Accreditation Report: Charles Sturt University, School of Rural Medicine

Medical School Accreditation Committee

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Australian Medical Council Limited

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Acknowledgement of Country

The Australian Medical Council (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 AMC offices are on the land of the Ngunnawal and Ngambri Peoples. The Charles Sturt University, School of Rural Medicine main campus is located on the lands of the Wiradjuri peoples. The Program operates across many lands within New South Wales and Victoria.

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 history

The Charles Sturt University (CSU) School of Rural Medicine's five-year Bachelor of Clinical Science (Medicine)/Doctor of Medicine (BClinSc(Med)/MD) medical program is currently accredited as the Joint Program in Medicine (JPM) with the Western Sydney University (WSU) School of Medicine. This partnership was first accredited in October 2020 through to 31 March 2027 and supported the establishment of the CSU School of Rural Medicine (the School). The JPM is delivered such that WSU and CSU retain their identities as two distinct Schools of Medicine delivering a common accredited program. Clinical training sites and students clearly identify with one of the JPM providers rather than with the program itself.

The JPM is now in its fifth year of delivery, with the first cohort of students in their final year of the program. It is clear that the communities served and clinical locations engaged with by each School have distinct and unique needs, particularly the difference in context between metropolitan and rural teaching and healthcare delivery, and that there are nuanced differences in the providers' purposes for teaching medicine.

In November 2023, CSU requested that the AMC assess their delivery independently for a standalone accredited medical program, with WSU supportive of the CSU's independence.

The AMC determined that the dissolution of the Joint Program in Medicine was a material change to the accredited program jointly offered and that delivery as a standalone accredited medical program would require a full accreditation assessment.

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

Accreditation process

When undertaking accreditations the AMC refers to the:

- *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)

According to the *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2024*, accredited medical education providers may seek reaccreditation when their period of accreditation expires. Accreditation is based on the medical program demonstrating that it satisfies the accreditation standards for primary medical education. The provider prepares a submission to support the reaccreditation. An AMC team (the team) assesses the submission and visits the provider and its clinical teaching sites.

The team conducted a reaccreditation assessment of the Charles Sturt University, School of Rural Medicine, meeting with staff (academic and operational), medical students, clinical supervisors and other groups involved in the delivery of the Program. The team visited clinical training sites in Orange, Bathurst and Parkes, and met with other training sites virtually. The team composition is found in Appendix 2.

The goals of this accreditation report are to:

- Provide an assessment of the provider and program against the Standards, and the reasons behind the outcomes. This includes highlighting commendations, outlining conditions placed to ensure the provider and program meet the Standards within a reasonable time, and offering recommendations to support ongoing quality improvement.
- Give a brief overview of the accreditation context, including key program data, previous accreditation activity and provisions for future monitoring and accreditation activity.

This report presents the AMC's findings against the *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2023*.

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 13 August 2025 meeting, the AMC's Medical School Accreditation Committee resolved:

i. that the medical program of the Charles Sturt University, School of Rural Medicine substantially meets the accreditation standards;

ii. that accreditation of the five year Bachelor of Clinical Science (Medicine)/Doctor of Medicine (BClinSc(Med)/MD) medical program of the Charles Sturt University, School of Rural Medicine be granted to 31 March 2032 (commencing January 2026);

iii. that accreditation of the program is subject to the meeting of the conditions contained in the accreditation report and to meeting the 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 a clear definition of the mutual benefit resulting from (existing and new) partnerships between the program and Aboriginal and/or Torres Strait Islander people and organisations in relation to promoting community sustainability of health services and increasing the capacity of partners. (Standard 1.2.3)	2026
2. Provide evidence that community groups and stakeholders are actively involved in the development of an independent program. They should be represented in key decision-	2027

Condition	To be met by
making processes and consulted on important matters, including the program's objectives, curriculum content, outcomes, and governance. This involvement should specifically include health consumers and groups affected by health inequities, as outlined in the glossary of the AMC Standards. (Standard 1.2.1 and 1.3.1)	
3. Establish and execute a structured program to ensure leadership and management teams receive the necessary training and resources to implement the fully articulated program, equitably and consistently across sites by: a. Ensuring that everyone has a clear understanding of their roles and responsibilities regarding the management of confidentiality, conflicts of interest (both actual and perceived), and the risks associated with imprudent practices that could impact the health, well-being, and inclusive environment for staff, students, and stakeholders. (Standard 1.3.6) b. Report annually to 2030 with evidence that demonstrates alignment between the available and required resources to adequately operate the program independently, until the new curriculum is fully implemented. (Standard 1.4.3).	Annually to 2030
4. Develop and implement a structured plan to ensure the Associate Head of School, Indigenous Health has the appropriate authority, financial and staff resources (considering FTE, head count and appointment level), to develop, steer and influence Aboriginal and/or Torres Strait Islander health and cultural safety in the program effectively. (Standard 1.4.4, 5.2.3 and 5.3.3)	2026
5. Review membership and Terms of Reference for the governance structure of the standalone CSU program (Committees and Sub-committees and the program's Governance and Decision-Making Framework) to ensure Aboriginal and/or Torres Strait Islander academic staff, clinical supervisors and students are participating at all levels in the medical education provider's governance structure, and in medical program decision-making processes. (Standard 1.3.5)	2026
Standard 2: Curriculum	
6. To ensure constructive alignment of the medical program with program objectives and assessment: a. Map the program's purpose with its learning outcomes to strategically meet the needs of the communities it serves, driving meaningful impact and fostering lasting change. (Standard 2.1.1) b. Demonstrate students are supported with equitable access and comparable quality learning and supervisory experiences across clinical schools and educational settings. (Standard 2.1.2) c. Map learning outcomes to AMC graduate outcome statements. A plan of communication to students, teaching staff and placements should be developed in tandem. (Standard 2.1 and 2.2.9) d. Map learning outcomes to methods of teaching and learning and assessment – and evidence of the practical application of this in various clinical settings. (Standard 2.2.5 and 2.3.8)	a. 2026 b. 2027 c. 2026 d. 2028

Condition	To be met by
7. Provide an update on the design and development of the curriculum for the independent program, ensuring continued alignment of the program's purpose with learning objectives and AMC graduate outcome statements. (Standard 2.2.1)	2027
8. Develop and implement an Aboriginal and/or Torres Strait Islander health curriculum across all campuses and years, ensuring: a. An evidence-based design in a strengths-based framework, led and authored by Aboriginal and/or Torres Strait Islander health experts. (Standard 2.2.3). b. The integration of Aboriginal and/or Torres Strait Islander health content throughout the pre-clinical and clinical curriculum across all disciplines of medicine. (Standard 2.2.2) c. A program of research and scholarship in Aboriginal and/or Torres Strait Islander health. (Standard 2.2.4) d. Detailed plans for the incorporation of Aboriginal and/or Torres Strait Islander knowledge systems and medicines in the curriculum, and how this will be delivered in a culturally safe environment. (Standard 2.3.7)	2027
9. As part of a program of planned learning activities, develop and implement structured learning opportunities for students to achieve graduate outcomes through: a. Interprofessional learning with students and/or professionals from other relevant health professions. This could include collaboration with other health programs in the Faculty or that are co-located. (Standard 2.3.3) by 2027 b. Learning and addressing the differing needs of community groups who experience health inequities, including Aboriginal and/or Torres Strait islander communities. (Standard 2.3.6) by 2027	2027
Standard 3: Assessment	
10. Develop and implement meaningful assessment of Aboriginal and/or Torres Strait Islander health and culturally safe practice, integrated across the entire curriculum, informed by Aboriginal and/or Torres Strait Islander health experts. (Standard 3.1.4 and 3.1.6)	2027
11. As part of a documented system of assessment: a. Provide an update on the attainment and implementation of Risr software. (Standard 3.1.1 and 5.1.4) b. Provide evidence of a systematic approach and blueprinting across all five years of the program, with clear mapping of assessment to learning outcomes and AMC graduate outcomes. (Standard 3.1.2 and 3.1.3)	2026
12. Demonstrate that academic staff and clinical supervisors receive feedback on overall student cohort performance. (Standard 3.2.3)	2026
Standard 4: Students	
13. To improve recruitment strategies and culturally safe processes for Aboriginal and/or Torres Strait Islander students, ensure Aboriginal and/or Torres Strait Islander people are involved in developing these strategies and the supports provided in the School's admission process. (Standard 4.1.2 and 4.1.5)	2026

Condition	To be met by
14. Revise or develop clear and safe policies and strategies (e.g. complaints process, and communication of this) to identify, address and prevent bullying, harassment, racism and discrimination effectively, with clear communication on the implementation of these changes. Consultation with Aboriginal and/or Torres Strait Islander staff or experts is essential to ensure culturally safe processes by 2027. These policies should apply to: a. The recruitment of students (Standard 4.1.3) b. Students already in the program, where confidentiality must be maintained, particularly in consideration of the small size of the cohort. (Standard 4.2.7) c. Safe mechanisms for students to raise concerns about behaviours by staff or experienced on placements and in clinical settings. (Standard 4.2.7) d. Detail the processes for timely follow-up and support, with consideration of cultural safety and safety of all learning environments. (Standard 4.2.7)	2027
15. Develop and implement a student wellbeing and inclusion strategy across the program that includes training for staff providing support to students. (Standard 4.2)	2027
16. Detail the processes for timely follow-up and support, with consideration of cultural safety and safety of all learning environments. (Standard 4.2.7)	2027
Standard 5: Learning environment	
17. Evaluate whether the physical facilities at each site, particularly the smaller rural clinical schools, are equipped to support the outcomes of the medical program, and report on the implementation of the solutions identified by 2027. The evaluation should include: a. Ensuring student-specific spaces at each clinical site, that is separate from staff spaces. (Standard 5.1.2 and 5.1.3) b. Ensuring access to culturally safe spaces at each site. (Standard 5.1.2 and 5.1.3) c. Assessing whether provision of accommodation to students on placement should be dependent on their home address rather than the clinical school location. (Standard 5.1.3)	2027
18. To sustain the development of the Aboriginal and/or Torres Strait Islander health curriculum and cultural safety within the program: a. Demonstrate that the profile of Aboriginal and/or Torres Strait Islander staff is sufficient to facilitate the implementation and development of the curriculum. (Standard 5.2.3) b. Develop and implement a clear succession plan for all staff in the unit. (Standard 5.2.3) c. Ensure relevant Aboriginal and/or Torres Strait Islander staff are engaged in and leading program development and management. (Standard 5.2.4) d. Demonstrate that there are appropriate professional development opportunities for Aboriginal and/or Torres Strait Islander staff. This should include opportunities to work together with or be mentored by other Aboriginal and/or Torres Strait Islander staff in the Faculty or University. (Standard 5.3.3)	2027

Condition	To be met by
e. Ensure regular cultural safety training is compulsory for all students, staff and clinical supervisors and develop a plan for continuous learning in this area. (Standard 5.3.4)	
19. Ensure that the recruitment, support and training of simulated patients and community members is appropriately resourced and culturally safe to promote inclusivity and engagement of Aboriginal and/or Torres Strait Islander as well as diverse groups who experience health inequity in communities for the benefit of student learning. (Standard 5.2.5).	July 2027
20. To ensure an effective system of clinical supervision that ensures safe involvement of students in clinical practice by 2026: a. Demonstrate that all clinical supervisors are provided with adequate training, and develop and implement a plan for safe supervision for medical students by visiting staff and locums. (Standard 5.5.2) b. Develop and implement a plan for monitoring the performance of clinical supervisors. (Standard 5.5.3) c. Clearly define the responsibilities of the School to clinical supervisors. (Standard 5.5.5)	2026
21. Demonstrate that the School has an adequate and appropriate professional staff profile (EFT head count and appointment levels) to achieve its purpose such that the program is adequately resourced to develop and operate the independent program and revised curriculum. (Standard 5.2.2)	Annually until satisfied
Standard 6: Evaluation and continuous improvement	
22. Develop and implement a formal and strategic program of evaluation across the program, ensuring: (Standard 6.1.1) by 2027 a. Regular and systematic opportunities for feedback from students, staff, prevocational training providers, health services and communities. (Standard 6.1.2) b. Consideration of national and international developments in medicine and medical education and how these inform program development and review. (Standard 6.1.3) c. Consultation with Aboriginal and/or Torres Strait Islander education experts on how they will engage with evaluation processes, particularly in informing, reviewing and/or undertaking evaluation of Aboriginal and/or Torres Strait Islander student cohorts. (Standard 6.2.4)	2027
23. Ensure that relevant external stakeholders have consistent access to evaluation findings and outcomes, and visibility of how their feedback is responded to by the medical program. (Standard 6.2.3, 6.3.1 and 6.3.2)	2027

Commendations

A	The yarn-up program. (Standard 1.1.4)
B	The First Nations Student Connect team are evidently committed to providing high-quality support for Aboriginal and/or Torres Strait Islander students. (Standard 1.1.4)
C	The medical program leadership team has developed many effective partnership networks with local councils and charitable organisations within communities, over the large geographical area in which the program works. (Standard 1.2.1)
D	CSU has strong and consistent support from staff, health services, stakeholders, and students for the purpose of the Charles Sturt Medical Program. (Standard 1.2.1)
E	The work of the Associate Head of School, Research, Evaluation and Graduate Studies, particularly their formative work developing the Stakeholder Engagement Forum 2023 that provided insight into four key themes that defined the areas of need of local rural communities: (i) People & Culture, (ii) Health & Wellbeing, (iii) Resources, and (iv) Access & Availability. (Standard 1.2.1)
F	The program is consistent with meeting the needs of the rural communities it serves. (Standard 2.1.1)
G	The School is working with students to understand where issues around comparable quality arise and remedy these. (Standard 2.1.2)
H	Clinical supervisors were highly impressed with the quality of students and their preparation for practice. (Standard 2.2.6)
I	The engagement, commitment and enthusiasm of the senior lecturer in Indigenous health, who in their previous role has set strong foundations for the Aboriginal and/or Torres Strait Islander health curriculum across the program. (Standard 2.3.7)
J	How the School has been able to educate and assess students to be well adjusted to their rural context despite the limitations of the JPM assessment policies and forms. (Standard 3.1)
K	The team was impressed by the evidence of strong engagement and a good relationship between the program leadership and Charles Sturt Health & Rural Medicine Society (CHARMS). (Standard 4)
L	The School's strongly stated intention to increase rural intake and its orientation to the needs of rural and underserved populations are admirable. Its support for local students to study in and return to serve their communities of origin is highly commendable. (Standard 4.1.1 and 4.1.2)
M	The School recognises family circumstances and broader personal context well in its approach to student wellbeing. Its sensitivity to students' backgrounds aligns with CSU's inclusive values and is commendable. (Standard 4.1.3)
N	The implementation of wellbeing days for students is a positive development. It is a good example of collaboration with cohort and student representatives, and a mature approach to accommodating the demands of adult learning (e.g. no fixed attendance requirements but emphasise active participation). (Standard 4.2)
O	The Clinical School Support Officers provide strong student support at the clinical sites. (Standard 4.2)

P	The development and delivery of a rural program in line with the medical program's purpose, and with clear support from rural and remote sites. It is evident that substantial work has gone into building this program. (Standard 5)
Q	There are impressive, built for purpose, facilities at many of the sites. It is evident that the teaching resources and teaching and learning spaces are part of the positive student experience. (Standard 5.1.1)
R	That there is an IT staff member specifically for the medical program. (Standard 5.1.6)
S	The appropriate recognition of rural and remote expertise of staff members in terms of managing clinical schools in their appointment levels. (Standard 5.3.1)
T	The engagement with the physiotherapists at the Parkes clinical site to support student learning and collaborative care opportunities. (Standard 5.3.3)
U	That students can undertake longitudinal placements at an Aboriginal Medical Service. (Standard 5.4.2)
V	The School has a strong appetite for improving the program and a clear commitment to continuous quality improvement with a demonstrated record of incorporating changes based on feedback from stakeholders. (Standard 6.1.1)

Recommendations for improvement

I	Increase strategic engagement with consumer stakeholders, particularly "grass roots" consumers and carers, to enable diverse consumer and carer voices to be heard in the interests of current and potential health services users and facilitate participation in decision-making processes and evaluation of training outcomes. (Standard 1.2.1)
II	Further embed consumer partnerships to include diverse community organisations in the interests of current and potential health services users, to facilitate participation in decision-making processes, and evaluation of training outcomes. (Standard 1.2.2)
III	Engage with the CSU Indigenous Board of Studies and School of Indigenous Australian Studies and utilise these connections to inform learning, teaching and assessment within the medical program. (Standard 2.2.4)
IV	Consider whether a graduate entry pathway may be beneficial to meeting the aims of the program, considering the makeup of the current cohort, as well as the number of undergraduate degrees offered by the Faculty. (Standard 2.2.8)
V	Develop a strategy for engaging with co-located health profession education providers and medical programs on providing opportunities for students to work with and learn from students and/or professionals of other relevant health professions. (Standard 2.3.3)
VI	Review of policies for assessment to ensure that they are consistent with principles of fairness, flexibility equity, validity and reliability, thereby ensuring that they are fit for purpose and align with contemporary practice in Medical Education. (Standard 3.1.1)
VII	Develop policies that detail or reference the specific principles of professionalism as relevant to the program and articulate a clear process for managing concerns in this area. (Standard 3.1.2)

VIII	Consult best practice resources and review support processes to improve engagement with and support for applicants and students living with disabilities. (Standard 4.1.4)
IX	Undertake ongoing reflection and review of support services, to ensure that support mechanisms for Aboriginal and/or Torres Strait Islander students are culturally responsive and intersectional, recognising the multiple and overlapping identities that may influence a student's experience. (Standard 4.2.2)
X	Establish a formal and visible line of communication with First Nations Student Connect, ensuring students can easily access culturally safe support throughout their studies. Enhancing direct access to Aboriginal and/or Torres Strait Islander support staff would improve responsiveness and help build stronger relationships between students and the support network available to them. (Standard 4.2.2)
XI	Within the framework of curriculum redesign, consider mechanisms for flexibility such as six-month study units in the program to enable optimum opportunity for completion (including part-time study), considering the cohort consists of students in various stages of life. (Standard 4.2.5)
XII	Consider provision of access to accommodation (at market rates or otherwise) for students and their dependants on placement in the footprint of their clinical school, and if access to short stay accommodation to support regularly commuting students would benefit their wellbeing and safety. (Standard 5.1.3)
XIII	Consider active recruitment and mutual benefit available for local First Nations peoples including Elders, Aboriginal Liaison Officers (ALO's) and Aboriginal Health Practitioners currently being utilised as cultural mentors. This would include adjunct status for those who already have other appointments they may not wish to change. (Standard 5.2.3)

Monitoring and next steps

As part of the monitoring process, the Program is asked to provide periodic (as completed) or annual updates to the AMC on the following:

1. The School and program's purpose for independent delivery of the medical program ensures advancing health equity and addressing place-based healthcare needs for the communities within its footprint. (Standard 1.1.1 and 1.1.2).
2. The new governance structure for the independent delivery of the medical program, ensuring there is effective oversight and has the authority and resources to develop, implement, review and have continuous improvement mechanisms. (Standard 1.3.1, 1.3.2 and 1.3.3)
3. There is a plan to engage the active participation of students in the decision-making process towards the delivery of the independent medical program, with clear communication strategies to various cohort levels on changes that directly impact upon their education and wellbeing. (Standard 1.3.4)
4. Provide assurance of the sustainability of the independent medical program with a full cohort. (Standard 1.4.1) *This should include providing testimony from the Dean and similar aligned commitment from the University to support the program's required resourcing.*
5. Demonstrate clear and accurate information regarding policies and requirements relevant to the independent delivery of the medical program are available and accessible to the public, applicants, students, staff and clinical supervisors. This includes up-to-date information about the planned separation and its implications for those delivering and undertaking the program. (Standard 1.4.6)

6. Demonstrate that the first graduating cohort has achieved all medical program outcomes and AMC graduate outcome statements. (Standard 2.2.8)
7. Confirm that the pre-internship program ran successfully in 2025 and provide an update on any changes to the program moving forward. (Standard 2.3.9)
8. Provide information on plans to transition to an independent system of assessment with evidence that planned processes for systematic review of assessments is working as intended. There should be a plan for quality assurance processes and validity evidence for assessments to be incorporated across the whole program. (Standard 3.1.4, 3.1.5 and 3.3.1)
9. Provide an update on the planned retrospective blueprinting of the last four years across all assessments (Standard 3.1.3)
10. Provide an update on the proposed Cadetship program. (Standard 4.1.2 and 4.1.3) *Demonstrate this has been co-designed with First Nations Elders, community members and relevant stakeholders, especially in the locations where the program will roll out,to ensure that cultural safety, community expectations and student wellbeing are central to its development.*
11. Provide an update on the School of Rural Medicine Assessment Design and Progression Committee including; its resourcing, evaluation function, and any changes to structure and Terms of Reference. (Standard 6.1.1)
12. Provide an update on evaluation of graduate cohorts, how this is conducted and who is engaged. (Standard 6.2)
13. Provide an update on engagement with NSW Health Education and Training Institute (HETI) and Prevocational Medical Council of Victoria (PMCV) regarding 2025 CSU graduates. (Standard 6.3.2.)

Appreciation

The team is grateful to staff and students who prepared the accreditation submissions and managed the preparations for the assessment. It acknowledges, with thanks to all staff in clinical sites who coordinated the site visits, and the assistance of those who participated in discussions with team members.

Summaries of the program of meetings and visits for this assessment are provided at Appendix 3.

Assessment against the Accreditation Standards

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	Not 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	Not 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	Not 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	SM	SM	M	M	SM	M	SM	SM	SM	SM	SM	NM	SM	SM	M	SM	SM	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	SM	SM	NM	SM	NM	SM	M	M	SM	SM	M	M	M	SM	SM	M	NM	NM	M	SM
	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	NM	SM	SM	NM	SM	M	SM	SM	SM
	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	M	SM	SM	NM	SM	SM	SM	M	SM	M	SM	NM	M	NM	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	M	SM	SM	SM	SM	M	M	SM	SM	SM	NM	M	SM	SM	SM	NM	M	SM	M	SM	NM	SM	M	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	NM	SM	NM	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

STANDARD 1: Purpose, context and accountability

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.

Charles Sturt University (CSU) currently delivers the Joint Program in Medicine (JPM) through its School of Rural Medicine (the School). The JPM has a clear purpose, agreed upon by both partners, Western Sydney University (WSU) and CSU, that underpins the development and delivery of the program. This clearly defines the purpose for the development of the program in response to community needs in rural, regional and remote NSW, with the aim to graduate doctors with the desire, attributes and competencies to be excellent health care practitioners in this broad health setting and beyond.

In preparation for the separation of the JPM, and the ability for CSU to independently develop and deliver its own medical program, the School developed a renewed and revised vision statement in consultation with staff in Orange and the rural clinical schools. The School's defined purpose is captured by the vision and mission statements, described below.

The vision is: *"Charles Sturt University School of Rural Medicine will be recognised as one of the leading medical schools in Australia and the preferred provider of rural medical school training."*

The mission is: "*To enable rural Australians including First Nations people to study medicine and pursue a career as a medical practitioner. We aim for our graduates to be doctors with a rural commitment and perspective, who provide the highest quality and compassionate care to their patients and contribute to healthier rural communities. We will aim to become an internationally recognised medical school leading rural health research and our students' and school's research will have significant and demonstrable impacts on rural health outcomes."* The School believes this renewed vision and mission can be met more effectively and efficiently by being a sole provider, and there is strong and consistent support and enthusiasm from staff, health services, stakeholders, and students for this purpose.

With this renewed vision and mission, the team notes the specific mention of rural communities but also the lack of commentary on social responsibilities in the revised purpose alongside a deliberate choice to use the term mission, which carries historical and cultural associations distinct from purpose, and potentially risks impeding deepening engagement with Aboriginal and/or Torres Strait Islander community. Students are pro-active and able to capitalise on encounters where they can engage with the place-based needs of communities or follow their interests to find opportunities for research activities. The team observed that both the understanding of community health needs and identification of research projects that engage with these could be better embedded in the school. This would enable more students to engage with these opportunities and for a strategic health equity lens to be applied. The Program establishes students as lifelong learners who are ready to practice as interns. The team was impressed with feedback from clinical supervisors and community members, across the footprint, who spoke highly of students' competency and considered them to be valuable, contributing members of the medical team.

There is a strong commitment from the School and University to furthering Aboriginal and/or Torres Strait Islander peoples' health equity and participation in the program as staff, leaders and students. The Associate

Head of School, Indigenous Health position sits on the program executive, and there is an exceptional team of Aboriginal and/or Torres Strait Islander staff who are committed to the School's purpose.

With support from the Pro Vice-Chancellor, First Nations Student Success, the School has established an ambitious target of 8% for Aboriginal and/or Torres Strait Islander student admissions and graduations and is currently exceeding that enrolment target. This achievement reflects a strong commitment to fostering Indigenous participation in medical education and the success of initiatives such as the on country Yarn Up for students and staff.

The First Nations Student Connect team are commended for their passion, dedication and culturally responsive support, which have been instrumental in enhancing the academic success and well-being of Aboriginal and/or Torres Strait Islander students. Governance and quality assurance in curriculum development are strengthened through the University's Indigenous Board of Studies. This body is chaired with Indigenous leadership and decision-making and collaborates with key stakeholders across the institution to oversee the development and implementation of Indigenous Australian content in courses and subjects. The model ensures that Indigenous perspectives are authentically integrated into the curriculum, aligning with community priorities, national good practice principles for Indigenous course accreditation and curriculum development.

The Pro Vice-Chancellor (PVC) First Nations Engagement, situated within the Office of the Deputy Vice-Chancellor (Research), provides strategic leadership across the institution in advancing Indigenous engagement and outcomes. The PVC has delegated authority for the University's Reconciliation Action Plan and Indigenous Strategy, and the PVC has cultivated strong relationships across the university to deliver meaningful impact.

While the commitment is strong, with various resources in place and available, there remain opportunities to enhance effective participation in the program and maintain momentum. The team noted that Aboriginal and/or Torres Strait Islander staffing levels in the program are anticipated to increase with the more distributed place-based staff and identified multiple areas where continuous improvement can occur. This is particularly relevant across community engagement, and the anticipated development of curriculum and assessment, which will be made possible through the stand-alone program. Alongside this, the team noted continued consideration of student experiences will also be essential to further advance Aboriginal and/or Torres Strait Islander health equity.

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.

Establishing formal partnerships and shared decision-making processes – this aligns with national frameworks, such as the National Agreement on Closing the Gap, which emphasises the importance of empowering Aboriginal and/or Torres Strait Islander people through formal partnerships and shared decision-making. By fostering these relationships, the School can enhance the cultural relevance and effectiveness of its medical program, ultimately contributing to improved health outcomes for Aboriginal and/or Torres Strait Islander communities.

The School demonstrated they are committed to engaging with rural, regional and remote communities and with Aboriginal and/or Torres Strait Islander people and organisations. The School acknowledges that this work continues and will further develop in breadth and depth as the program establishes itself independently. While they were engaged with the program generally, it was unclear how these community groups are engaged to define the purpose and medical program learning outcomes, or in the design and implementation of the assessment system. To address this, considerable strategic alignment with formal agreements particularly with Aboriginal Medical Services and other key stakeholders is essential. Such partnerships are crucial for ensuring that the program's objectives and assessments are culturally appropriate and meet the needs of the communities served.

Various other groups who experience health inequity, including the LGBTQIA+ community, did not seem to be engaged other than limited interactions with students on placement. Strategic and systematic engagement of healthcare consumers and carers, especially those from groups with a lived experience of health inequity, will support the program to achieve its purpose.

The work of the Medical Education and Research Unit to develop a Stakeholder Engagement Forum in 2023, and subsequent research and work are promising first steps towards meaningful and genuine consumer, community and carer engagement. The School is encouraged to integrate this research and insight into their stakeholder engagement, and allow it to inform the purpose, curriculum, evaluation and student experience opportunities.

The School has built many sound relationships with health services and clinical placement providers, particularly in primary health and community care settings, including Orange Aboriginal Health Service, as well as with local government and corporate donors to support the education and training of medical students.

There are formal agreements in place with each placement provider. Many express that they have capacity for additional students and have affinity for the purpose of the program, especially taking pride when many students are able to undertake their placement in their hometown or nearby. There was a sense that the health service providers really see the School as filling workforce need into the future.

The team saw opportunity to further develop mutually beneficial partnerships with Aboriginal and/or Torres Strait Islander people and organisations across the program's full geographic footprint. A clearly defined engagement strategy and localised staff resourcing in the School would support this further.

Students undertake placements at various Aboriginal Medical Services (AMS) including the Orange Aboriginal Medical Service (OAMS), and do fill some workforce needs. The University has provided some infrastructure including a dental chair to OAMS and it was clear there was mutual benefit. The team were able to meet with many engaged stakeholders, however there was a noted lack of engagement with the Griffith Aboriginal Medical Service and other AMS or Aboriginal Community Controlled Health Organisations (ACHHO's) on the visit. The team saw opportunities for School engagement with the planned Walhuu AMS development in Bathurst.

Due to this, it is unclear if CSU's partnerships with AMS define the expectations of partners, are mutually beneficial, and promote the community sustainability of health services beyond OAMS.

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.

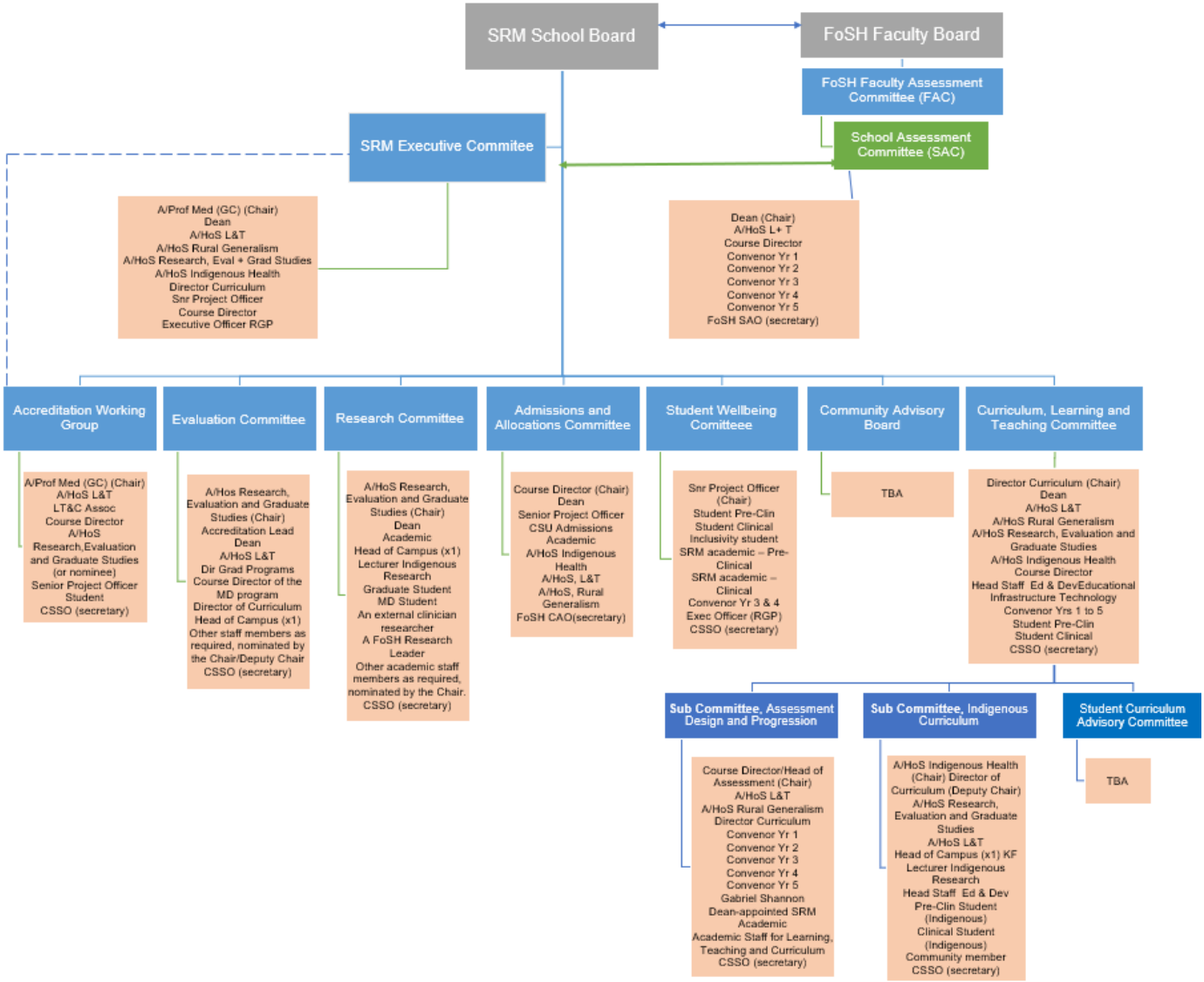
The team acknowledges that the current joint governance arrangements with WSU as part of the JPM have been collegiate and effective but, due to the difference in context between metropolitan and rural settings, are not perceived to be beneficial to the future development of the CSU, School of Rural Medicine.

It is acknowledged that many external stakeholders are unaware of the nature of the JPM, and engage primarily with CSU. The team found this strong provider identity and direct relationships support the School's objective to deliver the program wholly independently.

The CSU Faculty of Science and Health is led by the Executive Dean and comprises five schools including the School of Rural Medicine (SRM). The Dean of the School reports to the Executive Dean of the Faculty. The governance structure of a standalone CSU program had been considered and commenced operations in parallel to the existing program to support a seamless transition. The team saw that this governance arrangement and transition structure would provide the capacity to plan, implement and review and improve the program. It is still under refinement and this will continue as the separation moves forward. The extent to which this structure supports organisational units is yet to be demonstrated. The JPM governance structure and processes will continue to be fully functional and run uninterrupted in parallel to the School's newly developed governance structure and processes as the Joint Program is taught out.

It includes the following Committees and Sub-committees.

Figure 1: School of Rural Medicine Governance Structure



The SRM School Board, Faculty Board and School Assessment Committee are formally approved sub-committees of the Academic Senate. The Workload Committee and Community Advisory Board are not yet functional and do not currently have any members.

A Governance and Decision-Making Framework has been created to align with the AMC standards. The purpose of the framework is to ensure governance committees have strategic oversight of the AMC standards. The responsible Board or Committee is tasked with ensuring matters relating to their allocated standards are addressed through standing agenda items.

Currently the joint committees and constraints of being tied to the WSU curriculum do not give CSU authority to be in charge of its own curriculum. The School has taken the opportunity, when possible, to adapt the curriculum and assessments to its place-based and rural context. The School has begun reviewing the curriculum, and developing plans to improve it and implement changes once able to, through its own governance structures as an independent program.

The team noted that, from a CSU perspective, there would be less academic risk and stronger oversight of the program following separation from the JPM as this would significantly decrease the number of committees and steps involved.

The Head of Clinical School (HoCS) position has academic oversight of what happens in each clinical school. There is a risk that these might tend toward effectively functioning as stand-alone entities if their line of

reporting is not explicit and formally documented, and the School should maintain active oversight and engagement for all year levels and subjects at each of the rural clinical schools

Student engagement with the School about the medical program is encouraged and occurs both formally and informally. The team noted additional opportunities for student involvement in governance and decision making, and that documented representation and participation in these channels will support accountability and effective evaluation. Many examples of student engagement in program change or decision making seemed to be *ad hoc* and informal, however the team noted increased efforts to formalise these processes, including the addition of two student members to the Evaluation Committee.

The Terms of Reference (ToR) for the independent program's governance committees ensures clinical supervisors participate in all levels of the program's governance. These ToR are being reviewed to ensure all committees include strategic input of Aboriginal and/or Torres Strait Islander voice at an executive level and in program decision-making processes.

The role of the Associate Head of School, Indigenous Health, while highly respected and consultative, is not formally documented within the program's governance structure. As part of the ToR review, the School is exploring how this role and others like it can be formally recognised to ensure meaningful and sustained input at the strategic level. This will align with the Faculty's broader commitment to cultural safety and to ensuring that Aboriginal and/or Torres Strait Islander perspectives are not only heard but embedded in all program governance and decision-making. The team recommends that, as this is a new position, once established, the Associate Head of School, Indigenous Health will need to build relationships across the institution and be guided by the University's Indigenous Board of Studies to maintain quality assurance. The Indigenous Board of Studies serves as the key quality assurance and approval body for all Indigenous Australian studies subjects and content, ensuring that Indigenous perspectives are authentically integrated into the curriculum. By formalising this role within the governance structure and fostering collaboration with the Indigenous Board of Studies, the School aims to enhance the cultural relevance and effectiveness of its programs, ultimately contributing to improved outcomes for Aboriginal and/or Torres Strait Islander communities.

While an Aboriginal and/or Torres Strait Islander clinical supervisor happened to be involved in high-level decision making because of their existing leadership role, this did not seem to have been purposefully embedded in the governance structure. The School should review the membership and terms of reference for its governance and decision making groups to ensure there is appropriate representation at all levels from Aboriginal and/or Torres Strait Islander staff and clinical supervisors. Work must be done to proactively encourage relevant Aboriginal and/or Torres Strait Islander staff and supervisors to engage with its governance structure and create space for these voices in decision-making processes.

The team saw many advantages afforded by the small cohort size but also observed that, because of this, there is potential for concerns regarding confidentiality and conflicts of interest. Active management of these risks will be critical once the School is independent and can implement its own policies.

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.

The team saw a strong financial commitment from CSU to support the delivery of the medical program through the provider's ongoing financial operation of their activities on an expense budget model. It noted that the expense budget forecast to support the change to a stand-alone program may be beyond that which has been incurred to date and was assured that these increased costs will be supported by the University. To ensure sustainability as an independent medical program with full cohorts, the AMC will need to see this demonstrated through monitoring.

The Dean of the School of Rural Medicine is the dedicated and clearly defined academic head of the medical program. As the School currently only has the one major academic course, this is adequate, and the position has appropriate authority and responsibility to manage the medical program. The Dean is supported by a leadership team of dedicated, hardworking people, who have established a large number of effective partnerships.

While the current leadership team for the delivery of the JPM program by the School seemed to be adequately resourced, at the time of the assessment, the delivery of the final year of the program had only just begun, and anticipated student numbers reached. The level of resourcing of both staff and expertise needed for the fully articulated and independent program is unclear and the University's fulfilment of these needs will need to be monitored.

The University has a strong First Nations Strategy supported by well-resourced central units that also provide support to the medical program. The School is encouraged to build deeper connections with these central resources to embed strong support of Aboriginal and/or Torres Strait Islander staff and leadership within the program. The employment of the new Associate Head of School, Indigenous Health, who has an existing and continuous connection with the program from their previous role with WSU and in the design and delivery of the JPM, is a positive complement to the existing CSU Aboriginal and/or Torres Strait Islander staff. The Associate Head of School, Indigenous Health commenced their role in early July 2025. It is not yet clear what level of authority they will have or the resources available to support their work.

The level of the qualification delivered is assessed against national standards and is an approved Australian Qualifications Framework (AQF) Level 9E Degree. The University is registered with TEQSA as a self-accrediting authority and is authorised to self-accredit its courses.

The Program provides accurate, relevant information about its policies, and its requirements are available and accessible to the public, applicants, students, staff and clinical supervisors. This includes information necessary to support delivery of the program. As the Program seeks to become independent, it will be critical to ensure this information remains accurate and clearly outlines any relevant changes, particularly to admission processes, that have implications for those wishing to enrol in the Program.

STANDARD 2: Curriculum

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.

The medical program's current outcomes are those of the JPM, which are based on the previous AMC graduate outcome statements. Work is yet to commence to align the programs' graduate outcomes with the current AMC Graduate outcomes. Some of this work is contingent on the School being autonomous in the design and development of the curriculum. The learning outcomes and assessment across the JPM are consistent, but each provider (i.e. CSU and WSU) delivers slightly differentiated curriculums. The process of changing learning outcomes through the JPM committees is lengthy and, rather than amend outcomes corresponding to areas not yet addressed, the School has begun to add these to its curriculum informally at this point.

The provider is currently undertaking a mapping exercise, which highlights the work required to ensure curricular alignment between learning outcomes, teaching and assessments. Work has also begun to map the curriculum to the AMC Graduate Outcomes through a generalist lens, and this will be formally implemented once the School has autonomy over its curricular processes.

The program as currently articulated is consistent with meeting the needs of the communities, particularly rural communities, that the medical education provider serves. The 'Medicine in Context' and 'Medicine in Practice' elements prepare students for a safe transition to supervised practices as an intern in Australia and Aotearoa New Zealand.

There are not yet sufficient data to demonstrate that students achieve assessment outcomes supported by equitable access to learning and supervisory experience of comparable quality, and the AMC will need to be kept informed as the first cohort graduates and beyond. At this point, there seem to be adequate resources in place to address equitable access. At the end of 2024, each of the nine campuses achieved a similar rate of student progression. A formal outcome evaluation of equity of assessment outcomes between settings is planned by the School for 2025 through the Evaluation Committee.

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 curriculum design is built on a strong foundation, from WSU's medical program, and the School has commenced contextualising it to align with its program's purpose, within the constraints of keeping the original learning outcomes and shared assessments. Curriculum development to date has been constrained by the processes of the JPM. The School is enthusiastic to undertake its own design when separated.

The Program is a five-year direct entry program that provides a three-year Bachelor's level AQF Level 7 qualification with a two-year Masters Extended AQF Level 9E qualification in Years 4 and 5 of the course.

The current Aboriginal and/or Torres Strait Islander health formal curriculum is strengths-based and appropriately authored by Aboriginal and/or Torres Strait Islander health experts. There could be further work to ensure the curriculum demonstrates the evidence base on which it draws. Additionally, there is currently a significant variability in how Aboriginal and/or Torres Strait Islander health content is taught and communicated, and how students learn about Aboriginal and/or Torres Strait Islander health content outside the formal curriculum, which is partly due to the dispersed clinical learning sites. Feedback from students indicates that, in some instances, teaching outside the structured curriculum can reflect a deficit-based narrative, which can undermine the strengths-based approach embedded within the core curriculum.

Further work is needed to ensure that Aboriginal and/or Torres Strait Islander health content, and traditional health knowledge and teaching practices, are integrated throughout the curriculum, including clinical aspects across all disciplines of medicine. A range of opportunities for learning was available, but clear integration across all disciplines of medicine was not evident.

The University has impressive resources, including the Indigenous Board of Studies and the School of Indigenous Australian Studies, that are active in research and scholarship of Aboriginal and/or Torres Strait Islander education, teaching and learning. It is recommended that the School build and utilise these connections to inform learning, teaching and assessment within the medical program.

The curriculum design of early longitudinal engagement with clinical care encourages students to apply and integrate knowledge, skills and professional behaviours, evaluate them and take responsibility for their own learning. This prepares them for lifelong learning and safe transition to subsequent stages of training. The team was impressed with the student cohort and their appetite for taking responsibility for their own learning. Some of this can be attributed to the 'hidden curriculum' whereby they are influenced by the attitudes of their teachers and leaders in the course.

There has been some discourse between staff and students on the level of specific learning outcomes to be communicated to students about each stage of the medical program, with some feeling anxious or unprepared for clinical placements. While this anxiety is commonly observed amongst medical students, the School has developed study guides to address this after engaging with feedback and suggestions from student interviews. These guides advise students on the depth of understanding they should have, and comment on what is necessary knowledge versus supplementary knowledge that may be of interest.

Conversations between staff and students in this space is ongoing, and the School is working to find the balance.

Students who spoke with the team on the whole felt prepared for their placements, and clinical supervisors were complimentary of the skills and level of competency of students placed with them. While the curriculum design and duration provide evidence that they will enable graduates to demonstrate achievement of all medical program and AMC graduate outcome statements, this has yet to be tested with the first cohort of graduating students.

Students have opportunities to pursue studies of choice that promote breadth and variety of experience. Students are encouraged to seek out additional opportunities where possible. There is some variation depending on the clinical school location, and there is a need for written policy to formalise the process. Consistency of approach across sites may need to be improved as the team heard of opportunities students found through consultants at their clinical site that may not be available to others.

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 program employs a range of teaching methods, including presentation-based learning and longitudinal immersive clinical placements that build meaningful supervised involvement in clinical care with patients.

The team observed that the clinical schools employ a strong values-driven approach in modelling quality care in partnership with patients. Ensuring learning and teaching methods promote this should be formalised and documented as a focus in the development of the independent curriculum. By all accounts, students were passionate and seeking out opportunities to work in collaboration with patients on their care.

The program's context provides many opportunities for interprofessional education, and promising first steps are evident, but the formalisation and delivery of a coherent and comprehensive curriculum, including assessment of interprofessional learning outcomes, is still to occur. As mentioned above, the School is constrained by the JPM learning outcomes, of which fewer than five relate to interdisciplinary care.

The current opportunities, while limited, include a session in year 2 with Pharmacy students and some 'medicine in context' placements. The School is excited about the potential in this area and intends to expand both the number of learning outcomes and learning opportunities related to collaborative practice. With the number of co-located medical programs and other health profession education providers, the School is encouraged to develop a strategy for engagement with them on teaching and learning about and working with other health professionals.

Students have the opportunity to learn, develop, and practice many clinical, procedural, and practical skills. However, there is no evidence that students are provided opportunities to develop and practice communication skills with patients and groups who experience health inequities, which is a key part of medical practice. Students begin their clinical exposure early followed with the final three years of the program which are embedded in clinical settings.

While students have some learning about systemic disadvantage and the differing needs of groups who experience health inequities, there was limited evidence that students have intentional opportunities to learn how to address systemic disadvantage and historical injustices to increase the inclusivity of health services for these groups. There were some circumstantial opportunities, particularly on placement when engaging with people from these groups.

To meet this standard fully, the curriculum needs to be strengthened to ensure that all students engage with clear and purposeful learning on the historical and social determinants of health and how these directly influence health outcomes for Aboriginal and/or Torres Strait Islander people. These efforts will help shift incidental or circumstantial learning to a deliberate, scaffolded approach that is consistent across the program, thereby ensuring that all graduates have a robust understanding of the factors influencing Aboriginal and/or Torres Strait Islander health.

The School acknowledges that Aboriginal and/or Torres Strait Islander traditional knowledge and medicines are currently not well integrated into the program. While there are some instances of case-based learning that touch on traditional healing practices, and students may gain limited exposure through placements in AMSs, and ACCHOs, or through experiences such as the Day on Country in the Medicine in Context program, this content is not yet embedded in a consistent or structured way across the curriculum.

The School has been transparent about this gap and has expressed a strong commitment to improving this area. The Senior Lecturer in Indigenous Health, whose leadership, engagement, and enthusiasm have been clearly recognised, has laid the foundations for future development. Their work has created early opportunities for inclusion and opened the door for deeper integration of traditional knowledge in both curriculum and pedagogy. However, limited capacity, particularly under previous constraints at WSU, has restricted the ability to progress this work more broadly across the program to date. The School has voiced a commitment to building on this foundation and is exploring ways to increase staff resourcing, community engagement, and cultural capability to ensure Aboriginal and/or Torres Strait Islander traditional knowledge and medicines are respectfully and meaningfully included in future curriculum design.

Across its nine clinical sites, the School has a large footprint that provides students access to a wide variety of experiential learning experiences. Many of the these occur in rural and remote settings, in line with the School's purpose.

Students have a breadth of clinical learning opportunities in multiple contexts. Clinical exposure occurs early in the program, in Year 1 and 2, where students undertake a two-week placement in community-based general practice and hospital-based rotations.

The Medicine in Context course runs longitudinally throughout the five-year program includes a 1-2 day placement in Years 1 and 2 in community organisations within the students' clinical school footprint. These include food banks, community allied health and nursing, mental health services and school programs. The

team heard from students and stakeholders in these organisations of the benefit of these placements. They provide students with exposure to a variety health promotion and care networks within the community that they would not experience at traditional placement locations, and the opportunity for the organisations to be engaged with the medical program and young locals.

In Years 3, 4 and 5 students undertake a three-year longitudinal integrated placement in primary care. The team was impressed to learn that students can undertake this at an Aboriginal Medical Service or Aboriginal Community Controlled Health Organisation.

While the program is limited in terms of its mandatory placements in metropolitan health settings due to its Rural Health Multidisciplinary Training Program funding (that covers areas categorised as 2-7 on the Modified Monash Model), staff are willing to work with students to obtain and provide these placements when requested. There are opportunities for some students to attend metropolitan centres but not all. The School enables students to explore this in their electives if they wish to gain awareness of metropolitan system of healthcare. Specifically, to focus on the interplay between rural and metro health settings including transferring patients to tertiary settings.

Through the curriculum and placements, students learn about the full lifecycle of care. The longitudinal placements in primary care are key to enabling this.

The first cohort of Year 5 students commenced in 2025. There are plans for their pre-internship program to be undertaken in the second half of 2025 once students have completed their final written and clinical exams. This will begin with a centralised teaching program with common internship scenarios such as prescribing fluids, surgical skills and cannulation. The pre-internship will include at least two EPAs across clinical, investigation, interpretation, patient encounters and other skills. Students will undertake four rotations – medicine, surgery, general practice and one selective. This pre-internship program follows updated AMC guidelines from the national prevocational framework for medical training

STANDARD 3: Assessment

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 basis of assessment design and process is currently reliant on the Western Sydney program, with some adaptations made for contextual differences. The assessment process is underpinned by CSU policies and processes which appear to support fairness, flexibility, equity, reliability and validity in assessment. Significant work is needed to ensure complete contextualisation and alignment with the program's purpose with the transition to an independent program. In preparation for becoming an independent provider of a medical program, the School has created the Assessment Design and Progression Committee, which has oversight of CSU assessment processes.

As discussed in Standard 2, the School needs to undertake and articulate a clear mapping of learning outcomes to assessments and to AMC Graduate Outcomes, as well as to undertake program-level blueprinting. Currently, this blueprinting occurs through JPM. The School has plans for retrospective blueprinting of the last four years across all year assessments, and for higher-level blueprinting; however, this work is yet to be occur. The ongoing blueprinting process, as planned, will depend on the urgent availability to the program of Risr software, which is projected to be July 2025.

As the School develops its own independent assessment strategy, looking into models from other programs, considering the current process with WSU, and ensuring alignment with Australian Health Practitioner Regulation Agency (Ahpra) assessment standards will be beneficial. Central CSU policies adequately address academic integrity; however, the team observed that central University governance does not consider the specific principles of professionalism as relevant to the medical profession. The School and CSU governance are urged to consider how these principles of professionalism are understood and upheld by the central university. The School indicated their awareness of this, articulated as the difference between academic professionalism and medical professionalism. Thus far, the Dean has been able to manage any issues arising due to the discrepancy, but a clear process and definition are recommended. There are indications that assessment of professionalism will be integrated into all assessments as CSU becomes independent, noting that this is still in the planning stages.

Assessment follows the horizontal and vertical spiral curriculum, which is designed to build basic and clinical science knowledge in earlier years and progress to application of the knowledge and build clinical skills in the later years. While the transition to an independent CSU medical program will follow a similar format, staff were forthcoming about areas of challenge and significant work needed to ensure adequate contextualisation, and alignment with the program's purpose. The JPM currently delivers assessment to follow the horizontal and vertical spiral curriculum.

The team notes the documented system of assessment, which ensures that students have attained minimum acceptable levels of understanding and competence at each year level before progressing to the next. As CSU transitions through the separation, they plan to keep a similar format of a variety of assessment formats across the program. The School's system of assessment currently includes workplace-based assessment (WBA), structured exams, portfolios, and online OSCEs. The range of assessment formats utilised gives students multiple ways to demonstrate knowledge and skills. The School shared verbal plans to develop a more programmatic approach to assessment, and to increase and strengthen WBAs (including increasing the EPAs).

There are current concerns stemming from the use of clinical exam forms designed for WSU, which are not felt to be fit for purpose, and which the School has worked around thus far. In particular, WSU's subspecialty, siloed approach has been found to not be compatible with CSU rotations, or a generalist approach to clinical learning. CSU noted that, post-separation, the School would have the autonomy to tailor these assessment forms more closely to its needs and unique context, for the benefit of students and examiners.

The lack of standardisation of assessment is another key concern. CSU students stated that they are often supervised and assessed by locum practitioners, who may not be locally trained in assessments, and thus may have different approaches to standards for assessment. It is unclear how engagement with assessment occurs for nursing and other allied health supervisors of students. Additionally, the School provides no routine training for mini-CEX assessments. The School relies on most supervisors being Australian General Practice Training (AGPT) supervisors who likely have experience in these assessments. However, this may not always be the case.

The School is encouraged to develop agreed 'standards' for individual student performance levels. Currently, the forms for Year 4 and Year 5 students look the same and have no written guidance for the standard against which the student is marked.

The team heard of the standard setting methodologies used by the JPM, however it is unclear the capacity with which CSU will utilise these once independent. The lack of coding and blueprinting for exams is significantly impacting the evaluation of student performance.

The program structure causes concerns about flexibility of study. Each year of the program is currently considered a single 64-credit-point subject, and thus, failure in one discipline results in failure of, and a requirement to repeat, the whole year. The School has expressed no current plans to change this as part of the split from WSU.

To ensure that Aboriginal and/or Torres Strait Islander health and culturally safe practice are meaningfully assessed across the program, it is essential that assessment design, implementation and review are informed and guided by Aboriginal and/or Torres Strait Islander health experts. Embedding Aboriginal and/or Torres Strait Islander leadership in this process brings significant benefits, including ensuring cultural integrity, enhancing the relevance and authenticity of assessments, and strengthening the alignment of learning outcomes with community expectations and graduate capabilities. It also reinforces the broader goal of embedding Aboriginal and/or Torres Strait Islander knowledges and self-determination within medical education. A culturally safe practitioner must not only have knowledge but also demonstrate attitudes and behaviours that reflect respect, humility, and accountability. These attributes must be explicitly and reliably assessed throughout the program.

A key issue identified was the current lack of transparency and accountability in assessment mapping. Although the School has outlined how assessments align with First Nations Health learning outcomes, it does not currently have a mechanism to monitor individual student performance. It is unclear whether students who consistently underperform in Aboriginal and/or Torres Strait Islander health or cultural safety components can still pass the course overall, raising concerns about the significance afforded to these assessments within the broader curriculum.

Currently, the assessment of Aboriginal and/or Torres Strait Islander health and cultural safety across the program is inconsistent and insufficiently integrated. In Years 1 and 2, Aboriginal and/or Torres Strait Islander health content is assessed primarily through online quizzes, with cultural safety minimally addressed in any

formal or structured way. While Problem-Based Learning (PBL) is a core component of early-year assessment, there is no evidence that PBL assessments specifically evaluate students' understanding or application of Aboriginal and/or Torres Strait Islander health or cultural safety principles. This suggests a gap between curriculum intentions and assessment practice.

In Years 3 to 5, the assessment of Aboriginal and/or Torres Strait Islander health and cultural safety becomes even more limited. Some activities, such as reflective writing, may offer moments of cultural engagement, but these are isolated and not systemically embedded into the clinical curriculum. Feedback from students supports this finding – with reports that Aboriginal and/or Torres Strait Islander health is not a prominent feature of their clinical years, and that there is minimal formal assessment of these capabilities. While some students noted that external resources are available for those with personal interest in this area, the lack of required assessment means there is little incentive for broad engagement. With assessment being a driving force for learning, it is important that Aboriginal and/or Torres Strait Islander health learning is not perceived as being optional.

It is also worth noting that students placed in Aboriginal Medical Services (AMS) settings may receive a more immersive experience of Aboriginal and/or Torres Strait Islander health and cultural safety, with these concepts naturally integrated into their clinical learning and informal assessment. However, this is not due to deliberate program design, but rather the context of the placement. This highlights a broader issue – that exposure to Aboriginal and/or Torres Strait Islander health and cultural safety learning is heavily dependent on chance rather than being a guaranteed, structured element of the program for all students.

While the employment of two new Aboriginal academics is a welcome and strategic step toward improving these assessments, meaningful change requires a whole-of-school responsibility. Without systemic support and curricular integration, these individuals risk being isolated in their efforts. Addressing these challenges is essential to embedding cultural safety as a foundational, assessable and respected part of the program.

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 School identifies that this is a constant area for improvement. In the written submission, it provided examples of written feedback from assessments that were extremely detailed. Consideration should be given to whether this level of granular feedback is the best approach to guide student learning, and indeed support life-long learning. There are opportunities for students to seek further feedback after review of this report and discuss it with relevant staff. In Years 1 and 2, students have 30+ assessment pieces and it was not clear to the team how often students are utilising further feedback opportunities. In Years 3 to 5, students receive "instant" feedback via electronic forms. This may lead to a lack of confidence from clinical supervisors in scoring students lower or identifying and highlighting performance deficits. The parameters for the feedback discussion are very loose and vary depending on site and supervisors.

From a more practical perspective, there are reports from clinical schools that the students can approach the Head of Clinical School (HoCS) for feedback as required – due to small numbers the students do feel they have good access to academics. There were also examples given from clinical supervisors that the HoCS has time and resourcing to give feedback to under-performing students, that remediation plans put in place are appropriate and that good outcomes have occurred. The student report and discussions with students showed that the student body was largely in support of the processes as they currently stand.

The team saw evidence that students who are not performing to the expected level are identified and provided with support and performance improvement programs in a timely manner. Year convenors meet weekly with the Associate Head of School, Learning and Teaching to review assessment results. Students who

are not performing well in their assessments are provided advice on how to improve including through direction to relevant resources such as central academic skills help. In Years 1 and 2, underperforming students work with their year convenor to put in place a study plan or revised learning plan to ensure they meet necessary requirements to progress.

In Years 3 to 5 clinical placements, students are deemed at risk of failing the unit if they fail a clinical attachment and are referred to the HoCS who might deal with the concerns locally, or can escalate to the Associate Head of School, Learning and Teaching for oversight. Students going through remediation, including for an exam, are encouraged to disclose this to their HoCS for local support, but can choose to keep this confidential. For the MD Project, students can discuss concerns with supervisors. The JPM Results and Progression Committee meets mid and end of year to discuss academic performance. The SRM Assessment Design and Progression Sub-Committee creates a summary of marks for each cohort.

Feedback on student performance is provided by the year convenor to respective year committees and block coordinators. As an independent program, the School will continue many of these processes, including:

- The weekly meetings of the Associate Head of School Learning and Teaching and year coordinators
- Regular touchpoints with supervisors of professional portfolios
- The Assessment Design and Progression Sub-Committee will review assessments monthly, as well as progression reviews in mid and end of year
- The SRM Research team will review MD Projects monthly, and issues are tabled at the Research and Evaluation team fortnightly meetings.

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.

In 2024, the JPM moved to a Satisfactory/Unsatisfactory program and during implementation, a comprehensive review of assessment was conducted. The School intends to continue regular reviews as an independent provider with a variety of methods including focus groups with students to evaluate feedback. The results of written exams across all years are standard-set using the modified Cohen method which may not be as appropriate in the context of the smaller cohort size with only CSU students.

While assessment practices and processes are technically uniform across the WSU and CSU programs, there is variation in the use and format of mini-CEx forms. This is due to their design and original use in a tertiary hospital setting, and contributes to a lack of standardisation in completion of the assessments. This concern is exacerbated by insufficient training for supervisors in completing the mini-CEx forms and that they can be signed off by locums. Although there may be situations where it is unavoidable for locum practitioners to undertake assessment, care is needed to ensure clarity about the standards against which students should be assessed.

STANDARD 4: Students

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 team welcomed the enthusiasm and engagement with students in Orange, Bathurst, Parkes, with other clinical sites virtually, and through CHARMS. It was observed by the team that students are known by staff members and valued as individuals by the School. In line with its purpose, the School is determined to increase its student numbers and has support from CSU for this – they have continuously bid for additional Commonwealth Supported Places in medicine and will continue to do so.

Many students expressed their intention to practice rurally and were positive about the opportunity to study in their local community. The School has expressed a realistic estimate of its required resourcing, but was also ambitious about increasing student capacity in rural clinical sites in the near future.

The existing admissions process is reliant on WSU systems, and the team acknowledges the School's intentions to develop further purpose-driven entry pathways and selection processes inclusive of students with disability. The School has demonstrated ability to resource all stages of the medical program in real time while learning how to operate as a medical program since its inception in 2021. The team recognises that challenges and learning points are to be expected along the way and has no major concerns about the School's ability to adapt to those they identify.

Since the accreditation visit, the School has made progress toward defining its student cohort to align with developing targeted recruitment strategies. In collaboration with the Pro-Vice Chancellor First Nations Student Success, the School has agreed to an intake target of 8% Aboriginal and/or Torres Strait Islander students, reflecting a positive step toward increasing Aboriginal and/or Torres Strait Islander participation in the program. The School identifies rural, underserved, and Aboriginal and/or Torres Strait Islander populations as core to its purpose and has articulated strategies to recruit students from these backgrounds. However, the safe and effective implementation of these strategies is yet to occur.

Currently, there is a recognised need for more strategic and meaningful involvement of Aboriginal and/or Torres Strait Islander staff in the admissions process. While the School Manager is working alongside an Indigenous Liaison Officer, the team recommends that this role be filled by someone appropriately positioned to maintain supportive yet objective relationships with applicants, ensuring that both cultural safety and professional boundaries are upheld.

The School clearly connects its academic and professional identity to rural medicine and undertakes an outreach program to recruit local students in its clinical footprint. There is also a significant mature-age/non school-leaver cohort in the program, but there does not seem to be an explicit strategy to recruit students via non-conventional entry pathways, despite an extensive range of health programs (including physiotherapy and nursing) at CSU. The school is also conducting research on the demographics (e.g. SES) of applicants,

although the results are forthcoming, and there is currently no policy in place for recruiting other equity groups. Critically, it is paramount that the School understands the importance of ensuring culturally safe, strategic, and well-supported pathways for Aboriginal and/or Torres Strait Islander students entering the medical program.

A proposed Cadetship program is in development with the intention that it serve as an Indigenous Support Pathway into the program. This would provide a Cadetship within each rural clinical school for Aboriginal and/or Torres Strait Islander people and allow them to engage with the program in a paid capacity, upskill them and support and encourage them to consider medicine as a future career. This proposed Cadetship Program must be underpinned by strong community involvement and culturally grounded design and implementation. To meet this standard, the Cadetship Program should be co-designed with Aboriginal and/or Torres Strait Islander Elders, community members, and relevant stakeholders, ensuring that cultural safety, community expectations, and cadet wellbeing are central to its development.

There is an opportunity to integrate the central CSU supports for Aboriginal and/or Torres Strait Islander students further within the School. This extends to (culturally safe) professional engagement with prospective students and during the admissions process. While there is a lot of goodwill evident, clarity for staff on the process, the extent of collaboration, and when to inform central support would be beneficial for all.

The School demonstrates a commendable approach to student wellbeing, particularly in its recognition of students' family circumstances and broader personal context. This sensitivity to students' backgrounds and needs aligns with CSU's inclusive values, and the team would like to acknowledge it formally.

Currently, the management of racism experienced by Aboriginal and/or Torres Strait Islander students within the program relies heavily on Aboriginal and/or Torres Strait Islander staff, who are informally tasked with addressing and resolving incidents. This is neither sustainable nor appropriate and raises concerns about cultural load as well as institutional responsibility. The School would benefit from implementing formal anti-racism strategies, including program-specific policies and clear processes for preventing, reporting and responding to incidents of racism or bullying. This should include options for anonymous reporting (which extends into clinical settings) and a structured mechanism to close feedback loops with affected students and staff.

While Aboriginal and/or Torres Strait Islander student retention rates are showing signs of improvement, current data suggests that retention remains an ongoing area for development. Continued attention to both structural support and cultural safety will be critical to achieving lasting progress. Embedding proactive, system-wide strategies that promote inclusion, wellbeing and safety and provision of flexible study options will further support the success and retention of Aboriginal and/or Torres Strait Islander students in the program.

The current inclusion of Aboriginal and/or Torres Strait Islander representation on assessment and admissions panels is limited to one. To ensure a culturally safe and equitable process, particularly for Aboriginal and/or Torres Strait Islander applicants, there is a need to increase the active involvement of Aboriginal and/or Torres Strait Islander people in interview and selection processes. Greater Aboriginal and/or Torres Strait Islander representation on these panels enhances the cultural responsiveness of admissions, supports a more holistic understanding of applicants' strengths and backgrounds, and affirms the importance of Aboriginal and/or Torres Strait Islander leadership in decision making processes that affect Aboriginal and/or Torres Strait Islander student pathways.

The current selection and admission processes at the School reveal areas where greater transparency, fairness, and cultural safety are urgently needed to meet the expectations of Standard 4.1.5. Most notably, there is limited inclusion of Aboriginal and/or Torres Strait Islander representation on assessment and admissions panels, including those responsible for evaluating applicants through the Indigenous Entry Pathway. This lack of representation presents a risk to cultural safety and equity, particularly for Aboriginal and/or Torres Strait Islander applicants. Increasing Aboriginal and/or Torres Strait Islander involvement in interview and selection panels is critical for ensuring culturally safe decision-making. It also reinforces Aboriginal and/or Torres Strait Islander leadership in processes that significantly impact pathways into

medicine and contributes to a more holistic understanding of applicants' strengths, experiences, and community connections.

Concerns have also been raised about the current structure and accessibility of the Indigenous Entry Pathway. Applicants who identify as Aboriginal and/or Torres Strait Islander but face challenges with formal community identification – due to displacement, family disruption, or the intergenerational trauma associated with the Stolen Generation – may find themselves unintentionally excluded. The School currently requires documentation aligned with the three-part definition of Aboriginality, and in cases where applicants cannot provide this, the decision is delegated to a single Indigenous staff member. While this role is currently supported by a respected academic, the practice places undue burden on one individual and lacks procedural robustness. A review of this policy is warranted to ensure alignment with equity principles, especially considering the diversity of Aboriginal and/or Torres Strait Islander lived experiences.

The inclusion of consumers and carers in the admissions and evaluation process was also identified as a valuable strategy. Their presence signals a commitment to community engagement and centres the perspectives of end-users of the health system. Incorporating their voices helps ensure that the selection process reflects not only academic aptitude but also community values and social accountability.

While there is goodwill and emerging initiatives within the School to improve the fairness and inclusivity of admissions, these must be supported by clear policies, training, and structural change. Affirmative action measures are a positive step, but must be underpinned by transparent and anti-racist systems to ensure the goal is meaningfully and ethically achieved.

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.

Students who spoke to the team felt their wellbeing was a priority of the program staff and enjoyed generally close connections with staff. Each clinical school has a dedicated Clinical School Support Officer (CSSO) who forms supportive relationships with students and keeps an eye on their wellbeing. The team found the CSSOs

to be extremely dedicated, many going beyond their role to provide students and clinicians with the best experience possible. While there were many examples of the School providing tailored support and offering accessible services for student wellbeing, there was insufficient evidence, as yet, of an overarching strategy to support wellbeing across the program.

The School demonstrates a commitment to supporting Aboriginal and/or Torres Strait Islander students. However, there is an opportunity to strengthen this support through clearer, more accessible lines of communication with key support personnel and services, particularly First Nations Student Connect. The School is encouraged to establish a formal and visible line of communication with First Nations Student Connect, ensuring students can easily access culturally safe support throughout their studies. In particular, enhancing direct access to Aboriginal and/or Torres Strait Islander support staff would improve responsiveness and help build stronger relationships between students and the support network available to them.

In addition, while the School provides support mechanisms for Aboriginal and/or Torres Strait Islander students, it is important to ensure that there are mechanisms available for those with diverse identities and experiences within this cohort, including students who identify as LGBTQIA+, live with disability, or experience other forms of marginalisation. Ongoing reflection and review of support services is recommended to ensure they are culturally responsive and intersectional, recognising the multiple and overlapping identities that may influence a student's experience. By improving communication pathways and embedding inclusive practices, the School can ensure that all students feel culturally, emotionally, and personally supported throughout their medical education.

The team noted general student feedback indicating that students felt well supported in their individual needs across the Orange campus, rural sites and clinical settings, and staff were seen to be very accommodating. However, the team also heard from some students in clinical settings, who did not feel well supported, or that support was provided equitably

Study Access Plans are available to students, which can include extra time for exams, separate rooms for exams, deferment of exams, tailored timetables, larger font on exam papers, and allocation to specific, preferred clinical schools. PBL tutors meet weekly with the Year 1-2 convenors and identify any students who may require extra support. The Accessibility and Inclusion Support Service is available to ensure students receive the necessary support. As discussed above, it is difficult to determine whether students with disabilities and chronic conditions are adequately identified and provided with support, although the school has the largest proportion of students with Study Access Plans comparative to other programs in the Faculty.

Students utilising a Study Access Plans, or students who had sought support from clinical school staff regarding an issue on placement, expressed feeling they were appropriately consulted and consent sought, prior to any information being shared or accommodations developed. However, there were concerning comments from some students that they were proactively reached out to by staff when experiencing adverse circumstances. There are potential implications on student privacy and wellbeing, but it is unclear as to the extent of these practices. The School should ensure that there are clear processes and policies in place and that these are followed, so that clinical staff can provide adequate support whilst upholding the student's privacy.

The School shows a commitment towards a flexible study environment, that is supportive of family needs. Recent changes to flexible study policies were developed in collaboration with students have been well received. The implementation of wellbeing days is a positive initiative to support students. The School should consider whether providing part time study pathways for students would be a viable option, as this could further increase flexibility of the program. Comments in Standard 3.1 discuss the lack of flexibility with the 64 point unit in each year of the program, and the need to repeat an entire year when one unit is failed.

The School has multiple procedures in place to ensure academic decision-making processes are separated from academic progression, and states that school staff are referring students to CSU Central Support as issues arise. However, in many cases, school staff do seem to take on student support roles informally. As the separation from the JMP occurs, the School must ensure it has clear policies in place separating student support and academic progression, and that staff roles are clearly defined without overlap in these areas.

While CSU has a strong centralised model for reporting bullying, harassment, racism and discrimination, with clear policies and accessible mechanisms, there is an observed disconnect between these systems and the School's local practices. The program operates with relative isolation from central support, and this disconnect hinders the effective implementation of University-wide policies at a local level. There is limited integration and collaboration between central University service and the medical program when managing incidents related to student or staff wellbeing.

The team observed uncertainty around when and how to escalate concerns to central support, and there is a lack of clarity regarding roles and responsibilities within the School when an incident is reported. Although the University has clear reporting lines, the experience within the School appears to be more fragmented. When a student raises a concern, it is not known to them who within the staff receives the report, how it is managed, timeframes for this, or how outcomes and follow-ups are communicated back to the student. This lack of transparency and feedback contributes to a perception of inaction, which may deter further reporting and undermine trust in the system.

This issue is compounded by questions around governance. Concerns around professionalism are triaged "in-house," rather than being escalated through appropriate university channels which can lead to inconsistent handling of serious matters. Delegation of responsibility for policy implementation formally lies with the Dean, but in practice may fall to local Clinical School Support Officers (CSSOs), which raises the risk of inconsistent or high-risk responses without appropriate oversight.

To address this, the School must establish clearer, safer, and more culturally responsive pathways for reporting and managing incidents of bullying, racism, harassment, and discrimination. Improved collaboration with central university systems, including clearer communication protocols and defined escalation pathways, will be critical. Strengthening governance structures and ensuring timely follow-up and culturally safe feedback mechanisms will help restore student confidence and promote a safer, more inclusive learning environment for all students.

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 was impressed by the resilience of the student cohort, particularly the current Year 5 students, as they have remained positive and engaged throughout the 'teething period' of the new School.

The School uses the University's Fitness for Study Procedure to manage students who may have an impairment that could impact on their fitness to study medicine. Upon hearing about issues from stakeholders, including students, clinicians and those delivering the program, the Dean and Course Director will meet with the student to discuss their concerns, and together they put a plan in place for the student to implement the feedback they have received. If there is no improvement within the agreed timeframe, the student will meet again with the Dean and Course Director, and the formal process will begin which may include submitting the 'Fitness to Study' form to the Division of Safety, Security and Wellbeing. A CSU Student Conduct Officer then meets with the relevant School staff to discuss the process according to the Fitness to Study Procedure.

The team identified a lack of clarity and timeliness in implementing policies and procedures regarding students' professionalism and fitness to practice. It will be highly valuable to ensure that these policies and procedures are comprehensive, clearly articulated to staff, and implemented consistently.

The School should be mindful that the process for managing fitness to practice concerns should extend to closing the loop and informing relevant students and staff of the outcomes.

Procedures for reporting and taking further action on racism do not seem to be enforced in a timely way - of particular concern when many of these issues occur acutely. While the School is working within its policy, this is not always implemented in a culturally safe way. Professional behaviour does include racism and the team was unable to find a clear policy on this. There was an example of a complaint of racism by a student that was assigned to a staff member, but this progress was not relayed to the student who was unaware of any steps being taken to resolve it. It is also unclear whether this incident was formally addressed on the grounds of racism or poor professional behaviour.

While the outcome of this incident was in the best interest of those involved, it was circumstantial and not the result of a planned response to this particular situation. In order to ensure safety for students, which needs to be the primary focus, the School must establish a planned pathway and reporting system for dealing with bullying, harassment, racism and other unprofessional conduct.

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.

The School has relevant and adequate indemnity and insurance which extends to applicable clinical placements students undertake, both as part of the longitudinal integrated program starting from Years 1-2 and the full-time clinical placements in Years 3-5, including overseas placements.

STANDARD 5: Learning environment

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.

The School delivers Years 1 and 2 at the Charles Sturt University (CSU) campus in North Orange, New South Wales. The program has nine clinical sites, across rural New South Wales and Victoria, and each deliver Years 3 to 5 as a three-year longitudinal rural placement. The School has impressive educational facilities and infrastructure to support the program and is in the process of developing further facilities. The facilities available at the CSU North Orange campus are large, spacious and have many dedicated student spaces. Staff offices are close to learning and teaching and student spaces.

At some clinical sites, learning facilities are in need of further development. Many clinical sites have impressive and amply spacious new facilities. With any potential growth in the cohort, it is unclear whether the facilities and infrastructure would remain adequate at all clinical hub sites. For example, students at Parkes do not have an allocated student space and so utilise free space when they can. Whilst clinical staff were generous in sharing their offices for students to work in, this arrangement causes concern for both student and staff wellbeing. Changes at the hospital or to the cohort would further impact this.

Many sites did not contain facilities such as cultural safety spaces and parents' rooms. With any potential growth in the cohort, it's unclear whether the facilities and infrastructure would still be adequate. However, it is noted that the School is developing some comprehensive new facilities, which will support learning and teaching as well as student and staff wellbeing and has access to resources to support further improvements at the new facilities.

Students who are on a clinical placement more than an hour from their 'base' clinical school site are provided with accommodation. This accommodation is funded by either the School or the Rural Health Multidisciplinary Training program. The team heard concerns from students and staff about the students' need to travel long distances to placement and the cumulative impact this fatigue had on them as well as the safety of students doing so. This was particularly prevalent in the Northern Rivers Clinical School due to the challenging rental market which students were navigating and contributed to commutes and because placement locations students attended (such as the General Practice and the Health Service) were quite spread apart. The School does attempt to provide accommodation and rental relief where possible.

The School generally offers good support in relation to technologies. Most sites have adequate technology for virtual meetings in place, and they are working to ensure other sites meet similar standards.

Currently, the School is restricted by JPM IT facilities used for assessment, which are not effective for the School's needs. The School is working to obtain the Risr eAssessment platform to support the program's assessment more adequately. This is discussed in Standard 3.

The team was impressed by the dedication of staff to ensuring the usefulness and use of library and reference materials. This extended to asking students which journals and resources they might want access to, and relevant subscriptions were sourced for them. The allocation of a medical program-specific IT staff member is also hugely valuable.

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.

The School currently believes it has broadly adequate academic staffing and has a Workforce Plan which includes recruitment of additional academic staff which will support the delivery of the independent program. The current operational model is largely independent, the School is supported to some extent by WSU (for example, some academic staff and admissions expertise) as part of the JPM. The extent to which the CSU program will continue to need to draw on support from WSU for certain aspects is unclear. At the time of assessment, CSU had identified that they would still need support in the admissions process and WSU has agreed to extend this support as required. As an independent program, CSU's planned processes including assessment and evaluation will mirror or build off WSU processes, the School may find it has not fully anticipated the external support or in-house resources required.

The School is supported by centralised CSU professional staff. The School additionally has a small, strong and dedicated team of professional staff who are key to the running of the program, including the School Manager who plays an invaluable and critical role in many aspects of the program's delivery and holds a large portfolio of responsibility. An Executive Support Officer at the main campus has oversight of the Clinical School Support Officers at each clinical site. The Executive Support Officer will have further work as the program seeks to ensure implementation and alignment of formalised policy and procedures across the sites and to support the program as it better integrates with central support services. Maintenance of School-based professional staff who undertake the unique functions required for a geographically distributed medical program is vital for the effective ongoing operation of the program, especially after separation from WSU.

The team was impressed by the quality and breadth of work undertaken by the professional staff and by the University's pragmatic approach to noting the limitations of the central support model for the medical program by enabling some program-specific roles – it is unclear if these roles are adequately resourced

/structured to support the full student cohort and for an independent program. Deeper engagement with the central supports to build an understanding of the School's unique needs may also be beneficial.

As the School is relatively new, it is not yet clear whether staff are sufficiently retained. The AMC will monitor staff retention with the graduation of the first cohort, and the move to an independent delivery.

Development and delivery of the medical program, and in particular the Aboriginal and/or Torres Strait Islander curriculum has been led thus far by the Associate Head of School, Indigenous Health at Western Sydney University, and the former Director of Indigenous Program, with the involvement of clinical academics working in partnership with Aboriginal Medical Services.

The University has a First Nations Recruitment Strategy and the School has recently established and recruited to the position of Associate Head of School, Indigenous Health who will begin in the role in June 2025. As the Aboriginal and/or Torres Strait Islander health curriculum is not yet articulated, it is not clear whether the current staffing levels will be sufficient. As the curriculum is developed, it is vital that adequate staffing levels and resources are allocated for its ongoing development and implementation.

The Associate Head of School, Indigenous Health has verbally expressed a succession plan for the role which is for the incoming Lecturer in Indigenous Health to take over. This succession plan is insufficient and further succession planning will be required to meet this standard. Succession planning for other Aboriginal and/or Torres Strait Islander staff positions has not been outlined.

The School does not appear to engage sufficiently with the First Nations Success Unit. There are plans for an Elders in Residence program (a working title the AMC notes is to be confirmed through community engagement and consultation) to include local Aboriginal and/or Torres Strait Islander people from the communities students are placed in to provide support to the program. As the School develops and implements its Elders in Residence program, it will be vital to ensure that there are appropriate professional staffing and peer supports in place by further engaging with central Aboriginal and/or Torres Strait Islander professional staff and programs. Whilst 0.1 FTE (a half day per week) has been allocated to Elders in Residence at each clinical school, there are concerns at the significant cultural load this may cause, and due consideration should be given to allocating additional resources in this space.

There is limited evidence that the School adequately engages with patients and community members, including community groups who experience health inequities. In their submission and in meetings throughout the assessment, the School has identified the need to further this engagement, and ensure that engagement with these people and groups is formalised. The School must implement inclusive and culturally safe processes for recruiting patients and community members.

The program has adequate and appropriate indemnification for staff involved in 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.

The School has policies in place supporting the appointment and promotion of academic staff. The CSU Academic Promotions Policy highlights the need for promotion processes to be culturally safe for Aboriginal and/or Torres Strait Islander staff. It is important that the School implements this requirement in its process. The School currently has an induction process for new staff that involves a booklet, guide, and new starter checklist. More comprehensive induction processes will be important in ensuring the quality of teaching in the program.

While recruitment for Aboriginal and/or Torres Strait Islander academic positions is being actively worked on at the main Orange campus, it was noted that active recruitment of local Aboriginal and/or Torres Strait Islander individuals within the rural clinical schools has not yet been undertaken. This group of cultural mentors including Elders, ALOs and AHPs within the communities are utilised by the school to support students, but there was no evidence that they have been offered the opportunity to be recruited into academic positions or offered adjunct status, and that it is mutually beneficial to them.

School staff use the University staff performance review system and can also access central professional development support. In addition to these central university systems, the School has a Staff Education and Development Team that manages the medical education and training of practitioners across the clinical school network in relation to their specific needs and the program's objectives. This team is currently working to develop a curriculum for this.

There are no explicit professional development opportunities for Aboriginal and/or Torres Strait Islander staff. To date, staff have had opportunities to attend relevant conferences, including with Leaders in Indigenous Medical Education (LIME) and Australian Indigenous Doctors Association (AIDA). The School has identified a need to formalise and extend professional development opportunities for Aboriginal and/or Torres Strait Islander staff. It should work with staff to understand what opportunities are sought and develop and/or provide access to these.

Staff in the First Nations Student Success unit are involved in the Yarn Up program, but it would be beneficial for the School to identify other areas where this cross-unit collaboration, mentorship and professional development can occur, and ensure it does not increase workloads. The School is encouraged to identify and develop further opportunities for Aboriginal and/or Torres Strait Islander staff to work together in teams (such as planning and enabling time for building professional networks of the Elders in Residence across sites) and participate in mentoring within the Faculty and wider University.

The School offers cultural safety modules for staff; however, these are not mandatory. Further work is required to ensure that formal systems for ensuring all staff and clinical supervisors have engagement with regular cultural safety professional development activities to support ongoing learning. Additionally, it is essential to consider the unique needs of the CSSOs and other staff working alongside Elders to support the cultural safety of clinical sites.

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.

Each clinical school has a dedicated Head of Clinical School (HoCS), who is well-known to students and the program centrally. This role is primarily responsible for clinical placements and is the key program liaison with clinical supervisors at that site. The team saw as essential the incumbent's ability to have professional and good relationships with the health service and hospital, which was evidenced at the majority of sites.

The School has partnerships with a number of general practices and primary care providers at which students undertake longitudinal placements. The team was particularly impressed with the high-quality learning placements at Orange Aboriginal Medical Service.

The Medicine in Context unit that runs throughout the program enables students to have experiences in community-based placements and is a real strength of the program. This includes aged care homes, residential disability homes, headspace, allied health settings and many more. The School has strong relationships with these providers who were complimentary of both the Program and the students with whom they engaged. Following these placements, students discuss their experiences with other students who proactively look to engage with these types of services at their next clinical school and sometimes even begin to foster new relationships between community services and the School.

All students have clinical experience providing health care to Aboriginal and/or Torres Strait Islander peoples. However, further consideration is needed to ensure the cultural safety and adequacy of these experiences. Further engagement is also needed between the School and ALOs at clinical sites to ensure the cultural safety of patients, students, and ALOs.

The School has been actively engaging with co-located health professional education providers to ensure its medical program has adequate clinical facilities and teaching capacity. The minutiae of specific rotations and placements could be further documented and distributed in a timely fashion to benefit shared clinical supervisors, and student wellbeing at some sites. There are some concerns about pressurised capacity at shared clinical sites. The School has, and should ensure that it continues to, work with co-located schools to ensure sufficient amenities are available to students if student numbers were to increase.

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.

Clinical supervision at the nine clinical sites was provided by a range of professionals, including General Practitioners, Rural Generalists, Specialists, Registrars (inclusive of GP/RG registrars), House Medical Officers, Aboriginal Health Workers, and Clinical Nurse Consultants/Nurse Practitioners. Clinicians expressed their commitment to the program and appreciated the continuous longitudinal presence of the students they supervise as highly valued members of their workforce. The team heard from multiple sources about the strength and high regard of the program and stakeholder's affinity with its purpose.

Due to the varying rurality and size of the sites, the team heard that this often expands to a secondary pool of supervisors that includes locums, nurses, allied health workers, other junior/prevocational medical officers, interns and visiting specialists. Due to this workforce, there are challenges with ensuring an effective system of clinical supervision across the program, further complicated as a standardised method of providing training to supervisors has not yet been defined (noting the program's supervisor guide (a resource) is provided to the primary pool of supervisors). The School must consider workforce trends in their clinical school footprint, and how to adequately and safely address concerns that students are often supervised by those who are most available, and this may be individuals who may not have undergone formal onboarding

As discussed in Standard 3, the School could improve consistency across sites of the training in supervision, assessment and the use of relevant health education technologies This observation also flows into the appraisal and development of clinical title holders and staff who hold a joint appointment and to build stronger understanding of the clearly defined responsibilities of the School and the hospital and community practitioners. At many sites, Junior Medical Officers (JMOs) appear to be taking on some clinical supervision responsibilities when the supervising doctor is unavailable. The School should consider implementing orientation processes or short courses for JMOs, and other second tier supervisors, that prepare them for clinical supervision. The team observed that supervisor support and training were very site-dependent. The Head of Clinical School (HoCS) could be encouraged to work towards alignment and positive engagement with local supervisors so that the support delivered is equitable across sites. While it appears that supervisors and campus heads would be aware of problems arising, systemic processes and policies must be implemented to ensure problems are appropriately escalated and managed.

The School's submission outlines two key processes in place for monitoring the performance of clinical supervisors. The School has implemented student term evaluations, which are reviewed by the School, who provide feedback to the supervisors. Additionally, the Associate Head of School of Learning and Teaching, and Directors of Curriculum and Rural Generalism visit each clinical site annually to maintain direct relationships with supervisors. There is a planned thorough evaluation of the effectiveness of term evaluations in 2025.

The School has arrangements in place with healthcare facilities to ensure that time is allocated for teaching and supervision of students, and that communication with supervisors and other hospital staff around this is clear and comprehensive. The supervisor guide defines the responsibilities of hospital and community practitioners, and these are generally provided to supervisors through the Head of Clinical School as part of their orientation. However, as discussed previously, the workforce in the placement footprint means that not all clinicians who end up supervising CSU students have access to this guide.

The School's submission outlines that student placement agreements are in place for clinical placements that CSU holds with many private and public health services.

STANDARD 6: Evaluation and continuous improvement

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.

There is a strong appetite for improving the program and a clear commitment to continuous quality improvement. The team heard of multiple instances where the program has responded to feedback from students and clinicians, and implemented change in a timely manner. However, there is a need for a formal and coherent system of evaluation and continuous quality improvement across the program. This must include engagement with Aboriginal and/or Torres Strait Islander leaders; actively seeking out and identifying areas for improvement; student cohort analysis including for equity groups; and closing the loop with students and those delivering the program. An evaluation plan has been drafted, which is a positive support as the program implements changes, and the School should report on its progress to the AMC.

The School currently undertakes all evaluation of its program according to relevant University evaluation policies and procedures. This includes an Annual Course Health Check, undertaken by the central CSU Division of Learning and Teaching, which looks at student load, first year attrition, progress rates, completion rates, student feedback, financial viability data and marketing data. Following these annual checks, any concerns are monitored by the Faculty Board. Additionally, the University's Enterprise Action Register monitors any concerns identified by internal or external audits and reviews and ensures that adequate action is undertaken to address the concerns identified.

A Comprehensive Course Review is mandated by the University every seven years and is led by the Course Director. A report is submitted to the Faculty Course and Subject Review Panel at the completion of the review, and necessary changes are implemented following approval from the relevant boards/committees. As the School has only been delivering its program for five years, it is expected that progress reports will be provided once the Comprehensive Course Review commences.

Whilst these central university processes are appropriate and well established, program-specific evaluation is vital for ensuring the quality of the program. The School appears to address concerns that are raised about aspects of the medical program quickly and effectively. However, there do not appear to be formal systems for evaluation and risk identification in place.

The School has drafted detailed plans for an evaluation strategy that aims to work cohesively within existing central evaluation processes. This evaluation strategy has not yet engaged with Aboriginal and/or Torres Strait Islander people or organisations and community groups who experience health inequity. The evaluation plan will assess across nine domains:

- students;
- curriculum;
- assessment;

- clinical learning;
- local capacity building;
- community engagement and partnerships;
- Aboriginal and Torres Strait Islander health;
- research and evaluation;
- graduate outcomes;
- governance; and
- compliance.

The School's Research and Evaluation team will provide statistical support and analysis of evaluation data being collected. Further information is needed about how this strategy will be practically implemented, how opportunities for educational innovation will be identified and evaluated, and how identified risks will be systematically managed. It is also noted that, as a newer program, the School will initially have a smaller set of data points to work with as it implements this evaluation strategy.

The School regularly seeks the feedback of students through surveys, to which students have typically been responsive. Feedback collected has been used by staff to inform changes to the program. Additionally, through the advantage of a small cohort, there are regular opportunities for informal feedback to be provided to staff. The School clearly is open to and responds to student feedback. It should work to develop policies and procedures to ensure student feedback is systematically sought, analysed and evaluated.

Whilst there is some evidence that the School engages in regular discussions with community supervisors and that feedback is often provided as part of these discussions, the School does not currently systematically seek and evaluate the feedback of health services and communities. Ensuring this is addressed in the evaluation strategy will be beneficial for appropriately tailoring the program to its context.

Although there are not yet graduates of the program, the Dean and leadership team have been proactive in building relationships with the relevant prevocational training providers – Prevocational Medical Council of Victoria (PMCV) and NSW Health Education and Training Institute (HETI). There are regular meetings with HETI and the NSW medical schools, which the Dean has begun attending in preparation for the first cohort of graduates.

The School, as part of the JPM, has engaged in collaboration with other education providers through the Australian Medical Schools Assessment Collaboration (AMSAC), ACCLAiM, and University Clinical Aptitude Test (UCAT-ANZ) to undertake benchmarking activities. The School has also engaged informally with the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) rural, including with an ACRRM medical educator who attended the *Yarn Up* program. Additionally, the School attends Medical Deans Australia and New Zealand (MDANZ) conferences annually, which provides a valuable opportunity to consider national developments in medicine and medical education. Further consideration of national and international developments in medical education, and the ways in which the School implements them, will be important for informing future progress.

Because of its shared clinical sites with other providers, the School shares many resources and clinical supervisors with other schools. However, this collaboration is not adequately formalised. This requirement for resources will need greater consideration as the School moves to deliver the program independently.

Further work is needed to ensure that the School's collaboration with other providers effectively supports the continuous evaluation and review of its program, and that the School ensures collaboration continues following the separation from WSU.

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 School analyses student assessment performance, undertaking regular internal benchmarking exercises across clinical sites. It is not clear whether the School analyses this data against program outcomes.

As the School has not yet graduated any students, the provider has not yet been able to analyse the performance of its graduate cohorts. The School's submission notes that preparation has begun to evaluate end-of-program performance. The School also intends to track graduate performance via an ongoing database and through MDANZ's Medical Schools Outcomes Database (MSOD). The School has outlined plans to analyse the performance of graduated students as well as the 'impact of place-based medical education on the recruitment and retention of the rural health workforce in Australia'. It will be important for the School to analyse these data against the medical program's outcomes.

The team did not find evidence of analysis of differences in outcomes between student cohorts. As the School begins to graduate cohorts, it will be important to undertake an analysis of graduate cohort performance to ensure that similar outcomes are being achieved between cohorts. As the School moves towards its first graduating cohort, it is critical that a comprehensive plan is developed with regard to analysis of differences between student cohorts

The School does examine student performance in relation to student characteristics, and the SRM Admissions and Allocation Committee reviews these data and reports to the Executive Committee. The submission notes that poor academic performance is an indicator of a student needing additional support and will lead to referral into student support processes. It is however not clear how evaluation data relating to the interaction between student characteristics and student performance is communicated to the Student Wellbeing Committee and used to inform adequate student support.

Evaluation of assessment is currently undertaken jointly. Post-separation, this function will be managed by the SRM Assessment Design and Progression Sub-Committee. In implementing this sub-committee, it will be important to ensure that interactions between student performance and characteristics are sufficiently evaluated. As noted in Standard 5, the School is working to obtain the Risr eAssessment platform to better support assessment of the program, and this will be beneficial for more detailed monitoring of student performance.

The School submission has identified that the School has not undertaken an evaluation of outcomes for students from equity groups, including Aboriginal and/or Torres Strait Islander students. The School noted challenges relating to privacy and small cohort numbers as barriers to undertaking this evaluation, and also highlighted the need to increase resourcing for this task by employing additional Aboriginal and/or Torres Strait Islander staff.

It is vital that the School develops plans to undertake this evaluation of outcomes for equity groups, and considers practical and timely measures to manage the challenges identified. Ensuring that Aboriginal and/or Torres Strait Islander staff with evaluation expertise are involved in the development and implementation of these plans is essential.

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.

Systems are in place for sharing evaluation, improvement and review processes with the School's governance and administration teams. However, these data are not sufficiently shared with students and those delivering the program across the sites. Further work is required to develop a communication and feedback framework such that evaluation outcomes and process improvements can be appropriately shared with students and those involved in program delivery.

While there are not yet graduates of the program, the Dean and leadership team have been proactive in building relationships with the relevant prevocational training providers – PMCV and HETI. There are regular meetings with HETI and the NSW medical schools which the Dean has begun attending in preparation for the first cohort of graduates. As the School graduates its first cohort, evaluation results should be made available to these providers, and their feedback should be incorporated for continuous evaluation and improvement of the medical program. The School has secured with PMCV that their students will be considered priority group one in their intern intake. The school could further consider how to engage stakeholders with the evaluation process.

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 2025 AMC Assessment Team

Name	Role
Professor Gary Rogers (Chair), MBBS MGPPsych, PhD, FANZAHPE, FAMEE, PFHEA	Professor and Dean of the School of Medicine, Deakin University
Dr Sarah Chalmers, BSc (Hons), PGDipEd, MBBS, FRACGP, FACRRM	Rural Generalist and President Elect of the Rural Doctors Association of Australia
Professor Shane Hearn, BAppSci, MPP, PhD	Lead, First Nations Health Program, Faculty of Health Sciences and Medicine, Bond University
Debra Letica, FRACP (Hon)	Consumer/ Carer representative and advocate
Māia Lockyer	Medical Student, University of Otago, 2024 Māori Advocacy Representative, New Zealand Medical Student Association
Allen Xiao, BBMed	Medical Student, University of Melbourne, 2024 President, Australian Medical Students Association
Sophie Burke	Manager, Medical School Assessments, Australian Medical Council
Melissa Johnson	Cultural Strategic Facilitator, Indigenous Policy and Programs, Australian Medical Council
Esther Jurkowicz	Program Support Officer, Medical School Assessments, Australian Medical Council
Clare Stuparich	Program Coordinator, Medical Schools Accreditation, Australian Medical Council

Appendix 3: Summary of the 2025 AMC Assessment Team's Accreditation Program

Meetings	Roles engaged with
Monday 10 March 2025 ***Charles Sturt University, Orange Campus***	
Welcome to Country	Elder, Wiradjuri Nation Dean, School of Rural Medicine Professor of Medicine, Associate Head of School 2021-Jan 2025, School of Rural Medicine Associate Head of School, Teaching and Learning, School of Rural Medicine Associate Head of School, Rural Generalism, School of Rural Medicine Course Director and Head of Assessment, School of Rural Medicine Head of Curriculum, School of Rural Medicine Associate Head of School, Research, Evaluation and Graduate Studies, School of Rural Medicine Executive Officer, RHMT Program, School of Rural Medicine School Manager, School of Rural Medicine Associate Professor, Accreditation and Evaluation, School of Rural Medicine Associate Dean, Indigenous Health, Western Sydney University*
Governance and Medical Program Management	Dean, School of Rural Medicine Professor of Medicine, Associate Head of School 2021-Jan 2025, School of Rural Medicine Associate Head of School, Teaching and Learning, School of Rural Medicine Associate Head of School, Rural Generalism, School of Rural Medicine Course Director and Head of Assessment, School of Rural Medicine Head of Curriculum, School of Rural Medicine Associate Head of School, Research, Evaluation and Graduate Studies, School of Rural Medicine Executive Officer, RHMT Program, School of Rural Medicine School Manager, School of Rural Medicine Associate Professor, Accreditation and Evaluation, School of Rural Medicine Associate Dean, Indigenous Health, Western Sydney University*
Aboriginal and/or Torres Strait Islander Strategy – School Perspective	Head of Curriculum, School of Rural Medicine Dean, School of Rural Medicine Indigenous Health Coordinator and Lecturer in Medicine, School of Rural Medicine Professor of Medicine, Associate Head of School 2021-Jan 2025 Associate Dean, Indigenous Health, Western Sydney University* Associate Head of School, Rural Generalism, School of Rural Medicine

* this role-holder is now Associate Head of School, Indigenous Health, School of Rural Medicine, Charles Sturt University

Meetings		Roles engaged with
		Head of Staff Education and Development and Portfolio Lead, School of Rural Medicine
Aboriginal and/or Torres Strait Islander and Māori Staff		Indigenous Health Coordinator and Lecturer in Medicine, School of Rural Medicine Clinical School Services Officer, Hastings Macleay Clinical School Adviser, First Nations Student Connect, School of Rural Medicine Manager, First Nations Student Services, School of Rural Medicine Associate Dean, Indigenous Health, Western Sydney University*
Community Stakeholder Engagement	Community Stakeholder Engagement Staff	Year 3 and 4 Convenor and Medicine in Context Lead, School of Rural Medicine Associate Head of School, Research, Evaluation and Graduate Studies, School of Rural Medicine Professor of Medicine, Associate Head of School 2021-Jan 2025, School of Rural Generalism Associate Head of School, Rural Generalism, School of Rural Medicine School Manager, School of Rural Medicine Director of External Engagement, Orange & Bathurst
	Community Stakeholders	Member of Rotary Club, Orange Daybreak Director of Headspace Operations, Wagga Wagga, Batemans Bay, Moruya and Narooma HR Operations Manager, Wangarang Industries – not for profit Australian Disability Enterprise Director of Care, Benjamin Short Grove, Aged Care Facility Federal Member for Calare
Faculty Executive		Provost and Deputy Vice-Chancellor (Academic), Charles Sturt University Executive Dean, Faculty of Science and Health, Charles Sturt University Dean, School of Rural Medicine Associate Dean Academic, Faculty of Science and Health, Charles Sturt University Senior Finance Business Partner, Academic Portfolio, Charles Sturt University
Aboriginal and/or Torres Strait Islander community stakeholder engagement	Aboriginal and/or Torres Strait Islander community stakeholders	CEO/Managing Director Orange Aboriginal Medical Service (OAMS)
	Staff involved in Aboriginal and/or Torres Strait Islander community	Head of Staff, Education and Development and Portfolio Lead Clinical School Services Officer, Murrumbidgee Clinical School

* this role-holder is now Associate Head of School, Indigenous Health, School of Rural Medicine, Charles Sturt University

Meetings		Roles engaged with
	stakeholder engagement	
Curriculum		Head of Curriculum, School of Rural Medicine Associate Head of School, Teaching and Learning, School of Rural Medicine Course Director and Head of Assessment, School of Rural Medicine Professor of Medicine, Associate Head of School 2021-Jan 2025, School of Rural Medicine Associate Head of School, Research, Evaluation and Graduate Studies, School of Rural Medicine Associate Head of School, Rural Generalism, School of Rural Medicine Indigenous Health Coordinator and Lecturer in Medicine, School of Rural Medicine Learning, Teaching and Curriculum Associate, School of Rural Medicine
Student Wellbeing		Associate Head of School, Teaching and Learning, School of Rural Medicine Associate Head of School, Rural Generalism, School of Rural Medicine School Manager, School of Rural Medicine Head of Curriculum, School of Rural Medicine Year 3 and Year 4 Convenor and Medicine in Context Lead, School of Rural Medicine Clinical School Services Officer, Murrumbidgee Clinical School, School of Rural Medicine Executive Officer, RHMT programAssociate Director, Safe and Respectful Communities Unit. Division of Safety, Security and Wellbeing, Charles Sturt University Associate Director, Accessibility and Inclusion Support, Charles Sturt Accessibility and Inclusion Adviser, Charles Sturt University Residence Life Coordinator, Charles Sturt University, Orange
Student Experience		Charles Sturt University students (Years 3, 4 and 5) from a range of sites, including the President and Vice President of CHARMS
Aboriginal and/or Torres Strait Islander and Māori Student Experience		Aboriginal and/or Torres Strait Islander Charles Sturt University students
Meeting with Western Sydney University Aboriginal and/or Torres Strait Islander Staff		Associate Dean, Indigenous Health, Western Sydney University*
Tuesday 11 March ***Charles Sturt University, Orange Campus***		
Chair of Academic Senate		Chair, Academic Senate

* this role-holder is now Associate Head of School, Indigenous Health, School of Rural Medicine, Charles Sturt University

Meetings	Roles engaged with
Meeting with Western Sydney University School of Medicine	Dean, School of Medicine, Western Sydney University Manager of School of Medicine, Western Sydney University Deputy Dean, School of Medicine, Western Sydney University Associate Dean – Learning and Innovation, School of Medicine, Western Sydney University
Teaching, Learning and Curriculum Delivery	Head of Curriculum, School of Rural Medicine Associate Head of School, Teaching and Learning, School of Rural Medicine Year 1 and Year 2 Convenor, School of Rural Medicine Year 3 and 4 Convenor and Medicine in Context Lead, School of Rural Medicine Year 5 Convenor, School of Rural Medicine Professor of Medicine, Associate Head of School 2021-Jan 2025 Senior Lecturer in Human Anatomy & Physiology, School of Rural Medicine Head of Clinical School, Orange and PBL Stream Lead, School of Rural Medicine Head of Population Health, School of Rural Medicine Head of Personal and Professional Development, School of Rural Medicine Head of Staff Education and Development and Portfolio Lead
Continuous Review, Evaluation and Improvement, Outcome Evaluation, and Feedback and Reporting	Associate Head of School, Research, Evaluation and Graduate Studies, School of Rural Medicine Associate Professor, Accreditation and Evaluation, School of Rural Medicine Course Director and Head of Assessment, School of Rural Medicine 2nd Year Medical Student and Vice President (Pre-Clinical) Indigenous Representative CHARMS
Assessment Strategy, Professionalism and Fitness to Practice, Assessing Cultural Safety, Evaluation of Assessment	Course Director and Head of Assessment, School of Rural Medicine Head of Curriculum, School of Rural Medicine Associate Head of School, Teaching and Learning, School of Rural Medicine Professor of Medicine, Associate Head of School 2021-Jan 2025 Associate Dean, Indigenous Health, Western Sydney University*
Admissions and selection	School Manager, School of Rural Medicine Associate Director, Admissions and Conversion Admissions Team Leader, Faculty of Science and Health Domestic Admissions Officer, Western Sydney University
Assessment	Course Director and Head of Assessment, School of Rural Medicine Head of Curriculum, School of Rural Medicine Associate Head of School, Teaching and Learning, School of Rural Medicine

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Meetings	Roles engaged with
	Associate Head of School, Research, Evaluation and Graduate Studies, School of Rural Medicine Learning, Teaching and Curriculum Associate Head of Staff Education and Development and Portfolio Lead Educational Infrastructure & Digital Health Technology / Lecturer in Medicine
Professional Staff	School Manager School Executive Support Officer, School of Rural Medicine Manager, Course Administration Team, Faculty of Science and Health Manager, Workplace Learning Administration Team, Faculty of Science and Health Senior Technical Officer, Faculty of Science and Health Clinical School Services Officer, Northern Rivers Clinical School Executive Officer, RHMT Clinical School Services Officer, Murrumbidgee Clinical School Faculty Administration Manager, Faculty of Science and Health
Vice Chancellor	Vice Chancellor, Charles Sturt University
Prevocational training authority: PMCV	Manager, Accreditation and Standards, PMCV Senior Workforce Lead, Prevocational, PMCV
Meeting with co-located schools: University of Wollongong and University of Notre Dame Australia	Chair of Phase 3, Graduate School of Medicine, Faculty of Science, Medicine, and Health, University of Wollongong Head of Clinical School – Wagga Wagga, School of Medicine, University of Notre Dame Australia
Meeting with co-located school: University of Sydney, School of Rural Health	Head of School of Rural Health, University of Sydney
Sector engagement	Future Workforce Manager, NSWRDN Manager, Research Ethics and Governance, WNSWLHD Consumer Representative, Rural Applied Drug and Alcohol Group Senior Radiographer, Mobile CT Service, WNSWLHD Manager Strategy and Partnerships, Rural Workforce Agency Victoria Project Manager, Sustainability Primary Care Initiative, Western NSW PHN Paediatrician, Albury Eating Disorders Coordinator, WNSWLHD Rural Generalist – Surgery/Emergency (Scone and Parkes Hospital), Parkes Surgical Audit Program Internal Medicine Specialist and General Physician
Meeting with Co-Located School: University of New South Wales, Rural Clinical Campuses	Associate Dean and Head of School of Clinical Medicine, Rural Clinical Campuses School Manager, Rural Clinical Campuses
Interprofessional Learning	Head of Curriculum, School of Rural Medicine Professor Quality and Safety, School of Rural Medicine Lecturer in Pharmacology, School of Dentistry and Medical Sciences

Meetings	Roles engaged with
	Year 3 and Year 4 Convenor and Medicine in Context Lead, School of Rural Medicine
Meeting with Primary Care Clinical Supervisors and Sites	GP/Anaesthetist, Your Health, Griffith GP and Clinical Supervisor, Griffith AMS CEO, The Gardens, Albury Doctors, Lake Cargelligo Family Practice GP, Molong Health Service
Meeting with Primary Care Lead and Education Team	Head of Curriculum, School of Rural Medicine Associate Head of School, Teaching and Learning, School of Rural Medicine Head of Central West Clinical School, GP in Parkes Head of Mallee Clinical School and GP in Swan Hill
Wednesday 12 March ***Bathurst Hospital***	
Hospital/Site Executive (CEO/CMO	Director of Medical Services, Bathurst Health Service General Manager, Bathurst Health Service
Clinical Site Leadership	Director of ED, DPET of Bathurst Health Service GP Anaesthetist and Principal of WeCare Health
Clinical Supervisors	Oncologist and Lecturer for Yr3 Students Clinical Skills Nurse and Emergency Department Clinical Nurse Educator
Clinical Supervisors	GP and Lecturer, Yr3 and Yr5 Students Palliative Care, Bathurst Health Service and Adjunct Lecturer Medicine
Community Stakeholders	Mayor of Bathurst Deputy Mayor of Bathurst and Member of the CSU Board
Students	Five Yr 3 Students Two Yr 4 Students Three Yr 5 Students
Meeting with Aboriginal Liaison Office	Cultural Safety Officer Aboriginal Liaison Officer, Bathurst Health Service
Clinical Placement Supervision, Strategy, Process, and Orientation	Head of Central Tablelands Clinical School and Clinical Supervisor of Medical Registrars and Junior Doctors Clinical Lead in Quality Improvement Initiatives at Bathurst Health Services Clinical School Services Officer
Clinical Supervisors	Paediatrician and Lecturer for Yr4 Students Psychiatrist, Lecturer and PPD Tutor
Tour of Facilities	
Meeting with WSU Bathurst	Clinical Dean and Professor, Bathurst Clinical School, Western Sydney University Student Coordinator, Bathurst Clinical School, Western Sydney University

Meetings	Roles engaged with
Wednesday 12 March ***Parkes Hospital***	
Meet with Clinical School Services Officers	Clinical School Services Officers
Tour of Facilities	Year 5 Students
Meeting with Students	Year 3 Students Year 4 Students Year 5 Students
Hospital/Site Executive (CEO/CMO)	General Manager, Parkes Hospital Nursing Unit Manager, Parkes Hospital
Process and Orientation for Students and Staff	Head of Central West Clinical School and Director of Medical Services, Parkes Hospital Clinical School Services Officers
Clinical Site Leadership	Head of Central West Clinical School and Director of Medical Services, Parkes Hospital Doctor, Inpatient Unit Nurse Practitioner and Lecturer, Yr 3 and Yr 5 Students Physiotherapist, Parkes Hospital and Lead, Medicine in Context (MiC) Sprouts Program
Clinical Supervisors, PGY1 Lead, and Junior Medical Staff	Head of Central West Clinical School and Director of Medical Services, Parkes Hospital Junior Doctors, John Fynn JMO Program
Community Representatives	Mayor of Parkes General Manager, Parkes Shire Council
Meeting with Aboriginal Liaison Office	Aboriginal Health Worker, Parkes Hospital Aboriginal Health Worker, Community Health, Forbes Hospital
Wednesday 12 March ***Orange Clinical School***	
Tour of Facilities	Head of Orange Clinical School and Problem-Based Learning Lead Clinical School Services Officer, Orange
Clinical Supervisors	Infectious Diseases Physician/Senior Lecturer in Medicine Nephrologist and Adjunct Associate Professor in Medicine Endocrinologist and Lecturer in Medicine GP, Emergency Registrar/PBL Tutor and Lecturer in Medicine ENT Registrar, Orange Health Service Urological Surgeon, Orange Health Service
Clinical Placement Supervision and Strategy	Head of Orange Clinical School and PBL Lead Clinical School Services Officer
Students	Year 3 Students Year 4 Students Year 5 Students
Meeting with Dudley Private Hospital	CEO, Dudley Private Hospital Clinical Nurse Educator and NUM of Operating Theatres Surgeon in Orange and Parkes

Meetings	Roles engaged with
Meeting with Murrumbidgee Clinical School	Head of Murrumbidgee Clinical School, GP, Your Health and GP/Anaesthetist at Griffith Base Hospital General Surgeon and Lecturer in Medicine Clinical School Services Officer
Meeting with Junior Medical Officers	Junior Medical Officer, Griffith Hospital Junior Medical Officer, Griffith Hospital Junior Medical Officer, Orange Health Service Junior Medical Officer, Orange Health Service
Meeting with Mallee Clinical School	Head of Mallee Clinical School and GP Obstetrician, Swan Hill District Health Adjunct, Mallee Clinical School, Executive Director of Swan Hill District Health Clinical School Services Officer, Mallee Clinical School
Thursday 13 March ***Charles Sturt University, Orange Campus***	
Aboriginal and/or Torres Strait Islander and Māori Staff	Indigenous Health Coordinator and Lecturer in Medicine Clinical School Services Officer, Hastings Macleay Clinical School Adviser, First Nations Student Connect Manager, First Nations Student Services Associate Dean, Indigenous Health, Western Sydney University*
Virtual Meeting with Northern Rivers Clinical School	Head of Northern Rivers Clinical School, Medical Director of Macksville District Hospital CMO, Macksville Hospital GP, Urunga and VMO, Macksville Hospital
Meeting with co-located school – Monash Rural Health	Head of School, Monash Rural Health School Manager, Monash Rural Health
Meeting with prevocational training provider - HETI	Medical Director, HETI Manager, Allocation, Accreditation & Faculty, HETI
Friday 14 March ***Charles Sturt University Orange Campus***	
Final Debrief with Dean and School Leadership	Dean, School of Rural Medicine Course Director and Head of Assessment, School of Rural Medicine School Manager, School of Rural Medicine Associate Professor in Medical Research, School of Rural Medicine School Executive Support Officer (note taker)
Additional meeting – 7 April 2025	
Meeting with Pro-Vice Chancellor, First Nations Engagement	Pro Vice-Chancellor, First Nations Strategy, Charles Sturt University

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