The programs evaluation team met for the first time in July 2024. The proposals are for the Accreditation and Evaluation Committee to report to the Faculty of Health Senior Executive and an annual report to be shared with staff and student cohorts.

The supporting documentation articulated clear governance and described how outcomes would be reported to the curriculum and assessment committees. The Accreditation and Evaluation Committee Terms of Reference were provided. The Committee's membership will include a student member but currently has no community stakeholder members. Adding community membership would provide community perspective in the governance of evaluation, assisting prioritisation of community perspectives in the development of the evaluation framework and the review of the program as implementation begins.

The centrally administered evaluation instrument MyView, which includes survey capability, will support monitoring of course subject/unit and teaching quality.

Considering that the WSU curriculum is being customised to make it suitable for the Northern Territory, continuous evaluation of the revised curriculum content and method of implementation is paramount, and staffing to support evaluation and reporting should be addressed as a priority.

The submission indicated plans to join existing collaborations such as the Australian Medical Schools Assessment Collaboration (AMSAC) and the Australasian Collaboration for Clinical Assessment in Medicine (ACCLAiM). CDU will apply for membership of MDANZ and the Australian and New Zealand Association for Health Professional Educators (ANZAHPE).

There are plans for the graduate outcomes analysis framework (from 2030) to be co-designed with prevocational providers in the Northern Territory and include graduate destinations and specialty training choices in the longer term.

6.2 Outcome evaluation	
6.2.1	The medical education provider analyses the performance of student cohorts and graduate cohorts to determine that all students meet the medical program outcomes.
6.2.2	The medical education provider analyses the performance of student cohorts and graduate cohorts to ensure that the outcomes of the medical program are similar.
6.2.3	The medical education provider examines performance in relation to student characteristics and feeds this data back to the committees responsible for student selection, curriculum and student support.
6.2.4	The medical education provider evaluates outcomes of the medical program for cohorts of students from equity groups. For evaluation of Aboriginal and/or Torres Strait Islander and Māori cohorts, evaluation activity is informed and reviewed by Aboriginal and/or Torres Strait Islander and Māori education experts.

The team established that early plans are in place for monitoring student progress against the medical program outcomes and to analyse student cohort performance by characteristics. There is capability for reporting through the Tableau software platform.

It was not yet clear how evaluation activity will be informed and reviewed by Aboriginal and/or Torres Strait Islander education experts or whether there will be sufficient capacity across these experts to meet the needs of evaluation as well as curriculum development and consequential refinement.

6.3 Feedback and reporting	
6.3.1	The outcomes of evaluation, improvement and review processes are reported through the governance and administration of the medical education provider and shared with students and those delivering the program.
6.3.2	The medical education provider makes evaluation results available to stakeholders with an interest in graduate outcomes, particularly prevocational training providers, and considers their views in the continuous evaluation and improvement of the medical program.

The Program plans to provide stakeholders and partners with an annual report outlining how the medical program is meeting the agreed vision and purpose of the program and important key outcomes for the year. It would be beneficial to establish more frequent mechanisms for providing feedback on evaluation to students, staff, health services and community, particularly in the early stages of program implementation where many opportunities for refinements are likely to be identified.

Appendices

Appendix 1: Accreditation in Australia and Aotearoa New Zealand

The purpose of the Medical Board of Australia (the Board) is to ensure that Australia's medical practitioners are suitably trained, qualified and safe to practise. The Board operates in accordance with the Health Practitioner Regulation National Law (the National Law), as in force in each state and territory. One of the objectives of the National Law is to facilitate the provision of high-quality education and training of health practitioners. The accreditation of programs of study and education providers is the primary way of achieving this. The Board has appointed the AMC as the accreditation authority for medicine to conduct accreditation functions under the National Law.

The AMC has responsibility for developing accreditation standards, assessing education providers and their programs of study for the medical profession, and accrediting programs that meet the standards. Accreditation standards are used to assess whether a program of study, and the education provider that provides the program, equips people who complete the program with the knowledge, skills and professional attributes necessary to practise the profession. The AMC develops accreditation standards, which the Board approves.

When the AMC assesses a program of study and the education provider against the approved accreditation standards and makes a decision to grant accreditation, the AMC provides its accreditation report to the Board. The Board makes a decision to approve or refuse to approve the accredited program of study as providing a qualification for the purposes of registration to practise medicine. The Board publishes on its website the accredited programs of study it has approved as providing a qualification for the purposes of general registration.

The Medical Council of New Zealand (MCNZ) is a statutory body operating under the Health Practitioners Competence Assurance Act 2003, which has as its principal purpose the protection of the health and safety of the public by providing for mechanisms to ensure that doctors are competent and fit to practise medicine. It is responsible for both registration of medical practitioners and accreditation of medical education in Aotearoa New Zealand.

The AMC and the MCNZ have a long history of cooperation to assist both organisations in setting standards for medical education and assessment that promote high standards of medical practice, and that respond to evolving health needs and practices, and educational and scientific developments. The AMC develops accreditation standards in consultation with the MCNZ, which adopts the standards.

The AMC and the MCNZ work collaboratively to assess Australian and New Zealand medical education providers and their programs. In the case of education providers offering programs of study in Aotearoa New Zealand, the accreditation assessment team will include at least one assessor from New Zealand, appointed after consultation with the MCNZ. The accreditation report is also provided to the MCNZ to make its accreditation and registration decisions.

The standards and procedures relevant to the assessment and accreditation of primary medical programs and underpinning the accreditation process and findings in this report are:

- *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2023* (the Standards)
- *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2024* (the Procedures)

Appendix 2: Membership of the 2024 AMC Assessment Team

Name	Background
Professor Jane Dahlstrom OAM (Chair) MBBS (Hons), PhD, FPAC, FRCPA, FFOP, FFSc, Grad Cert Ed Stud (Higher Education), SFHEA	Emeritus Professor, School of Medicine and Psychology, College of Health and Medicine, Australian National University Senior Staff Specialist, Anatomical Pathology, Canberra Hospital, ACT
Professor Dinesh Arya MBBS, MD, DPM, MRCPsych, DM, FRANZCP, CHMS, DipHSM, MBS, FRACMA, FAHCSE, AFNIZM, MBHL, GAICD	Chief Medical Officer and Chief Psychiatrist, Tasmanian Department of Health
Associate Professor Cheryl Davis BHSc (Hons), MPH	Aboriginal Health Domain Chair, School of Medicine, The University of Notre Dame, Fremantle Campus
Professor Sandra Kemp (Deputy Chair) BHMS (Ed), MA, PhD	Deputy Dean, Innovation and Scholarship Medical Education, Graduate School of Medicine, University of Wollongong
Tisshapaa Sivagnanan	Medical Student, James Cook University Immediate Past President, Australian Medical Students Association
Professor Jennifer Williams BA, BSc, MBBS, FACEM, MClinEd	Dean of Medicine and Head of School of Clinical Medicine, Queensland University of Technology Senior Staff Specialist Emergency Physician, Sunshine Coast Hospital and Health Service
David Byrnes BA (Ed), CertIIICommServ, CertIII Aboriginal Education, DipCommServ	Aboriginal Community Engagement Lead, Monash Rural Health, Monash University
Juliana Simon	Head of Accreditation Assessments, Australian Medical Council
Sophie Burke	Manager, Medical School Assessments, Australian Medical Council
Esther Jurkowicz	Program Support Officer, Medical School Assessments, Australian Medical Council

Appendix 3: Meetings by the 2024 AMC Assessment Team

Meetings	Roles engaged with
Monday 15 July 2024 ***Charles Darwin University, Casuarina Campus***	
Program Executive	Pro Vice-Chancellor, Faculty of Health Deputy Vice-Chancellor Executive Director Menzies School of Health Research Dean of Medicine Course Coordinator Medical Program First Nations Lead
Aboriginal and/or Torres Strait Islander Strategy – Program Perspective	Medical Program First Nations Lead First Nations Health and Culture Specialist, Faculty of Health Dean of Medicine Executive Director Workforce Development, Indigenous Allied Health Australia
Faculty of Health Leadership/Executive	Pro Vice-Chancellor, Faculty of Health Dean School of Nursing and Midwifery Head School of Allied Health Dean of Medicine Director of Health Workforce Associate Dean Work Integrated Learning Outgoing Associate Dean, Learning and Teaching Associate Dean, Learning and Teaching Associate Dean, Research
Teaching and Learning Overview	Dean of Medicine Outgoing Associate Dean Learning and Teaching Associate Dean Learning and Teaching Course Coordinator Medical Program First Nations Lead Curriculum Working Group Members
Information Technology	Course Coordinator Medical Program First Nations Lead Associate Director Digital Learning Design Digital Learning Designer Manager LearnLine
Professional Staff	Dean of Medicine Director of Health Workforce Administration Officer, Faculty of Health Faculty of Health Operations Manager Medical Program Support Officer Medical Program Admin Assistant

Meetings	Roles engaged with
Assessment	Dean of Medicine Medical Program Course Coordinator Outgoing Associate Dean Learning and Teaching Associate Dean Learning and Teaching Medical Program First Nations Lead
Tuesday 16 July 2024 ***Charles Darwin University, Casuarina Campus***	
Vice Chancellor and President	Vice Chancellor and President Pro Vice-Chancellor, Faculty of Health
Admissions and Selection	Dean of Medicine Medical Program Course Coordinator Medical Program First Nations Lead Associate Director Customer Experience Manager Future Students & Admissions
Student Support and Wellbeing	Dean of Medicine Medical Program Course Coordinator Associate Director Student Support
Aboriginal and/or Torres Strait Islander Staff	Medical Program First Nations Lead First Nations Health and Culture Specialist Faculty of Health
Student Services	Medical Program Course Coordinator Medical Program First Nations Lead Enrolments Scholarships Officer, Student Administration Academic and Research Librarian Language and Learning Advisor
Meeting with co-located school Flinders NTMP	Executive Dean, College of Medicine and Public Health Dean, Rural and Remote Health, College of Medicine and Public Health
Aboriginal and/or Torres Strait Islander Strategy – Faculty/University perspective	Deputy Vice Chancellor First Nations Leadership (online) Pro Vice-Chancellor, Faculty of Health
Tour of Facilities	Dean of Medicine Medical Program Course Coordinator First Nations Lead
Curriculum Year 1 and 2 – detailed presentation/LMS tour	Dean of Medicine Medical Program Course Coordinator Medical Program First Nations Lead Simulation Lead
Current program students	2nd year Bachelor of Clinical Science students
Research	Dean of Medicine Director Menzies School of Health Research Associate Dean Research Faculty of Health

Meetings	Roles engaged with
	School of Medicine, Research Integrity Officer Menzies Clinician Researchers
First Nations CDU student experience of First Nations Student Support including tutoring	CDU Nursing Graduate and post grad student CDU Grad Cert Aeromedical Retrieval
Wednesday 17 July 2024 ***Charles Darwin University, Casuarina Campus***	
Royal Darwin Hospital - Hospital Executives and Clinical Leadership	Dean of Medicine Medical Program Course Coordinator Faculty of Health Director Strategy and Partnerships Director Menzies School of Health Research Regional Executive Director Top End NT Health and ED RDPH Director Medical Services RDPH Deputy Director Medical Services Executive Director, Medical Services and Director Emergency Medicine Senior Clinician RDH / Menzies Co-Director Surgery and Critical Care Co-Director Medicine Chair Medical Advisory Committee
Royal Darwin Hospital - Tour of teaching and student facilities	Dean of Medicine Medical Program Course Coordinator Director Menzies School of Health Research Faculty of Health Director Strategy and Partnerships
Darwin Private Hospital - Hospital Executive and Clinical Leadership Team	Dean of Medicine Faculty of Health Director Strategy and Partnerships Medical Program Course Coordinator DPH Director of Nursing DPH Education and Training Manager DPH General Manager
Meeting with community partners	CDU Menzies Medical Program Strategic Board Executive Director of Medical & Clinical Services, Alice Springs Hospital NT Chief Medical Officer Executive Director Medical Services, NT Health CEO, Danila Dilba Health Service Executive Director, Remote Health & Primary Care
Meeting with ACCHO	CEO, Danilla Dilba Health Service Darwin CEO, Central Australia Aboriginal Congress Alice Springs Chief Medical Officer, Central Australia Aboriginal Congress Alice Springs

Meetings	Roles engaged with
Clinical Training Site FCD Palmerston SuperClinic and Urgent Care Centre - virtual meeting	CEO Clinical Supervisors
Thursday 18 July 2024 ***Charles Darwin University, Casuarina Campus***	
NT Health	CEO, NT Health Chief Medical Officer Executive Director, Medical & Clinical Services Executive Director of Medical Services
NT Prevocational Medical Assurance Services	A/Manager, NT PMAS PMAS Medical Director
Meeting with Junior Doctors	Junior Doctors
Friday 19 July 2024 ***Charles Darwin University, Casuarina Campus***	
Final Debrief with CDU and program leadership to discuss team findings	Pro Vice-Chancellor, Faculty of Health Associate Dean Learning and Teaching Director Menzies School of Health Research Dean of Medicine Course Coordinator Medical Program First Nations Lead

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