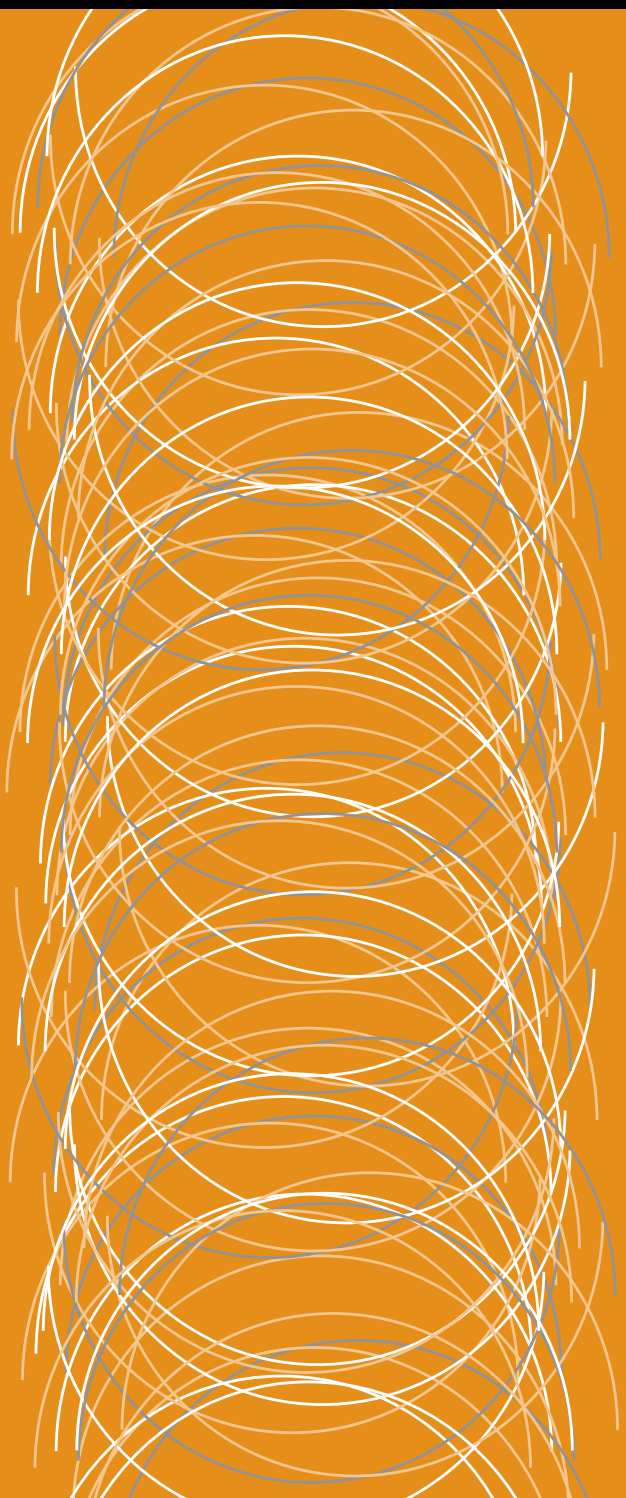
Australian Medical Council Limited

Accreditation of The University of Adelaide Faculty of Health Sciences

AMC



Medical School Accreditation Committee
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Executive summary 2014

The AMC in 2014 conducted a follow-up assessment of the medical program of the University of Adelaide. This assessment was one of the conditions on accreditation placed on the program following the AMC's 2011 reaccreditation assessment. This accreditation report includes the 2011 and the 2014 findings.

2011 reaccreditation assessment

In 2011 an AMC team conducted a reaccreditation assessment of the University of Adelaide's medical program. The team reviewed the Faculty's reaccreditation submission, and visited the Faculty and associated clinical teaching sites. An executive summary of this accreditation assessment is provided at **Appendix One**.

The team identified strengths and continuing challenges, particularly concerning governance and program management, curriculum, evaluation and teaching facilities.

The Medical School Accreditation Committee determined that a three-year period of accreditation, with three progress reports required during this period, would ensure that the Faculty responded in 2012 to urgent matters relating to Standard 1 (governance, leadership and autonomy, medical course management, and educational budget) and Standard 8 (physical facilities), as well as allow the Faculty reasonable time to make plans to address other accreditation standards and implement change before a 2014 follow-up assessment.

The AMC Directors on 25 August 2011 agreed that the MBBS program of the Faculty of Health Sciences, University of Adelaide substantially met the accreditation standards, and that the Faculty was well placed to complete the work required to meet the standards. The Faculty was granted accreditation for a period of three years, to 31 December 2014, subject to conditions.

The conditions placed on the Faculty's accreditation required that:

- By 31 January 2012, show evidence that the program had: an effective governance structure; plans to ensure appropriate autonomy and leadership; plans to improve the authority of the Curriculum Committee; plans for a revised funding model; and evidence of funding and plans for the redevelopment of student facilities.
- In its 2012 progress report, the Faculty was required to provide evidence of the implementation of these plans. It was also required to provide evidence to address conditions including: interaction with the health sector; an adequate staffing plan; curriculum review and renewal; review of teaching and learning methods; reviews of assessment policy, blueprints and evaluation; program monitoring and evaluation; student numbers, support and representation; and student facilities, IT access and a clinical placement strategy.
- In its 2013 progress report, the Faculty was required to provide evidence of the implementation of the plans regarding the 2012 conditions. It was also required to provide evidence that it had sufficient educational expertise.
- In 2014, the AMC would conduct a follow-up assessment to assess progress on the conditions and areas for improvement.

In January 2012, the Faculty submitted its first report on conditions which provided updates predominantly on Standard 1 Governance and Standard 8 Physical facilities. The

Committee accepted the report, noted that it addressed the conditions on accreditation, acknowledged that substantial progress had been made towards meeting the required standards and commended the Faculty on its progress.

In June 2012, the Faculty submitted its mid-year report on conditions and progress report. The Committee considered the report at its 6 August 2012 meeting, agreed that the Faculty continued to make substantial progress against the conditions and had met all but one of the 2012 conditions.

The Faculty's 2013 progress report was considered by the Committee at its 29 July 2013 meeting. The Committee accepted the progress report and determined that three conditions and one area for improvement regarding Standard 3 were progressing; the condition on accreditation and area for improvement at Standard 4 were progressing; two of the four conditions on accreditation at Standard 5 were satisfied and closed in 2013; three conditions on accreditation at Standard 6 were progressing with reporting required in 2014. One area for improvement at this standard was satisfied and closed. All remaining conditions and areas for improvement would be included for reporting in the Faculty's 2014 follow-up submission.

Scope of the 2014 assessment

The 2014 follow-up assessment evaluated the Faculty's progress on the conditions and areas for improvement detailed in the 2011 reaccreditation report. The team also assessed the MBBS program against the approved accreditation standards in order to advise the Committee on whether the Faculty is meeting, substantially meeting or not meeting the accreditation standards.

The Faculty's 2014 submission advised the Faculty intends to introduce a new Bachelor/ MD program in 2017 that would replace the current MBBS program. Once the Faculty submits this proposal to the AMC, the Medical School Accreditation Committee will consider if it is a major change. As such, the scope of the 2014 follow-up assessment did not include this proposed Bachelor / MD program change.

The 2014 team reviewed the School's follow-up submission and the medical student society's submission, and visited the School and associated clinical teaching sites in the week of 15 – 19 September 2014. This report presents the AMC's findings against the *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012*.

Decision on accreditation: 2014

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 an approved accreditation standard. It may also grant accreditation if it is reasonably satisfied that the provider and the program of study substantially meet an approved accreditation standard, and the imposition of conditions on the approval will ensure the program meets the standard 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.

The accreditation decision that can be made by the AMC as a result of this assessment is:

(i) extend the Faculty's accreditation up to six years from the 2011 assessment, taking the accreditation of the program to 31 March 2018[1] subject to satisfactory progress reports;

(ii) if the Faculty is found not to meet all the standards, to set conditions to ensure the standards are met in a reasonable timeframe.

At their 11 March 2015 meeting, the AMC Directors agreed that they were reasonably satisfied the University of Adelaide's medical program meets the approved accreditation standards.

The University of Adelaide has made substantial progress in addressing the conditions and recommendations contained in the 2011 accreditation report concerning governance and program management, curriculum, evaluation and teaching facilities.

The program has now addressed all outstanding conditions on accreditation contained in the 2011 report.

The Faculty has provided impressive resources and shown strong commitment in addressing the challenges raised by the 2011 team and the vision for the future highlighted by the opening of a new medical school building co located with a new Royal Adelaide Hospital.

There are positive changes in the program regarding governance, including the creation of a full-time Head of School and Dean of Medicine and the inclusion of the Medicine Learning and Teaching Unit to the School of Medicine.

The Faculty has made progress since 2011 in Indigenous health teaching, increasing the profile of cultural competency in the early years of the program. With regard to evaluation, students are now able to provide on line feedback following clinical placements to facilitate evaluation and monitoring. The teaching and student facilities are greatly improved since the 2011 assessment.

The AMC Directors agreed:

(i) That accreditation of the Bachelor of Medicine/Bachelor of Surgery six-year degree of the University of Adelaide is confirmed to 31 March 2018, subject to satisfactory progress reports:

(ii) That accreditation is subject to the following conditions:

2015 conditions

By the 2015 progress report, evidence that the Faculty has addressed the following conditions from the accreditation report:

- Demonstrate alignment of the medical program's revised Graduate Outcomes with the AMC Graduate Outcome Statements (Standard 2.2).

[1] From 2014, at the time of an accreditation decision the AMC accreditation end dates will change from 31 December to 31 March (the following year).

- Review the recruitment strategy for Indigenous students in order to increase the representation of Indigenous students in the program (Standard 7.1).

2016 conditions

In the 2016 progress report, evidence that the Faculty has addressed the following conditions from the accreditation report:

- Formalise curriculum reviews into an overall review plan and timetable (Standard 3.2).
- Prepare a curriculum map that includes objectives for all years of the program; that consolidates existing elements regarding the curriculum, teaching format and content; and make it available to staff and students in an accessible format (Standard 3.2).
- Further develop Indigenous health teaching and learning, particularly in the latter years of the program, building on the positive achievements to date in cultural competency training (Standard 3.5 and linked to Standard 8.4).
- Implement a consistent approach to assessment in the various clinical year placements to ensure equivalence of teaching and assessment at sites and between disciplines (Standard 5.4).

Key findings of the University of Adelaide, Faculty of Health Sciences

1. The context of the medical program	MET

All standards are met.

Conditions

Nil

Commendations

The creation of a full-time Head of School and Dean of Medicine who holds the executive authority to effectively manage most of the budget and staffing for the medical program (Standard 1.2).

The organisational re-alignment of the Medicine Learning and Teaching Unit from the School of Population Health to the School of Medicine (Standard 1.3).

2015 recommendations for improvement

Consider committee realignment in order to further delineate the responsibilities of the Curriculum Committee and the Strategy Board (Standard 1.1).

Clearly communicate the division of accountabilities and responsibilities between the Head of School and Dean of Medicine, and Deputy Dean/Program Director to staff and key stakeholders (Standard 1.1).

Examine the feasibility of consolidating administrative and financial control for all aspects of the medical program under the executive management of the Head of School and Dean of Medicine (Standard 1.5).

Report on the feasibility of hiring an Indigenous medical academic as role modelling is an important factor in attracting Indigenous students into the program and such a position would help ensure that Indigenous health issues are reflected throughout the clinical curricula (Standard 1.8).

2. The outcomes of the medical program	MET

Standard 2.2 is substantially met.

2015 condition

Demonstrate alignment of the medical program's revised Graduate Outcomes with the AMC Graduate Outcome Statements (Standard 2.2)

3. The medical curriculum	MET

Standards 3.2 and 3.5 are substantially met.

2016 conditions

Formalise curriculum reviews into an overall review plan and timetable (Standard 3.2).

Prepare a curriculum map that includes objectives for all years of the program; that consolidates existing elements regarding the curriculum, teaching format and content; and make it available to staff and students in an accessible format (Standard 3.2).

Further develop Indigenous health teaching and learning, particularly in the latter years of the program, building on the positive achievements to date in cultural competency training (Standard 3.5 and linked to Standard 8.4).

Commendations

The Faculty's well-developed patient safety curriculum, incorporating 'TeamSTEPPS' which is an evidence-based tool to improve teamwork, communication and patient safety. Modules have been rolled-out state-wide, with some undertaken as inter-professional exercises with the School of Nursing, which is an excellent innovation (Standard 3.2).

The significant progress made since 2011 in increasing the profile of cultural competency, and the work of the Yaitya Purrana Indigenous Health Unit in achieving this (Standard 3.5).

2016 recommendations for improvement

Review the assessment of anatomy with the intent to better focus student learning (Standard 3.2).

Review and standardise the learning objectives and content knowledge required for clinical attachments in order to provide consistency in the depth, breadth and format of learning objectives between clinical rotations (Standard 3.4).

4. Teaching and learning	MET

All standards are met.

Conditions

Nil

Commendation

The use of peer-assisted learning, in particular the Year 6 selectives in medical education and simulation (Standard 4.1).

5. The curriculum – assessment of student learning	MET

Standard 5.4 is substantially met.

2016 condition

Implement a consistent approach to assessment in the various clinical year placements to ensure equivalence of teaching and assessment at sites and between disciplines (Standard 5.4).

Commendation

The additional assessment offered to students who are determined by the Board of Examiners to fail an examination with a D grade on the scale of A-E in one of the four summative assessments (Standard 5.3).

2015 recommendations for improvement

Clarify the function of the tutor reports as formative or summative assessments to both staff and students (Standard 5.1).

Review the standard setting of the end-of-rotation assessments, and blueprint these assessment items to placement learning outcomes and end-of-year assessments (Standard 5.2).

6. The curriculum – monitoring	MET

All standards are met.

Conditions

Nil

Commendation

The Years 4-6 Online Clinical Placements Survey (OCPS) gives students an opportunity to provide feedback at the completion of each of their clinical placements (Standard 6.1).

2016 recommendations for improvement

Review the processes to track student performance in relation to student characteristics in order to inform monitoring and quality assurance for student selection, curriculum and student support (Standard 6.2).

7. Implementing the curriculum – students	MET

Standard 7.1 is substantially met.

2015 condition

Review the recruitment strategy for Indigenous students in order to increase the representation of Indigenous students in the program (Standard 7.1).

2016 recommendations for improvement

Investigate strategies to increase student representation from under-represented groups (Standard 7.1).

Assign a senior academic with oversight for student support in order to provide consistency across the program (Standard 7.4).

Clarify to staff and students the processes and penalties for breaches of the Code of Conduct (Standard 7.4).

8. Implementing the curriculum – learning environment	MET

All standards are met.

Conditions

Nil

2015 recommendations for improvement

Further integrate the Medicine Learning and Teaching Unit website with the University's MyUni platform and improve signposting of content (Standard 8.2).

Review the Faculty's methods of communication and engagement with clinicians at metropolitan Adelaide hospital-based teaching sites (Standard 8.3).

Report on the outstanding conditions

The following tables list the outstanding conditions and recommendations for improvement arising from the 2011 accreditation report. All 2011 conditions and reporting items are now satisfied and closed.

Standard 3: The Medical Curriculum

Standards cover: duration of the medical program, the content of the curriculum, curriculum design, curriculum description, indigenous health and opportunities for choice to promote breadth and diversity.

Outstanding accreditation condition:
• Please report on progress in curriculum review (3.2). Should plans for implementation of the MD program progress, a notice of intent can be lodged with the AMC in advance of the 2014 progress report. As part of curriculum renewal, the AMC requires a plan for review of the curriculum structure and content, including plans to address the following Accreditation Standards (3.2): o Indigenous health content (3.2.7) o Content relating to patient safety and quality assurance of medical care (3.2.8)

- Interprofessional learning (3.2.9).

2014 Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
				X

Team commentary

Since 2011 the curriculum has undergone rolling review, with specific subject areas revisited every 2-3 years. The team recommends preparing a plan and timetable to formalise the program of curriculum reviews.

There has been a significant increase and modification of specific curricula and content dealing with population health, behavioural and social sciences, indigenous health, quality and safety, and interprofessional education.

Outstanding accreditation condition:

- As part of curriculum renewal, the AMC requires a plan detailing strategies to increase integration in curriculum delivery and design, including appropriate leadership and management of the curriculum domains. Please report on strategies to increase integration in curriculum delivery and design (3.3).

2014 Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
				X

Team commentary

The curriculum consists of horizontal and vertical integration across all years and topics which is supported by the committee structure. There are programmed reviews of content of the curriculum by the Year Management committees (addressing horizontal integration) and both Domain Committees (addressing both horizontal and vertical integration of the three major themes) and discipline-based groups (addressing vertical integration of specific disciplines, such as pathology and immunology).

Standard 4: Learning and Teaching

Outstanding accreditation condition:

- In keeping with the Faculty's goals and taking into account the cohort expansion, the AMC requires a review of the teaching and learning methods employed, in particular:
  - Consistency of teaching methods across sites (4.1)
  - Support and rationalisation of IT learning resources, such as the learning management systems. This should include reviewing the reliance on student representatives to gather lecture notes and presentations for uploading into the

learning management systems (4.1).				
2014 Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
				X
Team commentary				
Significant effort has been directed towards enhancing the consistency of teaching and assessment methods across sites. Much of the progress is attributable to the establishment of a Year 4-6 Co-ordinator position. In addition, the development and dissemination of extensive online resources (which can be easily accessed by staff at multiple sites) has addressed many of the issues identified previously. The program has made developments in simulation, which extend across several disciplines and sites. The school is to be commended on its progress in this area. The Medicine Learning and Teaching Unit have made investment in IT resourcing, allowing staff to easily upload learning material. This has removed the need for students to gather notes and presentations. Students remain concerned about the need to access two learning management systems, but the team was satisfied with the Faculty's progress in enhancing the integration of the platforms.				

Standard 5: The Curriculum – Assessment of Student Learning

Standards cover: assessment approach, assessment methods, assessment feedback and assessment quality.

Outstanding accreditation condition:				
• As part of curriculum renewal, the AMC requires: a Evidence that the assessment policy appropriately guides student learning and that its implementation is adequately resourced (5.1) b Evidence of a plan and timelines for review of: ▪ The overall assessment lead and coordination of assessment in Years 1 to 3 ▪ The mix of formative and summative assessments to provide adequate student feedback and guidance (5.1)				
2014 Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
				X
Team commentary				
The medical program has put significant effort into strengthening the assessment practices of the program since 2011. The program now has a full time assessment academic (at senior lecturer level) to lead a coordinated approach to assessment.				

Outstanding accreditation condition:				
• The AMC requires: o Evidence of development of an assessment evaluation plan, including reliability and validity measures and consistency across all sites (5.4) o Progress towards the introduction of standards setting methods for the clinical assessments supported by appropriate training and development. These plans should address concerns about variability; and quality assurance and training of assessors (5.4).				
2014 Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
				X With a new 2014 condition at 5.4
Team commentary				
There is evidence of substantial progress in this area, with an evaluation plan and increased focus on consistency across sites. Training of assessors and other quality assurance measures have been implemented, but there are areas of the assessment where reliability and validity are still being tested. The program has made considerable progress with regard to standardisation of assessment. However, a more consistent approach to assessment in the various clinical year placements is required. Currently, there is significant variation between disciplines.				

Standard 6: The Curriculum - Monitoring

Standards cover: monitoring, outcome evaluation and feedback and reporting

Outstanding accreditation conditions:
• Evidence of a plan for an overall and ongoing Program monitoring and evaluation framework including: o Relevant monitoring in the clinical years and systematic assessment of student clinical placement experience (6.1) o Improved capacity for students to self-monitor their performance formatively (6.1) o the review processes and tools, that is supported by adequate and ongoing resources and staffing (6.2). • As reported in the Faculty's 2012 Progress Report please provide information on the implementation of plans to establish a committee to oversee evaluation and any other relevant initiatives (6.2).

2014 Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
				X
Team commentary				
The program has appointed a full time evaluation and quality assurance coordinator and created an evaluation committee. There is a comprehensive plan to guide the review of many aspects of the medical program. The Years 4-6 Online Clinical Placements Survey (OCPS) gives students an opportunity to provide feedback at the completion of each of their clinical placements				

Outstanding accreditation condition:				
• As at 6.2, evidence of a plan for an overall Program monitoring and evaluation framework, with processes to ensure consistent closure of the feedback loop and accessibility of feedback to stakeholders (6.3).				
2014 Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
				X
Team commentary				
The Evaluation Committee reports on evaluation outcomes through several committees for information and action where required. The school's submission provided several examples of evaluation coordinators utilising evaluation summaries in order to improve aspects of the medical program and providing this feedback on a summary form.				

Standard 8: Implementing the curriculum – learning environment

Standards cover: physical facilities, information resources and library services, clinical learning environment and clinical supervision.

Outstanding accreditation condition:				
• By the AMC follow-up assessment in 2014, evidence of implementation of the redevelopment plan.				
2014 Finding	Unsatisfactory	Not Progressing	Progressing	Satisfied
				X
Team commentary				
The re-developments that have occurred following the 2011 assessment have been				

addressed through the Faculty of Health Sciences working in conjunction with the Central University Management.

Report on the reporting items

Standard 3: The Medical Curriculum

Standards cover: duration of the medical program, the content of the curriculum, curriculum design, curriculum description, indigenous health and opportunities for choice to promote breadth and diversity.

Outstanding reporting item:			
• Review and enhance the following areas of the curriculum (3.2): o Behavioural and social science content o The integration of population health o Communication skills.			
2014 Finding	No Rating	Progressing	Satisfied and closed
			X
Team commentary			
There has been a significant increase and modification of specific curricula and content dealing with population health, behavioural and social sciences, Indigenous health (see Standard 3.5) quality and safety, and interprofessional education.			

Standard 4: Learning and Teaching

Outstanding reporting item:			
• Increase the professional development opportunities for teachers to support the teaching and learning methods employed (4.1).			
2014 Finding	No Rating	Progressing	Satisfied and closed
			X
Team commentary			
The team considers that this recommendation has been met; however there remains room to improve clinical supervisor access to teacher training and other relevant professional development opportunities.			

Introduction

The AMC accreditation process

The AMC is a national standards body for medical education and training. Its principal functions include assessing Australian and New Zealand medical education providers and their programs of study, and granting accreditation to those that meet AMC accreditation standards.

The purpose of AMC accreditation is to recognise medical programs that produce graduates competent to practice safely and effectively under supervision as interns in Australia and New Zealand, with an appropriate foundation for lifelong learning and further training in any branch of medicine.

The standards for accreditation are published in the *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012*. The accreditation standards list the graduate outcomes that collectively provide the requirements students must demonstrate at graduation, define the curriculum in broad outline, and defines the educational framework, institutional processes, settings and resources necessary for successful medical education.

The AMC's Medical School Accreditation Committee oversees the AMC process of assessment and accreditation of primary medical education programs and their providers, and reports to AMC Directors. The Committee includes members nominated by the Australian Medical Students' Association, the Confederation of Postgraduate Medical Education Councils, the Committee of Presidents of Medical Colleges, the Medical Council of New Zealand, the Medical Board of Australia, and the Medical Deans of Australia and New Zealand. The Committee also includes a member of the Council, and a member with background in, and knowledge of, health consumer issues.

The school's accreditation submission forms the basis of the assessment. Following a review of the submission, the team conducts a visit to the school and its clinical teaching sites. This visit may take a week. Following the visit, the team prepares a detailed report for the Medical School Accreditation Committee, providing opportunities for the medical school to comment on successive drafts. The Committee considers the team's report and then submits the report, amended as necessary, to AMC Directors. The Directors make the final accreditation decision. The granting of accreditation may be subject to conditions, such as a requirement for follow-up assessments.

Once accredited by the AMC, all medical schools are required to report periodically to the Medical School Accreditation Committee on the ongoing evolution of the medical program, emerging issues that may affect the medical school's ability to deliver the medical curriculum, and issues raised in the AMC accreditation report. The AMC requires new medical schools and those that have made major program changes to report annually.

The medical program

The University of Adelaide's medical program is a six-year, school-leaver entry program.

The medical program is the responsibility of the Faculty of Health Sciences, one of five faculties of the University. The Faculty is led by an Executive Dean who reports directly to the Deputy Vice-Chancellor and Vice-President (Academic). The Faculty of Health

Sciences currently has eight schools, following the creation of the School of Translational Health Sciences in 2013. The medical program is largely located in the School of Medicine. The School of Medicine, the School of Medical Sciences, the School of Population Health and the School of Paediatrics and Reproductive Health are the four schools involved in delivering the medical program. The Dean of Medicine is also the Head of the School of Medicine.

Accreditation history

The University of Adelaide, Faculty of Health Sciences' MBBS program was first assessed by the AMC in 1991. The program was then assessed in 2001 for reaccreditation, which coincided with a major change to the curriculum. Accreditation was granted for six years with conditions, including a review in 2002 that confirmed the accreditation decision until 31 July 2007. The Faculty submitted a comprehensive report in 2006 which was accepted and the AMC extended the Faculty's accreditation until 31 December 2011, subject to satisfactory progress reports, this being the maximum ten year period permitted between accreditation assessments.

In 2011 an AMC team conducted a reaccreditation assessment of the medical program. The team reviewed the Faculty's reaccreditation submission, and visited the Faculty and associated clinical teaching sites.

The team identified strengths and continuing challenges, particularly concerning governance and program management, curriculum, evaluation and teaching facilities.

The Medical School Accreditation Committee determined that a three-year period of accreditation, with three progress reports required during this period, would ensure that the Faculty responded in 2012 to urgent matters relating to Standard 1 (governance, leadership and autonomy, medical course management, and educational budget) and Standard 8 (physical facilities), as well as allow the Faculty reasonable time to make plans to address other accreditation standards and implement change before a 2014 follow-up assessment.

The AMC Directors on 25 August 2011 agreed that the MBBS program of the Faculty of Health Sciences, University of Adelaide substantially met the accreditation standards, and was well placed to complete the work required to meet the standards. The Faculty was granted accreditation for a period of three years, to 31 December 2014, subject to conditions.

The conditions placed on the Faculty's accreditation required that:

- By 31 January 2012, show evidence that the program had: an effective governance structure; plans to ensure appropriate autonomy and leadership; plans to improve the authority of the Curriculum Committee; plans for a revised funding model; and evidence of funding and plans for the redevelopment of student facilities.
- In its 2012 progress report, the Faculty was required to provide evidence of the implementation of these plans. It was also required to provide evidence to address conditions including: interaction with the health sector; an adequate staffing plan; curriculum review and renewal; review of teaching and learning methods; reviews of assessment policy, blueprints and evaluation; program monitoring and evaluation; student numbers, support and representation; and student facilities, IT access and a clinical placement strategy.

- In its 2013 progress report, the Faculty was required to provide evidence of the implementation of the plans regarding the 2012 conditions. It was also required to provide evidence that it had sufficient educational expertise.
- In 2014, the AMC was to conduct a follow-up assessment to assess progress on the conditions and areas for improvement.

In January 2012, the Faculty submitted its first report on conditions which provided updates predominantly on Standard 1 Governance and Standard 8 Physical facilities. The Committee accepted the report, noted that it addressed the conditions on accreditation, acknowledged that substantial progress had been made towards meeting the required standards and commended the Faculty on its progress.

In June 2012, the Faculty submitted its mid-year report on conditions and progress report. The Committee considered the report at its 6 August 2012 meeting, agreed that the Faculty continued to make substantial progress against the conditions and had met all but one of the 2012 conditions.

The Faculty's 2013 progress report was considered by the Committee at its 29 July 2013 meeting. The Committee accepted the progress report and determined:

- three conditions and one area for improvement regarding Standard 3 were progressing for further reporting in 2014
- the condition on accreditation and area for improvement at Standard 4 were progressing with reporting to be provided in 2014
- two of the four conditions on accreditation at Standard 5 were satisfied and closed in 2013; with two conditions for reporting in 2014
- at Standard 6 three conditions on accreditation were progressing with reporting required in 2014. One area for improvement was satisfied and closed.

Scope of the 2014 assessment

The 2014 follow-up assessment evaluated the Faculty's progress on the conditions and areas for improvement detailed in the 2011 reaccreditation report. The team also assessed the MBBS program against the approved accreditation standards in order to advise the Committee on whether the Faculty is meeting, substantially meeting or not meeting the accreditation standards.

The Faculty's 2014 submission advised the Faculty intends to introduce a new Bachelor/ MD program in 2017 that would replace the current MBBS program. Once the Faculty submits this proposal to the AMC, the Medical School Accreditation Committee will consider if it is a major change. As such, the scope of the 2014 follow-up assessment did not include this proposed Bachelor / MD program change.

The Committee will consider the team's report and decide on the final report and recommendations for accreditation. The Committee presents its recommendations to the AMC Directors who make the final decision on accreditation.

The accreditation decision that can be made by the AMC as a result of this assessment is:

(a) extend the Faculty's accreditation up to six years from the 2011 assessment, taking the accreditation of the program to 31 March 2018; subject to satisfactory progress reports

(b) if the Faculty is found not to meet all the standards, to set conditions to ensure the standards are met in a reasonable timeframe.

If the Faculty is found to not meet the standards, as outlined at Item 5.1 (iv) in the *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2011 a*ccreditation may be withdrawn.

The Committee will consider the team's report and decide on the final report and recommendations for accreditation. The Committee presents its recommendations to the AMC Directors who make the final decision on accreditation.

If the accreditation is confirmed to 2018, in the twelve months prior to the expiry of accreditation the Faculty will be required to submit a comprehensive report seeking a further period of up to four years of accreditation, before a reaccreditation assessment is required in 2021.

This report

This report details the findings of the 2011 and 2014 assessments. Each section of the accreditation report begins with the relevant accreditation standards. The comments of the two AMC assessment teams are recorded under the standards in chronological order.

AMC accreditation standard review 2012

Since the AMC last accredited the University of Adelaide medical program in 2011, the AMC completed a review of the approved accreditation standards in 2011-2012. AMC Directors endorsed the revised accreditation standards and the Medical Board of Australia approved the accreditation standards for use from 2013. The approved standards are published in *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012.*

This report is prepared against the 2012 standards, and where changes have been made since the 2011 report was written, there are notes that indicate if a standard has been moved, subsumed by another, or if the standard is new.

The members of the 2011 and 2014 AMC teams are given at **Appendix Two.**

The groups met by the AMC in 2011 and 2014 are given at **Appendix Three.**

Appreciation

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

1 The context of the medical program

1.1 Governance

1.1.1 The medical education provider's governance structures and functions are defined and understood by those delivering the medical program, as relevant to each position. The definition encompasses the provider's relationships with internal units such as campuses and clinical schools and with the higher education institution.

1.1.2 The governance structures set out for each committee, the composition, terms of reference, powers and reporting relationships, and allow relevant groups to be represented in decision making.

1.1.3 The medical education provider consults relevant groups on key issues relating to its purpose, the curriculum, graduate outcomes and governance.

2011 team findings

At the time of the 2002 AMC accreditation the University of Adelaide had five academic Faculties: Engineering, Computer and Mathematical Sciences; Humanities and Social Sciences; the Professions; Sciences; and Health Sciences. At that time the Faculty of Health Sciences included the Medical School and the Dental School. The executive dean of the Faculty of Health Sciences was also the dean of the medical school from which the MBBS Program was administered. The faculty has since changed this structure, and now has seven schools and two institutes. This has allowed for alignment with other university faculties and has improved reporting lines through to senior university management. It has enhanced the faculty's ability to more effectively meet the strategic priorities encompassing research, teaching and learning. It also removed the previous misconception that the MBBS Program was unfairly advantaged over the other degree programs.

The current University structure continues with the same five Faculties. Within the Faculty of Health Sciences, the seven Schools are Dentistry, Medical Sciences, Medicine, Nursing, Psychology, Paediatrics and Reproductive Health, and Population Health and Clinical Practice. Each of the Schools within the Faculty of Health Sciences contains one or more Disciplines, each with a Discipline Head. The heads of schools report to the executive dean of faculty.

Schools in Faculty of Health Sciences	**Disciplines / Units within each School**
School of Psychology	Single Discipline
School of Dentistry	Single Discipline
School of Nursing	Single Discipline
School of Medical Sciences	• Anatomical Sciences and Pathology • Pharmacology • Physiology

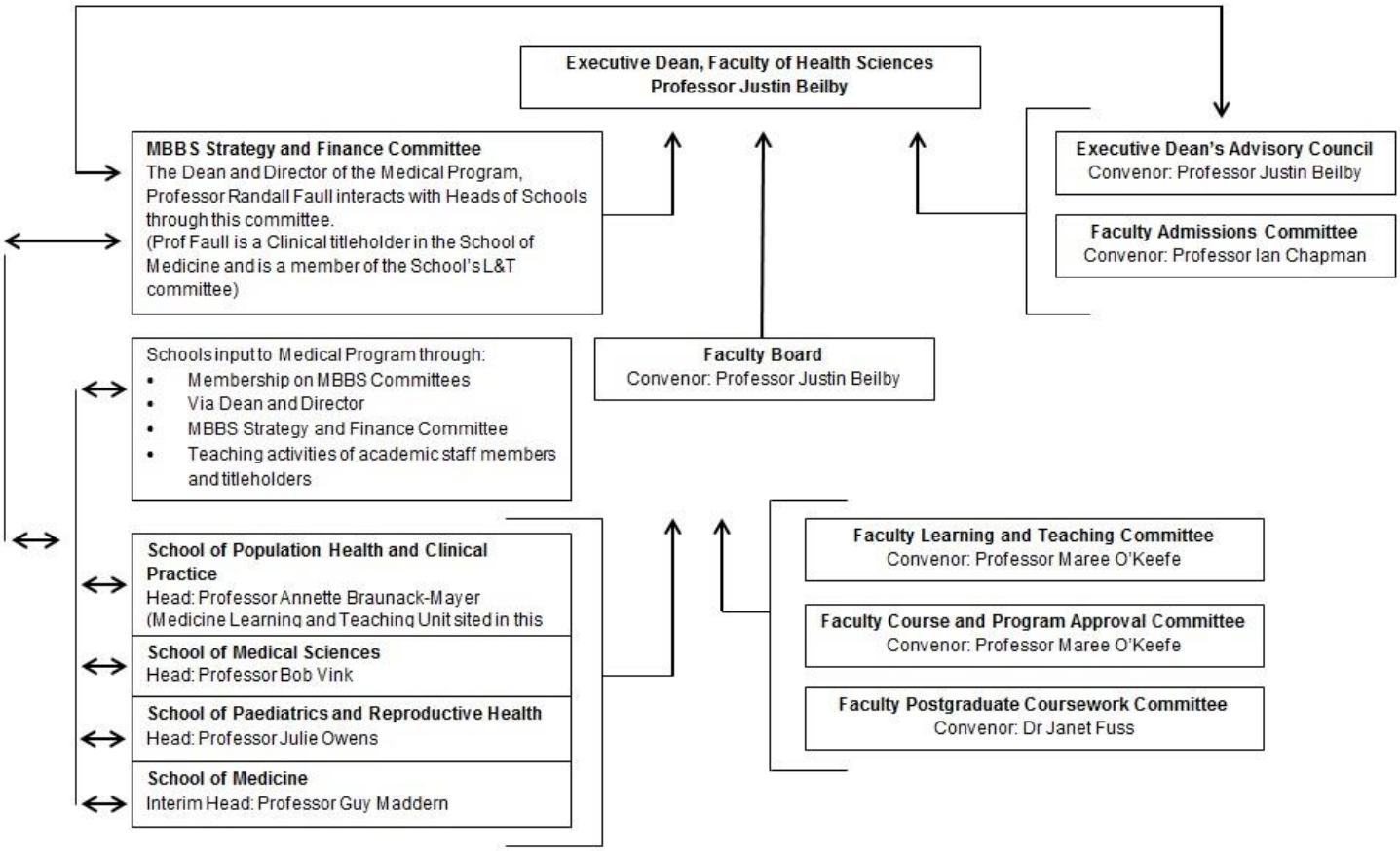
Schools in Faculty of Health Sciences	Disciplines / Units within each School
School of Medicine	• Acute Care Medicine • Medicine • Orthopaedics and Trauma • Psychiatry • Surgery • Ophthalmology and Visual Sciences
School of Paediatrics and Reproductive Health	• Obstetrics & Gynaecology • Paediatrics
School of Population Health and Clinical Practice	• General Practice • Public Health • Rural Health • Centre for Military and Veterans' Health • Medicine Learning and Teaching Unit • Yaitya Purruna – Indigenous Health Unit

The governance of the Faculty of Health Sciences rests with the Executive Dean's Advisory Council, which is comprised of the executive dean and the seven Heads of Schools. The MBBS Strategy and Finance Committee reports to the Advisory Council and was established in 2009. The MBBS Strategy and Finance Committee is chaired by the executive dean and includes the four Heads of Schools who teach into the MBBS Program, the dean and director of the program and the director of the Medicine Learning and Teaching Unit.

The main operational and strategic committee of the Faculty of Health Sciences is the Faculty Board that reports to the Academic Board of the University. Membership includes the heads of schools, dean of dentistry and associate deans of research, international, and learning and teaching. The dean and director of the MBBS Program have recently been appointed to this committee.

The major committees of the Faculty and the position of the MBBS Program in the Faculty are mapped in the table below, as provided in the Faculty's 2011 submission.

Figure 1.1 Faculty of Health Science Structure and Relationship to Medical Program



The MBBS Program lies outside this structure and has no ownership by any of the seven Schools within the Faculty. Staff in the Schools of Population Health and Clinical Practice, Paediatrics and Reproductive Health, Medical Sciences, and Medicine contribute to program delivery. The Faculty notes in its submission that "engagement by the Schools tends to focus on their specific area of responsibility, rather than the overall MBBS Program, and in some Schools there is a sense that their teaching in the MBBS Program is expensive 'service-teaching' only (not cost-effective) with little sense of ownership".

A "Dean and Director" is the academic head of the MBBS program and the incumbent reports directly to the executive dean. The head of the program (dean and director, MBBS Program) is a 0.3 FTE position with no financial responsibility apart from a small budget line set aside for innovation and no line management responsibility for any contributing staff members. With no executive authority this position relies on advocacy for funding and staffing. This creates an important distinction from the School of Dentistry where the Head has retained the title of Dean and its programs include the Bachelor of Dental Surgery and the Bachelor of Oral Health together with a range of postgraduate courses.

The apparent isolation of the MBBS Program is of widespread concern to staff, students and external stakeholders. The team considers that this seriously limits opportunities for innovation and creativity. Furthermore, as the MBBS Program is undoubtedly one of the University's flagship programs, there is a common perception amongst those interviewed that the effects of this isolation pose a true threat to the University brand.

2014 team findings

There have been numerous organisational changes within the University of Adelaide and the Faculty of Health Sciences since the 2011 AMC assessment. At the highest level of the University's management, Professor Warren Bebbington assumed the role of Vice-Chancellor and President in mid-2012. In 2013 the University released its ten year Strategic Plan along with supporting operational and financial plans.

The medical program is the responsibility of the Faculty of Health Sciences, one of five faculties of the University. The Faculty is led by an Executive Dean who reports directly to the Deputy Vice-Chancellor and Vice-President (Academic). The Faculty of Health Sciences currently has eight schools, following the creation of the School of Translational Health Sciences in 2013.

Each of the eight schools within the Faculty now has a head of school who reports directly to the Executive Dean. The Executive Dean remains the convenor of the Faculty Board and the Executive Dean's Advisory Council and has overall responsibility for resource allocation across all schools in the Faculty.

Shortly before the assessment team's visit, the Executive Dean of the Faculty of Health Sciences, Professor Justin Beilby, resigned his position. Pending recruitment of a new Executive Dean, Professor Alastair Burt was acting Executive Director of the Faculty at the time of the team's visit. Professor Burt joined the Faculty in January 2013 in the newly created role of Head of School of Medicine and Dean of Medicine,

In order to backfill Professor Burt, an acting Head of School (Medicine) was also in place. The team views the roles of Executive Dean of the Faculty and Head of School and Dean of Medicine as critical for the medical program.

Following the assessment team's visit, the AMC was advised that Professor Burt was the successful candidate for the role of Executive Dean. The University planned to advertise and fill the position of Head of School of Medicine and Dean of Medicine. The AMC requests an update on the recruitment to the role of Head of School and Dean of Medicine in the program's next progress report.

Since the 2011 assessment the Faculty has created a new position of Deputy Dean and Program Director. This role is Chair of the Curriculum Committee and participates in organisation of program delivery and student affairs. The team considers that the division of accountabilities and responsibilities between the Dean of Medicine and Deputy Dean/Program Director are not clear to some members of staff, and suggests there is value in communicating with staff and stakeholders to clarify and further delineate these roles.

The Executive Dean, the Head of School and Dean, and Deputy Dean and Program Director all sit on the University's Academic Board, as do several other heads of school from the Faculty.

A significant development since the 2011 assessment is that most of the administration for the medical program now resides within the School of Medicine. The new position of Head of School is the Dean of Medicine with overall responsibility for the MBBS program. In 2011, the head of the medical program was the Dean and Director of the MBBS program who carried out the role on an a 0.3 FTE basis, with no financial responsibility apart from a small budget line set aside for innovation, and no line management responsibility for any contributing staff members. The 2014 team

commends the creation of the role of a full time Head of School and Dean who holds the executive authority to effectively manage most of the budget and staffing for the medical program.

The medical program continues to be delivered by four schools within the Faculty. The medical program also includes courses and teaching from outside of the Faculty, offered by the School of Molecular and Biomedical Science in the Faculty of Sciences.

This arrangement results in a medical program with significant elements sitting organisationally outside of the School of Medicine, with each of the schools that make a considerable contribution to the medical program retaining a level of autonomy over their allocated resources. There appears to be greater clarity regarding responsibilities and financing of the medical program since 2011, which the 2014 team viewed as largely attributed to the leadership of the Head of School and Dean of Medicine. However, the team considered that consolidating the administrative and financial control for all aspects of the medical program under the executive management of the Head of School and Dean of Medicine would be advantageous for the program.

Schools within the Faculty of Health Sciences

Schools **** Denotes schools which teach into the MBBS program***	**Discipline / Teaching unit**
School of Dentistry	Single Discipline
School of Medical Sciences *	• Pharmacology • Physiology • Anatomy and Pathology
School of Medicine*	• Acute Care Medicine • Medicine • Ophthalmology • Orthopaedics and Trauma • Psychiatry • Medicine Learning and Teaching Unit • Surgery
School of Nursing	• Single Discipline
School of Paediatrics & Reproductive Health*	• Paediatrics • Obstetrics and Gynaecology
School of Population Health*	• General Practice • Rural Health School • Public Health • Centre for Military and Veterans' Health

Schools **** Denotes schools which teach into the MBBS program***	**Discipline / Teaching unit**
	• Yaita Purruna
School of Psychology	Single Discipline
School of Translational Health Sciences	Single Discipline

Since 2011, the University has undertaken reviews of the structure and governance of the Faculty of Health Sciences and the School of Medicine.

With the support of the Vice Chancellor, in 2014 the Faculty of Health Sciences has undergone an external review led by Emeritus Professor Richard Larkins, former Dean of Medicine at the University of Melbourne and Vice-Chancellor of Monash University. The purpose of the review was "to assist the Faculty in developing the most appropriate structure that promotes excellent in learning teaching and research and drives business effectiveness and sustainability". All schools within the Faculty were included in the scope of the review.

The University is seeking to streamline its administrative functions, and it is anticipated that there is likely to be some rationalisation of the number and shape of schools within the Faculty following this review.

The recommendations arising from the review were due to go the Vice-Chancellor soon after the team's visit in September 2014. One of the options discussed with the team would reduce the number of schools within the Faculty of Health Sciences, potentially bringing together the medical program into one school. This potential consolidation of resources teaching into the medical program into one organisational unit represents an opportunity to provide direct control of the program to the Head of School and Dean of Medicine. The team strongly supports this direction. Any significant changes to the governance structure of the Faculty arising from the review should be reported to the AMC in the next progress report.

An internal review of the School of Medicine was also undertaken in 2013/14 to provide recommendations as to how the School could operate most efficiently and effectively. The School was consulting on proposed changes at the time of the 2014 team's visit. The AMC expects to be apprised of any major changes resulting from the internal review in the next progress report.

Changes to the governance of the medical program since 2011 include the creation in 2012 of the Medical Programs Education Committee, now named the Medical Programs Governance and Strategy Board, and simply referred to as the Strategy Board. The Strategy Board has responsibility for oversight of the program including consideration of budgetary matters, quality assurance and decision-making on major curriculum change. It is the key decision making committee for the program and chaired by the Dean of Medicine. The Strategy Board reports to the Faculty Board and on funding and budgetary matters to the Executive Dean's Advisory Council.

The Evaluation and Quality Assurance Committee, Future Projects Committee, and the Curriculum Committee are key committees that report to the Strategy Board.

Evaluation and Quality Assurance Committee: This committee was established in 2013. It advises the Curriculum Committee if there is urgent need for remedial actions as a result of its evaluation. The committee advises the Curriculum Committee, Year Level and Domain Committees on the scope, methodology and conduct of the evaluation of learning and teaching within the program. The membership of the committee includes academic staff, hospital/health service representatives and medical students. The Chair of this committee reports directly to the Dean of Medicine.

Future Projects Committee: The Future Projects Committee is responsible for major change initiatives within the medical program. Two significant projects are the new medical school building, and the planned implementation of a Bachelor/MD program.

This committee has lead responsibility for developing learning and teaching plans for the new Adelaide Medical and Nursing School building that will be established within the South Australia Health and Biomedical Precinct. This precinct will also include the new Royal Adelaide Hospital and South Australian Health and Medical Research Institute.

In mid-2013 it was agreed that the development of the Bachelor/MD program would be the responsibility of the Future Projects Committee rather than the Curriculum Committee. Once the new program is fully developed, it is envisioned the responsibility for implementation and ongoing renewal of the new program would shift to the Curriculum Committee.

Curriculum Committee: The medical program's curriculum planning, implementation and review is coordinated through the Curriculum Committee. The committee remains responsible for reviewing and revising the content of the existing program but major changes are referred to the Strategy Board for consideration. The Deputy Dean and Program Director chairs the Curriculum Committee.

The team observes over-lapping functions and responsibilities of the Curriculum Committee and the Strategy Board. The program may wish to consider committee realignment in order to further delineate the responsibilities of these bodies.

Medical program staff indicated a refinement of the subcommittees of the Strategy Board may be necessary, with a re-evaluation of the roles of Year Level committees and increased clarity of reporting lines for Boards of Examiners. This work is currently being completed and is linked to the recent review of the structure and governance of the School of Medicine. The team considers that there would be benefit in improving access to all committee minutes, so that they are more readily and broadly available. Communication between committees at present appears to rely on cross-membership and, while the value of this is not questioned, sharing of minutes provides a fall-back position.

1.2 Leadership and autonomy

1.2.1 The medical education provider has autonomy to design and develop the medical program.

1.2.2 The responsibilities of the academic head of the medical school for the medical program are clearly stated.

2011 team findings

The dean and director of the MBBS Program is responsible to the executive dean of faculty for the program's leadership and quality and for the overview of program content and delivery. The role advocates for staffing and budget, and is required to be the decision-maker in student cases of leave and appeals. The faculty noted in its submission that while the dean and director of the MBBS Program "is afforded considerable respect and cooperation, the ability to direct change is limited as the heads of schools report directly to the executive dean". Importantly, the dean and director is a member of the main MBBS committees and is therefore able to maintain appropriate monitoring of the program.

While the program is tasked to autonomously design and implement the course, its isolation through lack of positioning within a single school in the Faculty of Health Sciences makes it particularly vulnerable. This specifically relates to the previously stated issues of lack of budget and line management responsibility of the dean and director (head) of the MBBS program. The faculty identified in its submission that this autonomy is limited by the lack of direct control over funding or the dispersal of funds within the program, which severely limits the introduction of any initiatives that would require additional staffing or resources. The result is little true autonomy particularly in areas of innovation and development.

There is also considerable diversion of effort in persuading staff to participate in the program and this often requires careful negotiation with the heads of schools within the faculty. The faculty noted that there is an inclination for each of the schools to concentrate on programs or courses entirely housed within their own school. A conflict resolution pathway exists through the MBBS Strategy and Finance Committee. This is the forum through which the dean and director of the MBBS program can negotiate with the contributing heads of schools. If negotiations fail, then issues default to the executive dean who has the authority to be directive and to provide assistance to the dean and director of the MBBS program.

2014 team findings

Organisational changes implemented within the Faculty of Health Sciences since the 2011 assessment, particularly the creation of a Head of School and Dean of Medicine, have substantially improved the level of autonomy of the Dean to develop and run the medical program. The team considers there remains scope to further consolidate the resources of the medical program into one organisational structure under the executive authority of the Head of School and Dean of Medicine.

There was clearly a strong sense of collaboration among the schools who teach into the medical program and evidence of significant cross-school teaching contributions. The latter is clearly important for a well-coordinated and integrated program. The team believes that while there was clearly a collaborative will to achieve this end, there remains a natural tension when a program is being delivered with resources drawn from and controlled by multiples. This potential tension could be alleviated with the transfer of all resources responsible for the delivery of the medical program into one school.

The Head of School and Dean of Medicine has a clear role as the academic head of the program which was not present in the previous leadership structure.

1.3 Medical program management

1.3.1 The medical education provider has a committee or similar entity with the responsibility, authority and capacity to plan, implement and review the curriculum to achieve the objectives of the medical program.

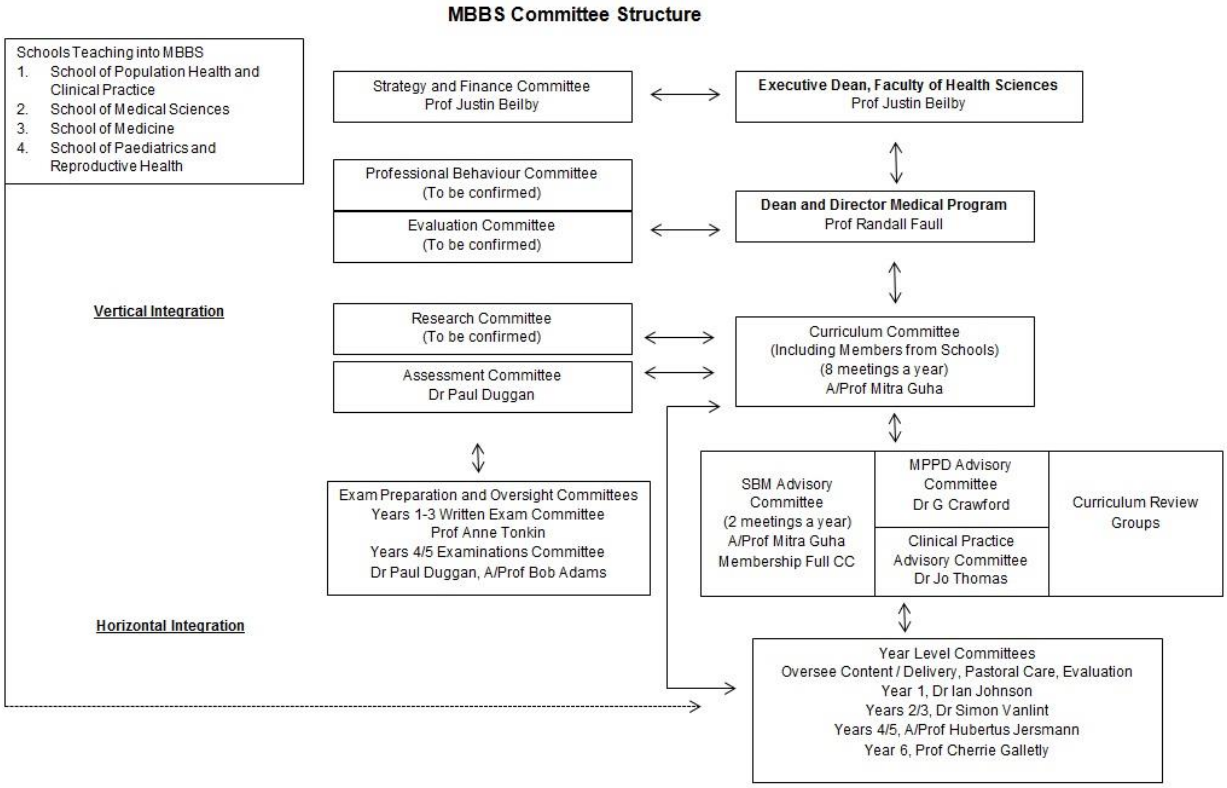
1.3.2 The medical education provider assesses the level of qualification offered against any national standards.

2011 team findings

The MBBS Curriculum Committee is responsible for content and delivery of the MBBS Program and the policies related to this. It is well positioned to have considerable influence over the program with all MBBS committees reporting to it with the exception of the Strategy and Finance Committee. The faculty noted with concern in its submission that a relatively small number of senior staff members are relied on and there is limited capacity for succession planning. Additionally, membership is heavily reliant on the good will of clinicians, which is considered an area of vulnerability and risk by committee members. For example, the faculty noted that the current dean and director of the MBBS program and the Chair of the Curriculum Committee are hospital staff who hold clinical titles.

Quite often there is an inability to fund key contributors to the program. This risk is exacerbated by the lack of a Curriculum Committee budget where all funding requirements must be subject to relevant budget holders who are generally the Heads of Schools. In addition, there is no power or autonomy for decisions of the MBBS committees to be implemented. This has contributed to disarticulation between the Curriculum and Assessment Committees and their capacity to implement change.

The following diagram sets out the MBBS committee structure in 2011:



The Medicine Learning and Teaching Unit is responsible for the implementation of the MBBS curriculum. There is no Discipline of Medical Education in any of the schools and the Dean and executive dean recognise the need to establish a Discipline of Medical Education. The Medical Learning and Teaching Unit currently functions as an implementation unit from within the School of Population Health and Clinical Practice. It is engaged in medical education research, leadership and participation in assessment development and implementation and counselling of students experiencing difficulties with the program. However, the faculty noted in its submission that academic staffing levels in the Medicine Learning and Teaching Unit allow for little, if any, time for academic activities or research.

The MLTU also has administrative responsibility for timetabling, lecturer support, room bookings, on-line information delivery, and the organisation and support of examinations and MBBS committees.

There is a close relationship between the Medicine Learning and Teaching Unit and the Curriculum Committee, which is responsible for design and content of the curriculum, with several staff being members of both entities. These groups are to be commended for the very good communication and support that exists between them.

2014 team findings

In 2012 the Medicine Learning and Teaching Unit moved from the School of Population Health to the School of Medicine. The Faculty's submission suggests that following the review of the School of Medicine the unit may change its name to reflect a broader base of support for the medical program. The Director of the Medicine Learning and Teaching Unit reports directly to the Head of School and Dean of Medicine, and the team commends this organisational realignment, which places the Medicine Learning and Teaching Unit as an equivalent to a discipline of medical education within the School of Medicine. The Director of the Medicine Learning and Teaching Unit is a member of all of the key decision making bodies in the program including the Strategy Board, Future Projects Committee and Curriculum Committee.

The relationship between the Medicine Learning and Teaching Unit and the Curriculum Committee is largely unchanged from 2011. The Curriculum Committee is responsible for the oversight of design, content and renewal of the program whereas the Medicine Learning and Teaching Unit is responsible for organisation and delivery (particularly in Years 1-3).

1.4 Educational expertise

1.4.1 The medical education provider uses educational expertise, including that of Indigenous peoples, in the development and management of the medical program.

2011 team findings

The Medicine Learning and Teaching Unit currently resides within the School of Population Health with the head of the Medicine Learning and Teaching Unit reporting directly to the head of this school. The work of this Unit is vital to the program. Unfortunately, the Medicine Learning and Teaching Unit's capacity to support up-skilling of staff teaching into the MBBS program is limited by lack of funding. In addition, the capability of the Unit would be greatly enhanced by the appointment of additional staff

with specific expertise in education methods, curriculum design, assessment and evaluation. The Faculty must view this with some urgency.

The academic staffing of the MLTU is shown below, with 1 Professor (E) and 4 Lecturers (B):

Medicine Learning and Teaching Unit				
University funded (FTE)	Jointly funded (FTE)	Externally funded (FTE)	Clinical titles etc.	Research only (FTE)
In post 1 E 4 B			1	
Vacant - Nil				
Proposed (with funding) 0.6FTE Level B Lecturer in Clinical Skills and Assessment (to commence in 2011)				

The Year 6 elective term in medical education where students participate in the delivery of education and planning into the Year 1 and 2 programs is highly regarded by students and staff and is highly commended.

There are two Indigenous academics and one Indigenous administrative support officer. These staff teach into a range of academic programs but are all on short-term contracts with little prospect of permanent appointment. Of concern is that there appears to be no particular support for the development of educational expertise for Indigenous people.

The team was greatly impressed by the professionalism and academic leadership provided by the Medicine Learning and Teaching Unit. The Director of the Unit plans to retire at the end of 2014, and the team highlights her significant contributions to the University of Adelaide medical program. The team reinforces the importance of this position to the medical program and its students.

Since 2011 the Medicine Learning and Teaching Unit also incorporates medical education research and development in its portfolio. A Medical Education Research Collaborative has been established which will form the academic platform in future development of the new discipline of medical education. The Medicine Learning and Teaching Unit now also incorporates the MLTU-IT group, which has an essential role in maintaining the custom-built MLTU website.

A lead for simulation was appointed within the Medicine Learning and Teaching Unit in 2013. The team was impressed with the progress made in clinical simulation and the accomplishments of the MLTU-IT team.

1.5 Educational budget and resource allocation

1.5.1 The medical education provider has an identified line of responsibility and authority for the medical program.

1.5.2 The medical education provider has autonomy to direct resources in order to achieve its purpose and the objectives of the medical program.

1.5.3 The medical education provider has the financial resources and financial management capacity to sustain its medical program.

2011 team findings

The isolation of the MBBS Program within the Faculty of Health Sciences has created serious budgetary issues. The Faculty of Health Sciences budget allocation is determined after a prescribed central University amount for shared and central services is deducted. From this, funding is distributed in a transparent manner to the seven schools making up the Faculty that includes the four schools contributing to the MBBS Program. The current funding allocation from the University to the Faculty is generally regarded as adequate. The team agrees with this assessment. It is, however, of considerable concern that there is no specification as to how funds should be allocated by each of the four Schools to the Program.

Both the team's interviews and the Faculty's submission indicated that many School staff believe that they have no obligation to contribute to the MBBS Program teaching which results in reliance on a considerable amount of goodwill, powers of persuasion, and preparedness of the Heads of Schools to be directive in order for the Program to be effectively delivered. This is blamed for a growing dependence on clinical titleholders and carries a risk should their cooperation not continue. In addition, the Medicine Learning and Teaching Unit is a part of the School of Population Health and while the Medicine Learning and Teaching Unit budget is defined, it is controlled by the Head of School and not by the Head of Unit. The Faculty noted in its submission that "there has been some tendency to see the funding provided to the MLTU as a potential pool of money which could be re-allocated for other purposes within Schools".

Student intake has increased in a step-wise manner since the last accreditation, though is not expected to rise further. In 2005, student intake was 124, and in 2010, this intake peaked with a student cohort of 200. As the increased numbers of students reach the clinical years, the continued commitment of title-holders and use of 'free' space in the hospitals will be tested, particularly as South Australia Health (SA Health) has discussed potential tenancy agreements and annual rent for hospital space.

The Faculty Strategy and Finance Committee is responsible for determining appropriate resource allocation. This Committee must ensure that the MBBS Program, through its staff, committee structures and physical resources, is supported in a manner that is more directly aligned to teaching and learning functions.

2014 team findings

At the time of the 2011 assessment, the program had experienced considerable growth in student load. Student intake increased from 124 students in 2005 to peak at 200 students in 2010. However, the program has steadily reduced the size of the cohort to arrive at its current intake of approximately 150 students per year (190 students entered the program in 2011, 208 in 2012 and 159 in 2013).

The Faculty has consciously reduced the size of the enrolment as the increased student numbers would have significant implications for clinical placements over time and would lead to a graduate output that exceeded the School's Commonwealth contracted numbers. The Faculty has a projected an intake of approximately 150 students in Year 1 over the next three - four years. The breakdown of students includes 70 Commonwealth

Supported Places, 50 government funded bonded students and 30 international fee paying students.

This stabilisation of student numbers, particularly the intent to maintain the current target for international students, clearly has implications for the major source of funding for the medical program. The team notes that despite improvements in the budgetary position of the Faculty, the acting Executive Dean faced a requirement to produce a sustainable cost structure that will require further efficiency savings from the schools. The Faculty of Health Sciences has experienced significant cost pressures over the past two years and unanticipated drops in income, for example through reduction of block grant funding. This is a challenge shared by other higher education institutions. In order to mitigate a negative variance in 2014 and achieve a balanced position by 2016, the Faculty has implemented cost savings on salaries through vacancy management.

The review of the Faculty structure is part of an overall efficiency mandate, and there will be pressure to reduce costs in the next few years. A further risk to the program is the possibility of direct charging for clinical placements by SA Health.

This environment reinforces the need to ensure that available funding and resources are used for the medical program and not directed towards other functions. Given the current organisational structure, it is not surprising that there remains a lack of clarity about the specific allocation from different schools to the medical program, noting that in practice at this point this does not appear to be having negative effects. However, this will need to be monitored as the Faculty comes under increasing pressure to maintain a balanced budget. The team will be interested in an update on the financial position of the medical program in its next progress report.

In 2013 the University adopted a new financial planning model with the objective of simplifying the budget allocation process and providing greater transparency at the faculty and school level. The fundamental change is that all teaching and research revenue is now allocated to faculties as earned. The Faculty is required to meet a gross margin target set by the University and these targets are then flowed on to schools and Faculty Office to meet budget requirements.

Allocation to schools involved in the medical program is calculated on the basis of teaching load with the model for assignment of time blocks for teaching differing between that in Years 1 – 3 from Years 4 – 6.

The Faculty believes this new budget allocation has improved the transparency of funding related to the medical program. The team understands that at the time of the assessment, the Dean of Medicine was working with the Faculty Manager to investigate the feasibility of putting the MBBS budget entirely in the School of Medicine with cross charging to the other schools according to the student load principles adopted in the last two budget cycles. It is anticipated the Faculty review will have some impact on the allocation process, which will need to be factored in 2015 budget process.

1.6 Interaction with health sector and society

1.6.1 The medical education provider has effective partnerships with health-related sectors of society and government, and relevant organisations and communities, to promote the education and training of medical graduates. These partnerships are underpinned by formal agreements.

1.6.2 The medical education provider has effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to promote the education and training of medical graduates. These partnerships recognise the unique challenges faced by this sector.

2011 team findings

The Faculty of Health Sciences has developed and maintained relationships with Commonwealth and State Government agencies. This includes the recently established South Australian Institute of Medical Education and Training that aims to improve the quality of education, training and welfare for trainee medical officers within the State, and to make recommendations for the accreditation of trainee medical officer positions in health services. SA Health remains informed about medical graduate projections and it has given reassurance that sufficient placements will be available for all graduating domestic students in 2012. The health agencies report that communication with the MBBS Program can be challenging. In part, this is blamed on a lack of clarity regarding key contacts and on the lack of identity of the MBBS Program. This causes uncertainty about how information is shared, which also appears to hamper effective strategic dialogue.

There remains a very close relationship between the Faculty and the Royal Adelaide Hospital largely due to the excellent clinician involvement in the MBBS Program. It is important that the University supports this by ensuring appropriate and effective senior academic staff representation on the Hospital's senior management committees. Good relationships exist with The Queen Elizabeth Hospital, the Women's and Children's Hospital, Modbury Hospital and the Lyell McEwin Health Service. Nevertheless, these relationships would be greatly enhanced by improved communication and greater recognition of staff contribution by the University. The Spencer Gulf Rural Health School welcomes student placements through a close working relationship with clinical staff employed by Country Health SA. Unicare, the general practice company in the Faculty of Health Sciences, now has eight practices that are being developed as teaching networks.

Construction of the new Royal Adelaide Hospital is set to start late in 2011 and is scheduled to be completed in 2016. Located on North Terrace the new hospital will replace the existing Royal Adelaide Hospital and will be co-located with the new South Australian Health and Medical Research Institute, making the health precinct the hub of medical research in the State. The new Royal Adelaide Hospital will remain a major teaching hospital with the intention of working closely with the State's three main tertiary institutions. The Faculty is cognisant of the priority to have a medical school building within the new Royal Adelaide Hospital and linked to the South Australian Health and Medical Research Institute. There are key Faculty staff involved in South Australian Health and Medical Research Institute and Royal Adelaide Hospital committees and in groups related to the re-development.

The Faculty of Health Sciences must maintain effective ongoing dialogue with SA Health and senior hospital management to ensure its needs are clearly stated and its requirements for physical space are understood and formally agreed. This is particularly important given the University of South Australia's Horizon 2020 statement indicates that the University aspires, in the next decade, to establish an innovative medical school that focuses on addressing the health needs of disadvantaged populations and complements its already strong teaching and research in health-related disciplines.

2014 team findings

The team met with senior SA Health officials who indicated engagement with the medical program had improved with the appointment of the Head of School and Dean of Medicine. SA Health is experiencing budget cuts and increasing service demands, as well as undergoing continuing organisational change. The transfer of services to the new Royal Adelaide Hospital and the flow on consequences for other hospitals, which are as yet unquantified from a service perspective, could have significant effects for the teaching environment of the medical program and the level of support from clinicians. It was clear that all parties were aware of these issues and highly engaged in resolving them.

SA Health officials noted their concerns about the impact of the significant increase in medical student numbers, while noting positively the recent moves to stabilise the medical program's intake. The demand for intern places was also high on the agenda of health department representatives who noted that the cessation of the Commonwealth Government funding for the Prevocational General Practice Placements Program would have an immediate consequence on intern numbers in South Australia from 2015. The Faculty is encouraged to continue discussions on this matter with SA Health particularly given the potential flow on consequences for international students.

Staff at the Modbury and the Lyell McEwin Hospitals voiced concerns regarding the level of resource commitment by the program to these facilities. The Acting Executive Dean informed the team that a commitment had been made for a fulltime Level E Chair of Medicine at Lyell McEwin Hospital, which was about to be advertised at the time of the team's visit (see also Standard 1.8).

The Faculty's Strategy Board has approved the creation of a Medical Program Advisory Council that will provide external stakeholder input into the program, specifically as an external validation on the purpose and mission of the program**.** At the time of the team's visit, membership had not yet been finalised but it was anticipated an initial meeting would be held before the end of 2014.

The Yaitya Purruna Indigenous Health Unit (YPIHU) is based in the School of Population Health within the Faculty of Health Sciences. YPIHU staff have strong community links and profiles and contribute to ongoing information sharing and promotion in the South Australian Aboriginal community. YPIHU also has strong ties with the peak Aboriginal Community Controlled Health organisation and many of its members.

1.7 Research and scholarship

1.7.1 The medical education provider is active in research and scholarship, which informs learning and teaching in the medical program.

2011 team findings

The four Schools in the Faculty of Health Sciences that contribute to the MBBS Program are highly research intensive and account for the majority of research income and publications within the Faculty. Their contribution to the University is reflected in the University's highly commendable world ranking of 73rd in The Times Higher Education List for 2010.

Importantly, most academic staff participating in the delivery of the MBBS Program are research active and many "research only" staff contribute lectures and workshops in their areas of expertise.

The Faculty is to be further commended for the establishment of several outstanding centres of research excellence and institutes including the Population Research Outcome Studies Unit, the Robinson Institute and the Adelaide Centre for Neuroscience Research. The South Australian Health and Medical Research Institute is a particularly exciting collaborative venture that has the potential to deliver a greater number of tangible health outcomes. This venture already has the essential underpinnings of a globally recognised leadership team with strong financial, government and community support.

2014 team findings

Relative to its size, the University of Adelaide has retained an extra-ordinary standing internationally for its research. In 2013-14 the University ranked 95th internationally in research in health and pre-clinical sciences in the Times Higher Education World University rankings. The Faculty of Health Sciences remains the University's most significant research income generator. In Excellence in Research for Australia 2012 the overarching Field of Research for the Faculty's research received the highest possible rating of 5, indicating that the evidence provided was "well above world average".

The development of the new medical school building and the University's engagement in the South Australia Health and Medical Research Institute should position it well to continue this outstanding research profile.

In South Australia the key partners with respect to research are: SA Health (and its constituent networks and hospitals); South Australian Health and Medical Research Institute; SA Pathology; South Australian Research and Development Institute and the Commonwealth Scientific and Industrial Research Organisation.

Since 2011, the construction of the South Australian Health and Medical Research Institute has been completed in the new South Australia Health and Biomedical Precinct. The Faculty has significant academic presence at the South Australian Health and Medical Research Institute, with five research groups relocating from the Frome Road site to the new biomedical precinct.

The Royal Adelaide Hospital will move from its position adjacent to the medical school buildings to the biomedical precinct. The opening is planned for 2016.

In 2013 the University secured $60m from the Commonwealth Government for the development of the building that will house the Schools of Medicine and Nursing and most of the major clinical research groups in the Faculty of Health Sciences. The new medical school will be integral part of the biomedical precinct, and adjacent to the new Royal Adelaide Hospital and the South Australian Health and Medical Research Institute. The medical school will continue its colocation with the new Royal Adelaide Hospital and also provide opportunities for partnerships in basic and clinical research. The total University capital investment in the precinct will be over $200M. Further commentary on these investments in infrastructure can be found in this report under Standard 8.

The team endorsed the importance of the University's integration to the South Australian Health and Medical Research Institute in terms of attracting high quality academic staff and in informing the science of medicine. The Faculty hosts the Joanna Briggs Institute, as part of the School of Translational Health Science, an international

not-for-profit research organisation with links to over 70 partners worldwide. The Institute and its collaborating entities promote and support the synthesis, transfer and utilisation of evidence based healthcare practices to assist the improvement of healthcare outcomes globally. Maintaining this internationally recognised research profile requires a significant additional funding from the University's core funding and given financial pressures, this is likely to be challenging.

The team notes that given the research profile of the Faculty, the current level of engagement of students in research was relatively low. However, there were a number of new initiatives from the Research sub-committee that were noteworthy in addressing this. The team was impressed with the research skill development framework, a conceptual framework to guide skills associated with research, problem solving critical thinking and clinical reasoning.

1.8 Staff resources

1.8.1 The medical education provider has the staff necessary to deliver the medical program.

1.8.2 The medical education provider has an appropriate profile of administrative and technical staff to support the implementation of the medical program and other activities, and to manage and deploy its resources.

1.8.3 The medical education provider actively recruits, trains and supports Indigenous staff.

1.8.4 The medical education provider follows appropriate recruitment, support, and training processes for patients and community members formally engaged in planned learning and teaching activities.

1.8.5 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.

(Note: The responsibilities of hospital and community practitioners have been moved in the 2012 standards to 8.4; and the 2010 standard 1.10 staff indemnification standard is subsumed here).

2011 team findings

The governance structure of the Faculty of Health Sciences determines that the responsibility for staffing the MBBS Program rests with heads of schools and the executive dean, rather than with the dean and director (head) of the Program itself. This means that the MBBS Program is dependent on the goodwill of staff where many contribute to the teaching program and participate in Faculty and School committees on a voluntary basis, often in addition to their normal clinical workload. There is generally no provision for reducing the workload of the substantive positions for those serving on these committees and this has reportedly lead to some being either unwilling or unable to contribute to the Program.

It is also apparent that a large number of staff do not have their expected contribution to the MBBS Program stated explicitly as part of their job description. This, combined with the previously stated lack of budgetary responsibility, was raised as an area of concern

in the AMC response to the 2008 periodic report from the Faculty. The University must be encouraged to rectify these weaknesses as a matter of considerable urgency.

The increase in student numbers has increased the workload of administrative staff. In particular, the service responsibilities of the MLTU have increased and the Faculty must insure that the level of support provided to the MLTU remains appropriate to these changing circumstances. If this does not occur, then ongoing development and innovation in the key areas of curriculum design, evaluation and assessment will remain under threat.

Yaitya Purruna, the Faculty's Indigenous Health Unit, is part of the School of Population Health and Clinical Practice. While this Unit has appointed two new Indigenous staff in 2010 the team strongly encourages the implementation of an active recruitment program of Aboriginal and Torres Strait people onto the staff of the MBBS Program.

The University has Professional Indemnity insurance cover for University staff involved in clinical research and in the delivery of teaching programs. There is additional insurance cover for medical malpractice and clinical and human study trials.

2014 team findings

At the time of the 2014 assessment, the Faculty was undertaking vacancy management to contain costs. The team noted that these strategies, while necessary, have the potential to de-stabilise smaller units and suggests the Faculty closely consider the importance of particular vacancies for the medical program. Specifically, the team holds the view the Medicine Learning and Teaching Unit, given its central role in maintaining the current curriculum, development of the new curriculum and the support of students, should be exempted from vacancy management or any potential downsizing.

The team also notes the vacancy in the role of Year 4-6 Co-ordinator, which has played an important role in improving consistency with assessment across sites. Given this position was vacant at the time of the assessment visit, an update on recruitment is requested in the next progress report (also discussed at Standard 4.1).

The team noted the substantial contribution of Yaitya Purruna, the Faculty's small Indigenous Health Unit and the work the Unit has been undertaking in implementing the cultural competency program. It was evident to the team that this essential work left little capacity for other Indigenous health education development activity. The team also noted the lack of Indigenous clinical staff as part of the unit or elsewhere in the medical program. It is recommended that the Faculty consider recruiting an Indigenous medical academic; given that role modelling is an important factor in attracting Indigenous students into the program. Moreover, such a position would help ensure that Indigenous health issues are reflected throughout the clinical curricula.

The School of Medicine seeks to better align the administrative and professional support for Years 1-3 of the current MBBS program with those of Years 4-6. To achieve this, there is a proposal to develop a single administrative platform that combines the support currently contained within Medicine Learning and Teaching Unit with that in the more dispersed Clinical Education Offices within the public hospitals (and other providers). The proposal suggested no overall reduction in the number of professional staff but significant changes to the staff reporting lines. At the time of the team's visit, this was the subject of consultation with staff and the unions and final iterations of the proposals were not yet agreed.

The team noted that the potential impact of the review of the Faculty of Health Sciences on professional staff structures. As one of the drivers for the review is to ensure on-going financial viability, it can be assumed that there will be some proposals to reduce staff numbers.

The Faculty appointed a number of key staff in order to meet the accreditation conditions arising from the 2011 assessment. The only academic vacancy at the time of the assessment was a Level E in the Discipline of Surgery following the retirement of a previous Head of Discipline. This post has not yet been advertised, but the Faculty notes recruitment to academic surgical posts is not without its challenges. The team will be interested in an update regarding recruitment to this position. The team also requests an update regarding the recruitment of a fulltime Level E Chair in Medicine at Lyell McEwin Hospital, which was about to be advertised at the time of the team's visit.

1.9 Staff appointment, promotion & development

1.9.1 The medical education provider's appointment and promotion policies for academic staff address a balance of capacity for teaching, research and service functions.

1.9.2 The medical education provider has processes for development and appraisal of administrative, technical and academic staff, including clinical title holders and those staff who hold a joint appointment with another body.

2011 team findings

Until recently, promotion for academic staff within the University of Adelaide had largely been on the basis of research success. This has changed to permit recognition of teaching and service to the University as important components of the promotion process.

Performance excellence is a key initiative of the University of Adelaide Strategic Plan, which aims to support the University's culture of excellence and continual improvement.

There is a range of staff development programs available. These include courses run by the University's Centre for Learning and Professional Development Unit. Within the Faculty of Health Sciences there is a Quality Assurance Toolkit for Learning and Teaching to assist Faculty staff in the evaluation of teaching and learning. In addition, the Faculty has a policy that actively provides regular feedback to academic and clinical titleholders regarding the quality of their student teaching. There is extensive and active engagement with all clinical titleholders across all four Schools and they are provided with access to Student Experience of Learning and Teaching (SELT) student responses regarding their teaching performance. The Faculty has now run a number of "Teaching on the Run" programs for academic and clinical titleholders that have been very well received.

Employment practices for staff working on the MBBS Program adhere to University of Adelaide recruitment policy. There is a good gender mix and range of cultural backgrounds across both staff and titleholders. The University of Adelaide has an Aboriginal and Torres Strait Islander employment strategy. It is acknowledged that social, educational and economic disadvantage is experienced by many Aboriginal and Torres Strait Islander people and that this disadvantage is apparent in the continuing under-representation of Aboriginal and Torres Strait Islander people across the higher education sector. This includes the Faculty of Health Sciences that must continue to

work hard to ensure appropriate recruitment and retention of staff of Indigenous descent and background.

2014 team findings

The Faculty and the University appear to have in place good policy and infrastructure to meet these standards.

In 2013 the University adopted a new approach to promotion which recognises excellence in the development of teaching programs, and leadership in teaching and learning. Previously, promotions (particularly to Level D or E) were weighted towards research outputs but applicants now elect whether they are considered as 'general academic', 'research focused' or 'teaching focused'.

In 2013 there was an additional change to the way in which Clinical Titleholder applications seeking promotion to Level D were processed. Under the revised arrangements, applications are considered by a Committee drawn from Heads of School in the Faculty of Health Sciences, who are considered best placed to understand the spread of responsibilities of clinicians. This process has proved effective, and has resulted in promotion to Associate Professor of staff whose principal contributions to the University are in teaching rather than in research.

2 The outcomes of the medical program

2.1 Purpose

2.1.1 The medical education provider has defined its purpose, which includes learning, teaching, research, societal and community responsibilities.

2.1.2 The medical education provider's purpose addresses Aboriginal and Torres Strait Islander peoples and/or Maori and their health.

2.1.3 The medical education provider has defined its purpose in consultation with stakeholders.

2.1.4 The medical education provider relates its teaching, service and research activities to the health care needs of the communities it serves.

2011 team findings

The Faculty of Health Sciences has clearly defined its mission which encompasses the MBBS Program. The mission and vision statements can be found at http://health.adelaide.edu.au/faculty

While this refers to "local, national and global communities" there is no specific reference to the health of Indigenous people.

2014 team findings

The vision and purpose of the program were revised following a strategic retreat in 2013 with stakeholders and recent graduates. Additional patient and public input will be sought by the program through a further review by the Medical Program Advisory Council, which should be formed by the end of 2014 (see Standard 1.6). The team encourages the program to engage community representatives through appropriate and effective mechanisms, for example through the Medical Program Advisory Council.

The medical program's purpose is as follows:

> *To produce medical doctors with a diversity of talents*
>
> i. *who are passionate about, and committed to, the delivery of the highest quality patient-centred care*
>
> ii. *whose practice is research-informed and evidence-based and*
>
> iii. *who are equipped to contribute to and lead enhancement and enrichment of healthcare services throughout the world.*

The purpose statement is supplemented by a list of 18 aims for graduates of the University of Adelaide medical program. There is now reference to Indigenous peoples and health in the list of program aims which indicates graduates "understand and appreciate the healthcare needs of diverse populations including those from remote, low socio-economic and Indigenous backgrounds."

This aim aligns with the University of Adelaide's Integrated Aboriginal and Torres Strait Islander Education Strategy, Tarrkarri Tirrka (Future Learning). The Education Strategy was approved by the Academic Board in 2013 and documents the University's approach to recruiting Indigenous students and increasing Indigenous staff numbers.

As detailed in the University's Research Impact report the research strategies are responsive to emerging global and national research priorities. From 2007 to 2011 the University's research income increased from $115 to $170 million. In 2013 the Faculty generated 47% of the University's $174.6m in research income.

Although the medical program relates its curriculum and learning objectives to national health priorities, especially around the aging population, dementia, diabetes, obesity and inequities in rural and Indigenous health, the team could not identify a clear statement that highlights this alignment and the team encourages the development of such a statement.

2.2 Medical program outcomes

2.2.1 The medical education provider has defined graduate outcomes consistent with the AMC Graduate Outcome Statements and has related them to its purpose.

2.2.2 The medical program outcomes are consistent with the AMC's goal for medical education, to develop junior doctors who are competent to practise safely and effectively under supervision as interns in Australia or New Zealand, and who have an appropriate foundation for lifelong learning and for further training in any branch of medicine.

2011 team findings

The graduate outcomes include a description of required clinical skills but these have not yet been mapped to the Australian Curriculum Framework for Junior Doctors. This should be undertaken as part of the planned 2012 review of graduate attributes.

2014 team findings

In 2013 the University of Adelaide adopted common graduate attributes for all undergraduate programs:

- Knowledge and understanding of the content and techniques of a chosen discipline at advanced levels that are internationally recognised.
- The ability to locate, analyse, evaluate and synthesise information from a wide variety of sources in a planned and timely manner.
- An ability to apply effective, creative and innovative solutions, both independently and cooperatively, to current and future problems.
- Skills of a high order in interpersonal understanding, teamwork and communication.
- A proficiency in the appropriate use of contemporary technologies.
- A commitment to continuous learning and the capacity to maintain intellectual curiosity throughout life.
- A commitment to the highest standards of professional endeavour and the ability to take a leadership role in the community.
- An awareness of ethical, social and cultural issues within a global context and their importance in the exercise of professional skills and responsibilities.

These global university outcomes are incorporated into the medical program outcomes.

The 2014 graduate outcomes of the medical program have not been significantly altered since 2011. The medical program outcomes are organised according to three domains:

- Medical Professional & Personal Development
- Scientific Basis of Medicine; and
- Clinical Practice.

The program has mapped the outcomes of the medical program to the AMC Graduate Outcome Statements, which illustrates gaps in specific areas. As examples the following AMC graduate outcomes are not explicit in the medical program's outcomes:

3.4 Understand and describe the factors that contribute to the health and wellbeing of Aboriginal and Torres Strait Islander peoples and/or Māori, including history, spirituality and relationship to land, diversity of cultures and communities, epidemiology, social and political determinants of health and health experiences. Demonstrate effective and culturally competent communication and care for Aboriginal and Torres Strait Islander peoples and/or Māori.

3.6 Describe a systems approach to improving the quality and safety of health care.

3.8 Describe the attributes of the national systems of health care including those that pertain to the health care of Aboriginal and Torres Strait Islander peoples and/or Maori.

3.9 Demonstrate an understanding of global health issues and determinants of health and disease including their relevance to health care delivery in Australia and New Zealand and the broader Western Pacific region.

4.5 Demonstrate awareness of factors that affect doctors' health and wellbeing, including fatigue, stress management and infection control, to mitigate health risks of professional practice. Recognise their own health needs, when to consult and follow advice of a health professional and identify risks posed to patients by their own health.

4.6 Identify the boundaries that define professional and therapeutic relationships and demonstrate respect for these in clinical practice.

There is no specific mention of Indigenous health issues in the medical program outcomes, although there are details about respecting diversity, culture and language.

The team understands the alignment between the medical program's outcomes and the AMC Graduate Outcome Statements will be addressed in the development of the new Bachelor/MD program. The program is considering adopting a fourth domain (potentially Medical Advocacy, Leadership and Professionalism), which would be introduced with the new degree. As the implementation date of the new program has not been determined (but will not occur prior to 2017), the team considers the review and implementation of the medical program's revised Graduate Outcomes should be completed as a priority. While there is general alignment with the AMC Graduate Outcome Statements, the team recommends closer examination of the medical program's outcomes to identify areas where the emphasis or requirements within AMC standards are not explicit within the program's statements.

The program has made improvements in the standardisation of assessment since the last accreditation. The clinical component of Year 3 is delivered across four sites in

Adelaide and coordinated to deliver a consistent program. Assessment for clinical skills is carried out through a centrally run end of year Objective Structured Clinical Examinations (OSCE). Additionally, the program has added observers to OSCEs to monitor quality and variation within and across stations in all years of the program commencing in 2014.

The medical program evaluates the Year 6 internship semester and the selectives semester utilising assessment methods based on the intern assessment proforma. The medical program has indicated that comparable outcomes are achieved across all instructional sites (see standard 5.4 for additional commentary).

The Discipline of Rural Health has undertaken a comparison between Year 5 student performance in the longitudinal rural program with Year 5 students who spend the year primarily in Adelaide. The results suggest that students in the rural program are equivalent to their urban peers, and often better in some areas, although the areas in which rural cohort performance is superior vary from year to year.

3 The medical curriculum

3.1 Duration of the medical program

The medical program is of sufficient duration to ensure that the defined graduate outcomes can be achieved.

2011 team findings

The curriculum may be best described as a hybrid curriculum, combining case-based learning (CBL) and more didactic methods, such as lectures, seminars and practical sessions. There is some confusion among students and staff about the differences between problem-based learning (PBL) and the chosen CBL model. Both PBL and CBL are part of a continuum, and there is often substantial overlap in models and the acronyms often do not convey a clear message about the learning process. In this, curriculum clinical scenarios are the trigger for all of the cases, but they directly provide much more information than is usual in PBL. The sample cases that were provided to the team were rather long and complex, requiring six hours of student contact per week in Years 1-2 and four hours per week in Year 3. Each case was accompanied by a substantial amount of material that appears to reflect the content of what could be in lectures, but the associated lectures often add even more material that may or may not be linked to the cases. While this approach may be an attempt to make work easier for students, the team is concerned that it may also reduce the self-directedness of the case-based discussions and contribute to curriculum over-crowding. Although students enjoy the experience, the approach is not well understood by many students and staff. The Faculty could describe and communicate this better.

The current curriculum is now 11 years old. Despite periodic updating, the curriculum now requires an overall review. This is probably a reflection of ad hoc evolution over 11 years rather than a planned development. The Program's academic team has made improvements to areas of the curriculum as required, and it regularly reviews sections and updates cases. Its efforts are limited though by the resources available to the Program and the current governance structure. The substantial increase in the size of the student cohort also needs to be considered. The team is of the opinion that the curriculum is in urgent need of an overall review and renewal to optimise delivery to a current cohort of 190 in the re-configured South Australian health care system.

2014 team findings

The program duration and overall program outcomes are unchanged from the last accreditation. The program is a school-leaver entry, six-year program. The first three years are integrated and organised around case-based learning supported by lectures, small group teaching and clinical skills teaching. The second three years are based in standard clinical attachments to medical teams in hospitals with some attachments to primary care and opportunities to do elective courses.

3.2 The content of the curriculum

The curriculum content ensures that graduates can demonstrate all of the specified AMC graduate outcomes.

3.2.1 Science and Scholarship: The medical graduate as scientist and scholar

The curriculum includes the scientific foundations of medicine to equip graduates for evidence-based practice and the scholarly development of medical knowledge.

3.2.2 Clinical Practice: The medical graduate as practitioner

The curriculum contains the foundation communication, clinical, diagnostic, management and procedural skills to enable graduates to assume responsibility for safe patient care at entry to the profession.

3.2.3 Health & Society: The medical graduate as a health advocate

The curriculum prepares graduates to protect and advance the health and wellbeing of individuals, communities and populations.

3.2.4 Professionalism and Leadership: The medical graduate as a professional and leader

The curriculum ensures graduates are effectively prepared for their roles as professionals and leaders.

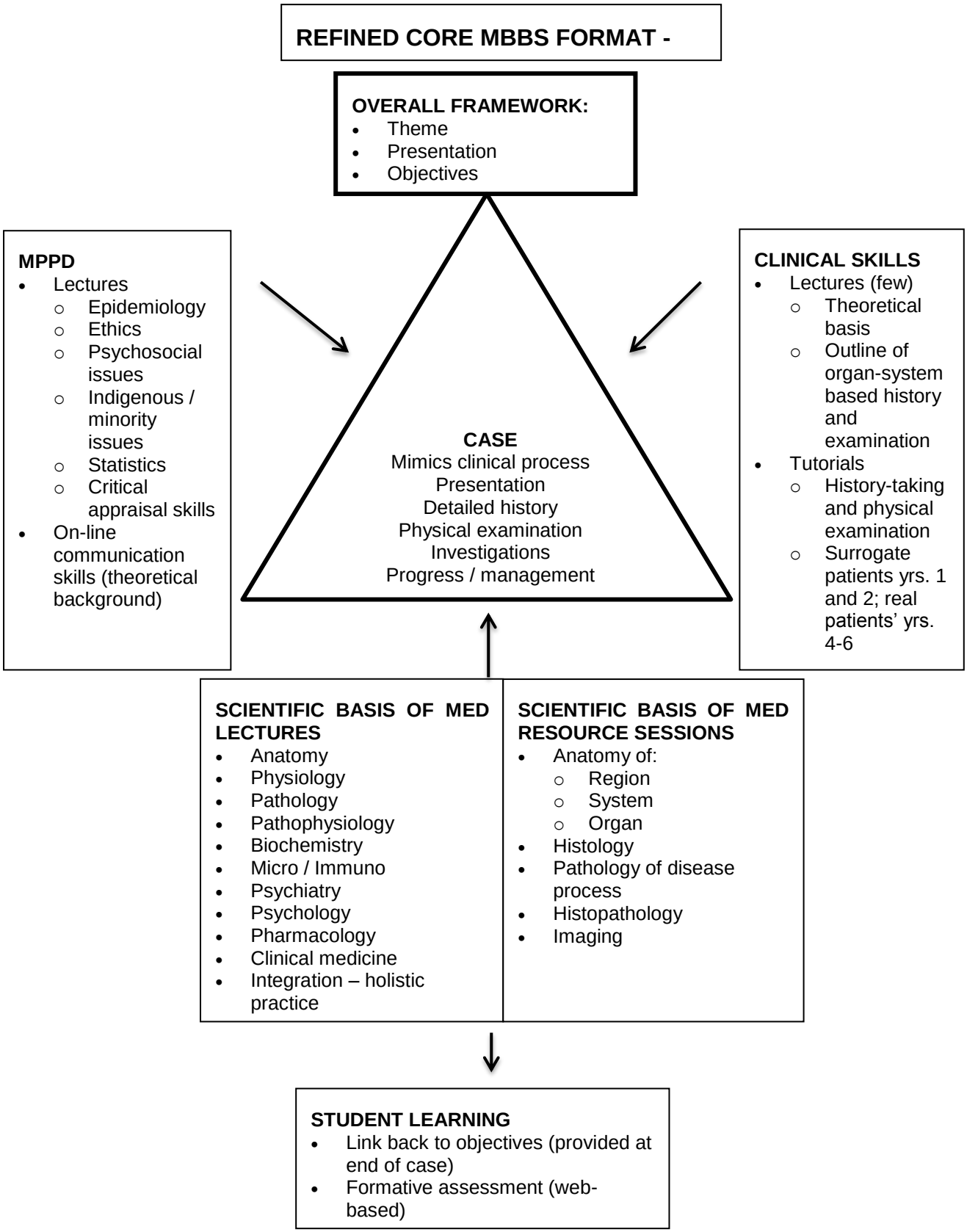
2011 team findings

Structure and duration

The medical school has developed descriptions of the content, extent and sequencing of the curriculum that guide staff and students on the level of knowledge and understanding, skills and attitudes expected at each stage of the course.

The curriculum is organised into three streams or domains: Scientific Basis of Medicine, Medical Personal and Professional Development, and Clinical Practice.

The refined core of the MBBS Program is shown in the diagram below, noting the three streams or domains:



Within the three streams, material is integrated and organised into four overlapping themes: Life Support and Movement, Life Control, Life Maintenance, and Life Cycle/Community. Each theme is visited in each year in progressively increasing complexity and each theme will cover all three streams. A key to the thematic structure of CBL cases is provided below:

Figure 3.2 Key to Thematic Structure of CBL Cases

Themes			**Areas** **(All areas include Anatomy, Pathology, Histology, Pharmacology and Physiology)**
Life Support & Movement	LSM		Musculoskeletal system, skin and connective tissue, Peripheral NS
Life Control	LCrl		Endocrinology, CNS (Mind,Brain)
Life Maintenance	LMo	oxygen delivery	Biochemistry, Cardiovascular, Respiratory and Haematological Systems
	LMp	protection	Immunology, Infection, Cancer & Molecular Biology, Preventative Medicine, Public Health Medicine
	LMb	balance	Nutrition, Gastrointestinal and Renal Systems
Life Cycle/Continuity	LCy		Reproductive System, Child Health and Development, Genetics, Sexual Health, Ageing, Death

In relation to the streams or domains, Medical Personal and Professional Development and Clinical Practice have identified individuals appointed as leaders to oversee their vertical implementation, with the Curriculum Committee as a group providing this role for the Scientific Basis of Medicine stream. There is limited guidance on how curriculum delivery is allocated to each stream, indicated by approximate weightings in assessment for Medical Personal and Professional Development (10%). Scores allocated to clinical assessment indicate the importance of Clinical Practice, but the message to students is that Scientific Basis of Medicine is the main stream on which to focus and that Medical Personal and Professional Development is a minor stream.

The curriculum in Years 1-3 occupies a relatively high proportion of the students' available time. Students are scheduled for 25-28 hours per week. This is partly because students requested additional tutorials and practical sessions such as Anatomy. Due to resource limitations the Faculty has largely scheduled additional lectures in response to the requests. At times this results in a repetition of content delivery with low attendance rates and is illustrative of poor strategic management of the curriculum.

There still appears to be a strong division between pre-clinical and clinical years, with relatively little patient contact in Years 1 and 2. The clinical years (4-6) have a series of core ("home") rotations and opportunities for gaining further experiences in a wide range of selective Specialist, Community or Ambulatory Placements. The rural placements are emerging as a strong feature that is both popular with students and produces good assessment outcomes. There is a strong and effective collaboration with the Flinders University Program in the Barossa Valley.

Scientific method

The curriculum is based upon principles of scientific method and evidence-based practice, and inculcates analytical and critical thinking.

The curriculum meets this standard.

Biomedical sciences

The curriculum includes those contributions from the biomedical sciences that enable understanding of the scientific knowledge, concepts and methods of clinical science.

The Program provides students with a strong grounding in the biomedical sciences relevant to medical care. Students highly value the Anatomy teaching. All students have access to prosection material and a highly regarded set of on-line resources for histology that are available through the e-Medici system. Dissection is available to a limited number of students as a selective. The externally sourced science teaching in "Fundamentals of Biomedical Science" (basic concepts in Biology and Chemistry for 2 semesters) was regarded as fitting poorly into the curriculum because of different teaching and assessment styles provided in the Faculty of Science. This biochemistry teaching initiative is advantageous to students entering the Program without prior learning in chemistry, thus improvement would be valuable.

Clinical sciences and skills

The course provides a comprehensive coverage of:

- *Clinical sciences relevant to the care of adults and children.*
- *Clinical skills (medical history construction, physical and mental state examination, diagnostic reasoning skills, problem formulation and construction of patient management plans).*
- *Management of common conditions, including pharmacological, physical, nutritional and psychological therapies.*

The Program has access to very good academic resources to support student learning in all required adult and paediatric clinical sciences. There are core rotations in Medicine, Surgery, Human Reproductive Health, Paediatrics and Child Health, Psychiatry, Musculo-skeletal Medicine (Orthopaedics/ Trauma/ Rehabilitation), as well as selective opportunities in a wide range of clinical specialties. Students currently have ample opportunities to learn the required clinical sciences and the management of common conditions.

Clinical skills teaching is delivered in dedicated facilities, including the Clinical Skills rooms on Level 2 of the Medical School South Building and the new Clinical Simulation Centre in the basement of the Medical School North Building. While the latter is

excellent, the former is in an old, poorly equipped and outdated building. Both facilities are small for a Program with an intake of around 190 students per year and have to be shared with students from other health professional courses, resulting in over-crowding and limited access outside of scheduled sessions. While students and staff report satisfaction with the clinical skills teaching that is provided, curriculum renewal should consider expanding the learning resources and opportunities offered to improve the vertical Clinical Practice stream.

Population health

The course provides a comprehensive coverage of population, social and community health.

The leadership of the School of Population Health and Clinical Practice has recently changed, but strong support remains for teaching into the MBBS Program. A Program strength is the inclusion of an aged care block which reflects a link to the changing demographics of health care. The curriculum content reflects substantial teaching of population health issues, but students report that the teaching often appears to be poorly related to clinical practice and is poorly integrated with other curriculum streams in both teaching and assessment. The place of this content within the three curriculum streams is not obvious. Curriculum renewal should consider strategies for improving the integration of population health into the delivered and assessed curriculum.

Behavioural and social sciences and medical law and ethics

The course provides:

- *An appreciation of Australian or New Zealand society and their cultural diversity.*
- *Development of appropriate skills and attitudes for medical practice in a culturally diverse society.*
- *Development of communication skills.*
- *An understanding of personal and professional development issues as they relate to medicine.*
- *An understanding of medical law and ethics.*

The curriculum is dominated by the biomedical and clinical sciences, with relatively little behavioural science and social science content. The Medical Personal and Professional Development stream is well represented in the lecture schedule, but students report that this appears to be poorly related to the rest of the curriculum. Curriculum renewal should consider strategies for making these important curriculum components more relevant and better integrated.

Indigenous health

The course provides curriculum coverage of Indigenous health (studies of the history, culture and health of the Indigenous peoples of Australia or New Zealand).

Currently, there is no clearly defined Indigenous health curriculum and this is acknowledged by the dean and director of the MBBS Program. Little progress has been made since the 2002 AMC visit in the development of a curriculum in Indigenous health. Plans to address this are required. The two new appointments in Indigenous health at the Faculty are to be commended.

Quality and safety

The curriculum addresses patient safety, risk assessment and quality assurance of medical care.

While elements of patient safety, risk assessment and quality assurance of medical care may be addressed in clinical placements, there is no clearly identifiable curriculum strand that supports students' understanding of these subjects prior to entering clinical placements.

Interprofessional education

The course includes curriculum coverage and practical experience of interprofessional education.

The Faculty noted in its submission that attempts have been made with little success to link MBBS training with other health professional programs. In a recent senior student online module involving MBBS, podiatry, physiotherapy and nursing students, the student feedback was unenthusiastic, and the proposed linkage has not been further developed.

While students in the clinical stage of the Program work within multidisciplinary teams in the hospitals attend team meetings and work closely with nursing staff, there is no formal inter-professional education. There appears to be a misunderstanding about what constitutes interprofessional education, which is defined as students from several health professions learning and being assessed together, which is quite different to other health professionals providing lectures to medical students. The Faculty has several health professional programs and therefore has excellent potential to do well in interprofessional education.

2011 team findings

(Previously at 2011 Standard 3.4 Research in the curriculum; subsumed in 2012 at standard 3.2).

The University of Adelaide has an enviable research record and the Faculty of Health Sciences is responsible for much of this success. Each of the Schools within the Faculty has substantial research infrastructure and research leadership. Students therefore have opportunities to participate in research through research electives, honours programs and PhD programs. The team was disappointed to learn that the level of participation by students is relatively low, although the numbers of students undertaking Honours has increased from three in 2006 to eight in 2011. The students who did participate reported high satisfaction with their research experience. Other students reported examples where further support would be motivating, such as more opportunity to pursue their Year 3 research proposal or the provision of a choice in tutor for their Year 5 elective. Curriculum renewal should include a greater emphasis on developing a research culture for students and on expanding opportunities for students to have meaningful exposure to research.

2014 team findings

The team understands that since 2011 the content of the curriculum has been reviewed on a regular basis, with a rolling program of reviews covering specific subject areas

every two to three years. The team recommends preparing a plan and timetable to formalise the curriculum reviews.

Since 2011, progress has been made in further defining the curriculum elements; however the team could not identify an overall curriculum map. Information about the curriculum and teaching format and content is readily available on the Medicine Learning and Teaching Unit website for Years 1-3 and for Years 4-6 on MyUni website. The team recommends the existing elements are formalised into detailed mapping of objectives for all years of the program, and made available on one platform in an easy to use format.

The program has developed detailed curricula for themes such as Clinical Practice and Safety and Quality. The Clinical Practice Competencies document provides a guide for teachers which outlines the clinical skills required over the six years of the program, organised under eight headings such as Safety of Medical Practice, Physical Examination and Clinical Reasoning. The clinical skills teaching facilities have been updated to a state of the art centre as discussed in Standard 8.

The objectives for the cases (CBL), lectures, Medical Professional and Personal Development Domain teaching and clinical skills have been updated and are clear.

There has been a significant increase and modification of specific curricula and content dealing with population health, behavioural and social sciences, Indigenous health (see Standard 3.5) quality and safety, and interprofessional education.

Students and clinicians spoke with the team about Anatomy teaching in the medical program. The team explored this issue with students, faculty and teaching staff at several sites and visited the upgrades made to the Ray Last Anatomy laboratory through significant infrastructure investments in 2012 and 2013. The enthusiasm and commitment of the teaching staff was commendable. From discussions with both students and academic staff, the team believes the quality of Anatomy teaching in the program is sufficient. The issue appears to lie in the extent to which the assessment focuses and incentivises students on appropriate and priority areas of learning. Consequently, the team recommends the assessment of Anatomy should be reviewed with the intent to better focus student learning.

The program has undertaken a review of population and public health with four actions arising from the report:

- case objectives will be restructured to make population health and epidemiology more explicit
- the School of Population Health staff will participate in professional development sessions for CBL tutors
- a population health group will identify key concepts and develop an implementation plan for delivery, assessment and staffing; and
- the School of Population Health staff will participate in assessment writing sessions.

The program plans to improve the visibility of population health aspects of the curriculum with implementation of the actions above planned for 2015. Population health teaching plans are in place, making objectives more obvious and introducing some case based teaching around populations rather than individuals. A global health

elective has been introduced. The team will be interested in an update on the implementation and outcomes of the population health review.

The Medical Professional and Personal Development Domain Committee undertook a review of teaching in the behavioural and social science content in the curriculum in order to identify gaps and create a clearly identifiable thread of teaching across all years of the curriculum. The program acknowledged while there was considerable content and teaching regarding behavioural and social sciences in the curriculum, the thread of learning was not distinctive. Communication, ethics, and patient-centred practice were recognised as being integral to teaching, but other areas of social and behavioural science were not clearly defined. The review was informed by the literature, and identified concepts that required additional teaching and learning. The review identified links to program objectives and developed an action plan with implementation planned for 2014-2015. The team will be interested to receive an update on this work.

Since the 2011 accreditation, there has been considerable progress in defining and developing a distinct thread of teaching in safety and quality. The Faculty now has a well-developed patient safety curriculum. Competencies in the area of safety and quality assurance have been defined with the development of a curriculum and eleven defined areas with learning objectives. This has been based on the World Health Organisation Patient Safety Curriculum Framework. Students must meet these objectives over the six years of the medical program. The document outlines the structure and the topic of the teaching and maps these back to their learning objectives. There has been a significant increase in the focus on quality and safety in simulation exercises and teaching about key human factors and medical error. A diverse range of activities are undertaken including written review and reflection on coroners findings, safety elements embedded in the Objective Structured Clinical Examinations (OSCE) and a series of six human factors teaching modules for medical and nursing students, run by the Faculty simulation team.

These modules are based on an evidence based tool to improve teamwork, communication and patient safety, TeamSTEPPS, which has been rolled out state-wide in South Australia. Some are undertaken as inter-professional exercises with the School of Nursing, which the team commends as an excellent innovation. The Year 6 students undertake simulation exercises in stressful situations such as task prioritisation, handover and conflict resolution.

3.3 Curriculum design

There is evidence of purposeful curriculum design which demonstrates horizontal and vertical integration and articulation with subsequent stages of training.

2011 team findings

The Faculty noted in its submission that horizontal integration is the responsibility of the Year Course Committees (Year 1, Year 2/3, Year 4/5 and Year 6). Vertical integration is overviewed by the Curriculum Committee, with contribution from discipline based review groups, Stream Advisory Committees and Year Committees.

The level of integration between curriculum strands could be strengthened. The Faculty acknowledged horizontal integration is a challenging task. It is weakened by strongly demarcated content by subject and specialty. The team considers that vertical integration requires enhancement particularly in view of the strong demarcation

between the pre-clinical and clinical stages. As part of the curriculum renewal process, integration should be increased in the design, delivery and assessment processes.

2011 team findings

(Previously at 2011 Standard 3.6 The continuum of learning; subsumed in 2012 at standard 3.3).

Overall the MBBS Program is regarded as preparing students well for their early postgraduate careers. The curriculum model, common program and collaborative arrangements with hospitals to jointly manage the final year are sound.

2014 team findings

The overall curriculum design has not changed since the last accreditation, although significant development work has been undertaken in the planning of the proposed new Bachelor/MD program.

The curriculum consists of horizontal and vertical integration across all years and topics which is supported by the committee structure. In Years 1-3, there is strong horizontal integration where all disciplines are taught together mainly related to case-based learning (CBL). Vertical integration is also strong within the first three years, where a spiral approach is utilised to allow students to build each year on knowledge that they gained in earlier years. Revisiting of both disciplines and body systems is built into this spiral approach to teaching. Vertical integration is also present in Years 4-6, when students revisit key disciplines (e.g. Medicine, Surgery, General Practice, Psychiatry) at greater levels of complexity as they move through the clinical years. There is less horizontal integration in Years 4-6. There are programmed reviews of content of the curriculum by the Year Level committees (addressing horizontal integration) and both Domain Committees (addressing both horizontal and vertical integration of the three major themes) and Discipline-based groups (addressing vertical integration of specific disciplines, such as Pathology and Immunology). These processes ensure that the issue of integration is addressed regularly and content adjusted as required to update content coverage and strengthen integration. The methods of communication between these committees were not obvious to the team. While individual members sit on more than one committee, and this cross representation facilitates the exchange of information, communication is not carried out in a systematic manner. The publishing of committee minutes, as discussed in Standard 1.1, should assist communication.

The program has introduced mechanisms to ease the transition to internship. Year 6 is regarded as the pre-intern year, and the Year 6 students in 2014 have a weekly teaching program in the internship semester that focuses on practical "work-ready" skills, which is well regarded by students. Clinical staff, who observed new interns having difficulty with the practical aspects of prescribing, provided feedback to the program which resulted in the introduction of a prescribing activity in Year 6 that requires students to interact with the National Prescribing Service (NPS) modules in common medical conditions. This has been made compulsory for all Year 6 students and spans several weeks of practical prescribing activities with feedback.

3.4 Curriculum description

The medical education provider has developed and effectively communicated specific learning outcomes or objectives describing what is expected of students at each stage of the medical program.

2011 team findings

(Previously 2011 Standard 3.1 Curriculum Structure, composition and duration; subsumed in 2012 at standard 3.4).

The philosophy underpinning the curriculum is sound, aiming to develop self-directed learners and critical thinkers who can manage the challenges of remaining competent clinicians throughout their careers. The outcomes of the course are consistent with the expectations of the Australian Medical Council. There are a large number of detailed learning objectives that are compartmentalised by case-based learning case and/or discipline, and relatively few depth indicators to help students understand their progress in achieving the learning objectives.

2014 team findings

The program's graduate outcomes define the attributes of graduates of the medical program. These are communicated to students on the MBBS website.

Learning objectives, especially in Years 1-3, are contained within a framework that is based around a series of cases (CBL) that provide the context for learning in the range of basic scientific and clinical disciplines. Each case has a set of clear objectives, classified into disciplines, which are provided to students towards the end of the case. These objectives, together with any specific objectives from the discipline-based activities occurring in conjunction with the cases, provide the students with the expectations of their achievement at their specific year level. Assessments, including examinations, are blue-printed based on these objectives by the Board of Examiners.

In Years 4-6, objectives are outlined for required clinical attachments, which define the outcomes expected at the end of the specific attachment. These outcomes are then assessable in the integrated end of year examinations. Students also rely on their clinical supervisors to provide guidelines for their specific attachment.

The Clinical Practice Competencies framework outlines the clinical skills required over the six years under eight headings, such as Safety of Medical Practice, Physical Examination and Clinical Reasoning.

Students in Years 4 and 5 indicated to the team that the learning objectives for some clinical attachments were not well developed, and when present the learning objectives were presented in different formats. The team noted some diversity in the presentation of learning outcomes. Psychiatry and Obstetrics and Gynaecology had very detailed learning outcome statements, whereas Medicine and Surgery were less developed. The team suggests further review and standardisation of the learning objectives and content knowledge required for clinical attachments would benefit the students.

3.5 Indigenous health

The medical program provides curriculum coverage of Indigenous Health (studies of the history, culture and health of the Indigenous peoples of Australia or New Zealand).

2014 team findings

The team recognises the significant development that has occurred with Indigenous health content and teaching since the 2011 accreditation visit. An Indigenous health curriculum has been created by the Yaitya Purruna Indigenous Health Unit based upon the Committee of Deans of Australian Medical Schools (now Medical Deans Australia and New Zealand) Indigenous Health Curriculum Framework, with input from the Aboriginal Health Council of Australia. Key academic staff have been recruited, however their workload appears significant as they are developing and delivering teaching for a number of degree programs. A Working Party is responsible for the development of the curriculum content on Indigenous Health.

Indigenous health content includes workshops, lectures, and small group teaching around cultural competency, mainly in Years 1-3. In 2013 the program introduced a compulsory Indigenous Cultural Workshop for Year 1 students. Based on student feedback, modifications were made to the structure and content of the workshop for 2014 with an increase in the reflective writing component. From 2015 forward compulsory workshops will also be offered to students in Years 2 and 3 of the program. Specific health problems in Indigenous patients are incorporated into Year 2 CBL, for example Type 2 diabetes in the Indigenous population. More teaching is planned in Year 3 with an inclusion of population health aspects of Indigenous Health.

A second year elective on Indigenous health is attracting 5-10 students per year. Indigenous health content is being further developed for Years 4, 5 and 6. Exposure to patients in the clinical years generally relates to the nature of their clinical attachment, e.g. renal medicine has a significant number of Indigenous patients whereas other clinical attachments may not provide students with significant exposure. Students in the Rural Clinical School generally have greater exposure to Indigenous health but this would vary depending on location.

The team recommends further teaching and resources in Indigenous Health in the clinical years, especially around cultural competency. Currently exposure to Indigenous health and patients generally relates to the nature of the clinical attachment as there is no systematic approach to ensuring that all Year 4 - 6 students have core teaching and learning in this area.

The team encourages the program to further develop Indigenous health teaching, particularly in the clinical years, building on the positive achievements to date around cultural competency training.

3.6 Opportunities for choice to promote breadth and diversity

There are opportunities for students to pursue studies of choice that promote breadth and diversity of experience.

2011 team findings

The team was impressed by the capacity of students to choose selectives and options in Years 4 and 5 through Medical and Scientific Attachments and in the final year through SCAPs. Staff and students reported many opportunities for students to pursue their interests.

2014 team findings

The program offers a number of opportunities for students to pursue studies in areas of their choice.

In Year 2, students undertake three units of study drawn from a list of biomedical electives that can be structured into the MBBS timetable.

The Medical and Scientific Attachments continue to be available to students in Years 4 and 5 and provide students with the opportunity for immersion in a broad spectrum of speciality areas, allowing students to focus on the clinical and scientific aspects of a speciality or discipline. There are opportunities to do Medical and Scientific Attachments in a wide range of specialty areas including research. All students are required to do a research proposal assignment (which is a group project) and this task has proved popular with students and supervisors. A small number of students continue their research and produce publications.

The Year 6 student created selective (previously referred to as Specialist, Community or Ambulatory Placements) gives students the option to create one four-week selective in the disciplines of Medicine, Surgery, Psychiatry or Primary Care. The selective created can be overseas, interstate or within South Australia.

Also in Year 6, students undertake student internships in the core clinical areas in one semester, and in the other semester they do five four-week clinical selectives, one of which may be self-created in an area of interest to them.

4 Learning and teaching

4.1 Learning and teaching methods

The medical education provider employs a range of learning and teaching methods to meet the outcomes of the medical program.

2011 team findings

The curriculum is divided into two relatively discrete components, with three pre-clinical followed by three clinical years. Teaching and learning methods employed in the pre-clinical years include case-based learning, lectures, resource sessions, tutorials and clinical skills tutorials. The following table summarises the teaching and learning methods used in the Program:

Year	Teaching and learning methods	Curriculum content and outcomes
4 and 5	Clinical placements (experiential learning)	Clinical sciences and skills in specific clinical disciplines (e.g. medicine, surgery)
4	Lectures (SMTS) – some on-line and interactive; some delivered in person	Review of basic science underpinning clinical practice
6	Clinical placements (experimental learning)	Clinical sciences and skills in specific clinical disciplines (e.g. medicine, surgery); preparation management
6	Lectures	Preparation for internship (theoretical aspects and practical management)

While a variety of teaching and learning methods are used, the curriculum remains largely didactic and reliant on face-to-face delivery methods. There is limited online curriculum support. The support available is split between two learning management systems. One learning management system is based on the University's Blackboard program (MyUni) that was phased in four to five years ago. The other is in a different LMS designed and managed within the Medicine Learning and Teaching Unit (MLTU). Despite a strong student preference for a single learning management system, students must regularly use both LMS's to participate in the Program.

In addition, resource constraints require student representatives to personally gather lecture notes and PowerPoint presentations from lecturers and deliver these to the Medical Learning and Teaching Unit for uploading into the learning management system. Very few lectures are available on podcasts (the exceptions are Year 5 Obstetrics and Gynaecology). There is limited online formative assessment. The access to the LMS is restricted by the low number of available computers and the restricted bandwidth for Wi-Fi access. Curriculum renewal needs to take into account contemporary education delivery methods and information management systems, which may require substantial upgrading.

There has been a recent shift from problem-based learning to CBL, where students and tutors are provided with more structure around learning objectives and outcomes. The CBL approach appears well placed to promote self-directed, inquiry-orientated learning. This change has been well regarded by students and staff. However, increasing student numbers and budgetary pressures have resulted in increased numbers of students in CBL groups, which potentially threatens the success of this approach.

There was concern about variability of clinical tutor quality in the CBL tutorials, in addition to formative assessment provided in CBL. The team acknowledged that consistency in these areas is a challenge for all medical schools. There appeared to be variation between groups with examination preparation, variable feedback, and monitoring of progress. While it was noted that there is a shortage of internal tutors, the team also recognised that recruitment of new tutors can be challenging.

In the pre-clinical years, there remains a heavy emphasis on large group sessions, including lectures that staff recognise are often not particularly interactive. In reviewing the timetables, the team observed that there are between 10 and 15 hours dedicated to lectures each week.

Anatomy, Histology and Pathology are taught through large group resource sessions based in the Anatomy laboratory. Staff recognise that these sessions have become more detailed than required and that there is a need to rationalize their content. In addition, there is the potential to make more of this material available online.

The Medical Personal and Professional Development stream is taught by providing an initial contextual framework, followed by small group discussions with skilled tutors. At present, students do not have the opportunity to have themselves video-recorded as part of their communication skills development. This is an important area for consideration of further development.

Over the last few years, a valuable initiative of the Medical Learning and Teaching Unit has been to implement a Clinical Skills program in Years 1 and 2. This is highly regarded by staff and students. In Year 3, this is followed by a one-day attachment in the hospital each week. The team was impressed by the dedication of staff in ensuring that this is a valuable learning experience for students.

In the clinical years, teaching and learning methods include clinical placements, lectures, and a full year dedicated to intern preparation. Clinical placements occur in all major areas, including medicine, surgery, psychiatry, obstetrics and gynaecology, paediatrics, critical care, geriatrics and general practice. Teaching and learning methods employed in obstetrics and gynaecology and paediatrics were highly regarded by students. With increasing student numbers, there is increasing pressure on clinical placements. With careful planning and additional funding there is potential to expand clinical placements to address this issue.

In the final year, students undertake a series of internships in Medicine, Surgery, and Emergency Medicine in addition to attachments in Primary Care and Psychiatry. Students are expected to act as trainee interns and work as part of the team to which they are allocated. As a result, students and staff believe that graduates are work-ready.

As part of the Year 6 program, students have the option to undertake an elective in medical education. The Faculty is commended for this positive development. Students are supported to develop some teaching skills that are deployed in tutorials for either

clinical skills or CBL cases in years 1-3. Year 6 students uniformly reported that this is a valuable, career-enhancing experience, and the junior students regard the student tutors highly. This elective ensures that students graduate with skills and understanding about teaching and learning methods. It also ensures that future clinical teachers have some basic teaching and learning skills.

University-employed staff are provided with formal courses in tertiary level teaching and these are well regarded by those who have participated in them. A concern uniformly raised by students and staff related to lack of consistency of teaching, learning and assessment methods across various clinical sites. There is currently no program of ongoing professional development to ensure consistent quality of educational delivery by the large number of clinicians who contribute to the Program. This is an area that requires further development. There is currently limited uptake by clinical and biomedical science staff in obtaining formal qualifications in medical education. Additional educational expertise amongst staff delivering the Program would be very helpful.

Overall, teaching and learning methods employed in this Program are appropriate. Further effort is required to ensure that plans are in place to meet the expected expansion in student numbers in order to maintain the small group tutorial program and sufficient high quality clinical placements. Consistency across clinical teaching sites needs to be addressed. Issues already identified by the Program, including IT support and rationalization of some learning resources need to be resolved. Areas such as staff professional development and interprofessional education also require development.

2014 team findings

The program utilises a range of learning and teaching strategies, including large and small group teaching, online activities, clinical placements and simulation. Methods vary throughout the course and are matched to the relevant educational objectives.

Teaching and learning in Years 1 - 3 emphasises an enquiry driven case-based learning (CBL) approach which integrates content across the three domains: Scientific Basis of Medicine, Clinical Practice, and Medical Personal and Professional Development. The program has been responsive to developments in educational theory as well as feedback from staff and students. For example, some changes in delivery methods have been introduced in the Year 1 and 3 CBL programs.

In Semester 1, a large group format is employed whereby students are seated and work in small groups, and the session is centrally facilitated. This appears to enable first year students to better understand the processes within CBL, and the standards that are required of them. Moreover, it has helped address issues with inconsistency between tutorials groups. Initial challenges with physical capacity and noise levels have been mitigated through relocation to a larger auditorium in the Eleanor Harrald building. A more appropriate space will be utilised from 2015, and will address some of the students' ongoing noise concerns.

The team was particularly impressed by developments in simulation, which extend across several disciplines and sites. Students in all years have access to some form of simulated learning, ranging from simulated patients (for clinical skills teaching) through to high-fidelity mannequins (for resuscitation and human factors training). The team members who observed the simulation session at the paediatric mental health teaching

unit at the Women's and Children's Hospital were tremendously impressed with the simulation work in that facility.

There are two scheduled simulation activities in Year 6, which are a key component of the transition to internship program. The team spent considerable time exploring concerns regarding Anatomy and Histology teaching noted in the student submission, and also observed a resource session in the Ray Last Anatomy Laboratory. The team considers that most of these concerns relate to the depth and breadth of assessment, rather than teaching methods. This issue is further discussed in Standard 3.

The use of peer assisted learning is a strength of the program, in particular the Year 6 selectives in medical education and simulation. Junior and senior students alike reflect favourably on these arrangements.

As discussed in the 2011 report, delivery of the curriculum is supported by a custom-built learning management system (the Medicine Learning and Teaching Unit website). The team commends the Medicine Learning and Teaching Unit IT staff on their work to continually enhance functionality and acknowledges the Faculty's efforts to better integrate this platform with the University's Blackboard system.

There is a level of discontent from students who remain frustrated about having to access two parallel learning management systems. Notwithstanding the positive developments in this area, the Faculty should continue to work with students to further enhance integration of the platforms and improve sign-posting of content. This issue is explored further in Standard 8.

Access to recorded lecture material has improved significantly since 2011, with the vast majority of lectures in the early years of the course now available on the Medicine Learning and Teaching Unit website as audio files with accompanying slides. Staff report that it is very easy to upload lecture notes onto the Medicine Learning and Teaching Unit website. The requirement for students to collect PowerPoint files at the end of certain teaching sessions (which was an issue in 2011) has been addressed.

Significant effort has been directed towards enhancing the consistency of teaching and assessment methods across sites, assisted by the development and dissemination of extensive online resources easily accessible by staff at multiple sites. Discipline co-ordinators and Year level committees are working to ensure all healthcare facilities offer equivalent experiences. While there is still a degree of variability in the teaching and assessment methods between clinical disciplines, students and staff did not report this to be problematic.

The Year 4-6 Co-ordinator has played an important role in guiding these initiatives and the team suggests recruiting to this role will be vital to continue with the progress made to date (discussed at Standard 1.8).

4.2 Self-directed and lifelong learning

The medical program encourages students to evaluate and take responsibility for their own learning, and prepares them for lifelong learning.

2014 team findings

Concepts of self-directed and lifelong learning are firmly embedded in the program. In the early years of the course, this is primarily achieved through case-based learning

where students are required to define their learning plan and direct proceedings. Objectives are provided to students towards the end of each case. A staged reduction in support occurs through Years 1 to 3, such that students in Year 3 only have tutor-facilitated sessions. Self- reflection is also an important component of Clinical Skills and Medical Personal and Professional Development tutorials.

In the later years of the course, learning is more independent and students are encouraged to take greater responsibility for their professional development. As discussed under Standard 3.4, the learning objectives for some clinical attachments can be further developed. The Year 6 Safety and Quality curriculum features selected components from "Teaching on the Run" that address the issues of "learning on patients" in a clinical setting and explores the concepts of adult learning.

4.3 Clinical skill development

The medical program enables students to develop core skills before they use these skills in a clinical setting.

2014 team findings

Since the 2011 visit, the Faculty has developed clinical practice competencies for each year level, which has clarified what is expected of students at each stage of the program. The Clinical Practice Competencies: Years 1- 6 document guides the progression of clinical skills through the medical program. This has been well received by both staff and students.

The Clinical Practice program in Years 1-3 is well developed. History taking and examination are taught through structured tutorials in the first two years, and sessions regularly feature simulated patients. Delivery of the program has been assisted by the development of the Warren Robin Clinical Skills facility. Students reported that bedside teaching during Year 3 is beneficial.

The Faculty has a simulation program to teach core procedural competencies prior to clinical attachments. This program was significantly enhanced in 2013 and has a clear thread through the program.

4.4 Increasing degree of independence

Students have sufficient supervised involvement with patients to develop their clinical skills to the required level and with an increasing level of participation in clinical care as they proceed through the medical program.

2014 team findings

Student exposure to patients increases progressively throughout the medical program. The program has well-structured transitions from a simulated environment in Years 1 and 2 to the clinical environment in Year 3, and from the carefully structured clinical skills program in Year 3 to the more independent and self-directed environment of clinical attachments in Years 4-6. Year 4 students receive more intensive senior supervision, with progression to more independent practice in Year 6.

In Years 1 and 2 students participate in a campus-based clinical skills program. As discussed above, this includes the use of simulated patients for the purposes of developing history and examination techniques. The program has been enhanced by the

development of the Robin Warren Clinical Skills facility, which has the capacity to simulate ward and clinic environments.

In Year 3, students spend one day per week at a teaching hospital. There are opportunities to refine clinical skills by interacting with patients and performing examinations. Some students also have the opportunity to spend a couple of days in general practice.

Years 4-6 are clinically based, with students rotating through a series of disciplines. In Year 6, students undertake two internship terms. In these attachments, they are encouraged to work closely with interns and participate in all unit activities. This is an important component of the transition to internship program.

4.5 Role modelling

The medical program promotes role modelling as a learning method, particularly in clinical practice and research.

2014 team findings

Role modelling is implicit in the program design. In the pre-clinical years, experienced clinicians, who are able to demonstrate appropriate professional behaviour, facilitate clinical skills tutorials. Role modelling by tutors also occurs in other course elements, including Medical Personal and Professional Development Domain and CBL. As students progress through the program, they undertake clinical placements at a number of sites, which ensures exposure to a range of junior and senior doctor role models.

With respect to research, role modelling primarily occurs through the research proposal project in third year. The new medical school building, which will feature integrated learning and research spaces, will facilitate increased exposure to senior researchers.

The Year 6 medical education and simulation selectives provide another opportunity for role modelling. Senior students are able to demonstrate appropriate professional behaviour, and their involvement reinforces the value of teaching as a component of medical practice.

4.6 Patient centred care and collaborative engagement

Learning and teaching methods in the clinical environment promote the concepts of patient centred care and collaborative engagement.

2014 team findings

The concept of patient-centred care is introduced during the pre-clinical years of the program. This mainly occurs through the Medical Personal and Professional Development Domain, although other program elements (including CBL and clinical placements) emphasise the importance of patient-centred care. Extensive use of simulated patients assists students to understand how patient-centred care can be applied in practice. These concepts are reinforced during the clinical years, when students spend extended periods of time immersed in the clinical environment working in multi-disciplinary teams.

4.7 Interprofessional learning

The medical program ensures that students work with, and learn from and about other health professionals, including experience working and learning in interprofessional teams.

2014 team findings

Since the 2011 review, the Faculty has made significant progress in increasing the emphasis on interprofessional learning within the program. A focus of activity has been the development of an interprofessional education plan in collaboration with the School of Nursing.

At the pre-clinical level, certain clinical skills activities are simultaneously provided to medical and nursing students. Joint simulation scenarios, focussed on human factors training, have also been introduced as pilots with implementation of full cohorts in 2014.

In the clinical years, students spend the majority of time in ward and community environments where multi-disciplinary care is practiced on a daily basis. The team viewed an excellent example of this at the Geriatrics Teaching and Research in Aged Care (G-TRAC) facility in Paradise. Allied health practitioners deliver a number of teaching sessions, including the pharmacist-led prescribing skills workshop in Year 6.

The development of the new medical school building will provide another opportunity to reinforce the importance of team-based care. The new space will better integrate teaching and learning for medical and nursing students, and enhance student exposure to medical research activities.

The Team commends the Faculty on its progress to further develop interprofessional learning, and will be interested on the ongoing implementation of teaching in this area.

5 The curriculum – assessment of student learning

5.1 Assessment approach

5.1.1 The medical education provider's assessment policy describes its assessment philosophy, principles, practices and rules. The assessment aligns with learning outcomes and is based on the principles of objectivity, fairness and transparency.

5.1.2 The medical education provider clearly documents its assessment and progression requirements. These documents are accessible to all staff and students.

5.1.3 The medical education provider ensures a balance of formative and summative assessments.

2011 team findings

The Faculty's assessment policy combines the University of Adelaide assessment policy with the MBBS Assessment Rules. The Faculty currently has a formal exemption from the University Policy on supplementary assessment on academic grounds. The MBBS Assessment Rules are reviewed by the MBBS Program Assessment Committee in consultation with the relevant Year Level Committees.

The MBBS Assessment Committee is representative of all Schools teaching into the Program. However, the Assessment Committee does not have authority to enforce decisions on assessment but is advisory to the Curriculum Committee consisting of representatives from each Year Committee. Each Year Committee operates independently.

Annual Assessment Documents are produced in two parts, with Part A dealing with general matters and Part B being year-level specific in relation to summative assessments and the rules of eligibility to sit summative assessments. Although the Program has these assessment documents, the team found that the assessment approach could be better defined and communicated. In particular, issues such as item development, quality assurance, standard setting, and examiner training could be more clearly explained.

The Faculty advised that assessment within the Program is blueprinted against the curriculum learning objectives for the specific year of the assessment. Each year's assessment is blueprinted independently of the others in terms of content, and there is continuity across the years in terms of format and style of examinations. The team encourages the Faculty to review its assessment blueprints which map learning objectives and curriculum content to the available assessment formats taking into consideration patient demographics, avoidance of overlap, and the use of more rigorous sampling. Furthermore, it was unclear how the "Domains" are assessed through the Program. In part, the assessment appears to be poorly integrated across these.

The team believes that the overall assessment load is high in Years 1-3, and appears relatively low in the last two years. The Faculty acknowledged in its submission that there is a lot of assessment in the Program. The Faculty aims to balance it across years by adopting a standard pattern of examinations in all years which become more complex as the students' progress.

There is a need for greater coordination of the number and types of assessments both in the pre-clinical and clinical years.

The Assessment Committee acknowledged the issues of high failure rates in the Year 1 – 3 examinations in Anatomy and Pathology. Students reported that the examinations were not representative of the learning objectives or curriculum delivery. The working group tasked to review the failure rates for the Faculty recommended that these examinations be abolished and material be included in integrated examinations from 2011. With respect to this the Assessment Committee has formed a sub-committee, the Written Examinations Committee, tasked with setting the Year 2 and 3 written exams. The team was concerned that this practice was not sustainable and did not completely address the issues that stemmed from a relatively weakly integrated curriculum in Years 1-3.

An equitable balance between formative and summative assessments is not evident. There is insufficient formative assessment throughout the Program. The Faculty noted in its submission that the mix of formative and summative assessments needs to be reviewed, as it may be over-assessing summatively in Years 4 and 5, and in Years 2 and 3 at the expense of formative assessment. The team was concerned that the recent decision to change the mid-year summative exam in Years 2 and 3 to a formative self-marked exam was not favoured by the student body. The submission noted that the student representatives are cautious about these changes, and while improved feedback mid-year is appreciated, there will be greater stress at the end-of-year examination. Many students stated that the only apparent reason for this change is a lack of resources to conduct a summative mid-year examination. The team believes that this change was poorly communicated to students and has created anxiety amongst the students.

The Faculty advised that the Board of Examiners identifies students at risk of failing each semester and sends a letter offering support. Students are able to identify if they are at risk from the mid-year assessments in Years 1 – 3. The Faculty also advised that the six week tutor reports are a good way to predict at-risk students as they correlate with student exam results. The team believes that there should be additional opportunities for students to assess their own performance and for staff to identify students at risk of failing. In addition, the team was concerned that the Program's exemption from University policy of supplementary exams on an academic basis following failure does not support students in remediation.

The removal of the Objective Structured Clinical Examination (OSCE) at the end of Year 4 does not appear to be associated with an overall plan for assessment at the end of each of the clinical rotations. Students reported that this OSCE was a good opportunity to consolidate skills for Year 5.

2011 team findings

(Previously 2011 Standard 5.3 Assessment rules and progression; subsumed in 2012 at Standard 5.1).

The Faculty's MBBS Assessment Rules are governed by the Assessment Committee, which monitors the implementation of the Assessment Rules by Year-Level Course Committees to ensure year-level programs are consistent with the Assessment Rules. The Year-Level Course Committees are responsible for timetabling, planning and designing both formative and summative assessment activities for each Semester. The Faculty provides an Assessment Document for each year early in Semester One, and Part B of these documents contains the specific requirements for passing each year level. It is

compulsory for students to read these requirements and confirm online that they are understood.

To progress in the Program, the Board of Examiners determine whether students have met the requirements set out in the Assessment Document. The Board of Examiners take into consideration adequate attendance at the mandatory activities of the course; minimum and essential competencies students are required to meet; and performance in all summative assessments including the overall objectives for the program at the particular year level.

The team considers that the progression rules are not explicit. Despite the Faculty's communication strategies, progression rules do not appear to be well understood. Of concern is that some academic staff reported that they do not fully understand the progression rules, especially the 10/20 rule. The 10/20 rule relates to students in Years 4 and 5 who are required to meet a minimum standard of performance in their clinical attachments before qualifying to sit the end of year examinations. If they fail the equivalent of ten weeks of clinical attachments (or have borderline results in twenty weeks), they are not permitted to sit the examinations and fail the year.

Furthermore, there is little transparency in how progression rules are applied to borderline and failing students. The team heard from students who reported unclear and changing progression rules. Students, particularly those in the clinical years, reported a lack of transparency in the application of the progression rules and frequent changes to the progression rules even during the course of the year. There is a requirement to develop progression rules that are fair and transparent. They also need to be clearly communicated and understood by staff and students.

The Program has a non-graded pass/competency based policy. An A-E banding system is in place for assessment tasks to give students feedback but does not appear on their transcript. This system aims to allow students to track their own performance – students should aim to be at B level or above; a C is borderline and a D indicates they are not doing well enough. The Faculty stated that there is a high correlation with the A-E results and end of year assessment results. However, the ABCDE grading system is poorly understood by students, who believe this to be an arbitrary system that poorly predicts end of year assessment results and therefore provides little useful formative assessment.

The team was concerned that, in light of the imbalance between formative and summative examinations, an exemption from the University policy to award supplementary examinations on academic basis was granted to the Program. This seems to be inequitable and inappropriate. The Faculty noted in its submission that it is possible that it may adopt the University policy in relation to academic supplementary assessment in 2013 (supplementary assessment automatically offered to any student with results between 45 – 49.9% assuming a pass mark of 50%). The Faculty has commented that students are currently allowed to pass while carrying a D result (below expected competence for year level; 46 – 49%) which, it was advised, actually benefits the student by not having to sit a supplementary exam. The team considers that this approach does not reflect current educational practice.

2014 team findings

Since 2011, the medical program has put significant effort into strengthening assessment practices. The program now has a full time assessment academic (at senior lecturer level) to lead a coordinated approach to assessment. The successful candidate was appointed in late 2012. The program's submission lists several initiatives designed to strengthen a coordinated approach to assessment across the program.

The Assessment Committee is primarily responsible for development of the assessment program and its principles. The Committee is an advisory committee to the Curriculum Committee and to the Boards of Examiners. The Committee meets regularly and has oversight of the standard setting of most summative written and clinical exams. Any major changes to policies and procedures raised by the Assessment Committee are considered by the Curriculum Committee and where necessary escalated to the Strategy Board.

A number of assessment sub committees (Year Level Committees, Domain Committees and the Rural School) devise suitable formative and summative assessment tasks for students in each year of the course. The Year Level Committees work well and have a clear reporting structure.

The relationship between the Year Level and Domain Committees is somewhat unclear to the team, although in practice the structure appears to be working. A clear mapping of the assessment of domains in each year needs to be done although the team considered that this would not be a high priority for the current program assuming the university progresses with its Bachelor/MD program planning.

The program has recently updated the terms of reference for the Boards of Examiners to confirm that the Boards report to the Dean as the Chair of the Strategy Board.

The only major change in assessment since 2011 is that the medical program no longer has an exemption from the University policy in relation to academic supplementary assessment. The A-E banding system remains in place to give students feedback on assessment tasks, but does not appear on their transcript. This system aims to allow students to track their own performance. In 2013 the medical program implemented a policy to offer automatic additional (previously called "supplementary") assessment to students who fail an examination with a D grade on the scale of A-E. Under the previous assessment framework students were allowed to carry a single D to the next year of the program. An additional assessment is now offered for students who are determined by the Board of Examiners to be in a D band in one of the four summative assessments. This change was implemented in 2013 and brings the MBBS program into line with the University policy. The team commends this development, which allows further information about a borderline student to be obtained.

Additionally the program has clarified the role of the Replacement Assessment Sub-Committee as the only body which considers applications from students for replacement examinations. Previously some decisions on replacement examinations had been taken by the Boards of Examiners.

The program participates in formative and summative written benchmarking exercises, and makes available for voluntary participation the International Foundations of Medicine (IFOM) examination to Year 5 students. The IFOM test is a 160-item MCQ examination using items derived from the US-based National Board of Medical

Examiners examinations. The IFOM is a major formative exercise 10 weeks before the final ("barrier") Year 5 examinations, and students receive their results four weeks after sitting the test.

Students perform well in benchmarking exercises in the Australian Medical Schools Assessment Collaboration (AMSAC) initiative (a basic sciences MCQ for participating Australian universities), the Medical Deans of Australia and New Zealand (MDANZ) initiative (clinical science MCQ assessment of senior Australian medical students) and in benchmarking in the Script Concordance Tests (SCT) between the University of Adelaide, University of Montreal and University of Notre Dame Australia School of Medicine, Sydney.

For example, AMSAC MCQs were included in the Year 3 end of year exam in 2013. The analysis of results showed that the University of Adelaide medical students performed in the upper middle range of the 12 participating AMSAC schools. These results provide the school with data that can be used to inform changes in curriculum and assessment.

Students report that they are well informed as to the assessment requirements of their semester/placement. Some clinical year students report a perception of variation in assessment at the different sites and it would be useful for the school to ensure that this is addressed.

Assessment within the medical program is guided by the Assessment for Coursework Programs Policy (2014) of the University of Adelaide. The University's approach to assessment is based on four principles, which must be observed within all faculties. The policy acknowledges that types of assessment used throughout the University are diverse and vary according to the academic discipline.

The medical program has additional assessment rules that are specific to the program. These rules are located in seven documents: "Part A" which is generic to the entire program and applies to all year levels, and six separate year level documents whose rules are specific to the particular year.

The assessment philosophy and requirements for progression are clearly described in these documents that are available online to staff and students. Students report that they understand the assessment requirements and there are several opportunities through each year for students to receive feedback on their performance.

There is a reasonable balance of formative and summative assessment in the program.

Formative assessment in Years 1-3 of the program includes verbal feedback from tutors in small group tutorials including case-based learning, Clinical Skills and Medical Personal and Professional Development. There are opportunities for formative assessment in laboratories and on-line (structured) activities.

For each course in Years 1-3, the major summative assessments in Semester 1 contribute 33% of the final mark and results in Semester 2 contribute 66% to the final mark. The Semester 1 results provide an opportunity for students to gauge their performance against the course criteria, with sufficient time to catch up, if necessary, in Semester 2. From 2014, Year 1 students have fortnightly formative assessments with immediate feedback during Semester 1.

Assessment in Years 4 and 5 of the program is a responsibility of both the individual disciplines and the Written and Clinical Examinations Committees. Disciplines provide opportunities for low stakes formative assessment in clinical attachments and through

on-line tasks. In Year 4, the majority of clinical disciplines include an Objective Structured Clinical Examination in the last week of the clinical attachment, with each student receiving personalised feedback.

In Years 4 and 5, each clinical discipline runs its own summative assessments, typically a mixture of observed performance and written tests of knowledge and reasoning. Students receive feedback on their performance through a range of summative assessments throughout the year prior to sitting the end of year multidisciplinary examinations.

The program introduced short written answer questions in 2014 in the summative end of year assessments in Years 4 and 5. This is better aligning the assessments in Years 1-3 (which have written short answer components) and Years 4 and 5, and allows assessment of the reasoning behind the students' answers as well as the answers themselves.

At the time of the assessment the program was writing exemplars, which will be posted on the MBBS Curriculum web site for access by the relevant cohorts.

Assessment in Year 6 is based on ward performance. The end of year examinations have been discontinued as it was determined they would detract from ward-based activities by encouraging students to return to 'book-based' study.

Some clinical teachers reported that they were not given clear instructions on how to complete the tutor reports required for the students' clinical attachments. Some supervisors reported they did not receive feedback on the quality of their reports. Further work is required on standard setting for end of placement assessments in the clinical years, and on ensuring as much consistency as possible in tutor reports. This is a challenging area because students are placed at many sites with variable levels of engagement of supervisors. The team acknowledged the progress being made on training supervisors, but considers that further gains could be made by review of the end-of-term assessment reporting framework.

There appears to be some variability in the understanding of the role of the tutor reports in the clinical years. While some students and staff view them as formative, the reports can be used to make end of year summative decisions. They may be more accurately described as 'hurdle' requirements, which can be remediated if required. The team encourages the program to clarify the role of the tutor reports and make this clear to both staff and students.

The program has flagged for consideration whether the program (or part of it) will change from a non-graded pass to a graded scheme. If this occurs, each summative assessment item will need to be weighted in order to contribute to the final mark and cut points will need to be calculated. The team notes this change would need to be clearly and carefully communicated to students and revised progression rules published well in advance of the change.

5.2 Assessment methods

5.2.1 The medical education provider assesses students throughout the medical program, using fit for purpose assessment methods and formats to assess the intended learning outcomes.

5.2.2 The medical education provider has a blueprint to guide the assessment of students for each year or phase of the medical program.

5.2.3 The medical education provider uses validated methods of standard setting.

2011 team findings

A number of assessment methods are used in the Program. These include Objective Structured Clinical Examinations and the Mini Clinical Evaluation Exercise (MiniCEX). There is a range of assessment formats across the Program. The table below provides an Assessment Summary:

Year	Semester 1	Semester 2
1	Tutorial performance (CBL, Clinical Skills, MPPD)	Tutorial performance (CBL, Clinical Skills, MPPD)
	Clinical Skills prescribed tasks	Clinical Skills prescribed tasks
	Assignment (Indigenous Health)	Remedial assignment (if required)
	Fundamentals of Biochemical Science Part 1 examination	Fundamentals of Biochemical Science Part 2 examination
	Examinations (30%): MCQ, MEQ, CRE	Examinations (70%): MCQ, MEQ, CRE, OSCE
2	Tutorial performance (BCL, Clinical Skills, MPPD) Clinical skills prescribed tasks Group project (Ethics) Medical Microbiology and Immunology examination	Tutorial performance (CBL, Clinical Skills, MPPD) Clinical skills prescribed tasks Selective assessment (varies depending on selective chosen by student) Examinations: MCQ, MEQ, CRE, OSCE
3	Tutorial performance (CBL, Clinical Skills, MPPD) Clinical skills prescribed tasks Assignment (critical appraisal of a publication)	Tutorial performance (CBL, Clinical Skills, MPPD) Clinical skills prescribed tasks Assignment (research proposal group task) Examinations: MCQ, MEQ, CRE, OSCE
4	End of attachment assessments (varies with discipline; many include mini-OSCE)	End of attachment assessments (varies with discipline; many include mini-OSCE) Examinations: MCQ, CRE(SCT)
5	End of attachment assessments (varies with discipline)	End of attachment assessments (varies with discipline)

Year	Semester 1	Semester 2
		Examinations: MCQ, CRE(SCT), OSCE
6	End of attachment assessments (varies with discipline)	End of attachment assessments (varies with discipline) Transition into internship procedural checklist

The Faculty indicated that it was moving towards adopting standard setting processes particular for Multiple Choice Assessments and Clinical Reasoning Examinations but acknowledged that further work is required. The precision of cut scores requires improvement. The Faculty acknowledged that difficulties were experienced with the implementation of criterion-referenced standard setting and advise that they have since used criterion-referenced cut-points in the 2011 mid-year examinations.

The team was concerned that there is inadequate standard setting for the Objective Structured Clinical Examinations and clinical exams.

Students in clinical years commented on inconsistency in the standards of examinations across rotations, among different examiners and at different sites. The Faculty stated that inconsistency in clinical assessments across sites in general relates to inappropriate passing of borderline students rather than inappropriate failure. The Board of Examiners assesses each failing grade and checks for consistency. Other progress has been made by standardising clinical assessment across sites for the core clinical rotations in Year 5, but the individual assessments vary considerably by specialty. The Faculty considered the numbers represent too small a sample to achieve validity and reliability for each of the rotations. Further development is required to improve the utility of these assessments.

The Faculty advised that CBL tutors are trained specifically and that assessments are centrally moderated for consistency. However, some students state that inconsistent assessment feedback for CBL sessions and inadequate training of tutors for assessment made it difficult for them to measure themselves against Program standard or peers.

2014 team findings

There are clearly defined assessment items throughout the program. These are a mixture of clinical and written assessments.

The assessment for the program is shown in the table below with changes since 2011 highlighted in **bold.**

The Year 2 and Year 3 written examinations are now run over both semesters with a one hour examination at the end of Semester 1 and a two hour examination in Semester 2.

The Year 4 and Year 5 written examinations include multiple choice questions, short answer questions (including justification or rationale) and script concordance testing.

MBBS Program Assessment

Year	Semester 1	Semester 2
1	Tutorial performance (CBL, Clinical Skills, MPPD) Clinical skills prescribed tasks Assignment (Indigenous Health) Fundamentals of Biomedical Science Part 1 examination Examinations (33%): MCQ, MEQ, CRE	Tutorial performance (CBL, Clinical Skills, MPPD) Clinical skills prescribed tasks Remedial assignment (if required) Fundamentals of Biomedical Science Part 2 examination Examinations (67%): MCQ, MEQ, CRE, OSCE
2	Tutorial performance (CBL, Clinical Skills, MPPD) Clinical skills prescribed tasks Group project (Ethics) Medical Microbiology and Immunology examination **Examinations (33%): MCQ, MEQ, CRE**	Tutorial performance (CBL, Clinical Skills, MPPD) Clinical skills prescribed tasks Selective assessment (varies depending on selective chosen by student) **Examinations (67%): MCQ, MEQ, CRE, OSCE**
3	Tutorial performance (CBL, Clinical Skills, MPPD) Clinical skills prescribed tasks Assignment (critical appraisal of a publication) **Examinations (33%): MCQ, MEQ, CRE, OSCE**	Tutorial performance (CBL, Clinical Skills, MPPD) Clinical skills prescribed tasks Assignment (research proposal group task) **Examinations (67%): MCQ, MEQ, CRE, OSCE**
4	End of attachment assessments (varies with discipline; many include mini-OSCE)	End of attachment assessments (varies with discipline; many include mini-OSCE) Examinations: **MCQ, SAQ, SCT**
5	End of attachment assessments (varies with discipline)	End of attachment assessments (varies with discipline) Examinations: **MCQ, SAQ, SCT, OSCE**
6	End of attachment assessments (varies with discipline)	End of attachment assessments (varies with discipline) Transition to internship procedural checklist

Early in 2014, the School held a series of workshops to develop blueprints to guide development of examination assessment items. Teaching staff who are involved in the various year levels have participated in this process.

The assessment academic has given significant attention to written assessments in Years 1, 2 and 3 including establishing the Written Examinations Committee and coordinating question review, examination paper preparation and standard setting. The Written Examinations Committee has improved both the standard setting practices prior to the exam as well the evaluation of items after written exams. In 2014 there will be further work with the Year 1, 2 and 3 Objective Structured Clinical Examination coordinators to review blueprinting and standard setting.

The establishment of a Clinical Examinations Committee in 2013 has resulted in a lead examiner for each Year 5 Objective Structured Clinical Examination station and this person has responsibility for the training of the assessors at that station as well as for ensuring calibration of the assessors. This practice should be strengthened and continued in order to ensure as little inter-assessor variability as possible. Teachers from the clinical sites were invited to participate in the Objective Structured Clinical Examinations (OSCEs) and this should be encouraged, however the time spent travelling to and from the OSCE is seen as an issue.

There continue to be differences in the assessments of the different clinical rotations in Years 4 and 5. This has been addressed to some extent by having end of rotation summative assessments for the urban-based students in a single site. The team suggests the Faculty further review the standard setting of these end of rotation assessments, and to ensure that these assessment items are blueprinted to placement learning outcomes and end of year assessments. Further work needs to be undertaken to address the differences in clinical placement assessment (see Standard 5.4 for further discussion).

Similarly, the team noted Year 2 Medical Microbiology and Immunology assessment would benefit from review and standard setting. Written assessment that requires students to 'fill in the blanks' would generally not be considered acceptable assessment at university level.

5.3 Assessment feedback

5.3.1 The medical education provider has processes for timely identification of underperforming students and implementing remediation.

5.3.2 The medical education provider facilitates regular feedback to students following assessments to guide their learning.

5.3.3 The medical education provider gives feedback to supervisors and teachers on student cohort performance.

2011 team findings

Standard 5.3 was subsumed in 2012 into Standard 5.1.

2014 team findings

Faculty members report that they are usually able to identify struggling students early in the academic year. Considerable effort goes into this particularly in the earlier years, where tutors are able to 'flag' students in difficulty and then provide appropriate remediation. In Years 4 and 5, a student who performs poorly in a particular placement is able to undertake a tailor made remediation placement the following year.

The team considered the process for this, while apparently well known by staff and students, appeared to be relatively complex with different views on who would take forward different problems. The team considered that this may benefit from refinement and documentation, possibly illustrated with examples.

In Years 1-3 there are a number of opportunities for students to receive feedback from both formative and summative assessment. In Year 4 and 5, this process is more dispersed. Clinical year students reported that they valued the opportunity to have formative Objective Structured Clinical Examination practice during their Medical Home Unit placement. Some students commented that it was hard to feel confident going into the end of Year 5 Summative Objective Structured Clinical Examination having had very little summative Objective Structured Clinical Examination practice in the preceding two years. There would be value in the school strengthening and more clearly signposting feedback to students in this area.

For each course in Years 1-3, the major summative assessments in Semester 1 contribute 33% of the final mark and results in Semester 2 contribute 67% to the final mark. The Semester 1 results provide an opportunity for students to gauge their performance against the course criteria, with sufficient time to catch up, if necessary, in Semester 2. From 2014, Year 1 students are having fortnightly formative assessments with immediate feedback. This involves sample questions related to the recent case, with model answers provided. By the time the students sit their summative exam in Semester 1, they will have had exposure (and feedback) on all the types of questions they will experience in the summative exam.

After major examinations, feedback sessions are held to discuss the examination questions and any issues the students may have had. Students who are identified as "at risk" meet with the relevant year level coordinator.

In parts of the program, students can create placements themselves (dedicated student electives, i.e. Medical and Scientific Attachments in Years 4 and 5, and selectives and student selected experience in Year 6). These placements are required to be approved by program academics. All clinical placement sites are evaluated by the discipline coordinator and by student feedback. Student feedback is gathered online and overseen by the Evaluation and Quality Assurance Committee, and students also have alternative pathways for feedback on placements via the discipline coordinator, Years 4-6 Coordinator and the relevant Year Educational Representatives nominated by the student body.

5.4 Assessment quality

5.4.1 The medical education provider regularly reviews its program of assessment including assessment policies and practices such as blueprinting and standard setting, psychometric data, quality of data, and attrition rates.

5.4.2 The medical education provider ensures that the scope of the assessment practices, processes and standards is consistent across its teaching sites.

2011 team findings

The team acknowledges the evaluation undertaken on the Modified Essay Question (MEQ) assessment in Years 4 and 5 that led to discontinuing of these assessments. The team acknowledges the work of the Assessment Committee in developing the script

concordance test. However, the program would benefit from improvement of its blueprinting, criterion-referenced standard setting and an overall assessment strategy to ensure the quality of assessment. Increased student numbers are likely to further impede quality assessment. Students across all years consistently reported concerns around assessment and assessment policy.

The Faculty advised that consistency is ensured by centralising major summative assessments. For clinical assessments, the marking templates clearly outline the expectations of the Faculty and use descriptive text in addition to grades. In some cases, visiting examiners are used. The Faculty found that generally the numbers in term based assessments are too small to make any statistically sound conclusions in a non-graded pass system. Staff across different sites reported poor communication with main campus staff that makes ensuring equivalent delivery of assessment difficult. Students stated that there is little consistency in assessments even at the same sites.

While there are instances of evaluation, the team was concerned that there was no overall assessment plan. Further, staff indicated that the recent changes made to assessment were reactive to issues with specific disciplines and/or resources needed to implement the assessment. Data on Program evaluation is received regularly from the University's central administration, however the Program lacks the resources to evaluate and interpret this data meaningfully.

2014 team findings

There has been notable effort and progress made by the program to address the concerns regarding assessment raised in the 2011 AMC assessment. As commented on in Standard 5.2 above, blueprinting and standard setting of end of year exams is now in place and there is a clear commitment to continuous review and improvement of assessment practices.

The program has made considerable progress with regard to standardisation of assessment. An important change has been the implementation at all clinical sites of the same pro- forma for ward-based assessments.

However, a more consistent approach to assessment in the various clinical year placements is required. Currently, there is significant variation between disciplines. For example, some rotations appear to require attendance as a summative item, whereas others do not. The relative weighting of different rotation assessment items is also unclear (e.g. supervisor report vs. written or clinical assessment).

The program has acknowledged that equivalence of teaching and assessment at sites and between disciplines is an issue, and have included several initiatives within their submission to address this issue.

6 The curriculum – monitoring

6.1 Monitoring

6.1.1 The medical education provider regularly monitors and reviews its medical program including curriculum content, quality of teaching and supervision, assessment and student progress decisions. It manages quickly and effectively concerns about, or risks to, the quality of any aspect of medical program.

6.1.2 The medical education provider systematically seeks teacher and student feedback, and analyses and uses the results of this feedback for monitoring and program development.

6.1.3 The medical education provider collaborates with other education providers in monitoring its medical program outcomes, teaching and learning methods, and assessment.

2011 team findings

The team noted the University policies on the use of the Student Experience of Learning and Teaching (SELT) surveys and the use of the surveys across the MBBS Program and in conjunction with specific changes in curricula. The strengths and limitations of the SELT surveys are recognised by staff and appear to be treated appropriately. It was noted that there are also other less formal avenues for feedback through the multiple course, curriculum, stream and discipline integrating committees.

The team was concerned that the monitoring components in the clinical years (Years 4-6) appear much less structured and in particular noted the absence of systematic assessment of student clinical placement experience incorporating feedback to individual clinician tutors. The clinical years involve students distributed over multiple sites and with many non-university clinicians providing teaching and supervision. The team considers that having an ongoing and relevant form of monitoring of student experience of clinical teaching should be a high priority.

The overall committee structure for course management included the Curriculum Management Committee, the Stream Advisory Committees, and other groups involved in monitoring course, lecture and case content and formats. The representation of students at all levels is to be commended. Nevertheless, the team noted the student perception about the lack of their feedback being incorporated into curriculum and assessment revisions, and about responses to issues of class size and changes to assessment. The Faculty commented that the recent changes to curriculum and assessment may take time to be accepted.

A contributing factor may be the limited capacity of students to self-monitor performance through formative assessment. There would appear to be substantial benefits to individual students, teachers and the Faculty in the introduction of information technology that could facilitate this. The Faculty noted in its submission that it is engaged in developing online components of the curriculum, including formative assessment, to benefit the geographically dispersed students. This development is encouraged by the team.

2011 team findings

(Previously 2011 Standard 6.4 Education exchanges; subsumed in 2012 at standard 6.1.3).

The Faculty has exchange programs in place with a range of other institutions. The good collaboration with Flinders University on rural placements, particularly in the Barossa Valley, is commended. There would appear to be benefits for jointly monitoring and benchmarking clinical placement experience more broadly.

A range of benchmarking activities had been put in place notably with the University of Tasmania and University of Newcastle medical schools. While comparison of student outcomes may be interesting, the main focus should remain the comparison of teaching and learning processes, and assessment.

The appropriateness of the chosen comparator Universities may need to be reconsidered given the University of Adelaide is a research-intensive university in the Group of Eight, even though some of the Group of Eight have larger medical student cohorts.

2014 team findings

The program has responded appropriately to the 2011 team's concerns regarding the lack of dedicated staff resources assigned to evaluation, and the absence of a functioning committee with oversight of program wide evaluation.

An Evaluation and Quality Assurance Coordinator, appointed in December 2012, is a full time resource who has brought extensive experience in both secondary and postgraduate education to lead the enhancements of the evaluation function in the medical program.

An Evaluation and Quality Assurance Committee, established in 2013, advises the Strategy Board on the monitoring, conduct and results evaluations within the medical program. The Committee advises the Curriculum Committee, Year Level and Domain Committees on the scope, methodology and conduct of the evaluation of learning and teaching within the program. The membership of the Committee includes academic staff, hospital/health service representatives and medical students. The Chair of this Committee reports directly to the Dean of Medicine.

The program has undertaken a comprehensive review of existing evaluation activities. The submission provided an overview of all reviews completed in 2013 and the team is satisfied these evaluations adequately address the requirements of this standard. Student feedback is sought through a variety of mechanisms at all levels of the program and the program has developed a four year evaluation plan (2013 – 2016) that will evaluate each component of the program on a biennial basis. The evaluation plan is structured around three components: admissions, the MBBS Program and graduate outcomes. The plan will consolidate current evaluation activities, determine any gaps and develop the required evaluation instruments. This is a working document subject to ongoing review. Importantly the plan will also communicate results to stakeholders and ensure the feedback is utilised in program modifications. This plan should provide the desired structure to the Years 4 – 6 evaluations that were missing in 2011. The addition of student members on the Evaluation Committee should also assist with addressing student concerns with lack of attention to feedback documented during the 2011 assessment will be addressed.

The results of evaluation of the various components of the medical program are reported to the Evaluation and Quality Assurance Committee, which forwards them to other committees (e.g. Year Level and Curriculum Committees) as appropriate.

The 2011 team identified establishing a means of gathering ongoing and relevant monitoring of the student experience of clinical teaching as a high priority. The Years 4-6 Online Clinical Placements Survey (OCPS) gives students an opportunity to provide feedback at the completion of each of their clinical placements (Core Clinical Attachments, Medical and Scientific Attachments, internships and selectives) through a survey that was developed in collaboration with academics and Years 5-6 medical students. The team commends this development.

The results of and staff responses to student feedback are communicated to students either at a student meeting, or on-line with students being advised about this communication through the Medicine Learning and Teaching Unit (MLTU) Bulletin Board. Examples include:

- Results of the Years 1-3 Program Student Experience of Learning and Teaching (completed at the end of Year 3) were presented by the Director of the MLTU and the Evaluation and Quality Assurance Coordinator at a special student meeting.
- Results of the Years 1-3 Lecture Survey 2013 were made available to students on-line at the end of each semester.

The Faculty is planning to survey clinical and academic staff in late 2014. This feedback will be integrated and analysed with student feedback and used to improve the program.

The Evaluation and Quality Assurance Co-ordinator has established links with Evaluation Co-ordinators of medical programs at Flinders University, The University of Melbourne and James Cook University about evaluation tools and collation of data.

The Course Experience Questionnaire has enabled comparison of University of Adelaide MBBS graduates with medical graduates from other Group of Eight universities (2008-2012). The medical program's results for overall satisfaction with the program and teaching has increased steadily over the four year period and rank well in comparison with the medical programs of these universities.

Following a trial in 2014, in 2015 the medical program will implement a survey developed at The University of Melbourne to evaluate the preparation for internship semester in Year 6 of the MBBS. This will enable comparison between the Faculty's program and the University of Melbourne's preparation for internship program.

6.2 Outcome evaluation

6.2.1 The medical education provider analyses the performance of cohorts of students and graduates in relation to the outcomes of the medical program.

6.2.2 The medical education provider evaluates the outcomes of the medical program.

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.

2011 team findings

The Faculty is commended for initiating the Medical Graduate Outcomes Evaluation Program with its follow-up of four consecutive year cohorts. It is important that the analysis of this evaluation is delivered promptly if it is to meaningfully inform curriculum content. It was not clear to the team how this will occur.

This reflected a broader issue of the lack of a clear framework for overall evaluation. There appeared to be:

- Lack of a strategic plan for evaluation resulting in piecemeal and disconnected evaluation activity.
- Lack of clear senior management, leadership and accountability for overall evaluation and monitoring.
- Weak evaluation tools and processes for monitoring clinical supervision and teaching.
- Inadequate resources for comprehensive evaluation and timely output.
- Unclear response mechanisms so the cycle of quality improvement appeared incomplete.

Currently, the MBBS Evaluation Officer is a 0.5 FTE six-month contract position. The previous Evaluation Coordinator finished in 2008 and the prior Evaluation Committee had its final meeting in 2008. The appointment of a full-time evaluation officer is an important remedial step. Given the nature of evaluation, it is important that there is continuity in this area. Clarification of the role of the Medicine Learning and Teaching Unit (MLTU) in evaluation and clear alignment of this group with the Dean and Director of the MBBS Program would also substantially improve the feedback loop.

A specific issue is the finite capacity of rural clinical locations. There was overwhelming positive feedback about the rural clinical program with only minor complaints about variability in teaching in some locations. However, both students and rural practitioners noted that the model is resource intensive and that the experience is very sensitive to student numbers. Given the University's undertaking to expand rural clinical placements, close monitoring of numbers and evaluation of the impact of this on the learning experience will need to be undertaken.

2014 team findings

The team considers that the Faculty has responded well to the concerns regarding outcome evaluation raised in the 2011 assessment.

The medical program is now a member of a national project investigating the predictive validity of the undergraduate medicine and health sciences admissions test (UMAT). The longitudinal study will be the most comprehensive evaluation of the UMAT testing that has yet been undertaken.

The Medical Graduates Outcomes Evaluation Program (MGOEP) has had some success in tracking graduates in order to provide information on career destinations and success in vocational and other licensure examinations. A survey was released in February 2014 to graduates from 2004 which asks questions about their current status, overall experiences in the MBBS, and seeks some advice on what should be included in the program based on their education and experience The program anticipates that contact

with graduates will be enhanced through links within SA Health to obtain contact details of graduates who complete their intern year in South Australia, and other graduates will be tracked via the University alumni.

The team noted some lack of clarity around the extent to which information about performance in relation to student characteristics informed monitoring and quality assurance for student selection, curriculum and student support and suggests that the Faculty further review this.

6.3 Feedback and reporting

6.3.1 The results of outcome evaluation are reported through the governance and administration of the medical education provider and to academic staff and students.

6.3.2 The medical education provider makes evaluation results available to stakeholders with an interest in graduate outcomes, and considers their views in continuous renewal of the medical program.

2011 team findings

Monitoring and evaluation information is provided to multiple committees. The cross membership of these committees should assist communication. In general, students acknowledged that they received feedback about evaluation but voiced concerns about the responsiveness to those evaluations. The team remains concerned about the adequacy and effectiveness of the feedback particularly where the feedback loop did not appear to be consistently closed. This issue needs to be addressed.

2014 team findings

The Evaluation Committee reports on evaluation outcomes through several committees for information and action where required. The School's submission provided several examples where evaluation summaries were used to improve aspects of the medical program and provide this feedback on a summary form.

Students acknowledge that the Faculty provides regular feedback both formally and informally in committees. Students specifically acknowledged that the Faculty had responded to a range of issues raised in the 2011 review and other subsequent matters.

Multiple types of performance feedback are offered to students across the program. However it was evident that not all students were aware of both the individual and program level feedback mechanisms. Signposting the feedback points in the program may enable students to better recognise and benefit from the individual and program level feedback. The Evaluation and Quality Assurance Committee also plans to build a webpage where evaluation outcomes can be reported to stakeholders.

7 Implementing the curriculum - students

7.1 Student Intake

7.1.1 The medical education provider has defined the size of the student intake in relation to its capacity to adequately resource the medical program at all stages.

7.1.2 The medical education provider has defined the nature of the student cohort, including targets for Aboriginal and Torres Strait Islander peoples and/or Maori students, rural origin students and students from under-represented groups, and international students.

7.1.3 The medical education provider complements targeted access schemes with appropriate infrastructure and support.

2011 team findings

The size of the student intake is determined on an annual basis by the executive dean of the Faculty of Health Sciences. Efforts have been made to align student numbers with South Australian workforce requirements, which is commendable.

Cohort size has increased substantially in recent years. This has occurred in a step-wise fashion since the MBBS Program was last accredited. Intake peaked at 200 in 2010 and is not expected to rise further (see table).

Commencing first year	Unbonded CSP	BMP/MRBS	AFBE	SA Bonded Scholarships	International	Cohort Total
2005	70	16	2	Not available	36	124
2006	75	21	9	Not available	16	121
2007	80	36	0	4	20	140
2008	97	38	0	1	20	156
2009	103	44	0	0	23	170
2010	132	51	0	Not available	16	200

The increased number of students has led to significant physical capacity issues, particularly in the Medical School Building. These challenges were explicitly acknowledged in the Faculty's submission to the AMC, which noted that the increased numbers have put "multiple pressures" on the Program. Comment was made that there are "insufficient rooms" for case-based learning (CBL) tutorials and that the increased numbers have placed "greater strain" on student support resources. It was also noted that other clinical placement areas were expected to "struggle to accommodate" the additional load. The Faculty noted in 2010 that there would be insufficient Year 3 clinical places in 2011. This issue was alleviated by the Faculty successfully arranging for clinical placements at two new sites (Modbury Public Hospital and St Andrews Private Hospital), with funding supplied by the Faculty and Health Workforce Australia.

Concerns around clinical placement capacity were also acknowledged by staff at clinical teaching sites. Some felt that the increased numbers would impact significantly on their capacity to deliver the curriculum in an effective manner. The team, however, saw several examples where clinical training capacity is being expanded, including the recruitment of St Andrew's Private Hospital and the GP Superclinic in Playford as teaching sites. The team was impressed with these facilities.

While there has been some readjustment of numbers as a result of space constraints (as evidenced by the recent decision to reduce intakes to 190 from 2012), the alignment of student numbers with available infrastructure is poor. This was concerning, particularly given the overall state of the physical resources available to the Program.

The nature of the student cohort is clearly defined with a strong emphasis on the enrolment of students from South Australia. There is proactive recruitment of rural origin school-leavers and tertiary transfer applicants. The team noted that the Fairway and Rural Background Entry schemes are well regarded by students.

The Faculty's submission to the AMC specified that the Program had capacity to accommodate up to six Indigenous medical students in each year level. However, actual enrolments fall well short of this target with only seven Indigenous medical students currently identified across the entire Program. This may reflect issues with recruitment strategy, as well as the selection process for Indigenous applicants.

2014 team findings

The program has recently reduced student intake in order to address physical capacity issues on campus, and to ensure that numbers are commensurate with the Faculty's contractual agreements with the Commonwealth Government. The decision also reflects the need to increase the number of clinical placement sites to absorb excess numbers. The Faculty has reduced intake to 143 students in 2014 from a recent high of 208 students in 2012. The Faculty has committed to a stabilised intake for the next few years.

Year	*Government supported*	*Government-funded bonded (Rural/Medical)*	*Fee-paying domestic*	*Fee-paying international*	*Total*
2014	*70*	*43*	*0*	*30*	*143*
2013	*87*	*37*	*0*	*35*	*159*
2012	*121*	*57*	*0*	*30*	*208*
2011	*129*	*46*	*0*	*15*	*190*
2010	*132*	*51*	*0*	*16*	*199*

The Faculty now reports no capacity issues, including for the large cohorts of 2010, 2011 and 2012. It appears the program has managed the increased cohort size. The School will continue with the agreed requirements for graduating domestic students with a stable fee paying international intake at the level currently being recruited (30 students). Students appear very satisfied with their placement experiences and report no overcrowding. Creative solutions, such as the use of after-hours rostering, had been

employed to spread student load in emergency departments. Clearly SA Health staff specialists are committed to research, teaching and quality service and to date SA Health has enabled them to do this. It is anticipated that the smaller cohort size requiring clinical placements by 2016 will enable potential simplifications of student placement arrangements.

The student body is well catered for and the program seems adequately resourced. The team was impressed with the very small group sizes that the Faculty uses for much of its teaching and there did not appear to be difficulties sourcing appropriate tutors for these numerous small groups. A suite of methods supports medical students in rural locations, including grouping students for local tutorials, utilising visiting specialists from Adelaide (including for simulations), and employing tools such as video conferencing and on-line teaching resources. Students especially appreciated the on-line resources created for paediatrics.

The team was impressed with the extensive range of placement opportunities available to students and the resource of enthusiastic and engaged teachers in both clinical and pre-clinical years. This is further discussed under Standard 8.

The program has defined the nature of the student cohort, including targets for Aboriginal and Torres Strait Islander peoples rural background students and students from under-represented groups, and international students.

The Australian Government Department of Health requires that 25% of all MBBS students in a Commonwealth Supported Place are from a rural background. Applicants (tertiary transfer, special entry and school leaver) who meet the residency requirements of spending at least five years in a designated rural area are eligible to apply under the Rural Background Entry Pathway. From 2011 the MBBS program has allocated specific places for applicants who apply under this pathway.

The University has access schemes to increase under-represented groups, such as Fairway Access and Fairway Equity Schemes. These schemes provide for bonus points added to university aggregate scores, which create a new tertiary admissions rank. The issue of under-represented groups apart from Aboriginal or Torres Strait Islanders (for instance those with socioeconomic disadvantage, refugees) has not been specifically considered or addressed by the Faculty. It is not clear how many students are assisted into medicine by these schemes. The program may wish to investigate strategies to increase student representation from under-represented groups.

Each year, there are up to ten guaranteed MBBS places for tertiary transfer applicants into first year of the MBBS program at the University of Adelaide.

Aboriginal or Torres Strait Islander peoples are eligible to apply to the University of Adelaide via the Aboriginal and Torres Strait Islander Access Scheme through Wirltu Yarlu Aboriginal Education. Up to six MBBS places are available each year.

Wirltu Yarlu is responsible for recruiting Aboriginal and Torres Strait Islander students to the University's foundation and degree programs and is guided by the 2012 Indigenous Education statement. In partnership with Wirltu Yarlu, the Yaitya Parruna Indigenous Health Unit (YPIHU) promotes tertiary study opportunities and careers for Indigenous people in the health sciences.

The staff of Yaitya Purruna Indigenous Health Unit are all Indigenous and all involved in various measures to increase the selection of Indigenous Australian students into the

medical program. YPIHU is located within the School of Population Health and one of the School's main strategic goals from 2013 has been to increase Indigenous and rural students into careers in the health sciences. The Bachelor of Health Sciences, which is administered by the School of Population Health, is already an accepted pathway for many students into the medical program.

Throughout 2013, staff of Yaitya Purruna Indigenous Health Unit in collaboration with Wirltu Yarlu: Aboriginal Education Student Services staff and the OFFS Indigenous Outreach Officer have put in place a number of strategies to increase the entry of Aboriginal and Torres Strait Islander students into the Medical program. The team observes the current Indigenous recruitment strategy is not effective and suggests the program conduct a review of its approach to the recruitment of Indigenous students.

The University has a visiting program to high schools. Plans have been developed to support students from Year 10 with 'Health Science Pathways', but these were dependent on grant funding and the application was not successful.

Currently there are 30 places for fee paying international students and they are a source of crucial revenue. They are primarily from Asia, with China replacing Singapore as the most significant country of origin. The program indicated it plans to hold the international cohort size at 30. The team commended the significant investment in comprehensive support for international students.

The medical education provider complements targeted access schemes with appropriate infrastructure and support.

Extensive support is available for Indigenous students from the Wirltu Yarlu Aboriginal Education Unit and the Yaijita Parruna Indigenous Health Unit and designated space is provided for these students and a medical mentoring program is also available.

The Discipline of Rural Health provides support for students from a rural background by facilitating networks and mentorship opportunities for rural students.

An excellent language and tutorial support program based in the MLTU and led by a co-ordinator of academic language and medicine program is in place for international students. This includes a Year 1 International Program, a Year 2 Academic Language and learning program and a Year 4 Bridging for International Medical University (IMU Malaysia) students. Both the co-ordinator and these programs were highly regarded by students.

7.2 Admission policy and selection

7.2.1 The medical education provider has clear selection policy and processes that can be implemented and sustained in practice, that are consistently applied and that prevent discrimination and bias, other than explicit affirmative action.

7.2.2 The medical education provider has policies on the admission of students with disabilities and students with infectious diseases, including blood-borne viruses.

7.2.3 The medical education provider has specific admission, recruitment and retention policies for Aboriginal and Torres Strait Islander peoples and/or Maori.

7.2.4 Information about the selection process, including the mechanism for appeals is publicly available.

2011 team findings

Selection into the medical program for domestic applicants involves three components: Australian Tertiary Admissions Rank, Undergraduate Medicine and Health Sciences Admission Test (UMAT) and Structured Oral Assessment (SOA).

International applicant admission requirements include sitting the Personal Qualities and Aptitude (PQA) Test, satisfactory academic performance and the SOA. Details of the process are published in the University's Undergraduate Prospectus and on its website. The SOA is a valued component of the selection pathway in that it is widely seen as an appropriate and effective mechanism by which to assess applicants. Overall, the selection process is well regarded by students and Faculty members. A summary of the selection steps, instruments, weightings and timelines for domestic and international applicants are provided in the below tables.

In relation to the recruitment of Indigenous students, the team noted that the University requires prospective students to complete the standard selection pathway in addition to Indigenous-specific requirements. This appears to be an unnecessarily complicated and lengthy process. While Indigenous applicants are eligible for academic concessions, these did not seem to be applied consistently as part of a systematic approach to Indigenous enrolment.

Overall, the Program's approach to the recruitment of Indigenous students is considered facilitatory but not affirmative. This may reflect the fact that two Indigenous units are involved in the process, with several staff members only employed on short-term contracts.

The team noted that selection criteria are clearly aligned to desired graduate outcomes.

Domestic Applicants		
Instruments	**Weighting**	**Timeline**
UMAT Test Results received mid-September	Initial Ranking for invitations to December Oral Assessments	Invitations to December Oral Assessments released in October
UMAT Test Results received mid-September	Invitations to January Oral Assessments are based on a combination of UMAT and TER scores in a 1:2 ratio	Invitations to January Oral Assessments are released mid-January
UMAT Test Results received mid-September	Results from the UMAT contribute to 20% of a candidate's overall merit ranking score	A candidate's overall merit ranking score is prepared in January in order to rank applicants for release of offers
Structured Oral Assessment First round of assessments are conducted in December	Scores from the Structured Oral Assessment contribute 40% of a candidates overall	A candidate's overall merit ranking score is prepared in January in order to rank applicants

Domestic Applicants		
Instruments	**Weighting**	**Timeline**
and second round of assessments are conducted in the last week of January	merit ranking score	for release of offers
Academic results	A candidate's academic results contribute 40% of their overall merit ranking score subject to their meeting of minimum academic standards	These results are received in late December/early January in order to rank applicants for release of offers

International Applicants		
Instrument	**Weighting**	**Timeline**
PQA Test	Ranking for invitations to Oral Assessments	PQA testing is conducted in July/August
Structured Oral Assessment	Scores from the Structured Oral Assessment are the first level of ranking applicants in the Merit Ranking list Candidates on equal scores will be further ranked on the results of their POQ test	Structured Oral Assessments are conducted in late September/early October
Academic results	Academic results are continued to be received until mid-January. These are used as threshold after being ranked according to Oral Assessment and PQA results	Recommendations for offers are submitted in October/November for release of formal offers once academic results are known

2014 team findings

The program's selection policy and processes are clear and publicly available. The 2015 Admissions Guide is also extremely clear. A minimum academic standard (of different forms for different students) is defined for all students, then either the undergraduate medicine and health sciences admissions test (UMAT) or Personal Qualities and Aptitude (PQA) is used to rank students for interview. There is a distinct process for academic assessment of Indigenous applicants.

Interview then serves two purposes, it provides a mark (40%) that is added to the student's academic score (40%) and UMAT/PQA (20%) score to determine a ranking and interview is used to exclude students that 2/4 interviewers consider not suitable for medicine. The interview consists of two 15 minute sessions (each student is assessed by four interviewers). One session deals with motivation and the other involves a problem solving exercise. Motivation, communication skills, problem solving, compatibility with the program and demonstration of attention to detail and professional behaviour are all considered by the assessors. Full interviewer training occurs, and interviewer teams consist of a medical person and a community member. Each interviewer will mark independently (not by consensus).

The program has policies on the admission of students with disabilities. The University of Adelaide supports the inclusion of students with disabilities by providing reasonable adjustments. These adjustments may include modification to assessment and provision of additional support services; however, adjustments cannot be provided which would undermine the core or inherent learning required and thus compromises the academic integrity of the MBBS Program.

The program has a Policy on Prescribed Communicable Infections, which is readily accessible on the web site, as well as an inherent requirements document for the MBBS program, which are present, and publically available. The Faculty also provides specific admission, recruitment and retention policies for Indigenous students, however there are few Indigenous students in the program. All information about the selection process, including the mechanism for appeals is publically available; however the information on the mechanism for appeals is not very clear on the Faculty's website.

7.3 Student support

7.3.1 The medical education provider offers a range of student support services including counselling, health, and academic advisory services to address students' financial, social, cultural, personal, physical and mental health needs.

7.3.2 The medical education provider has mechanisms to identify and support students who require health and academic advisory services, including:

- *students with disabilities and students with infectious diseases, including blood-borne viruses*
- *students with mental health needs*
- *students at risk of not completing the medical program.*

7.3.3 The medical education provider offers appropriate learning support for students with special needs including those coming from under-represented groups or admitted through schemes for increasing diversity.

7.3.4 The medical education provider separates student support and academic progression decision making.

2011 team findings

Those students who had accessed student support services regarded the level of support offered to them by individual Faculty members highly. The team received positive comments on the assistance provided by the Associate Dean (Students) and the staff of the Medicine Learning and Teaching Unit (MLTU). The team also noted that the Faculty has dedicated administrative staff who are firmly committed to the program and its students. Access to centralised support services, including counselling, appears adequate.

The Faculty advised that students are given multiple briefings regarding student support services and can access written advice on the website. However it appears students have difficulty in identifying the individual they should first contact concerning their health or welfare. There was confusion around the roles of the year level convenors, the Associate Deans and the MLTU in relation to student support. This may represent a communication issue.

Students also felt that the delineation between those responsible for progression and those responsible for student support services was indistinct. Similarly, the team was not entirely clear which individuals were practically responsible for student support as distinct from academic support. This blurring of responsibility has significant potential to create a conflict of interest.

Mechanisms for the early identification of under-performing or borderline students need to be improved. Students report that there are limited opportunities to judge their progress during the pre-clinical years. In particular, many students did not regard the A-E grading system for CBL as a useful predictor of performance in summative examinations. There is a high level of student anxiety compounded by the absence of academic supplementary examinations.

The program's policies on the admission and support of students with disabilities and prescribed communicable infections are adequate.

Indigenous students receive support from Wilto Yerlo, the Aboriginal and Torres Strait Islander Education Unit, and Yaitya Purruna, Indigenous Health Unit in the Faculty of Health Sciences. While both have an obvious and undisputed commitment to student care, the existence of two Indigenous units means there is potential for some students to fall between the gaps.

2014 team findings

The Medicine Learning and Teaching Unit (MLTU) website has created a student well-being webpage to help students navigate the university's options depending on the student's situation. The MLTU has been liaising with the University Counselling Service to improve student use of this service. Student support was in general viewed as a triage function (with the exception of academic support).

Since the last assessment in 2011 the medical program has discontinued the role of Dean of Students. While some of the student representatives were keen for a replacement, most students were clear that they could bring problems to the designated MLTU staff member who would triage them appropriately.

The Adelaide Student Counselling Service offers a Duty Counsellor who is able to physically attend the medical school if required.

While the program specifies high attendance requirements, no student dissatisfaction was elicited suggesting that students are able to take time off for health reasons and personal crises. There are formal processes for identifying students at academic risk both at the program and University level. At the program level, students' assessment results are monitored during the year, and students deemed to be at risk are notified in writing during the year and offered academic support. After the end of year assessment, students with unsatisfactory or borderline academic results are again notified in writing and offered assistance for the following year. At the University level, students are identified at the end of each year based on their academic results, and again are notified in writing.

There is a clear and well-established policy for identifying, managing and supporting students with infectious diseases. There is no specific policy or practice in regard to students with mental health needs but a clear student support referral pathway is available. Students at risk of not completing the program may be identified by tutor reports or by poor performance in examinations. Such students are requested to attend a diagnostic interview with two staff members and provided with counselling and referral to appropriate services.

In terms of learning support, substantial support is available for the six indigenous students in the program. The Discipline of Rural Health facilitates networks and mentorship opportunities for rural students.

The medical program separates student support and academic progression decision making. Boards of Examiners receive de-identified results, and any student support outcomes and identification to necessary staff are actioned post release of grades. Tutor/ward supervisor reports are also discussed at the Boards of Examiners meetings and are presumably identified reports. There was a lack of clarity about the contribution of these reports to academic progression (discussed further at Standard 5.1).

7.4 Professionalism and fitness to practise

7.4.1 The medical education provider has policies and procedures for managing medical students whose impairment raises concerns about their fitness to practise medicine.

7.4.2 The medical education provider has policies and procedures for identifying and supporting medical students whose professional behaviour raises concerns about their fitness to practise medicine or ability to interact with patients.

This is a new standard.

2014 team findings

The Faculty has an inherent requirements statement, a detailed statement of the skills that students require as a part of the University of Adelaide Medical Program. The program's web site clearly states that these skills are core/inherent learning requirements of the program. Students will be asked to sign the statement from 2015 but it is not clear what this acknowledgement will mean in terms of student and school responsibility. Faculty have also not yet considered a pathway for managing students who do not meet inherent requirements after reasonable adjustments are made. This

would include students who acquire a significant physical disability during the program and students who prove to be unable to meet the required behavioural and social skills.

The Medical Professional & Personal Development (MPPD) domain teaching provides ethical thinking basics in the first three years of the program and the program has designed ethical Objective Structured Clinical Examinations (OSCEs). New graduate outcomes are being developed in the MPPD domain. The team understands a fourth domain may be introduced, potentially entitled Medical Advocacy, Leadership and Professionalism, with its own assessment. It is intended that the change in assessment approaches with explicit inclusion of assessment of professionalism will allow the program to manage students with poor professional attitudes or behaviours to be managed through the University's Unsatisfactory Academic Progress Policy pathway, rather than requiring a specific pathway for this group. The University does not support exclusion of students on the basis of concerns about professionalism other than in the context of serious misdemeanours that breach the University's Student Misconduct Rules.

Staff told the team that professionalism issues were escalated to the academic head of the activity in which the problem occurred, for example case-based learning. The academic head and a colleague meet with the student and complete a form as a record of the conversation. More serious cases are referred to the Deputy Dean who may refer students onto the University for Action under the Student Misconduct Rules. The Student Misconduct Rules of the University of Adelaide include the following: 'Failing to adhere to the requirements of external organisations or codes of conduct relevant to the student's course of study while in placement, practicum, or work experience' which is helpful.

While the Faculty has to date maintained a three year exit degree so students who may chose to leave the medical program may still graduate with a degree, this option will not be available from 2015.

While senior central academics and Medicine Learning and Teaching Unit staff believed that existing practices were sufficient to identify and support students with behavioural problems or impairment, teachers at clinical sites had a different view. In particular, they felt that relevant information was not systematically shared and requested that appropriate notification be given in advance about students with disabilities or difficulties. Mechanisms for reducing the fragmented management of students and limited transfer of relevant student information need to be developed. The team suggests the program consider assigning a senior academic with oversight for student support in order to provide consistency across the program.

The program has a Code of Conduct; however processes and penalties for breaches of the Code of Conduct need to be consistent and clarified for staff and students.

7.5 Student representation

7.5.1 The medical education provider has formal processes and structures that facilitate and support student representation in the governance of their program.

2011 team findings

(Previously 2011 Standard 7.4 Student representation; subsumed in 2012 at standard 7.5).

The Faculty is commended on the extent to which students are represented on key committees. The team noted that there are strong links between the Program and the Adelaide Medical Students' Society (AMSS). It observed examples of warm and constructive relationships between students and senior Faculty members. The Faculty advised that AMSS education representatives on MBBS committees communicate extensively with the student body. If the Faculty's strategy is to use these representatives to communicate about important curriculum issues, then it must resource the AMSS for this task.

There is, however, widespread dissatisfaction about campus facilities and the extent to which the Faculty consults on key changes to the course. The AMSS noted in its submission that recent changes to the curriculum and assessment had caused a significant degree of student dissatisfaction, which may contribute to overly critical responses to its satisfaction survey. The recent adjustments to the assessment in Years 2 - 4 were repeatedly used as examples of poor consultation and communication by various student groups. The AMSS also stated that this discontentment has been present since before the recent changes and stems from an overall perception of deficiencies in the delivery and resourcing of the Program.

The team observed a significant concern among students about Faculty responsiveness to formal and informal feedback. The Faculty noted that many curricular changes have been made as a direct response to student feedback, such as the increase in the number of lectures for Years 1 – 3, and the change from problem-based learning to CBL style. The team noted that many students believe that their opinion was not sufficiently taken into account in Faculty decision-making. This disconnect requires urgent attention.

2014 team findings

Student representatives have a place on all major committees. The Dean of Medicine and the Director of the medical program meet with the Adelaide Medical Students' Society (AMSS) President and Vice President monthly, and are also in regular email or face to face contact with students about issues as they arise. The response rates to program surveys are very good and students are clearly engaged with the program.

Overall the student body was happy with the program and their relationships with Faculty staff. Minor issues appeared to be dealt with locally without needing referral to governance groups.

7.6 Student indemnification and insurance

7.6.1 The medical education provider ensures that medical students are adequately indemnified and insured for all education activities.

2011 team findings

(Previously 2011 Standard 7.5 Student indemnification; subsumed in 2012 at standard 7.6)

The Faculty provides appropriate indemnification for students undertaking course-related activities.

2014 team findings

The team considers that the arrangements for indemnification and insurance are present and satisfactory.

8 Implementing the curriculum – learning environment

8.1 Physical facilities

8.1.1 The medical education provider ensures students and staff have access to safe and well-maintained physical facilities in all its teaching and learning sites in order to achieve the outcomes of the medical program.

2011 team findings

Pre-clinical students are allocated educational facilities within the Medical School Building. These facilities have remained unchanged since previous accreditation visits, with the exception of the development of the new Ray Last Bioskills Laboratory. This new space provides facilities for Anatomy teaching and clinical simulation. While an excellent addition, this new facility is relatively small, given that there are close to 200 students in each year of the Program alone requiring access. In addition, medical students have very limited access to this facility.

Due to a centralised approach to bookings, MBBS students do not have priority to the facilities in the Medical School building precinct. This is especially problematic, given the rising number of MBBS students and the fact that many lecturers are clinicians who require the proximity of the Medical School Building facilities.

To deal with increasing student numbers, four additional tutorial rooms have been created, and two lecture theatres have had their capacity increased to cope with 200 students. However, the Program staff acknowledge that facilities in the Medical School Buildings are highly problematic. In particular, clinical based learning facilities are not fit for purpose. The rooms are poorly designed, poorly ventilated and poorly maintained. Taking into account the number of staff and students, and the level of activity of staff and students within this area, amenities such as toilets are seriously inadequate. There is very limited study and recreation space for students. The student common room is very small, considering that it provides a recreation and study facility for in excess of 500 medical students, in addition to students from other disciplines. This area requires urgent improvement including furniture, equipment, and maintenance and cleaning.

Staff and students consistently complained about the poor quality of ventilation and air-conditioning within the Medical School Building. This facility is shared with an animal research facility, and students and staff report frequent unpleasant odours permeating through their office and teaching areas. Formaldehyde from the dissection facility below can be smelt in the lecture theatre above.

The MBBS Program also highlighted the variability in space available for staff accommodation, meetings and conferences. Overall, the central University facilities available to the MBBS Program are not comparable to those of equivalent medical schools. In recognition of this, the University now has redevelopment of facilities with the Faculty of Health Sciences as the number one priority. Plans are underway to increase student space in the ground floor of the Medical School Building which will include a student educational hub. There are discussions regarding the possible construction of a new Medical School Building in the grounds of the new Royal Adelaide Hospital, though no details are yet available. The new hospital is not expected to open until 2016.

Clinical teaching facilities are provided by the University of Adelaide at most clinical teaching sites, including: the Royal Adelaide Hospital; Lyell McEwin Hospital; the Women's and Children's Hospital; The Queen Elizabeth Hospital; Modbury Hospital General Practices and the Spencer Gulf Rural Health School. In a number of locations, the University does not control the spaces that students require for clinical teaching. This means that academic staff are constantly negotiating with hospital authorities to ensure student access to these spaces. Some consideration needs to be given to having University of Adelaide controlled space within each teaching hospital. Resolution of the issues around clinical teaching spaces and clinical teaching resources within the new Royal Adelaide Hospital is an urgent priority.

Some of the clinical teaching facilities are outstanding. The newly developed clinical teaching facilities with a modern audio-visual system at St Andrew's Hospital provide an excellent environment for students. The team was impressed by the partnership the Program had developed with the private sector at this site. Facilities managed by the Spencer Gulf Rural Health School provide high quality accommodation and teaching and learning spaces for students. The GP Super Clinics also provide an excellent environment for students. There are plans for further expansion of clinical training sites over the next five years.

The team was impressed by the culturally inclusive efforts within the Faculty, and particularly noted the prayer rooms available in a number of facilities.

2014 team findings

The program's physical facilities have been improved since the 2011 visit. The main medical school building on Frome Road has been updated, and is now a more attractive and functional space. Access to computers has improved and the student common room has been refurbished. The program has adequately addressed all issues resulting from the co-located animal research facility.

The team visited the new medical program offices and teaching rooms at the Lyell McEwen hospital. The hospital also hosts the recently opened clinical education facility, which provides space for tutorials and clinical skills training together with simulation. The modifications to the hospital is evidence of the presence of the Faculty on that site, and enables further partnership opportunities with the Northern Adelaide Local Hospital Network. The clinical education facility will provide a base for medical students from Years 3-6 in addition to providing space for simulation training and inter-professional learning with nurses and other allied health professionals).

The Robin Warren Clinical Skills Facility, on the Frome Road site, is primarily used to facilitate the clinical skills program and is used by both medical and nursing students. The Faculty's simulation centre, co-located with the Ray Last Anatomy Laboratory, is also now fully operational. These facilities have helped develop inter-professional learning and simulation programs within the Faculty.

The Hub Central facility has opened on the main University campus, and includes a variety of smaller formal and informal teaching and learning spaces. The large group case-based learning sessions for first year students will remain on the North Terrace campus.

In addition to updating the existing facilities, there is ongoing and intensive planning of the teaching facilities in the new medical school building adjacent to the new Royal Adelaide Hospital (planned for opening in late 2016).

Construction of the building has commenced in the South Australia Health and Biomedical Precinct at the west end of North Terrace. The building is a major undertaking for the Faculty, and represents the largest capital works program ever undertaken at the University. The University Council initially approved a six-floor building to accommodate the teaching needs of the medical and nursing programs and house some of its successful research teams. Subsequent proposals have recently been approved to increase the number of floors to 13 in order to accommodate all five of the major research themes that are an integral part of the Precinct. The total University capital investment in the precinct will be over $200M.

The major activity within the Faculty has now turned to the design and development of teaching and learning facilities within this building. The planning includes consideration of the needs of the medical and nursing programs, and what teaching components will remain on the Frome Road / North Terrace site. It is anticipated that the vast majority of pre-clinical teaching will shift to the new medical school site. The Faculty intends to maintain some facilities in the current medical school building, including the Ray Last Anatomy Laboratory. It is likely that students will be timetabled to spend a block of time (for instance, one day per week) at the Frome Road site to minimise the need to move between locations.

The new building has been designed to enhance integration between the medicine and nursing courses. It will feature a range of versatile teaching and learning spaces, including an entire floor dedicated to clinical skills and simulation training. The building will also enhance student exposure to research, given that much of the University's biomedical research activity will occur at the site.

Until such time as the new building is occupied, attention will need to be paid to maintaining the current facilities at the Frome Road site.

8.2 Information resources and library services

8.2.1 The medical education provider has sufficient information communication technology infrastructure and support systems to achieve the learning objectives of the medical program.

8.2.2 The medical education provider ensures students have access to the information communication technology applications required to facilitate their learning in the clinical environment.

8.2.3 Library resources available to staff and students include access to computer-based reference systems, support staff and a reference collection adequate to meet curriculum and research needs.

2011 team findings

The curriculum is supported by a learning management platform that is managed by the Medicine Learning and Teaching Unit (MLTU). Since this platform was developed, the University developed an additional learning management platform (BlackBoard). The MLTU platform has a range of functionality that the University platform does not offer at this stage. However, the end result is that students use two different learning

management systems on a daily basis, which they find time consuming and frustrating. These two systems need to be rationalized.

Delivery of the Program is heavily reliant on information technology (IT), with information regarding timetables, rostering, allocation to groups and rooms and learning material all accessed online. Surprisingly, current facilities do not encourage students to utilise their own computing equipment and this leads to over-dependence on University provided facilities.

These computer facilities are inadequate, especially since they are shared with students from a variety of other programs. Students and staff also reported insufficient access to computer facilities within clinical teaching sites. Where students brought their own computers, they frequently struggled to find a space to sit to use their equipment. In addition, access to secure storage is limited. As noted at Standard 8.1, there are plans for a student hub to be built at the front of the Medical School Building, which will have extensive wireless facilities and small group access for all students. Similar hubs across campus are part of a long term University strategy.

Students are currently required to obtain lectures from lecturers for uploading on to the learning support system. The team considers that it is a reasonable expectation of students that this should be undertaken by the University through either the Schools or the MLTU. It is a reasonable expectation that all lectures should be prepared in a form suitable for uploading, accepting that some modification may need to occur because of copyright or other intellectual property issues. The Faculty has acknowledged that there are difficulties with IT access for both pre-clinical and clinical students. There have been major efforts to improve student access to IT within a number of clinical teaching locations.

The online library facilities are highly regarded by both students and staff, with most reporting that they rarely need to actually visit the physical library. Nonetheless, there are extensive and well-resourced physical library facilities. University librarians are regarded as highly accessible and helpful. At other locations, communication and level of affiliation with the University of Adelaide could be improved to improve access for students studying at those locations.

2014 team findings

The program continues to rely on two parallel learning management systems (LMS) to deliver curriculum content. There remains clear support for maintaining the Medicine Learning and Teaching Unit's (MLTU's) website, rather than relying entirely on the University's Blackboard-based IT platform (referred to as MyUni). As discussed in Standard 4, the MLTU website is continuously evolving and, since the AMC's 2011 assessment, functionality has been further enhanced. The MTLU platform is clearly the student's preferred learning management system.

The Faculty utilises IT to deliver crucial information to students, including progression guidelines, lecture notes, timetable, notices and assessment results. Students are also able to electronically evaluate tutors and lecturers through Student Experience of Learning and Teaching (SELT). The decision to utilise a specific website for these purposes predated the University's adoption of MyUni and the curriculum website was custom built for the purpose.

While the capabilities of MyUni have been progressively improving, it is still not able to provide all of the functions that are required to deliver this complex integrated program because it is designed for conventional courses with subjects and small numbers of teacher in each subject. The MLTU has a small team of IT staff who are responsible for the development and maintenance of the curriculum website, which has not had any unplanned down time over the past twelve years. In response to student feedback, the website was upgraded last year to provide each student with his/her own personalised timetable, including the specific times and rooms for each of his/her own small group sessions as well as information about sessions applicable to the whole class. The timetable also links directly to the lecture note collection to facilitate access of students to all lecture notes.

The IT systems used by the MBBS program are currently managed at two levels: the MyUni system is managed centrally for the whole university by IT Services, while the curriculum website is managed by the IT team within the MLTU. This latter arrangement makes it possible for the system to be changed rapidly in a tailored manner as the curriculum evolves, and also allows on-site support for any problems that may arise. For example, personalised student timetables, which also have links to specific resources for teaching sessions, are now available to all Years 1-3 students. The team encourages the program to maintain these IT resources for the medical program as they are crucial to the dissemination of critical information and the attainment of learning objectives.

A number of students reported that the requirement to access two systems at times hampers access to teaching and learning material. This mainly affects students in the clinical years of the course, who are required to use MyUni on a more regular basis. It is unclear to some students when new content has been posted, and where it is located. Some disciplines appear to favour one system over the other.

The team spent considerable time exploring this issue with academic and IT staff from the MLTU. Clearly the Faculty has directed significant effort towards better integrating the MLTU platform with the University's Blackboard system, and there are plans to further enhance integration by adoption of a new content management system. This should allow access to material on both platforms via a single portal.

In addition to the learning management systems, some clinical disciplines are using iPads to disseminate teaching and learning material and facilitate assessment.

In certain rotations, students also undertake online learning activities through eMedici. Students commented favourably on the quality of educational material provided through this medium.

Overall, the team was satisfied with the Faculty's response to the IT issues highlighted in the 2011 report. Academic and IT staff within the MLTU have clearly invested a lot of time and effort into building a bespoke website, which is highly regarded by students. Notwithstanding the positive developments, the Faculty should continue to work with students to further enhance integration of the platforms and improve sign-posting of content. The latter should address the practical issues that students face in locating material across the two systems. The AMC will be interested in updates on this activity.

Students at clinical facilities generally have good access to University of Adelaide online learning resources. Students reported that they are able to access both UpToDate and Best Practice, which the team considers particularly impressive.

The team did not reassess the library facilities visited in 2011, but received no evidence that library access is problematic. It is noted that the school's submission notes the new medical school and Royal Adelaide Hospital facilities will not have a substantial facility for traditional hard-backed textbooks, and the extent to which this impacts on learning will need to be monitored into the future.

8.3 Clinical learning environment

8.3.1 The medical education provider ensures that the clinical learning environment offers students sufficient patient contact, is appropriate to achieve the outcomes of the medical program and to prepare students for clinical practice.

8.3.2 The medical education provider has sufficient clinical teaching facilities to provide clinical experiences in a range of models of care and across metropolitan and rural health settings.

8.3.3 The medical education provider ensures the clinical learning environment provides students with experience in the provision of culturally competent health care to Aboriginal and Torres Strait Islander peoples and/or Maori.

8.3.4 The medical education provider actively engages with other health professional education providers whose activities may impact on the delivery of the curriculum to ensure its medical program has adequate clinical facilities and teaching capacity.

2011 team findings

Clinical placements occur across a wide variety of sites, including major metropolitan tertiary hospitals, regional hospitals, private healthcare settings, rural communities and in general practice. The Faculty has worked hard to create multiple new clinical rotations in the last three years to match increasing student numbers. Examples of these are St Andrews Private Hospital and eight Unicare practices that are currently being developed as teaching networks. At present, students have sufficient patient contact.

However, the increase in student intake in the period 2005 - 2010, needs to be accommodated. As an example, increasing numbers of students (both in the MBBS Program and in Midwifery Programs) within the obstetrics facilities means that it is possible for a student to graduate without having delivered a baby. Further development of an overall strategy for quality clinical placements is essential to continue to meet demand.

The Spencer Gulf Rural Health School has excellent leadership and provides a superb educational experience. It is staffed with experienced, organized clinicians. However, with growing numbers of students, it may prove difficult to ensure that all students have a meaningful experience in a rural setting.

With expanding student numbers, clinical teaching facilities within individual hospitals and other clinical sites are under pressure. Where these facilities are not directly owned by the University of Adelaide, but are rather owned by the health service, it is difficult for staff to constantly negotiate for appropriate teaching space for students. With expanding student cohorts, an overarching strategic plan regarding the development of University of Adelaide owned and/or controlled student facilities within clinical facilities is important.

At present, there is not a highly developed clinical school structure to support clinical placements. While each site has a clinical education office, there is no overall academic leadership within these sites. The Lyell McEwin Hospital is regarded by some as a clinical school. While there is an Associate Dean appointed to the Lyell McEwin Hospital to administer the clinical teaching delivered at this site, there is no University funding attached to this position.

While it is highly likely that students will experience the provision of health care to Indigenous people through their usual clinical attachments, there is no systematic approach to this. At present, there is no guarantee that students will be exposed to clinical care of Indigenous people. There are some community and Indigenous health centres that have the potential to be incorporated into the clinical placement scheme. The team noted that there were good relationships with the Flinders University medical program, particularly in the Barossa Valley where there is a shared clinical rotation.

2014 team findings

The clinical education program is set by the Curriculum Committee, and overseen by the Year Level Committees, which have representation from all disciplines with input into that year. For each discipline rotation, students are placed in clinical sites that are identified and monitored by the designated discipline coordinator to ensure that all sites provide the core educational requirements. The discipline coordinator reports back to the Year Course Committee. The quality of clinical sites is also monitored by student feedback. In 2013, an Online Clinical Placements Survey (OCPS), which facilitates this feedback process, was implemented for every rotation in Years 4 - 6.

The Evaluation and Quality Assurance Committee monitors the completion of this feedback loop via discipline and site coordinators. For the Year 5 rural cohort students, the Discipline of Rural Health ensures that a comparable educational program is provided for these students as their metropolitan peers, by close collaboration with the relevant disciplines (i.e. obstetrics and gynaecology, paediatrics, geriatrics) and appointment of geriatricians to deliver teaching to the rural cohort.

Clinical placement sites are reviewed every year in regards to their capacity in terms of student numbers and adequacy in providing students with the required clinical experience. The discipline coordinators and the MLTU jointly carry out this task.

The Faculty has access to a broad range of teaching facilities. Clinical placements continue to occur across a number of sites, including major hospitals, regional health services, rural communities and in general practice. Owing to a withdrawal of Health Workforce Australia funds, St Andrew's Private Hospital no longer provides clinical skills training, however clinical attachments still occur at the site. Clinical teaching in the program continues to be largely delivered by non-university employed clinicians.

The team noted that an overarching memorandum of understanding with SA Health (regarding medical education and other activities) is yet to be signed, but delays are not attributable to the University. This does not appear to be hampering access to teaching hospitals.

The Faculty's submission reported capacity challenges at some of the sites, including "overcrowding" at the Women's and Children's Hospital. The team found that this issue is being well managed, and was impressed with the quality of clinical teaching being delivered at the site.

The new teaching facilities at Lyell McEwin Hospital have greatly enhanced the visibility of the University, and are enabling the delivery of clinical skills and simulation teaching remote to the medical school. The team was impressed with the space available for small-group learning.

The Rural Clinical School continues to offer an excellent educational experience to students. With the exception of one recent year, the School is continually oversubscribed and the performance of the rural cohort is equal, if not better, than that of urban-based students.

The team was impressed with the new Geriatrics Teaching and Research in Aged Care (G-TRAC) centre at Resthaven Paradise. Staff at the facility are obviously enthusiastic about providing high quality, community-based teaching in geriatric medicine. The Faculty is to be commended for its innovation in this area.

During the team's site visits, selected hospital sites reported a lack of meaningful engagement with the University. A number of senior staff perceived that the University considers some hospital sites to be of secondary importance, with a deficiency of academic and administrative support relative to the size of the student cohort at those facilities. These sites acknowledged the efforts of the Acting Executive Dean to visit and engage with hospital leadership.

These issues did not seem to be impacting on teaching and learning at the relevant sites. The team spoke to students who reported a rich and diverse educational experience, and who valued the support and tutelage of their supervisors. Likewise, supervisors were positive about their involvement with medical student teaching.

Although the engagement issues do not appear to have adversely affected the clinical education program, the team considers that there is need for better communication between parties. The Faculty will need to consider how it can enhance support to peripheral teaching sites, and maintain the goodwill that is directed towards the program and its students.

There remains uncertainty around the extent to which teaching facilities will be incorporated into the new Royal Adelaide Hospital. While it appears there will sufficient ward-based rooms for small group teaching, there is apparently no current plan for a tiered lecture theatre. The co-location of the new medical school building may address some of these issues; however the team considers that there is a need for ongoing engagement with relevant authorities to ensure there is adequate capacity for teaching and learning activities.

Mechanisms are in place to monitor the quality of placements. Students can provide feedback via an Online Clinical Placements Survey, which has been custom built within the MLTU learning management system. Overall, students are very positive about their clinical experiences.

Student experience in the provision of care to Aboriginal and Torres Strait Islander people remains variable. The team supports the need to expand the Indigenous health components of the curriculum in Years 3-6.

While it is likely that students will have contact with Indigenous people through their clinical attachments, there is no systematic approach to this. Limited staffing resources in the Yaitya Purruna Indigenous Health Unit may be contributing to this deficiency.

The Faculty acknowledges the need to expand the Indigenous health components of the curriculum in Years 4-6. Plans for the roll-out of Indigenous health workshops to students in the clinical years are noted, and the AMC will be interested to hear of the Faculty's progress in this area.

There is little crossover with clinical teaching sites used by Flinders University. Overlap with other universities occurs at several Rural Clinical School sites, but the team was informed that these relationships are positive and productive.

8.4 Clinical supervision

8.4.1 The medical education provider ensures that there is an effective system of clinical supervision to ensure safe involvement of students in clinical practice.

8.4.2 The medical education provider supports clinical supervisors through orientation and training, and monitors their performance.

8.4.3 The medical education provider works with health care facilities to ensure staff have time allocated for teaching within clinical service requirements.

8.4.4 The medical education provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the medical program and the responsibilities of the medical education provider to these practitioners.

2011 team findings

(Previously 2011 Standard 1.8 Staff resources; subsumed in 2012 at standard 8.4).

Clinical titleholders are critical to the teaching program. The Faculty acknowledges their contribution and is to be commended for the ongoing work to clarify the University responsibilities and titleholder obligations.

2014 team findings

The Faculty has access to a large number of clinical supervisors across its network of teaching sites. The team met with a number of supervisors during the visit, and was impressed with their energy and enthusiasm for teaching medical students. In addition to senior clinicians, the Faculty is actively engaging junior doctors (including residents and vocational trainees) for selected teaching duties.

Discipline co-ordinators are responsible for the identification and support of clinical supervisors. There are no apparent issues with recruitment. At some sites, a Clinical Dean is available as an additional 'point of contact' for clinical supervisors. The level of administrative support available to clinical supervisors is variable.

Selected clinical supervisors suggested that there was room for improvement in the support provided by the Faculty, for instance by facilitating access to teacher training. Supervisors reported that they were well oriented to their roles, but there was limited ongoing communication from the University with respect to changes in the broader medical program and professional development opportunities.

There is a process for awarding clinical titles to supervisors who make a significant contribution to teaching and research. The roles and responsibilities of titleholders are defined in various policy documents.

As discussed at Standard 8.3, selected clinical sites reported a lack of high-level engagement with the Faculty. There is a perception among senior hospital staff that the University considers some sites to be of secondary concern, and has not been prepared to invest the necessary resources to support clinical supervisors. This may reflect that much of the communication with clinical supervisors comes via discipline co-ordinators, rather than via a designated academic lead at each of the teaching sites. This does not appear to be impacting on the provision of clinical supervision, however there is potential for it to do so.

Appendix One Executive Summary 2011

The Australian Medical Council's (AMC) *Assessment and Accreditation of Medical Schools: Standards and* Procedures provides for accredited medical schools to seek reaccreditation when a period of accreditation expires. Accreditation is based on the medical program demonstrating that it satisfies the Accreditation Standards for basic medical education. The school prepares a submission for reaccreditation. An AMC team assesses the submission and visits the school and its clinical teaching sites.

The University of Adelaide's Faculty of Health Sciences was assessed for reaccreditation of its MBBS Program (the Program) in 2011. The Program was last reaccredited in 2001 by the AMC following an assessment report by an AMC team.

The 2001 assessment coincided with significant changes in the Program's teaching and learning methods and to the organisation of the Program. The Program was granted accreditation for the maximum period with conditions, which took the accreditation to 31 July 2007. The conditions required a follow-up assessment by an AMC team during the second half of 2002. This follow-up confirmed the period of accreditation subject to satisfactory progress reports.

In 2006, the Faculty submitted a comprehensive report for extension of accreditation. The report detailed developments in the Program and described its plans for the next five years. Accreditation was extended until 31 December 2011 subject to satisfactory reports, this taking the Faculty to the maximum ten-year period of accreditation available between full assessments. Progress reports since have been satisfactory but have also required the Faculty to provide more information on some developments, such as the effect of increasing student load, a new funding model, and governance of the Program.

An AMC team reviewed the Faculty's reaccreditation submission and visited the Faculty and associated clinical teaching sites in the week of 6 June 2011. This report presents the team's recommendation on accreditation and the detailed findings against the approved Accreditation Standards to the AMC Medical School Assessment Committee.

Decision on accreditation

Under the *Health Practitioner Regulation National Law Act 2009*, the AMC may grant accreditation if it is reasonably satisfied that a program of study, and the education provider that provides it, meet an approved accreditation standard. It may also grant accreditation if it is reasonably satisfied that the provider and the program of study substantially meet an approved accreditation standard, and the imposition of conditions on the approval will ensure the program meets the standard 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.

The AMC's finding is that the MBBS Program of the Faculty of Health Sciences, University of Adelaide **substantially meets the Accreditation Standards** and is well placed to complete the work required to meet the Standards.

The report identifies many strengths of the Program. It also describes continuing challenges particularly concerning governance and Program management, curriculum,

evaluation and teaching facilities. Many of these challenges were acknowledged by the Faculty in its accreditation submission.

The AMC's *Assessment and Accreditation of Medical Schools: Standards and Procedures* provide the following options for decisions on accreditation of established medical courses:

(i) Accreditation for a period of six years subject to satisfactory progress reports. In the year the accreditation ends, the education provider will submit a comprehensive report for accreditation extension. Subject to a satisfactory report, the AMC may grant an extension of accreditation, up to a maximum of four years, before a new accreditation review.

(ii) Accreditation for six years subject to certain conditions being addressed within a specified period and to satisfactory progress reports. In the year the accreditation ends, the education provider will submit a comprehensive report for accreditation extension. Subject to a satisfactory report, the AMC may grant an extension of accreditation, up to a maximum of four years, before a new accreditation review.

(iii) Accreditation for shorter periods of time. If significant deficiencies are identified or there is insufficient information to determine that the program satisfies the Accreditation Standards, the AMC may award accreditation with conditions and for a period of less than six years. At the conclusion of this period, or sooner if the education provider considers it has addressed its deficiencies, the AMC will conduct a review. The provider may request either:

- a full accreditation assessment, with a view to granting accreditation for a further period of six years; or
- a more limited review, concentrating on the areas where deficiencies were identified, with a view to extending the current accreditation to the maximum period (six years since the original accreditation assessment).

(iv) Accreditation may be refused where the AMC considers that the deficiencies are so serious as to warrant that action or where the provider has not satisfied the AMC that the complete medical program can be implemented and delivered at a level consistent with the Accreditation Standards.

The August 2011 meeting of the AMC Directors endorsed the accreditation report and resolved:

That accreditation of the six year school leaver entry MBBS Program of the University of Adelaide, Faculty of Health Sciences is **granted accreditation for a period of three years to 31 December 2014 subject to the following conditions:**

A. **By 31 January 2012** evidence to address the conditions detailed in the Key Findings Table at:

- Standard 1.1 - Governance
- Standard 1.2 - Leadership and autonomy
- Standard 1.3 - Medical course management
- Standard 1.5 - Educational budget and resource allocation
- Standard 8.1 - Part a - Physical facilities.

B. **In the 2012 progress report:**

i. Evidence of implementation of plans to address the conditions relating to the standards listed at Section A, and;

ii. Evidence to address the conditions detailed in the Key Findings Table at:

- Standard 1.6 - Interaction with health sector
- Standard 1.8 - Staff resources
- Standard 3.1 - Curriculum framework
- Standard 3.2 - Curriculum structure, composition & duration
- Standard 3.3 - Curriculum integration
- Standard 4.1 - Teaching & learning methods
- Standard 5.1 - Assessment approach
- Standard 5.2 - Assessment methods
- Standard 5.3 - Assessment rules and progression
- Standard 5.4 - Assessment quality
- Standard 6.1 - Ongoing monitoring
- Standard 6.2 - Outcome evaluation
- Standard 6.3 - Feedback and reporting
- Standard 7.1 - Student intake
- Standard 7.3 - Student support
- Standard 7.4 - Student representation
- Standard 8.1 - Part b - Physical facilities
- Standard 8.2 - Information technology
- Standard 8.3 - Clinical teaching resources.

C. **In the 2013 progress report:**

i. Evidence of implementation of all Standards listed at Section B, and;

ii. Evidence to address the condition detailed in the Key Findings Table at:

- Standard 1.4 – Educational expertise.

D. **A follow up assessment in 2014** to assess progress on the conditions and areas for improvement.

Overview of Findings

The following table illustrates the key findings of the 2011 University of Adelaide, Faculty of Health Sciences MBBS Program AMC Assessment team.

Where Accreditation Standards are noted as "not met" or "substantially met" the Faculty must provide evidence to the AMC that actions have been taken to meet the specific standard, as specifically advised in the right column of the Key Findings Table and in accordance with the timeframe as specified in the 'Recommendations' section.

Areas for improvement with no attached condition for accreditation are suggestions from the Assessment team for areas of continuous improvement. They do not need to be reported against as a condition of accreditation. They are noted in the left column of the Key Findings Table.

KEY FINDINGS TABLE: THE UNIVERSITY OF ADELAIDE ASSESSMENT 2011	
Standards	**Conditions to meet the Standards**
1. THE CONTEXT OF THE MEDICAL SCHOOL	**Overall this set of Standards is NOT MET**
1.1 Governance Commendations There is good representation of key stakeholder groups on committees.	**1.1 Not met** The AMC requires evidence that the Faculty governance structure ensures that the MBBS Program has appropriate authority and input, and effective reporting lines for the management of the Program.
1.2 Leadership and autonomy Commendations The contribution of the current Dean which facilitates cooperation and support for the Program despite limited authority.	**1.2 Not met** The AMC requires evidence of plans that will ensure appropriate autonomy and leadership for the MBBS Program including clear responsibility for management of the curriculum supported by appropriate budgetary allocation.
1.3 Medical course management Commendations The Curriculum Committee is well positioned to have influence over the MBBS Program. Areas for improvement Engagement of a wider range of staff in the committees that plan, implement and review the curriculum.	**1.3 Substantially met** The AMC requires evidence of plans that the Curriculum Committee has the authority and capacity to implement and review the curriculum.
1.4 Educational expertise Commendations The commitment of the staff of the Medicine	**1.4 Substantially met** The AMC requires evidence that the MBBS Program is supported by sufficient

Learning and Teaching Unit. **Areas for improvement** Strategies to recruit develop and retain Indigenous staff able to support the MBBS Program's responsibilities for Indigenous health.	staff with specific expertise in education methods, curriculum design, assessment and evaluation.
1.5 Educational budget and resource allocation	**1.5 Not met** The AMC requires evidence of plans for a funding model which enables resources to be directed to achieve overall MBBS Program objectives. The model should include a clear line of responsibility and authority for the curriculum and its resourcing.
1.6 Interaction with health sector Commendations Strong clinician involvement with teaching. The executive dean is actively engaged in strategic development of new health facilities and there are good executive level relations between the Faculty and the Commonwealth and State Governments. Areas for improvement Develop strategies to improve partnerships with the Indigenous health sector.	**1.6 Substantially met** The AMC requires evidence that the MBBS Program has constructive partnerships and proactive communication with all relevant hospitals and health services that supports its teaching.
1.7 The research context of the school Commendations The Faculty of Health Science's strong research record.	**1.7 Met**
1.8 Staff resources	**1.8 Substantially met** The AMC requires evidence of a detailed staff plan to provide the academic, administrative and technical staff necessary to support MBBS Program requirements and to define staff responsibilities for the Program.
1.9 Staff appointment, promotion and development Areas for improvement Review the employment strategies to support recruitment and retention of Indigenous staff (see also 1.4)	**1.9 Substantially met**
1.10 Staff indemnification	**1.10 Met**

2. THE OUTCOMES OF THE MEDICAL COURSE	Overall this set of Standards is MET
2.1 Mission <u>Areas for improvement:</u> With appropriate stakeholder input, ensure the mission statement addresses Indigenous people and their health.	**2.1 Met**
2.2 Medical course outcomes	**2.2 Met**
3. THE MEDICAL CURRICULUM	**Overall this set of Standards is SUBSTANTIALLY MET**
3.1 Curriculum framework <u>Areas for improvement</u> Review the information describing the curriculum framework for staff and students to ensure a clear message about the learning process.	**3.1 Substantially Met** While the philosophy underpinning the curriculum is sound, the curriculum needs review. The AMC requires a plan for curriculum review, including review of the curriculum framework.
3.2 Curriculum structure, composition and duration <u>Commendations</u> The Rural Clinical School placements. The medical education placement option in the Year 6 Medicine Specialist, Community or Ambulatory Placement. <u>Areas for improvement</u> Review and enhance the following areas of the curriculum: • Behavioural and social science content • The integration of population health • Communication skills.	**3.2 Substantially met** As part of curriculum renewal, the AMC requires a plan for review of the curriculum structure and content, including plans to address the following Accreditation Standards: a) Indigenous health content (3.2.7) b) Content relating to patient safety and quality assurance of medical care (3.2.8) c) Interprofessional learning (3.2.9).
3.3 Curriculum integration	**3.3 Substantially met** As part of curriculum renewal, the AMC requires a plan detailing strategies to increase integration in curriculum delivery and design, including appropriate leadership and management of the curriculum domains.

3.4 Research in the curriculum <u>Areas for improvement</u> Strategies to continue to increase opportunities to engage students in research.	**3.4 Met**
3.5 Opportunities for students to pursue choices <u>Commendations</u> The capacity for students to choose electives and options in the final year.	**3.5 Met**
3.6 The continuum of learning	**3.6 Met**
4. THE CURRICULUM – TEACHING AND LEARNING	**Overall this set of Standards is SUBSTANTIALLY MET**
4.1 Teaching and learning methods <u>Commendations</u> The clinical skills program in Years 1 and 2. <u>Areas for improvement</u> Increase the professional development opportunities for teachers to support the teaching and learning methods employed.	**4.1 Substantially met** In keeping with the Faculty's goals and taking into account the cohort expansion, the AMC requires a review of the teaching and learning methods employed, in particular: a) The relative weight given to methods that are enquiry oriented, encourage students to take responsibility for their learning and prepare students for lifelong learning b) Consistency of teaching methods across sites c) Support and rationalisation of IT learning resources, such as the learning management systems. This should include reviewing the reliance on student representatives to gather lecture notes and presentations for uploading into the learning management systems.
5. THE CURRICULUM – ASSESSMENT OF STUDENT LEARNING	**Overall this set of Standards is SUBSTANTIALLY MET**
5.1 Assessment approach <u>Areas for improvement</u> The communication to students concerning changes to assessments.	**5.1 Substantially met** As part of curriculum renewal, the AMC requires: a) Evidence that the assessment policy appropriately guides

	student learning and that its implementation is adequately resourced b) Evidence of a plan and timelines for review of: i. The overall assessment lead and coordination of assessment in Years 1 to 3 ii. The mix of formative and summative assessments to provide adequate student feedback and guidance.
5.2 Assessment methods	**5.2 Substantially met** The AMC requires evidence of a plan and timelines for review of: a) An assessment blueprint across all years, appropriately aligned to the Program learning objectives, to guide policy and implementation b) the variation in the standards of assessment across clinical rotations, examiners and sites, and actions to address this c) A range of assessment formats to improve detection of under or borderline performance.
5.3 Assessment rules and progression	**5.3 Substantially met** The AMC requires evidence of review of: a) The Assessment and Progression Rules, assuring that the rules are transparent and clearly communicated to and understood by the staff and students. b) Review of the current Faculty policy that allows students to progress without remediation while carrying a D result, and appropriate policy on academic supplementary examinations c) Processes in place for informing students of changes to assessment rules before they take effect.

5.4 Assessment quality <u>Commendations</u> The evaluation undertaken of individual items and the action to address evaluation outcomes.	**5.4 Substantially met** The AMC requires: a) Evidence of development of an assessment evaluation plan, including reliability and validity measures and consistency across all sites b) Progress towards the introduction of standards setting methods for the clinical assessments supported by appropriate training and development. These plans should address concerns about variability; and quality assurance and training of assessors.
6. THE CURRICULUM – MONITORING AND EVALUATION	**Overall this set of Standards is SUBSTANTIALLY MET**
6.1 Ongoing monitoring <u>Commendations</u> Students are represented at many levels in the academic committee structure. <u>Areas for improvement</u> Respond actively to student feedback, to address perceptions that it does not influence Program development.	**6.1 Substantially met** Evidence of a plan for an overall and ongoing Program monitoring and evaluation framework including: a) Relevant monitoring in the clinical years and systematic assessment of student clinical placement experience b) Improved capacity for students to self-monitor their performance formatively.
6.2 Outcome evaluation <u>Commendations</u> The Medical Graduate Outcomes Evaluation Program following the 2003-06 student cohorts. <u>Areas for improvement</u> Evaluate the impact of increases in numbers on the learning experience, recognising the finite capacity of rural clinical locations and the Faculty's expansion plans.	**6.2 Substantially met** As above, evidence of a plan for an overall Program monitoring and evaluation framework, specifying the review processes and tools, that is supported by adequate and ongoing resources and staffing.
6.3 Feedback and reporting	**6.3 Substantially met** As above, evidence of a plan for an overall Program monitoring and evaluation framework, with processes to ensure consistent closure of the feedback loop and accessibility of feedback to stakeholders.

6.4 Educational exchanges <u>Areas for improvement</u> Consider benchmarking the University of Adelaide MBBS Program with other Group of Eight University Programs.	**6.4 Met**
7. IMPLEMENTING THE CURRICULUM – STUDENTS	**Overall this set of Standards is SUBSTANTIALLY MET**
7.1 Student intake <u>Commendations</u> Efforts to align student numbers with South Australian workforce requirements. <u>Areas for improvement</u> Review the approach to the recruitment of Indigenous students and the support available to support their success.	**7.1 Not met** The AMC requires evidence that the size of the student intake is aligned to resources available to deliver the Program.
7.2 Admission policy and selection <u>Commendations</u> The alignment of selection policy with desired graduate outcomes. <u>Areas for improvement</u> Review the requirement for Indigenous applicants to complete the standard selection pathway in addition to Indigenous-specific requirements, and the consistent application of available academic concessions.	**7.2 Met**
7.3 Student support <u>Commendations</u> Dedicated Faculty members firmly committed to the Program and its students. <u>Areas for improvement</u> Strengthen the support for students with special needs, including those from under-represented groups.	**7.3 Substantially met** The AMC requires evidence of: a) The delineation of student support and academic support b) Improved mechanisms to support student self-assessment of performance
7.4 Student representation <u>Commendations</u> Student representation on key committees. <u>Areas for improvement</u> Resource student representatives appropriately if	**7.4 Substantially met** The AMC requires evidence of improved mechanisms for consultation and communication with students about their experience in the Program, and Faculty plans for change to the Program.

the Faculty expects them to communicate important Program developments to the student group as a whole.	
7.5 Student indemnification	**7.5 Met**
8. IMPLEMENTING THE CURRICULUM – EDUCATIONAL RESOURCES	**Overall this set of Standards is NOT MET**
8.1 Physical facilities <u>Commendations</u> Student facilities at Spencer Gulf Rural Health School, Lyell McEwin, St. Andrews Hospital and GP SuperClinics.	**8.1. Not met** a) In line with the Faculty's proposal in the Five Year Facility Development Plan, the AMC requires by 31 January 2012, evidence of funding and confirmation of plans and timelines for redevelopment of facilities at main campus and at the new Royal Adelaide Hospital. This evidence should take into account the expansion of student numbers, and resulting staff and student needs b) In the 2012 progress report, the AMC requires evidence of processes to negotiate access to facilities for clinical teaching in the health services c) By the AMC follow-up assessment in 2014, evidence of implementation of the redevelopment plan.
8.2 Information technology <u>Commendations</u> The extensive and well-resourced University library facilities with highly accessible and helpful University librarians.	**8.2 Not met** The AMC requires evidence of a plan with timelines to ensure: a) That MBBS Program students have adequate access to printers and computers at the Medical School Building or nearby b) The learning management platform is reviewed and improved c) Sufficient resources are available for staff to make lecture material available for students electronically.
8.3 Clinical teaching resources	**8.3 Substantially met**

Commendations The excellent teaching facilities in primary care, general practice, private hospitals, rural and remote settings. Areas for Improvement Continued development of the clinical school structure to support clinical placements, with funding for academic leadership at these sites.	The AMC requires evidence of: d) An overall strategy to ensure that clinical placements continue to meet demand. The AMC requires evidence that the Faculty's placement plan for each clinical teaching site will provide students with the appropriate clinical experience in all models of care. e) A systematic approach to ensuring that all students receive experience of the provision of health care to Indigenous people in a range of settings.

Appendix Two Membership of the 2014 and 2011 assessment teams

Membership of the 2014 assessment team

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Manager, Medical School Assessment, Australian Medical Council

Ms Sarah Yoho
Accreditation Officer, Australian Medical Council

Appendix Three Groups met by the 2014 and 2011 assessment teams

Groups met by the 2014 assessment team

Senior Leadership

Acting Executive Dean of the Faculty of Health Sciences and Dean of Medicine

Acting Head of School of Medicine

Associate Dean, Learning & Teaching, Faculty of Health Sciences

Vice Chancellor

School of Medicine Leadership Staff

Acting Executive Dean, Dean of Medicine

Admissions Committee Chair

Director of the Medical Program

Director Yaitya Purruna Indigenous Health School of Medical Sciences

Discipline of Public Health (co-opted)

Evaluation Committee Chair

Faculty Associate Dean (Learning and Teaching)

Faculty of Sciences

Indigenous Health Representative

Medical Education / MLTU Director

Medical Program Director, Deputy Dean

MLTU Director

Rural Clinical School

Faculty of Medicine & Biochemical Sciences Staff

Academic Language and Learning in Medicine

Anaesthesia (RAH), APIC Coordinator

Anaesthesia (TQEH, APC)

Anaesthesia Representative

Anatomy Representative

Assessment Officer

Biochemistry Lecturer

Clinical Skills, Clinician

DCIO, Technology Services

Director of the Medical Program

Faculty of Health Science, Education and Innovation, Evaluation Committee Chair

Head of Discipline Rural Health, Rural Clinical School
MBBS Curriculum Representative
MBBS Years 1-3 Coordinator, Year 1 Chair (Acting)
MBBS Years 1-3 Coordinator, Year 1 Convenor
Medical Education / MLTU Director and WEC Chair
Medical Home Units Attachment Coordinator
Medical Programs Governance and Strategy Board
Medical Sciences Representative
Molecular and Biomedical Science
MPPD Coordinator
Musculoskeletal Medicine Attachment Coordinator
OSCE/Clinical Examinations Committee Chair
Paediatrics and Child Health, Attachment Coordinator
Pathology Representative
Physiology Representative
Program Administrator
Psychiatry Representative
Public Health Representative
Reproductive Health Attachment Coordinator
Research Program Coordinator
Rural Medical Program Coordinator
School of Medicine Teaching Series
School of Medicine, Faculty of Medicine & Biochemical Sciences
School of Paediatrics and Reproductive Health representative
School of Paediatrics Health Chair
School of Population Health Representative
Senior Lecturer in Medical Education (Assessment)
Student Support Officer
Transition to Internship Teaching Series
Year 3 Clinical Skills
Year 4/5 Exam Convenor
Year 4-6 Program Administrator
Years 1-2 Clinical Skills, Clinician
Years 1-3 CBL Coordinator

Years 2/3 Committee Chair, TQEH Teaching Hospital Site Lead
Faculty of Medicine & Biochemical Sciences Committees and Groups
Assessment Committee
CPAC Committee
Curriculum Committee
Domain Committees
Emergency Representative
Evaluation and Quality Assurance Committee
Future Projects Group
MBBS Research Committee
Medicine Learning and Teaching Unit
Medicine Representative
MLTU Director
MLTU IT
MPPD Committee
Primary Care Representative
SMB Committee
School of Paediatrics and Reproductive Health, Assessment Committee Chair
Yaitya Purruna Indigenous Health Unit
Year 1 Committee
Year 6 Committee
Years 2 – 3 Committee
Years 4 – 5 Committee

Medical students

Lyell McEwin Hospital and GP Site medical students
MBBS Graduate
Queen Elizabeth Year 4 and 5 medical students
The Women's and Children's Hospital O&G and PAED Students

Clinical Sites

The Women's and Children's Hospital
Assistant Executive Director, Medical Services
Course Coordinator, Deputy Head of School Paediatrics
Deputy Head of School Paediatrics

Director of Medical Training

Medical Director of Paediatric Medicine

O&G and PAED Clinicians

O&G and Paediatrics Teaching School Staff

Queen Elizabeth Hospital

Executive Director of Medical Services for Central Adelaide Local Health Network

Hospital Clinicians: Geriatrics, Gynaecology, General Medicine, Rheumatology, Surgery, Neurology, Palliative Care, Ophthalmology, Infectious diseases, Emergency Medicine

Teaching staff: Psychiatry, Neurology, Medicine

SA Medical Education and Training Unit

Chief Medical Officer

Deputy Chief Executive

Lyell McEwin Hospital and GP Site

Chief Executive Officer NALHN

Director of Division of Medical Subspecialties

Hospital and Network Management

Teaching Staff: Orthopaedics, Surgery

Adelaide G-TRAC Centre

Teaching Coordinator

Groups met by the 2011 AMC assessment team

Senior Executive Staff

Deputy Vice-Chancellor and Vice-President (Research)

Executive Dean, Faculty of Health Sciences

Dean and Director of the MBBS Program

Manager, Business and Finance, Faculty of Health Sciences

Medical School Academic Staff

Associate Dean, Teaching and Learning

Head of School, Paediatrics and Reproductive Health; Associate Dean Research

Head of School, Medicine

Head of School, Population Health and Clinical Practice

Head of School, Medical Sciences

Director, Medicine Learning and Teaching Unit

Deputy Director, Medicine Learning and Teaching Unit

Years 1 and 2 Clinical Skills Coordinator

Director, Simulation Training

Acting Dean, Wilto Yerlo

Head, Yaitya Purruna

Lecturer, Yaitya Purruna

Head of School, Spencer Gulf Rural Health School

Member of Faculty IT Committee

Head, Admissions Committee

Medical School Committees

MBBS Curriculum Committee

MBBS Assessment Committee

General Staff

Manager, Ray Last Anatomy Laboratory

Research Librarian, Barr Smith Library

Administrative staff, MBBS Program

Information Technology Manager, Medicine Learning and Teaching Unit

Health Facilities Staff

General Manager, Royal Adelaide Hospital

Director, Clinical Training, Royal Adelaide Hospital

Clinical Leaders, Royal Adelaide Hospital

Clinical Leaders, Women's and Children's Hospital

CEO and Executive Officer, Women's and Children's Hospital

General Manager and Clinical Coordinator, St. Andrews Private Hospital

Clinical Leaders, Playford Superclinic

CEO, Adelaide Unicare

Clinical Leaders and Teachers, Barossa Valley Parallel Rural Community Curriculum

Clinical Teachers, Spencer Gulf Rural Health School, Port Lincoln

Clinical Dean and Clinical Studies Senior Lecturer, Lyell McEwin Hospital

Medical Director, Clinical Teachers and Administrative Staff, Lyell McEwin Hospital

CEO, Clinical Dean and Clinical Leaders, The Queen Elizabeth Hospital

CEO and Clinical Dean, Modbury Hospital

Clinical Leaders and Teachers, Modbury Hospital

Student Groups

Adelaide Medical Student Society

Selection of Rural students Years 4 – 6

Student Focus Group Year 1 – 3

Selection of Royal Adelaide Hospital students Year 3 – 6 and graduate Interns

Selection of Women's and Children's Hospital students Years 5 – 6

Selection of St. Andrews Private Hospital students Year 3

Selection of Lyell McEwin Hospital students, Years 4 – 6

Selection of The Queen Elizabeth Hospital students, Years 3 - 6

Selection of Modbury Hospital students, Years 4 – 6

External Bodies

Chair, South Australian Institute of Medical Education and Training

General Manager, South Australian Institute of Medical Education and Training

Medical Dean, Flinders University

Indigenous Health Leader, Adelaide Central Health Service

Indigenous Health Leader, The Aboriginal Health Council SA

Executive Director of Medical Services, Adelaide Health Service, South Australian Health (also the Director of Medical Services and Clinical Governance, Royal Adelaide Hospital)