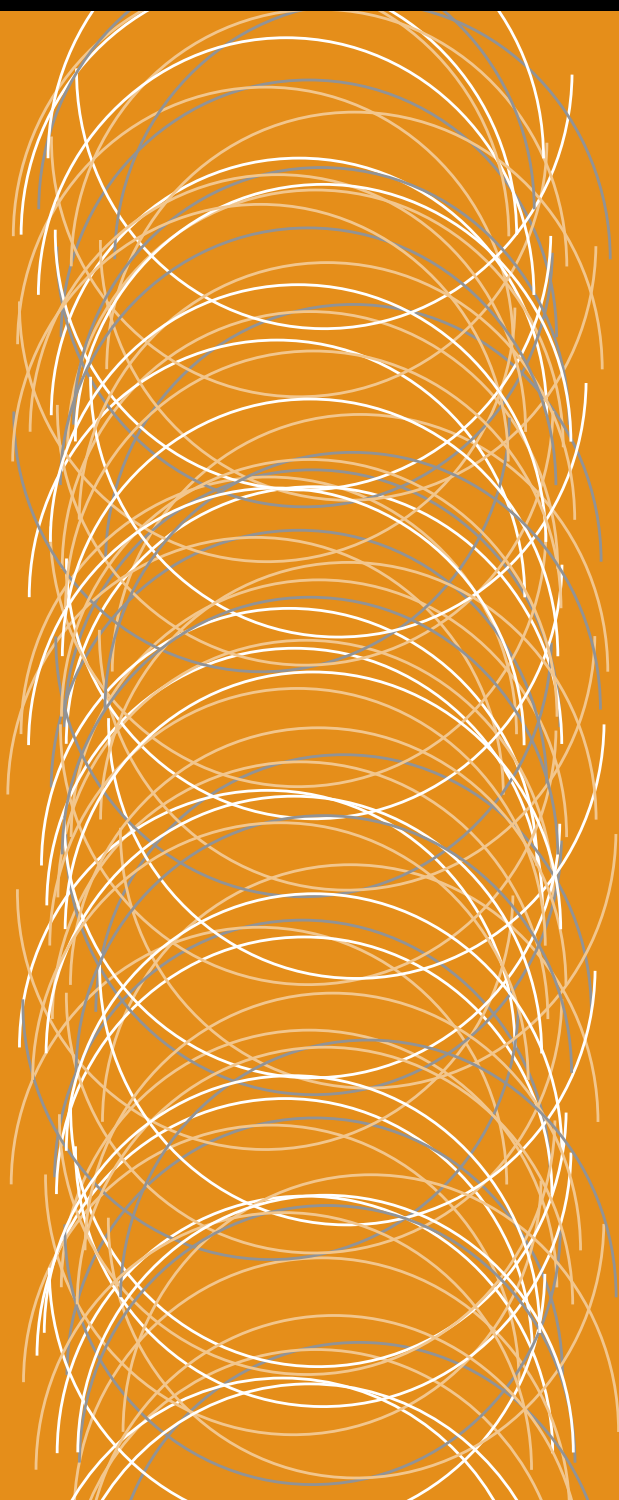


Australian Medical Council Limited

Accreditation of
Flinders University
School of Medicine

AMC



Medical School Accreditation Committee
February 2015

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Executive summary 2014

Accreditation process

Flinders University, School of Medicine is seeking reaccreditation of its medical programs. The AMC's *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2011* provides for accredited medical education providers to seek reaccreditation when a period of accreditation expires. Accreditation is based on the medical program demonstrating that it satisfies the accreditation standards for primary medical education. The provider prepares a submission for reaccreditation. An AMC team assesses the submission and visits the provider and its clinical teaching sites.

The Flinders medical program was first accredited by the AMC in 1994 as a six-year Bachelor of Medicine / Bachelor of Surgery (BMBS). In 1996 the School introduced Australia's first graduate-entry medical program, a four-year BMBS program. In 1998, the School commenced delivery of Years 3 and 4 in the Northern Territory and in 2010, the School first offered its six-year double degree Bachelor of Clinical Science /BMBS.

The medical program was last assessed by the AMC in 2010 following a major change proposal to deliver Years 1 and 2 in the Northern Territory. On the basis of this assessment accreditation was extended to 31 December 2014, subject to satisfactory progress reports, and in 2011, the School commenced delivery of Years 1 and 2 of the program in Darwin.

In 2012, the University approved the BMBS being changed to a Level 9 Masters (Extended) Doctor of Medicine (MD) award from 2013, with no change to the program content or duration. These changes were implemented from 1 January 2013 with a teach-out phase for the accredited BMBS program to December 2017. All continuing students in 2013 could choose to graduate with an MD or the BMBS (or for students in the double-degree a BClinSci/MD or a BClinSci/BMBS). In this report, the BMBS and the MD are referred to as 'the program'.

The program has three entry pathways: graduate entry; undergraduate via a double degree with Flinders Bachelor of Clinical Sciences in South Australia; or undergraduate via a double degree with a Bachelor of Clinical Sciences offered jointly in the Northern Territory by Flinders and Charles Darwin University.

In February 2014, the AMC extended accreditation from 31 December 2014 to 31 March 2015 in line with changes to AMC accreditation end-dates.

An AMC team reviewed the School's submission and the Flinders Medical Students' Society's submission, and visited the School and associated clinical teaching sites in the week of 13 October 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

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 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.

Reaccreditation of established education providers and programs of study

The accreditation options are:

- (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 extension of accreditation. Subject to a satisfactory report, the AMC may grant a further period 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 extension of accreditation. Subject to a satisfactory report, the AMC may grant a further period 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 the program satisfies the accreditation standards, the AMC may award accreditation with conditions and for a period of less than six years.
- (iv) Accreditation may be withdrawn where the education provider has not satisfied the AMC that the complete program is or can be implemented and delivered at a level consistent with the accreditation standards.

At their 11 March 2015 meeting, the AMC Directors agreed that they were reasonably satisfied that the medical programs of Flinders University, School of Medicine meet the approved accreditation standards.

The AMC Directors agreed:

- (i) That accreditation of the following medical programs of Flinders University, School of Medicine **be granted for a period of six years; that is until 31 March 2021**, subject to satisfactory progress reports:
 - o Doctor of Medicine (MD)
 - o Bachelor of Medicine / Bachelor of Surgery (BMBS) (N.B. accreditation of the BMBS will cease 31 December 2017 following its teach-out).

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

2015 conditions

By 1 November 2015, confirm that formal arrangements are in place for 2016 for medical students in the Northern Territory from James Cook University (Standard 1.6).

By 1 November 2015, finalise the assessment of competencies related to research skills for Year 3 in 2016 (Standard 5.3).

By 31 December 2015, confirm that the School's contracts with the Northern Territory Government and Commonwealth regarding the Northern Territory Medical Program are finalised (Standard 1.6).

2016 conditions

By 31 May 2016, confirm that a formal agreement with James Cook University for 2016/17 regarding their students in the Northern Territory is finalised (Standard 1.6).

Demonstrate that the results and outcomes of the 2015 Year 2 students remain consistent with those of previous years with regard to Health, Profession and Society outcomes following introduction of the Advanced Studies theme (Standard 3.2).

Demonstrate that the learning outcomes and objectives for all stages of the program are accessible to all teaching and clinical staff, and provide evidence that clinical staff have satisfactory direction from the School, including from theme and discipline leads, on the curriculum content (Standard 3.4).

Demonstrate improved feedback following summative assessments to those students who will remain under the existing assessment structure (i.e. those who will not immediately transition to programmatic assessment when this is introduced) (Standard 5.3).

Demonstrate an increase in formative assessment and feedback to students (Standard 5.3).

Show improved calibration and consistency in the conduct of 'within-rotation' clinical assessments across all sites (Standard 5.4).

Implement a systematic 'whole-of-school' process for the gathering of student feedback in Years 3 and 4 across all sites (Standard 6.1.2).

Provide adequate student common room facilities at the Flinders Medical Centre appropriate to the student numbers at that site (Standard 8.1).

Modernise the audio-visual resources in the problem-based learning tutorial rooms in the main Flinders Medical Centre building so that they adequately support these tutorials (Standard 8.1).

2017 conditions

In 2017, following the implementation of the 2016 Year 3 Advanced Studies program, demonstrate that:

- 1 student results and outcomes remain consistent with those of previous years with regard to Health, Profession and Society outcomes
- 2 at all Year 3 sites, that clinical contact time for Year 3 students remains satisfactory; and
- 3 that clinical skills assessment outcomes remain consistent with previous years (Standard 3.2).

Key findings of Flinders University, School of Medicine

1. The context of the medical program	Met
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Standard 1.6 is substantially met.

2015 conditions

By 1 November 2015, confirm that formal arrangements are in place for 2016 for medical students in the Northern Territory from James Cook University (Standard 1.6).

By 31 December 2015, confirm that the School's contracts with the Northern Territory Government and Commonwealth regarding the Northern Territory Medical Program are finalised (Standard 1.6).

Commendations

The well-regarded Northern Territory Medical Program Governance Committee, including representation from Flinders, Charles Darwin University and the NT Government, that has developed a strong relationship between Flinders and Charles Darwin University (Standard 1.1).

The high number of Aboriginal and Torres Strait Islander staff working in the program (Standard 1.8.3).

2016 conditions

By 31 May 2016, confirm that a formal agreement with James Cook University for 2016/17 regarding their students in the Northern Territory is finalised (Standard 1.6).

2016 recommendations for improvement

Improve the effectiveness of communication streams and the dissemination of information between various sub-committees and dispersed sites (Standard 1.1).

Complete the planned review of the Northern Territory Medical Program organisational structure, and evaluate the changes arising from this review, particularly in terms of their effect on staff and students (Standard 1.1).

Increase the number of medically qualified Aboriginal academic and clinical staff within the program to further strengthen the complement of Aboriginal staff, given the importance of the program in Indigenous medical education nationally (Standard 1.4).

2. The outcomes of the medical program	Met
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All standards are met.

Conditions

Nil

Commendation

The School's drive to achieve its purpose in its curriculum, teaching, research and varied clinical placement modalities, and in particular, its strong commitment to honour Indigenous perspectives and Indigenous health (Standard 2.1).

2016 recommendations for improvement

Improve staff and students' ability to interrogate the curriculum and identify the relationships between graduate outcomes, course outcomes, curriculum and assessment, noting that the Online Curriculum Framework and centralised Assessment Data Management System (due for completion by the end of 2015) will contribute in this regard (Standard 2.2).

Undertake additional processes to increase consistency of assessment and achievement of core educational outcomes across all sites (Standard 2.2).

3. The medical curriculum	Substantially met
----------------------------------	--------------------------

Standards 3.2 and 3.4 are substantially met.

2016 conditions

Demonstrate that the results and outcomes of the 2015 Year 2 students remain consistent with those of previous years with regard to Health, Profession and Society outcomes following introduction of the Advanced Studies theme (Standard 3.2).

Demonstrate that the learning outcomes and objectives for all stages of the program are accessible to all teaching and clinical staff, and provide evidence that clinical staff have satisfactory direction from the School, including from theme and discipline leads, on the curriculum content (Standard 3.4).

2017 conditions

In 2017, following the implementation of the 2016 Year 3 Advanced Studies program, demonstrate that:

- 1 student results and outcomes remain consistent with those of previous years with regard to Health, Profession and Society outcomes
- 2 at all Year 3 sites, that clinical contact time for Year 3 students remains satisfactory; and
- 3 that clinical skills assessment outcomes remain consistent with previous years (Standard 3.2).

Commendations

The commitment of the School to continuing its heritage of educational innovation, for example through its initiatives in a range of longitudinal clinical attachment models (Standard 3.3).

The involvement of the leadership of the School, and the quality contribution of staff from the Poche Centres and medical school, in meaningfully engaging with the local community and Elders, and embedding such Indigenous health teaching into the curriculum (Standard 3.5).

2016 recommendations for improvement

Complete a review of the content of all problem-based learning and streamed sessions to ensure all are up-to-date (Standard 3.2).

Improve the integration of relevant basic science concepts in Years 3 and 4 (Standard 3.3).

Establish a review to refresh and invigorate the Indigenous health content, cultural awareness, and cultural safety within the program and the School. The establishment of the Poche Centre and the Northern Territory Medical Program, and the recent changes in School structure, provide an ideal opportunity to undertake a review (Standard 3.5).

4. Teaching and learning	Met
---------------------------------	------------

All standards are met.

Conditions

Nil

Commendations

The adoption of a mastery model of remediation in the clinical skills course, particularly related to communication skills (Standard 4.1).

The multiple opportunities for students to develop their clinical skills in supervised settings, including the Northern Territory Medical Program's Palmerston student-led clinic and the practical component of the 'transition to practice' programs (Standard 4.4).

The commitment of basic and clinical researchers to the Advanced Studies research program (Standard 4.5).

The value placed by the School on patient centred education is clearly reflected in the views of both students and recent graduates (Standard 4.6).

The interprofessional learning opportunities for students in the Rural Clinical Program provide a good model of collaboration and teamwork (Standard 4.7).

2016 recommendations for improvement

Consider the place and particular models of eLearning that would best support the School's diverse clinical training settings (Standard 4.1).

Review how best to coordinate the involvement of junior staff in the clinical skills program for Year 2 students (Standard 4.5).

5. The curriculum – assessment of student learning	Substantially met
---	--------------------------

Standards 5.3 and 5.4 are substantially met.

2015 condition

By 1 November 2015, finalise the assessment of competencies related to research skills for Year 3 in 2016 (Standard 5.3).

2016 conditions

Demonstrate improved feedback following summative assessments to those students who will remain under the existing assessment structure (i.e. those who will not immediately transition to programmatic assessment when this is introduced) (Standard 5.3).

Demonstrate an increase in formative assessment and feedback to students (Standard 5.3).

Show improved calibration and consistency in the conduct of 'within rotation' clinical assessments across all sites (Standard 5.4).

Commendations

The School's detailed review of existing assessment methods, its clear plans for implementation of the new programmatic assessment for learning, and its plans for on-going quality assurance in assessment (Standard 5.1).

The explicit support for students who have failed examinations (Standard 5.1).

Recommendations for improvement

Enhance staff understanding around University policy in determining student progress and appeals (Standard 5.1).

Improve blueprinting at a program level, noting that the Online Curriculum Framework and Centralised Data Management System due for completion at the end of 2015 will contribute in this regard (Standard 5.2).

Review the breadth of assessment of student learning in problem-based learning sessions (Standard 5.3).

Improve feedback on student cohort performance to supervisors and teachers located away from the main campuses or those without a University appointment (Standard 5.3).

Address areas for improvement in assessment of assignments by better defining the marking criteria; and improving marking turn-around time and the quality of feedback (Standard 5.3).

6. The curriculum – monitoring	Met
---------------------------------------	------------

Standard 6.1 is substantially met.

2016 condition

Implement a systematic ‘whole-of-school’ process for the gathering of student feedback in Years 3 and 4 across all sites (Standard 6.1.2).

Commendation

The School’s strong commitment to monitor and evaluate its innovative programs (Standard 6.1.1).

2016 recommendations for improvement

Ensure the timely completion of the current review of curriculum content, specifically some problem-based learning and Year 3 online lecture content (Standard 6.1).

Review and improve the School’s processes for communicating with its students (Standard 6.1).

7. Implementing the curriculum – students	Met
--	------------

All standards are met.

Conditions

Nil

Commendations

The School's rural recruitment process – notably in the last 15 years over 95% of the Parallel Rural Community Curriculum sub-quota students have chosen a rural medical career on graduation (Standard 7.2).

The wide range of student welfare supports available at all sites, including at the School's rural and remote sites (Standard 7.3).

2016 recommendation for improvement

The School is encouraged to manage potential conflicts of interest for support staff, which may arise through their involvement in multiple roles in a relatively small jurisdiction (Standard 7.3).

8. Implementing the curriculum - learning environment	Met
--	------------

Standard 8.1 is substantially met.

2016 conditions

Provide adequate student common room facilities at the Flinders Medical Centre appropriate to the student numbers at that site (Standard 8.1).

Modernise the audio-visual resources in the problem-based learning tutorial rooms in the main Flinders Medical Centre building so that they adequately support these tutorials (Standard 8.1).

Commendations

The generally superb videoconferencing facilities and related technical support (Standard 8.2).

The staff of the University medical library, who provide a high standard of service provision and resourcing, and who are welcoming and supportive to students (Standard 8.2).

The emphasis on student safety and welfare in the student placement allocation process, particularly for students allocated to rural or remote placements with the perceived difficulties of isolation or educational disadvantage (Standard 8.3).

The evident enthusiasm, expertise and engagement of the School's staff who create a supportive yet challenging teaching and learning environment (Standard 8.3).

2016 recommendations for improvement

Provide a general student area at the Repatriation General Hospital (Standard 8.1).

Ensure the provision of high-speed internet in student accommodation (Standard 8.2).

Provide a solution to the delays experienced with staff log-on profiles at remote and rural sites (Standard 8.2).

Work to increase Indigenous health placement opportunities for students in southern Adelaide (Standard 8.3).

Monitor the time available for teaching and research across the School's academic and adjunct staff, and highlight any deficits both in discussions with stakeholders and in AMC progress reports (Standard 8.4).

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 and procedures for accreditation are published in the *AMC's Assessment and Accreditation of Medical Schools: Standards and Procedures 2012*. The accreditation standards list the graduate outcomes that collectively provide the requirements that 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. The medical student society is also invited to make a submission. Following a review of the submissions, 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 the 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.

After it has accredited a medical program, the AMC seeks regular progress reports. Accredited medical education providers are required to report any developments relevant to the accreditation standards and to address any conditions on their accreditation and recommendations for improvement made by the AMC. Reports are reviewed by an independent reviewer and by the Medical School Accreditation Committee.

The University, the Faculty and the School

Flinders University was established in 1966. In 2013 Flinders University had 23,261 students, including 3,905 international students and 2,616 staff.

The University organisational structure consists of four faculties: Education, Humanities and Law; Medicine, Nursing and Health Sciences; Science and Engineering; and Social and Behavioural Sciences.

The Faculty of Medicine, Nursing and Health Sciences consists of the School of Medicine, the School of Nursing and Midwifery and the School of Health Sciences. The Faculty places strong emphasis on rural and remote health in its teaching programs. It has established clinical schools and departments of rural health in Darwin and Alice Springs in the Northern Territory, the Riverland and south-east regions of South Australia and the south-western region of Victoria.

The School of Medicine is based in southern Adelaide, South Australia at the Flinders Medical Centre, an academic medical centre combining a tertiary teaching hospital and medical school. In Adelaide, the School is also affiliated with the Repatriation General Hospital and the Noarlunga Health Service. The medical program commenced in 1974, and in 2014, celebrated its fortieth year.

The School is organised into five academic units: Flinders Health Care and Workforce Innovation; Flinders Medical Science and Technology; Flinders Northern Territory; Flinders Southern Adelaide Clinical School and Flinders University Rural Clinical School.

The program has 165 students per cohort, across the three entry pathways, including approximately 24 students enrolled per year in its four-year Northern Territory Medical Program.

The School has a rural and remote presence with clinical training and research activities in regional areas of Australia. Flinders Northern Territory hosts the Northern Territory Medical Program (Darwin), the Northern Territory Remote Clinical School (Alice Springs, Katherine, Nhulunbuy), and the Centre for Remote Health (Alice Springs, Katherine). The Flinders University Rural Clinical School is based in Renmark, with sites at Mt Gambier, Victor Harbor, Nuriootpa and Murray Bridge.

The Flinders medical program was first accredited by the AMC in 1994 as a six-year Bachelor of Medicine / Bachelor of Surgery (BMBS), and in 1996, the School of Medicine introduced its four-year BMBS, becoming Australia's first graduate-entry medical program. From 2010, the School also commenced its six-year double degree Bachelor of Clinical Science / BMBS.

The medical program was last assessed by the AMC in 2010 following a major change proposal to deliver Years 1 and 2 in the Northern Territory. On the basis of this assessment, accreditation was extended to 31 December 2014, subject to satisfactory progress reports, and in 2011, the School commenced delivery of Years 1 and 2 of the program in Darwin.

In 2012, the University approved the BMBS being changed to a Level 9 Masters (Extended) Doctor of Medicine (MD) award from 2013, with no change to the program content or duration. These changes were implemented from 1 January 2013 with a teach-out phase for the accredited BMBS program to 31 December 2017. All continuing students in 2013 could choose to graduate with an MD or the BMBS (or for students in the double-degree a BClinSci/MD or a BClinSci/BMBS). In this report, the BMBS and the MD are referred to as 'the program'.

In February 2014, the AMC extended accreditation from 31 December 2014 to 31 March 2015 in line with changes to AMC accreditation end-dates.

This report

This report details the findings of the 2014 reaccreditation assessment. Each section of the accreditation report begins with the relevant AMC accreditation standards.

The members of the 2014 AMC team are given at **Appendix One**.

The groups met by the AMC in 2014 are given at **Appendix Two**.

Appreciation

The AMC thanks the University and School of Medicine 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.*

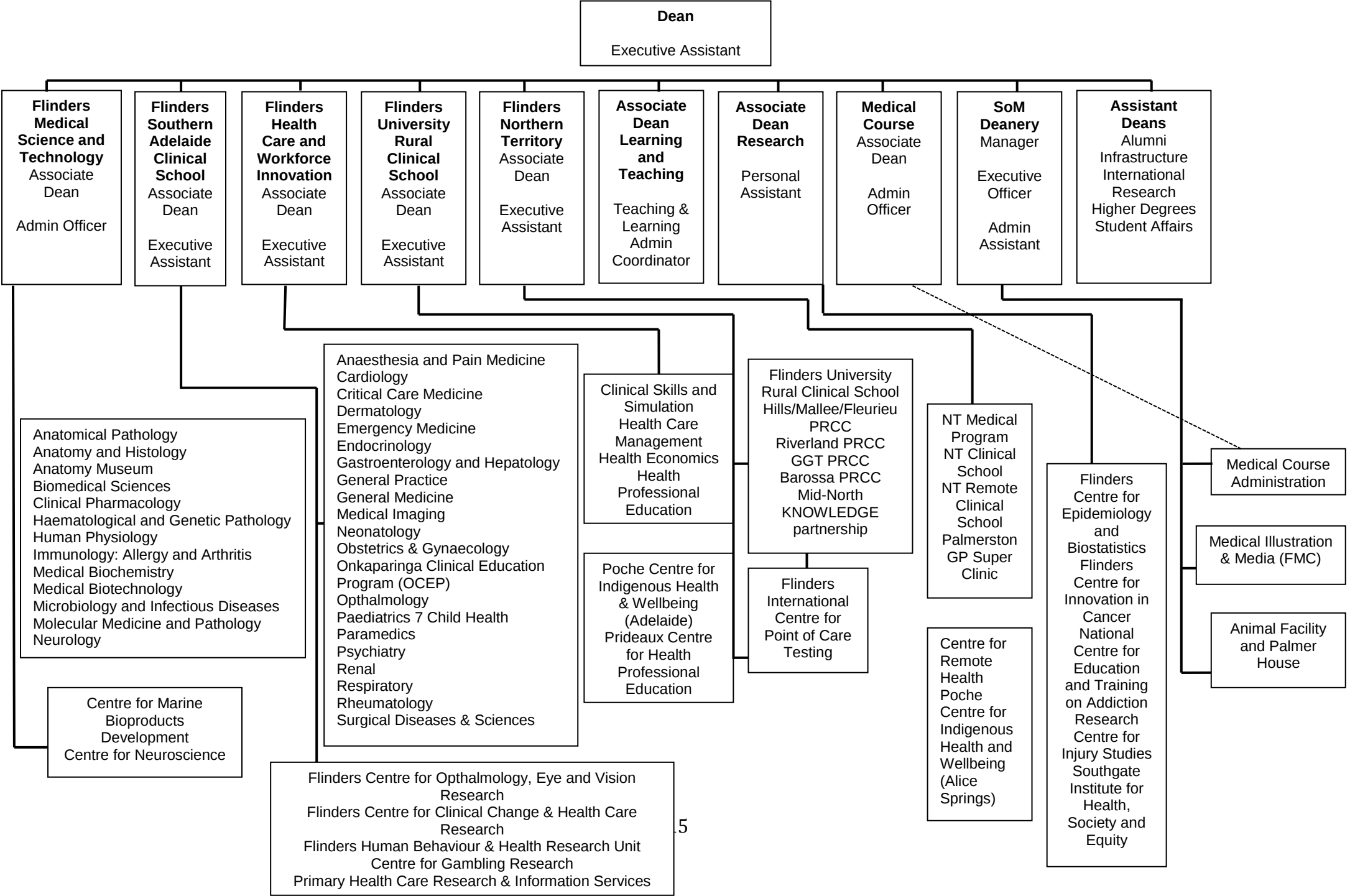
Organisational structure

The Flinders University organisational structure consists of four faculties: the Faculty of Medicine, Nursing and Health Sciences; the Faculty of Education, Humanities and Law; the Faculty of Science and Engineering; and the Faculty of Social and Behavioural Sciences.

Prior to 2012, the School of Medicine and the School of Nursing and Midwifery were the two schools in the Faculty of Health Sciences. Following a seven-year external strategic review in 2012, the University decided that the School of Medicine would be better restructured as two schools, and formed the School of Medicine and the School of Health Sciences within the re-named Faculty of Medicine, Nursing and Health Sciences in 2014. Although the School initially had reservations about its separation from the other health sciences, it now considers the restructure as advantageous, having permitted an increased focus on the medical program, and reduced co-teaching into many health science degrees while maintaining research collaborations. The School of Medicine also offers bachelor degrees in medical science, paramedic science and a smaller number of related postgraduate courses.

Following the Faculty restructure, the School of Medicine's organisational structure was reviewed. After consultation with staff, a new structure was approved by the Vice-Chancellor in October 2013. Previously, the School of Medicine had a multidisciplinary cluster structure with eight clusters based on teaching and research interests. From 2014, there are five academic units: Flinders Health Care and Workforce Innovation; Flinders Medical Science and Technology; Flinders Southern Adelaide Clinical School; Flinders Northern Territory; and Flinders University Rural Clinical School. Each academic unit has an associate dean as head that reports to the Dean, and has responsibility for delivery of particular topics or themes in the program. The organisational structure is depicted in Figure 1.

SCHOOL OF MEDICINE ORGANISATIONAL STRUCTURE



While the team considered that the School's organisational structure appeared complicated, it found that the structure was understood by staff and students. The School advised that the transition to the new structure had been successful with students noticing little impact on delivery. Staff reported that the structure had improved clarity regarding reporting lines.

The School of Medicine's Board of Studies is the main body that manages the School's teaching programs. Chaired by the Associate Dean, Teaching and Learning, its members include representatives from its teaching programs, strategic partners, staff, and student body. It receives reports from the Medical Course Committee and other School course committees, and from the Teaching and Learning Committee. Its role includes making decisions regarding new courses, significant course changes and reviews. The Faculty Teaching and Learning Committee advises the Board of Studies on academic and student policy matters.

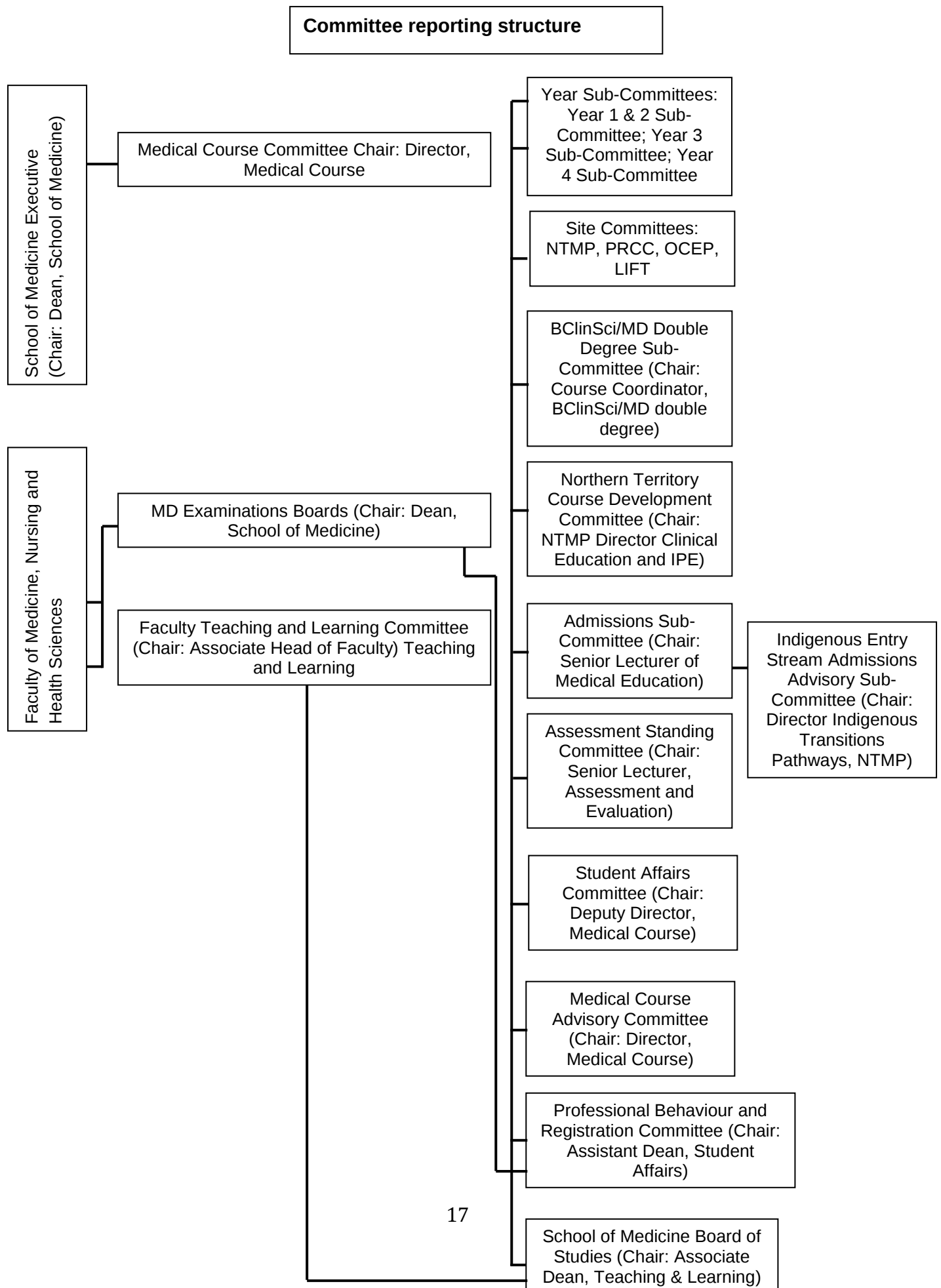
The School Executive supports the Dean in matters regarding strategic direction, performance and policy, and facilitates alignment across the program. It meets weekly and has thirteen members including the Dean; the Associate Deans of the five academic units and the Associate Deans for Research, Teaching and Learning, and the Medical Course; and four senior staff members. It receives reports from committees including the Medical Course Committee, the Board of Studies and the School Research Committee. The team considered that the School had a strong and representative leadership group.

The Medical Course Committee is responsible for decision-making and curriculum development of the program (details at Standard 1.3) and it reports to the Board of Studies. It has over 25 members and meetings are also open to all who have an interest in the program. Given the large membership, the School has made a dedicated effort to create clear lines of reporting from the various contributors to the MD. The team noted that ensuring clear communication from this group to all staff and students, as appropriate, is challenging. A range of committees and subcommittees report to the Medical Course Committee, as outlined in Figure 2.

The three year-level committees for Years 1 and 2; Year 3; and Year 4 are the 'engine rooms' for the Medical Course Committee. They organise, coordinate and evaluate their respective year, implementing decisions from the Medical Course Committee and making policy recommendations to it.

The subcommittees that report to the Medical Course Committee include those for the BCSc/MD, admissions, and the Indigenous entry stream. There are also subcommittees for the Parallel Rural Community Curriculum in rural South Australia; the Northern Territory Medical Program; the Onkaparinga Clinical Education Program (OCEP); and the Longitudinal Integrated Training at Flinders (LIFT) program run in Adelaide and Alice Springs.

Figure 1: Committee reporting structure



The School has examination boards for Years 1 and 2, Year 3, and Year 4 that are constituted under the School's Board of Studies, and may refer matters regarding curriculum to the Medical Course Committee. There is an Assessment Standing Committee that was formed in 2012 that reports to the Medical Course Committee. Its role is to monitor and advise on improvements to assessment and feedback in the program.

Campuses

The School has a large geographic footprint with sites across South Australia and the Northern Territory. The School's main campus is co-located with Flinders Medical Centre, a tertiary teaching hospital in southern Adelaide. Three of the five academic units are located on main campus. Their responsibilities as they relate to the program are:

- Flinders Health Care and Workforce Innovation: Delivery and development of the themes of Doctor and Patient; and Health Professions and Society; development and delivery of Indigenous Health curriculum within these topics; the Advanced Studies research topics; admissions expertise; responsibility for program evaluation and assessment; curriculum development; faculty development; and administrative support for the program.
- Flinders Medical Science and Technology: Delivery of theme of Knowledge, Health and Illness in Years 1 and 2; delivery of this theme in Years 3 and 4 in southern Adelaide.
- Flinders Southern Adelaide Clinical School: delivery and development of the Introduction to Clinical Practice courses; the Years 3 and 4 Clinical Performance topics; staff contributions to teaching in other themes; liaison with South Australia Local Health Network, Medicare Locals, and affiliated clinicians.

The Southern Adelaide Clinical School includes facilities at Flinders Medical Centre, the Repatriation General Hospital and the Noarlunga Health Service.

The Flinders University Rural Clinical School spans rural areas of South Australia and Victoria. Based in Renmark (the Riverland), it also has staff at Victor Harbor (for students in the Hills Mallee and Fleurieu / Kangaroo Island regions), at Mount Gambier ('Greater Green Triangle'), Nuriootpa (Barossa Valley), Murray Bridge and on the Flinders main campus. It is responsible for the Year 3 topics in the Parallel Rural Community Curriculum; Year 2 regional community week; Years 3 and 4 rural clinical placements; liaison with Country Health SA, Regional Health SA and Victoria Health.

The Flinders Northern Territory academic unit leads the School's activities in the Northern Territory (NT). This includes:

- the Northern Territory Medical Program based in Darwin at the Charles Darwin University campus, with staff also at the Royal Darwin Hospital
- the Centre for Remote Health in Alice Springs, a joint centre shared by Flinders and Charles Darwin Universities
- the NT Remote Clinical School, based at Alice Springs, Katherine and Nhulunbuy

- the Poche Centre for Indigenous Health and Wellbeing in Alice Springs.

Flinders NT is responsible for the program topics delivered in the Northern Territory Medical Program; Year 4 NT rotations; the Indigenous Entry Scheme; NT Indigenous health; remote health courses; and liaison with Charles Darwin University and the NT Government. Further detail on Flinders NT governance is below.

The team noted that each academic site organises its structure depending on the needs at its site, and the topics it delivers. As the academic units responsible for the curriculum are dispersed, there are many separate meetings regarding components of the program at the Rural School, Flinders NT, Southern Adelaide Clinical School, as there are at sites where longitudinal clinical placements occur. There has been a dedicated effort by the School to create clear lines of reporting from the various contributors to the program through to the year committees and the Medical Course Committee. Notwithstanding, the team considered that the School would benefit from further improvement in communication and dissemination of information between various sub-committees and between its sites. This would assist in maintaining a cohesive curriculum and maintaining assessment standards across multiple sites.

Flinders in the Northern Territory: structure

In 2010, Flinders University and Charles Darwin University (CDU) established a partnership to deliver CDU pathways into the Flinders medical program for NT Indigenous students and NT school leaver students. Flinders built its Northern Territory Medical Program (NTMP) building on the CDU campus, and CDU provides support for Flinders medical students on the CDU campus. The NT Government and Australian Government contribute funding to Flinders for the NTMP students, aiming to provide an increased number of medical graduates for the NT, and an increased number of Indigenous doctors. Since 2011 the School has offered Years 1 and 2 of the program in Darwin for 24 students per year. Years 3 and 4 have been delivered in the NT since 1998.

The NTMP Governance Committee includes the Vice-Chancellors of Flinders and CDU and the Chief Executive of the NT Department of Health, the Dean, Associate Dean Flinders NT, and NT clinicians and staff. It provides strategic advice to Flinders, reviews and endorses the selection criteria for the industry supported places in the NTMP, and provides guidance on the NT context relevant to the NTMP. The team commends the NTMP Governance Committee for leading the strong relationship between Flinders and CDU. All parties expected that the NTMP would remain as a Flinders program for the foreseeable future.

The Northern Territory Course Development Committee was established in November 2013 and comprises Flinders academics, medical educators, clinicians and other key stakeholders from South Australia and the NT, and NTMP student representatives. Its purpose is to deliver and develop the program appropriate to the NT context, particularly regarding rural and remote health practice. It provides feedback and makes

recommendations to the Medical Course Committee. As a new committee, the membership and terms of reference were due to be reviewed at the end of 2014. The team recognised that this committee has the capacity to provide a clear and valuable voice for the many NTMP contributors to the Medical Course Committee, and the terms of reference will need to carefully articulate expectations (for all stakeholders), reporting mechanisms and communication strategies, both within the NTCDC and the broader academic environment.

The team considered that the organisational and governance structure of the Flinders Northern Territory academic unit was complicated. The NTMP structure was set-up in a short period and grew for this phase, yet now requires review. The NT academic unit also incorporates the Poche Centre and the Centre for Remote Health Flinders. The NTMP and CDU staff reported an abundance of committees requiring representation, both in the NT and at Flinders. Staff at remote sites must video-conference into numerous meetings, presenting an onerous time commitment. Some staff reported concern regarding how information was shared, noting some siloing of knowledge between the committees.

The team was pleased to note the NTMP's plans to review its organisational structure to improve efficiency, and to harmonise the range of its policies. This review is timely as it will allow for streamlining of governance structures and should reinforce formal linkages between the Flinders NT sites and main campus. The team recommends that changes arising from this review are evaluated, particularly in terms of their effect on staff and students.

The School consults relevant groups on key issues relating to the program by way of external members on the School Board, and through a number of advisory committees. These groups include the Medical Course Advisory Group, the Northern Territory Course Development Committee and the Aboriginal and Torres Strait Islander Advisory Committee (previously the Indigenous Reference Group). Refer to Standard 1.6 for further detail. Feedback from the advisory groups directly informs the Medical Course Committee.

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.

The School has clear autonomy over the design and development of its program and prides itself on its reputation for innovation in medical education. The Dean has overarching academic and budgetary responsibility for the program and is responsible for the teaching, learning and research in the School. The Medical Course Director has delegated authority from the Dean for the program's curriculum and the policy

framework in which it operates. The Dean reports to the Executive Dean of the Faculty, who was seen as supportive of the School.

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.

The Medical Course Committee is the major strategic and operational committee responsible for academic leadership of the program, and makes decisions regarding curriculum development. It has a clearly defined structure to ensure contributions from all years and sites. Chaired by the Medical Course Director (also Associate Dean, Medical Program), it meets monthly, and has over 25 members including the Dean, Deputy Director, associate deans, heads of years, heads of educational programs, two student representatives and theme representatives.

As noted in Figure 2 (Standard 1.1), a number of sub-committees report to the Medical Course Committee, including the year management committees. The year coordinators are responsible for coordinating the implementation of curriculum and assessment through their respective year committee.

The University Senate assessed the MD program against the Australian Qualifications Framework criteria in 2012 and found it to meet the criteria for Level 9 Masters (Extended). Since 2012, the School commissioned an external review regarding the revised research criteria in the Australian Qualifications Framework, which found the program and its new Advanced Studies research content (refer to Standard 3.2) to be compliant. This finding was confirmed by the Vice-Chancellor in 2014.

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.

The School is known for its educational expertise and allocates resources to ensure it maintains this, both to guide the development of the program and to contribute to medical education research. Forty faculty members hold postgraduate qualifications in medical education.

The Health Professional Education unit, part of the Flinders Healthcare and Workforce Innovation academic unit, contributes to the program's curriculum design, student selection, eLearning, assessment and evaluation activities and has a brief across all School programs. Formerly known as the Department of Medical Education, it became the Health Professional Education Unit in 2009.

The program utilises the expertise of the faculty of the Prideaux Centre for Research in Health Professions Education, established in 2013. Some of the staff of this Centre also hold appointments in the Health Professional Education Unit.

The Poche Centres for Indigenous Health, in Adelaide and Alice Springs, were established in 2011. The Poche Centre in Adelaide, while it teaches in all three schools in the Faculty, has 1.25 full-time equivalent Indigenous academics who contribute to teaching the Health Professions and Society theme. In total, across the School in SA and NT, there are 9.9 full-time equivalent staff representing a mix of Aboriginal and non-Aboriginal academics with recognised Indigenous knowledge. The team encourages the program to increase the number of medically qualified Aboriginal academic and clinical staff within the program to further strengthen the complement of Aboriginal staff, given the importance of the program in Indigenous medical education nationally.

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.

The Dean is the identified authority for the program, and delegates program administration to the Medical Course Director. The Dean allocates budget to the academic units to be managed by the respective associate deans in conjunction with the Medical Course Director. The School Executive team, which includes the associate deans, provides an advisory, consensus framework for financial decisions. The allocation of budget by academic unit structure allows the School to direct resources to meet the needs of the program.

The School reported that in the last six years it has not run a deficit. It attributed this to careful financial management at program level, and noted that it does not rely on bequests. The School's budget projections to 2019 indicate a continued surplus.

The outgoing Vice-Chancellor demonstrated continued support of the School and advised that the University's current strategic direction will continue to 2016 to allow for a transition period for the incoming Vice-Chancellor in 2015.

The Faculty had made a substantial commitment of finances and resources to meet the educational requirements of the School and the rural clinical sites. The team had initial concerns regarding the School's ongoing ability to fund the range of four separate clinical placement models (detailed at Standard 3.2) given the substantial staffing bases relative to student numbers. The School considered that it had continued capacity to support these separate models and budgets. As an example, it noted that the Rural Clinical School had been in operation for 18 years, operates on a sustainable model and has a good relationship with South Australia (SA) Health.

The School has benefited from investment in its facilities at rural sites, having attracted considerable funds through Health Workforce Australia. It now has new facilities at most of its rural locations and at clinical sites in Adelaide, and on the main campus there is a new teaching complex in use, and a new student hub is planned. The School sees the need for a large financial investment in building and infrastructure at Flinders Medical Centre to accommodate student needs (refer to Standard 8.1). The team understood that this need is acknowledged by the Faculty but no commitment had yet been made to addressing it.

In the NTMP, the NT Government continued to provide funds to Flinders toward clinical placements at the Royal Darwin Hospital and Alice Springs Hospital, and advised that this remains secure.

The team noted that the School plans to update educational materials including patient-based learning cases and eLearning resources, and it advised it has the funds available for this needed investment.

The team found that the School is relatively well-placed financially and has adequate resources at its disposal to maintain the program, although the many challenges confronting South Australia and the health sector in general are acknowledged.

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.

The School engages with SA Health and Northern Territory (NT) Health. It meets regularly with executive staff of these health services; a number of senior staff members are appointed to advisory roles in both health networks; and SA Local Health Network clinicians are appointed to the School Board of Studies.

In South Australia, the School has relationships with two Local Health Networks: Southern Adelaide Local Health Network (SALHN) and Country Health SA Local Health Network. Representatives of SALHN indicated that following organisational restructures at both the School and SALHN, cross-representation on executive and substantive committees of both organisations could be improved.

The School has overarching placement agreements with SA Health and NT Health regarding student placements, joint staff appointments and collaborative activities at their sites. Agreements with private practices are negotiated individually and the School has over 50 agreements. In the NT, the School was exploring the possibility of an

agreement with the Darwin Private Hospital and also aimed to increase its community GP placements.

In the Northern Territory, the School works with the Northern Territory Government centrally and regionally with the Top End Health Service and the Central Australian Health Service. The Associate Dean Flinders NT meets at least monthly with an NT Government executive. The NT Governance Committee (refer to Standard 1.1) was well-regarded by all parties as an effective decision-making body for the NT.

At the time of the visit, a new four-year agreement between the NT Government, the Commonwealth and Flinders was being negotiated as the previous contract expired on 30 June 2014. Subsequent to the visit, the funding agreement remains to be finalised. The Commonwealth has made a commitment to directly fund Flinders for the next four years. The first year under the new arrangement has been funded through a variation to the existing agreement, and this variation deed expires on 30 June 2015, with a new three year funding agreement which includes both the NT Remote Clinical School and NTMP to be offered from 1 July 2015. Confirmation of the finalised agreement will be required.

It is expected that NT Government funding for the program will remain capped at 24 students in the new agreement, and the School will continue to be required to provide reports on student progression annually, and report informally to the Governance Committee. The NTMP is dependent on the relationship with the Royal Darwin Hospital non-academic clinicians to deliver tertiary hospital based clinical teaching within the program.

Flinders has had a long-standing agreement with James Cook University (JCU) for clinical training of JCU fifth-year students in Darwin. This agreement expired in 2013 and was being re-negotiated year by year, with JCU seeking a clearer joint governance arrangement and clarity for students based there. The contract for 2016/17 was under negotiation. The School and JCU noted that the number of JCU students would decrease as the annual cohort of 12 NTMP BClinSci/MD students progressed into the clinical years. Confirmation of the completion of the agreement with JCU will be required.

In South Australia, Flinders and the University of Adelaide have separate agreements with SA Health. There is minimal medical student collocation, although some at postgraduate level.

Deakin University reported a positive relationship with Flinders. It shares the joint Greater Green Triangle University Department of Rural Health, and has only a small number of students collocated in rural practice sites.

Flinders has an agreement with the NT Government to coordinate the placement of all medical students in the NT from other medical schools. Flinders students take preference, followed by JCU, then other medical schools. Flinders NT is contracted to arrange student placements, student orientation to the NT, and student support as required while students are placed in the NT.

The School partners with many local Indigenous communities where medical students are based, and works with a broad range of Indigenous organisations in health. It has community representation on the advisory groups.

The Medical Course Advisory Group meets twice a year and advises the Dean and the Medical Course Committee on community, professional and societal expectations of program graduates. The Group has a range of members from local, rural, Indigenous and clinical communities, government, education groups, graduates and consumers.

The Aboriginal and Torres Strait Islander Advisory Committee in the Northern Territory, previously the Indigenous Reference Group, is now more representative of the whole territory, not just the Top End. The Committee had met once at the time of the team's visit. Its membership includes representatives from NT Aboriginal community health organisations, and Aboriginal stakeholders in research, government and education. There are also some interstate Indigenous education experts. Its purpose is to advise on development and recruitment of Aboriginal people to the program and student support. The team considered that the revised advisory group structure in the NT was a positive change. Details on the work of this new group in future progress reports will be of interest.

Flinders' level of community engagement is a strength of the program. Given that the NTMP's primary characteristic is to grow a local cohort of students into medical practitioners for the NT, connection to and working with the many community stakeholders is core to the role the University plays. The NTMP has a unique role in the broader Australian medical fraternity, and all are keen to see this succeed. Managing views across a dispersed program can be a challenge, and the team encourages the School in its efforts to continue to engage and communicate with stakeholders, and monitor the effectiveness of the process.

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.

The Research and Evaluation Expert Reference Group has oversight of research and evaluation activities involving students and staff, and reports to the Medical Course Committee.

The School has an excellent research reputation and receives grants amounting to half of Flinders research income. In the Excellence in Research for Australia (ERA) 2012 evaluations, 10 health and medical disciplines were assessed at or above world standard. Flinders introduced a number of strategic professorial positions to build strength in key research areas, recruiting seven new researchers. The School of Medicine recognises over 15 research concentrations.

The Prideaux Research Centre for Health Professional Education leads medical education research that directly informs the learning and teaching in the program, linking theory to practice.

Flinders has a strong relationship with the South Australian Health and Medical Research Institute (SAHMRI). As a founding member of SAHMRI, Flinders has a presence at SAHMRI's North Terrace site in Adelaide, which provides opportunities to establish further collaborations. In the Northern Territory, Flinders has an excellent relationship with the Menzies School of Health Research located at the Charles Darwin University campus and is developing research collaborations. The team was impressed with the relationships with SAHMRI and the Menzies School. The Poche Centres for Indigenous Health, in Adelaide and in Alice Springs, have ties to both SAHMRI and Menzies, offering further potential for research synergies.

Students have the option to engage in research in each year of the program. The School has 84 research projects available, over 160 students a year doing research, and reports that over 300 students have published in the last ten years. The School has the capacity to continue to build its research profile and there was agreement from all, especially clinical researchers, that there is capacity to take on additional students for research projects with the new Advanced Studies Program.

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.

The team met committed staff and clinicians who were passionately engaged in delivering the program. The 2014 staffing profile is shown below. While some positions were vacant, the proportion is low and the School was actively recruiting to vacant positions at the time of the visit.

Figure 2: Staffing profile 2014

Academic positions associated with the medical program				
	University Funded (FTE)	Jointly Funded (FTE)	Externally Funded (FTE)	Clinical Titles etc.
In Post – Academic	102.6	17.4	3.5	824
In Post – Professional	122			
Vacant – Academic	4			
Vacant – Professional	4			

In the Northern Territory, recruitment was underway for the new position of NTMP Course Director who will also have a 0.5 full-time equivalent clinical appointment at Royal Darwin Hospital. The School anticipated the appointment would strengthen relations between the hospital and the program. The ongoing indefinite leave of the Director of the Indigenous Transitions Pathway (ITP) (also the Director of the Poche Centre, Alice Springs) was placing pressures on the ITP staff and the NTMP was working to address these pressures. Further consideration needs to be given to succession plans, as the absence of the Director highlighted the need for other suitably trained people to be able to perform in the role.

The team noted the apparent high turnover of staff in the NTMP. The actual numbers leaving were 2 in 2011, 14 in 2012, 9 in 2013 and 6 by October 2014, from the 49 FTE positions. To place this in context, the School advised that in the Northern Territory, 7% of the total population turns-over each year, and the turnover of NT general practitioners was 60%, and NT nurses 40%. The NTMP has a staff retention plan including performance development and conference leave. Adequacy of staffing to ensure the program can be delivered in the NT should be included in future progress reports.

Flinders have centralised a range of services including finance and human resources. Professional staff in the Faculty reported this had been a positive change as staff were better supported professionally and no resources had been lost to the School. The team heard of mooted changes to the allocation of some ICT staff from geographical areas to a central pool. It would be unfortunate if this diminished the expertise available at sites remote from Flinders Medical Centre, as the dispersed nature of the program requires a degree of geographical localisation of ICT. The team recommends reporting on any changes to ICT staffing, and related impacts, in future progress reports.

There were a commendable number of Aboriginal staff within the program. In the School overall, there were approximately 14.6 full-time equivalent Aboriginal or Torres Strait Islander staff associated with the program. The majority of these staff were in the NT, where there were 15 Indigenous staff not including the Poche professorial position, and of these 5.6 full-time equivalent were academic and 8 full-time equivalent were professional staff. These staff are supported by Flinders University policies on

employment of Indigenous Australians, and by the Poche Centres. The team considered that the program would benefit from more medically-qualified Aboriginal staff (as noted at Standard 1.4). There is potential to strengthen the links with Poche in the NT and ensure that the staff there are supported appropriately in all aspects of their roles, and there is scope to support all program staff in ongoing education, professional development and support related to Indigenous health.

The School had 114 standardised patients employed, including trained amateur actors, community members with chronic, stable conditions, and trained, standardised patients who participate as patients in clinical skills and physical examination training. It conducts interviews for these roles, and trains simulated patients in the teaching process and providing feedback as a patient / consumer.

The School indemnifies staff involved in the program.

1.9 Staff appointment, promotion and 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.

The School has a well-defined appointment and promotion policy. It defines the requirements of teaching and research output. The School also has education-focussed positions for academics, and teaching staff who perform well can gain recognition for this in promotion processes.

The School offers clinical teaching courses to staff, including a Masters in Clinical Education for health professional educators.

In the School, decisions related to award of academic status (Levels A – D) for people employed by other institutions is made by the Faculty Academic Status Advisory Committee.

The School offers a range of training and development opportunities for professional and technical staff, and funding for courses or conferences.

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.

The School has an overarching vision of 'Local wellbeing. Global influence.' and this is underpinned by a philosophy of social accountability that is a feature of Flinders University. It has articulated its purpose by way of a five-year plan of aspirations, and by 2018 it aims to be 'the medical school of first choice in Australia's central economic corridor and to be connected via Asia to the world'.

The School has a specific vision to embrace social responsibility and to serve the local communities in which it operates. This extends to all its clinical schools and in particular there is a commitment to train students from the Northern Territory within the Northern Territory, to eventually serve as the local workforce. The team commends the School's stated commitment to honour Indigenous perspectives and Indigenous health. The School was actively striving to increase the contribution of the Aboriginal and Torres Strait Islander Australians in the Australian medical workforce particularly through its Northern Territory Medical Program.

In formulating its revised purpose in 2012, the School consulted internal stakeholders, working closely with staff, students and the Faculty, and ensured the purpose related to the University's Strategic Plan. Externally, it conducted planning workshops with partner organisations, and with its Medical Course Advisory Group and the Northern Territory Course Development Committee. Following this consultation on the draft statement in 2012 and 2013, the School Executive ratified the new vision statement in February 2014.

The School is a founding member of the Training for Health Equity Network (THEnet), a global movement of medical schools committed to improving health equity for underserved and rural communities. The team observed how the School applies its vision and community focus in practice in its curriculum, teaching and learning, research opportunities, and varied clinical placement modalities, and commends the School on its drive to achieve its purpose.

2.2 Medical program outcomes

A thematic framework is used to organise the AMC graduate outcomes into four domains:

- 1 Science and Scholarship: the medical graduate as scientist and scholar*
- 2 Clinical Practice: the medical graduate as practitioner*
- 3 Health and Society: the medical graduate as a health advocate*
- 4 Professionalism and Leadership: the medical graduate as a professional and leader*

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.

2.2.3 The medical program achieves comparable outcomes through comparable educational experiences and equivalent methods of assessment across all instructional sites within a given discipline.

In 2013 the School endorsed the revised set of eight (previously fourteen) Flinders Medical Graduate Outcomes as consistent with its vision and purpose. These came into effect in 2014. The School had mapped its medical graduate outcomes to the four AMC domains as an overarching framework.

The School had also mapped the AMC Graduate Outcome Statements to its program's course codes, identifying at a high level where each AMC Graduate Outcome Statement was covered in each of the program's 19 courses. It had written a long and detailed account against each Graduate Outcome Statement by program theme stating where each was addressed in the program. Mapping of each AMC Graduate Outcome Statement to the Flinders Medical Graduate Outcomes would assist in summarising the detailed information provided into a single document.

The School viewed its medical graduate outcomes as a blueprint for program design and it was developing an Online Curriculum Framework for the program, to be delivered through the University web-based Learning Content Management System (also known as FLEX), to enable the mapping of its course learning outcomes to its medical graduate outcomes, and subsequently their alignment with the AMC Graduate Outcome Statements. This framework will allow staff and students to interrogate the curriculum and identify the relationship between graduate outcomes, course learning outcomes, and assessments. This project was underway and is due for completion at the end of 2015. The content will require ongoing review. The School is encouraged in its work to map all course learning outcomes to the Flinders Medical Graduate Outcomes.

The School seeks to achieve consistent learning outcomes across a wide range of clinical experiences and provide equivalent methods of assessment across all instructional sites. Due to the diversity of clinical experiences offered within the program this had

presented challenges. For example, student feedback indicated some inconsistency in educational experiences between sites and across some disciplines. Clinical teachers at some sites indicated they were not clear of teaching outcomes required. Students reported that clinical assessment experiences varied across sites.

The School will address this with the implementation of programmatic assessment (refer to Standard 5) from Year 1 in 2016, and the introduction of progress testing across all years from 2015. The team encourages the School's proposal to consider an earlier extension of programmatic assessment to all years, if the implementation is well-resourced, and if the evaluation of the initial experience indicates it has increased consistency in assessment and supported student learning.

The team noted that full implementation of programmatic assessment was likely to take time and therefore recommends the program undertake additional processes to ensure consistency of assessment and achievement of core educational outcomes across all sites.

Ensuring equivalence of teaching and assessment across the diverse clinical settings will require ongoing refinement and monitoring, which will be important in addressing this standard into the future.

3 The medical curriculum

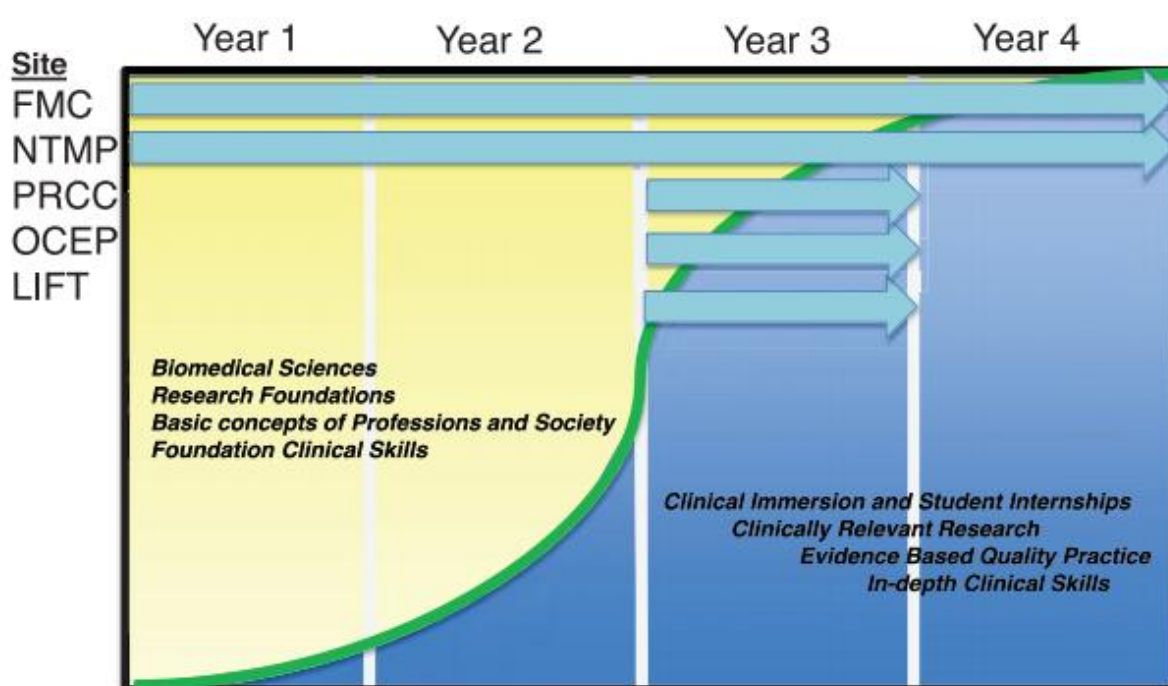
3.1 Duration of the medical program

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

Each year of the program has two semesters, though start and finish dates vary. Each semester organises topics by academic 'units' where a unit equates to approximately 30 hours of student commitment, and 36 units are required in each year.

The four-year program is thematically organised. It consists of an 18-month foundations phase, with the biomedical sciences theme Knowledge of Health and Illness (KHI) having the most curriculum time and weight; and equal time with the two themes of Doctor and Patient (D&P) and Health, Professions and Society (HPS). A transition 12-week block at the end of Year 2, Introduction to Clinical Practice, is an integrated practical and theoretical introduction to clinical work. The final two years of the program involve clinical immersion with additional Health, Professions and Society content in each semester.

Figure 3: Overview of the program structure, 2014



The program is of sufficient duration to provide students with adequate learning opportunities to meet the defined graduate outcomes.

The team explored whether the introduction of the Advanced Studies program of research across the four-years of the program (detailed at Standard 3.2) would impact on the duration of content or clinical time. It understood that topic teaching in Years 3 and 4 would not be reduced, and that clinical placement time would not be reduced.

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.

The curriculum content is comprehensive and well-integrated. The topics taught by semester in 2014 are displayed in Figure 5.

The AMC Graduate Outcome Statements for the domain of Science and Scholarship are satisfactorily covered by the content presented in the Knowledge of Health and Illness theme and the Health Professions and Society theme. In Adelaide, biomedical sciences are taught within the School and the interactions between staff were positive with closely located laboratories. In the NT, some material is delivered by staff from the Charles Darwin University biomedical departments while other teaching sessions are streamed from the Adelaide program, with NT students visible to the lecturer and able to actively participate. The content, assessment and feedback for this program are standardised.

The team was aware of student concern about the biomedical science teaching in Year 1 of the medical program in the NT, including the quality of the video-conferenced lectures, and the standards of basic science knowledge of the NT cohort. The School had addressed this by improving lecture quality and interaction, and ensuring student academic support from CDU staff. The team was reassured by these actions and considered that updates on NT student biomedical science outcomes should be included in future progress reports.

Figure 4: MD program 2014 by semester

	Semester 1	Semester 2
Year 1	Knowledge of Health and Illness 1A 9 Units Doctor and Patient 1A 4.5 Units Health Professions and Society 1A 4.5 Units	Knowledge of Health and Illness 1B 9 Units Doctor and Patient 1B 4.5 Units HPS 1B 4.5 Units
Year 2	Knowledge of Health and Illness 13.5 Units Doctor and Patient 4.5Units Health Professions and Society 2A 4.5 Units	Introduction to Clinical Performance (ICP) 9 Units HPS 2B 4.5 Units
Year 3	Clinical Performance 3A 13.5 Units Health Professions and Society 3A 4.5 Units	Clinical Performance 3B 13.5 Units HPS 3B 4.5 Units
Year 4	Clinical Performance 4A 13.5Units Includes elective clinical placements HPS 4 4.5 Units	Clinical Performance 4B 13.5Units Includes elective clinical placements Professional Induction to Practice 4.5Units

A number of sciences are taught over the entire program, including haematology, immunology, microbiology, pathology and pharmacology. This content is partly contained in the problem-based learning in Year 3, though given the varied nature of the Year 3 (refer to Standard 3.4), it is not immediately clear how the science content is covered in the clinical years (curriculum integration discussed at Standard 3.3). The team learned that some older problem-based learning (PBL) sessions would benefit from review, and given that the PBL and streamed sessions are key methods of content delivery, it is important that these are reviewed and up-to-date. The team expected that completion of the Online Curriculum Framework project would assist users to access curriculum details.

The AMC domain of Clinical Practice is covered by the program's Doctor and Patient theme which includes early clinical skills teaching and clinical immersion courses in Years 1 and 2. The comprehensive Introduction to Clinical Performance block in the latter half of Year 2 was highly valued by students. In Years 3 and 4 students are predominantly engaged in clinical settings, supported by an academic program of lectures, tutorials and workshops.

In Year 3, the program provides a diverse range of immersion clinical learning experiences in metropolitan, rural and remote clinical settings that are highly valued by students (detailed at Standard 3.3 and 4.1). There is a Transition to Internship module in Year 4. In Year 2 Introduction to Clinical Performance (ICP), students must complete an obligatory clinical skills passport to monitor clinical learning and acquisition of clinical skills, prior to sitting the Year 2 OSCE. The team considered the focus on reflective assessment in Years 3 and 4 through Mini-CEX and In-training progress reports to be valuable for students.

The AMC Health and Society domain is covered mainly by the Health Professions and Society (HPS) theme. The content and organisation of this theme has undergone significant recent revision with the introduction of the Advanced Studies stream.

The AMC domain of professionalism and leadership is taught within the Health Professions and Society theme, with a significant element in the Introduction to Clinical Performance in Year 2. In Year 4 students complete the Professional Induction to Practice topic. Students valued their early introduction to clinical environments, and the School's clear expectations of professional behaviour.

There is an extensive curriculum content list of aspects of professionalism as taught in the Health Professions and Society theme, and the curriculum mapping project underway will indicate where these outcomes are achieved following the introduction of Advanced Studies.

Students have a number of opportunities for leadership, ranging from the responsibility for learning that patient-based learning involves, helping students in years below them, and through student representation. The team noted the active role that students have had in leading student mental health and well-being initiatives. The community engagement programs encourage leadership, and there are also formal mechanisms to assist students to present at conferences.

Advanced Studies stream

The Advanced Studies stream in the Health Professions and Society (HPS) theme commenced in Semester 2 of Year 1, 2014 and will be rolled-out over four years. The first students to complete Advanced Studies as part of their MD will graduate in 2017. It consists of 18 units spread across the program (N.B. a full year of study is 36 units) and the School advised Advanced Studies will enhance existing research and scholarship opportunities while introducing new opportunities for clinical research and coursework topics. As noted at Standard 1.3, this change was approved by the University Senate.

A summary of changes with the introduction of Advanced Studies stream is shown:

	Advanced Studies stream	Overview of changes
Year 1	Semester 2 is now the 4.5 unit HPS Advanced Studies Research Foundation Course. It harmonises the existing research methods/skills content, adding an increased focus on research methodologies. Students also develop a research stream or coursework topic of interest.	Re-design of existing HPS research content across Years 1-3 into the Year 1 Advanced Studies Foundation course. Public Health moved to HPS 1A, includes Occupational health. Some changes in teaching methods (i.e. move to flipped classroom) and integration of topics. Discontinuation of the Year 1 elective.
Year 2	In Semester 2, students begin the Advanced Studies research topic OR elective postgraduate coursework topic. Programmatic assessment portfolio introduction after 2015.	Health Psychology moved to Doctor & Patient; Pharmacology moved to Knowledge of Health & Illness; Cultural Safety integrated into Medicine and Culture. Discontinuation of the reflective professionalism exercise after 2015.
Year 3	Continue Advanced Studies research topic OR elective postgraduate coursework topic. (No additional time allocated, but Programmatic assessment for learning to be introduced, and barrier exams removed so expected to allow for research time).	Reflective professionalism essay discontinued as replaced by programmatic assessment portfolio. Ethics and Law essay discontinued as topic covered in existing presentation. School expects no change to clinical immersion time given change to programmatic assessment, and less study time needed for exams.
Year 4	Advanced Studies Portfolio consisting of: - A reflective journal, AND a Peer reviewed research paper/journal article or Peer-reviewed presentation; OR -Evidence Based Medicine (EBM) Project, AND a Clinical Audit. Complete a capstone clinical project to be presented at a whole-of-School colloquium.	HPS assessment remains essentially the same but now linked to the Advanced Studies research project / coursework. The reflective professionalism portfolio discontinued and programmatic assessment portfolio to replace.

The changes to the Health Professions and Society theme largely involve restructure of content, with the move of a number of topics to other themes, and discontinuation of reflective professionalism exercises that the School advised would be included in the programmatic assessment portfolio. To make space in the curriculum, research content from other parts of the program had been consolidated in the 2014 Year 1 Foundation course, and modifications had been made to teaching and learning methods.

In Year 2, students begin either an Advanced Studies research topic, or an elective postgraduate coursework topic, and they continue this topic until completion in Year 4. In Year 3, there was no change to the Year 3 clinical immersion or Health Professions and Society time, and no specific dedicated curriculum time for the Advanced Studies work. In Year 4, students undertake the existing topic on clinical audit and evidence-based medicine, that will be thematically aligned to the student's coursework or research theme, and complete a capstone clinical project to be presented at a School colloquium.

The team had concerns that the introduction of Advanced Studies in Year 3, 2016 requiring research project work without specific dedicated curriculum time, and no change to the Year 3 clinical immersion or Health Professions and Society time, may reduce clinical contact and experience in Year 3, and may limit achievement of the Health Professions and Society objectives.

The School explained that with the introduction of programmatic assessment and removal of Year 3 barrier exams, students would require less study time in Year 3, they expected there would be less student absences due to studying, and students could therefore allocate this time to their Advanced Studies without impacting on their clinical placements. However, some clinical attachments (e.g. Onkaparinga) require detailed documentation of consistent attendance, and at least in this setting, it seems likely that increased time for Advanced Studies will reduce students' clinical contact time.

The team acknowledged the potential benefits of an earlier introduction of programmatic assessment in Year 3 in encouraging students to remain engaged in clinical experiences throughout the academic year, and supported the School's proposal to introduce programmatic assessment in 2016 to both Years 1 and 3 (also refer to Standard 5).

Advanced Studies appeared to be well-received by students and researchers, with capacity for expansion and an abundance of research opportunities available for students. It will further enhance the aspect of scholarship in the curriculum. The School has designed measures to evaluate the implementation of Advanced Studies from 2014.

While the team was supportive of the Advanced Studies changes, it recommends that the implementation of Advanced Studies be closely monitored with regard to clinical contact time in Year 3 at all sites, clinical skills assessment outcomes, and student achievement of the graduate outcomes in the Health Professions and Society theme in particular. The team recommends that the School report on this monitoring and any steps taken to ensure maintenance of all these important aspects of the program.

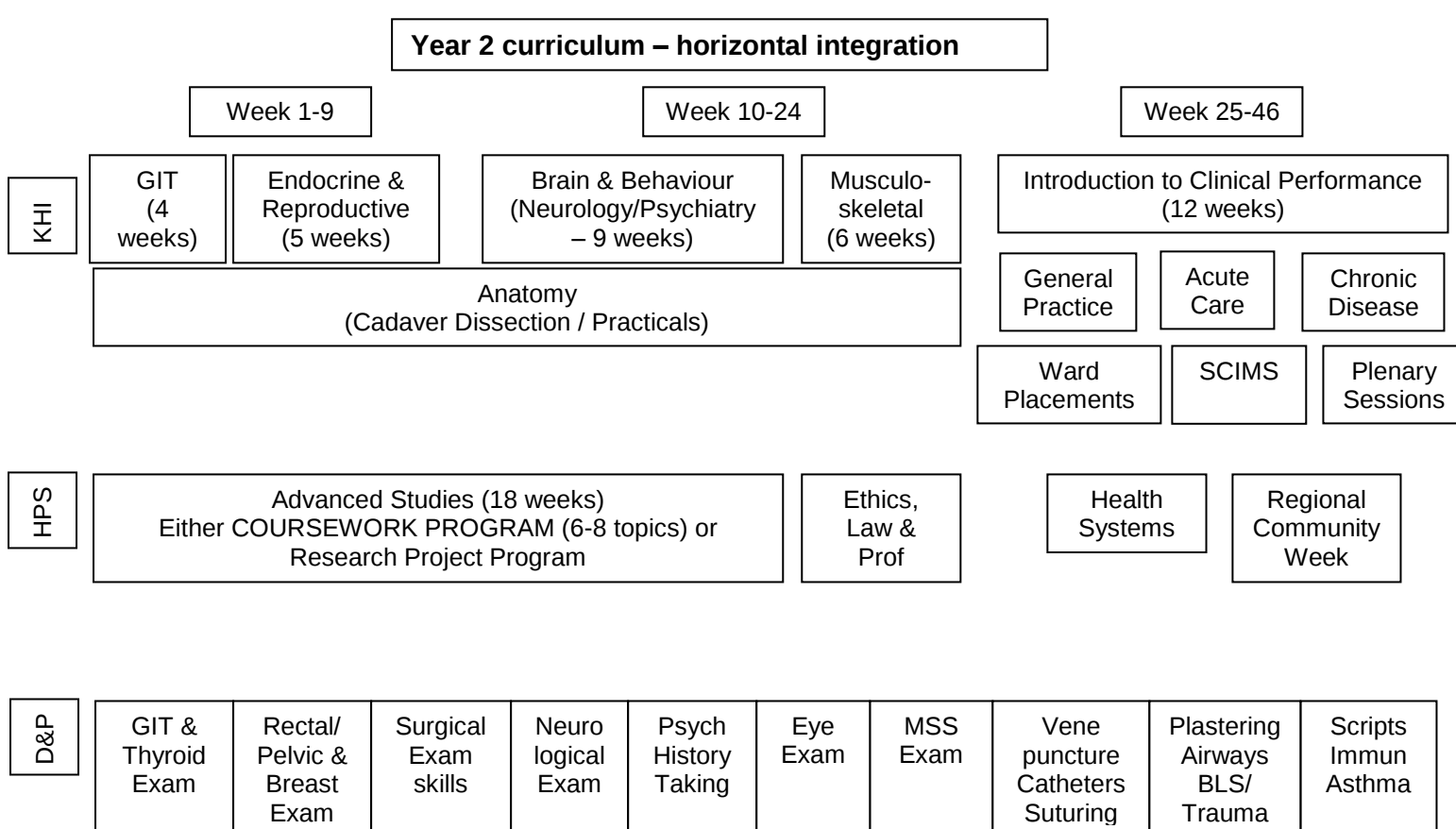
3.3 Curriculum design

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

The School has three key principles of curriculum design, being integration, adult learning and supported self-directed learning. The curriculum design is purposeful and is linked to the School's values.

In Years 1 and 2, the three major vertical themes are integrated into the weekly problem-based learning (PBL) case, and the relevant Doctor and Patient and Health, Profession and Society sessions include related content. An example of Year 2 integration is provided in Figure 6.

Figure 5: Year 2 curriculum - horizontal integration



The School had responded to student requests for greater alignment between clinical skills and anatomy sessions in

Years 1 and 2 by relatively minor timetabling changes. The resulting greater horizontal integrations between PBL topics, Knowledge of Health and Illness, and clinical skills sessions were appreciated by students and PBL tutors.

Vertical integration of the basic sciences was less clear in Years 3 and 4. The application of knowledge is the key feature of these years and prompts for this learning come from

the Year 3 PBLs. Students and some clinicians expressed concern about the details of the curriculum material as PBL delivery was not consistent across sites. Although students have access to the Years 1 and 2 basic science resources through Flinders Learning Online, there did not appear to be a systematic process to ensure that students revisited relevant basic science concepts. While the completion of the curriculum mapping project will assist staff and students better understand where concepts are integrated through the program, the team recommends that the School reflect on how best to integrate basic science concepts into Years 3 and 4.

The School has a reputation for innovation in curriculum design and delivery and the team noted the changes and innovation over the last ten years. The support for innovation and the enthusiasm of core staff is matched by a scholarly approach. The School's successful integrated longitudinal clerkships (summarised in Figure 7) are an example of its innovation.

Figure 6: Clinical placement design

- Traditional hospital block rotations in Flinders Medical Centre and the Repatriation Hospital (around 65 - 70 students per year)
- The Parallel Rural Community Curriculum (PRCC) which is a community-based medical education program placing students within rural South-Australian community general practices to learn within the context of regional health services and the broader community.(around 30 - 35 students per year)
- The Onkaparinga Clinical Education Program (OCEP) is a 'mixed' program centred at Noarlunga Health Service in outer metropolitan Adelaide and the regional general practices, which provides a mix of traditional hospital block rotations and community-based medical education. (around 23 students per year)
- The Northern Territory Medical Program (NTMP), which also provides a mix of hospital rotations and rural community-based medical education based either in Alice Springs, Darwin, Katherine or Nhulunbuy. (around 25 -30 students per year)
- The new Longitudinal Integrated Flinders Teaching (LIFT) pilot, providing a small group of students with a longitudinal experience of Year 3 clinical disciplines, applying the principles of the PRCC program to a tertiary hospital context (around 12 students per year).

The Parallel Rural Community Curriculum (PRCC) is the most sustained community-based medical education program in Australia. It commenced in 1997 and caters for around 30 – 35 students over 40 weeks at five rural sites in general practice and rural hospital experiences. The strengths of PRCC include continuity of supervision and students' active role in patient care.

PRCC has fostered further innovative work in integrated longitudinal clinical education programs: the Onkaparinga Clinical Education Program (OCEP) and the Longitudinally Integrated Flinders Teaching program (known as LIFT) at Alice Springs and Adelaide.

OCEP takes around 23 students per year who do two 20-week placements. Students undertake five four-week placements at Noarlunga Hospital, an outer metropolitan community hospital, in medicine, surgery, psychiatry, paediatrics and women's health. Students also spend a further 20-week attachment where each week they are attached for four sessions in general practice, two sessions in the emergency department, and

two private specialist sessions. The team noted the positive student and clinical feedback about the Onkaparinga Clinical Education Program and congratulates the School on this successful model.

The Longitudinally Integrated Flinders Teaching or 'LIFT' program pilots apply longitudinal principles of the Parallel Rural Community Curriculum to a tertiary hospital context for around 12 students per year. Students have inpatient contact by following patients through their health-care journey, and also participate in general practice one afternoon a week for 16 weeks. While there have been some difficulties in implementation, these have been acknowledged in proposed modifications for 2015 based on careful evaluation and feedback. The team considered that the LIFT student experiences were at least satisfactory, and overall less pressured than in several other settings in Australia. There remain questions about the feasibility of wider implementation of LIFT, given the structure of hospital units and updates should be included in future progress reports.

The NTMP model in Year 3 is similar to OCEP, with five four-week rotations at Royal Darwin Hospital, and 20 weeks in either a Darwin community setting; or in remote clinical settings in Katherine, Nhulunbuy or Alice Springs. Alternatively, NTMP students may undertake the Alice Springs LIFT program for 40 weeks, attached to preceptors in the Year 3 disciplines and Indigenous health.

For the program overall, there is significant articulation with subsequent stages of training through working in the same facilities and with similar or the same supervisors in postgraduate training as in basic medical training. Students and alumni perceive they are well-prepared for clinical work.

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.

There are documented Flinders Medical Graduate Outcomes and broad learning objectives for each course identified in its Statement of Assessment Methods document across all years.

In Year 3, students also have a Student Clinical Experience Checklist booklet outlining key presentations and conditions, and skills and procedures. There are course specific handbooks for some clinical rotations. Students at the various dispersed clinical sites may have different contextual learning experiences to achieve these same outcomes, and may have 'value added' learning opportunities: an impressive example is the well-received CUBE program at Noarlunga. The different pathways to achieving identical curriculum learning objectives appeared not clearly understood by some students, staff and clinicians.

The School had changed the structure of the problem-based learning (PBL) sessions in Years 1 and 2 so that learning outcomes are now provided at the beginning of each new

case (details at Standard 4.1). In Years 3 and 4, the PBL (or case-based learning in some settings) aims and structure varied across sites and rotations, making it difficult for students to rely on these as a guide to expected learning outcomes.

Overall, communication of learning outcomes to students, and the clarity with which the necessary aim (program equivalence) was explicated, and in fact met, was satisfactory. However, communication of learning outcomes to all staff, especially non-University clinicians, across the variety of dispersed sites was challenging and appeared to vary in its success. As many clinicians in Adelaide were Flinders graduates, they feel they know what is required of students, even if it is not explicit. There is a danger in this presumption that newer initiatives are not adequately captured. Alternatively, clinical teachers in Darwin had lists of objectives but were not aware of how these related to the overall curriculum or its presentation over time, and some felt they did not have direction on discipline-specific curriculum content. The regular clinical conferences and the Year 3 assessment retreat are an important mechanism for communication but the School may wish to consider how such key information can be delivered to those staff, particularly non-University clinicians, who do not attend these meetings.

The School is encouraged to improve communication and access to information for all teaching staff regarding learning objectives at all stages of the program. When the curriculum mapping project is completed it should provide the clarity that students and some clinical staff are missing, allowing staff and students to interrogate the curriculum and identify the relationships between graduate outcomes, unit learning outcomes, and assessments. However, reliance cannot be placed on all staff appropriately interacting with this map, particularly non-University clinicians.

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).

The School is a leader in Indigenous health teaching, embedding such teaching into the curriculum and meaningfully engaging with the local community and Elders. The team commends the leadership of the School in this, and noted the quality and contribution of staff from the Poche Centres.

The School had adopted a cultural safety framework that informs the teaching of Indigenous health, and students have exposure to, and teaching about the Indigenous understanding of health.

There is clear Indigenous health curriculum content outlined in the Health Professions and Society (HPS) theme in Years 1 and 2, delivered through lectures, seminars, tutorials and PBLs. Following the introduction of the Advanced Studies program, Cultural Awareness will be delivered under the HPS module of Medicine and Culture.

There did not appear to be a common set of learning objectives for Year 3 and 4 Indigenous health, although there are three related core PBLs for Year 3 students. The

School expected that once its Online Curriculum Framework was complete, this would reveal any areas requiring development.

Students indicated that there were some long term concerns over the content, teaching and assessment in the Indigenous Health and Culture component of the Health Professions and Society topic. There was significant concern about the teaching of Indigenous health in Years 1 and 2 in a safe manner for all students. International students' lack of background knowledge about the history of Aboriginal people was seen as problematic. The team were unclear whether Indigenous health was being contextualised as a specific health issue or viewed from a population and cultural diversity perspective.

The team was advised that the context in which Indigenous peoples are included in problem-based learning at times was seen as unintentionally resulting in marginalisation and stereotyping of Indigenous people. There is an opportunity to engage with experienced Aboriginal staff within the School, across the University, and in associated groups to work with PBL authors to improve this aspect of the program.

The team recommends that the School establish a review to refresh and invigorate the Indigenous health content, cultural awareness, and cultural safety within the program and the School. This review would also provide an opportunity to further improve communication with all students through consultation and discussion.

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.

Students have good breadth and diversity in their choice of studies and experiences. Examples include the diversity of the clinical learning environments in Year 3 and the choice in Year 4 regarding the two six-week electives. The Advanced Studies program will allow students to pursue research or coursework studies of their choice. This will however, replace the current Year 1 elective.

The NT preclinical electives are theoretically available to all students, although there are significant physical barriers to students in NT accessing electives at Flinders main campus. On site at Charles Darwin University, only pathology and biochemistry electives are available, compared with over nine options in Adelaide. The team encourages the School to consider solutions to expand options for NT students, particularly given the resources at Charles Darwin University and the good videoconference facilities available there.

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.

The School is committed to continuing its heritage of educational innovation through exploring more effective ways of providing medical education; evaluating their effectiveness and using this information to further develop the innovation. This process demonstrably acknowledges the challenges encountered and actively seeks alternative implementations to achieve educational objectives.

In Years 1 and 2, the School uses a variety of teaching and learning methods in alignment with the educational principles of the program. For Semesters 1 – 3, there is a weekly problem-based learning (PBL) case. There is anatomy lab teaching in both Adelaide and Darwin using models, wet specimens and dissection. The team was impressed with the tele-teaching technology for dissection, and with the touchscreen self-directed dissection tutorials observed in Darwin. Clinical skills teaching in small groups or workshops encompass a range of methods, such as standardised patients and peer-to-peer learning, with opportunities for self-assessment. In Year 2, Semester 2 students undertake a series of Structured Clinical Immersion Modules (known as SCIMs) and some clinical placements. Health Professions and Society topics are incorporated into PBLs, and there are lectures, seminars, and group work.

In response to student feedback on the former model of PBL, the teaching model had been revised. The full case, including learning objectives, is available to students at the outset of each PBL, rather than being progressively released during tutorials; tutorial time had been reduced and a final session with a discipline-specific specialist had been added. Providing the full case at outset is intended to better assist students identify the relevant learning objectives, and the final session is intended to help students generalise their learning to other related presentations. Students reported that this change helped focus their learning. The revised model is being evaluated.

The team was advised of some reservations about the pedagogical basis for the changes and concerns that some students were not engaging in hypothesis generation and testing in the same manner as under the former system. This suggested that some tutors were not well apprised of the basis for these changes. Students advised that there has been longstanding variation between the styles of different PBL tutors, particularly in relation to the extent to which they guide discussion back towards the learning objectives for that PBL. “Off-track” discussion is perceived as wasting learning time, particularly when this occurs repeatedly. Further communication with both students and tutors on the pedagogical process and its execution appeared indicated.

In Year 3, there are five different types of clinical learning programs that are designed for different health service contexts, while each having the same core curriculum and assessment. At Flinders Medical Centre, students undertake eight-week rotations,

whereas in the NT and at Onkaparinga, five four-week rotations are undertaken. The NT staff and students find this to be too short for students to maximise their learning. Year 4 was organised as seven clinical placements of six-weeks each.

The School has significant capacity in eLearning to develop appropriate resource material. The team understood that there is no overall strategy on the place of eLearning within the range of learning methods selected by the School as most appropriate to support student learning throughout the program. The School may wish to consider the development of such a strategy to identify the place and particular models of eLearning (and other learning strategies) that would best support its diverse curricular programs.

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.

The PBL tutorials provide students with encouragement for self-directed learning. There are several structured opportunities for self-reflection during the program, particularly within the Health Professions and Society module in Medicine and Culture, and Ethics and Law modules, and during experiential clinical skills sessions. Students are encouraged to use electronic resources on Flinders Learning Online to extend their learning.

The introduction of the Advanced Studies stream will provide students with structured support around self-directed learning related to their chosen research project.

4.3 Clinical skill development

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

Students are introduced to clinical skills throughout the first two years of the program, with a particular emphasis on this in the second semester of second year, before undertaking the clinical attachments that form the majority of Years 3 and 4.

The team was particularly impressed with the adoption of a mastery model of remediation in the clinical skills course, particularly related to communication skills. Year 1 students develop personal learning objectives that are tracked across six assessment points in Year 1. Students undertake self-assessment, receive feedback and if required, remediation is provided by the tutor or clinical skills lecturer until the required standard is met.

The ward-based component of the transition to practice program is greatly valued by students, who expressed a wish that the balance between theory and practice in this program could be reviewed, in favour of more practice.

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.

The School has placed particular emphasis on the strengths of a longitudinal integrated model in developing and providing assurance of competency in clinical skills among its graduates, and the success of the rural immersion programs attest to this.

Students advised that a number of other attachments, including community placements in the Northern Territory and the rotations at the Repatriation Hospital were highly regarded for the opportunities they provided for students to develop their clinical skills in a supervised setting. The Palmerston student-led clinic in Darwin enables the student to see the patient first, take a full history and make a diagnosis before being joined by their GP supervisor. Returning patients book in to see the same student, and students can also follow their patient to hospital. Students highly valued this responsibility.

4.5 Role modelling

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

The School values role modelling as one of the key elements of its educational program. Its intentional policy to 'remain small' by creating additional smaller teaching groups aims to promote student-supervisor mentorship and role-modelling.

Students considered that senior staff generally modelled a high standard of professional behaviour. Some students were critical of some junior staff assigned to assist their clinical skill training sessions who were repeatedly unable to discharge these commitments. It was unclear to what extent this represented competing clinical duties and whether this could have been avoided through more effective scheduling. The team noted the School's intention to better support these teaching sessions.

The team was impressed by the commitment of those researchers engaged in supporting the research component of the Advanced Studies program and considered that this bodes well for a highly supported and positive experience of both basic and clinical research for students.

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.

The emphasis on retaining the focus on the patient, rather than the problem, from the earliest stages of the program is an aspect that is particularly valued by graduates. It is also reflected in the revised course outcome statement and in year objectives, and in the pedagogical focus on patient/person-based learning. It is further reinforced by the Continuity of Care project in Year 3, in which students follow a patient for five months.

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.

Students have experiences of working with and learning from a diverse range of health professionals throughout the program, and particularly on clinical placements. As in many other medical schools, joint learning with other health professionals is limited at present. However, the School is to be commended for providing several innovative interprofessional learning opportunities for students, particularly in rural and remote settings through the allocation of dedicated interprofessional learning facilitators at the Rural Clinical School sites.

The new VITA Centre in Adelaide, a fourth generation rehabilitation centre comprising long-term, short-term, transitional care and rehabilitation places, appeared to offer an outstanding opportunity for students from a number of health professions to engage in joint learning experiences.

The Faculty has commenced the development of a strategic plan for delivery of interprofessional learning and this is welcomed. This is commencing with an audit of the diverse range of interprofessional learning opportunities across the medical and other programs and the multiple professional accreditation standards that must be satisfied in delivering such education. Updates in progress reports on the evolution of this initiative would be of interest.

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.

The School was in the process of making important changes in assessment, moving from an 'assessment of learning' approach to a 'programmatic assessment for learning' approach.

In 2012 the Dean established an Assessment Standing Committee to ensure quality of assessment in the program. The Committee reviewed assessment practises and consulted with staff and students at all School sites.

The two main recommendations arising from the review were that there should be a program-wide renewal of assessment to introduce programmatic assessment for learning, in line with current trends in medical education; and that progress testing should replace barrier and supplementary examinations in order to reduce student stress, provide feedback on learning, and support greater balance between the assessments of knowledge development, and of clinical skills, in progress decisions.

The concept of programmatic assessment for learning had been endorsed at all levels of program management and incorporated plans for a centralised assessment data management system, student monitoring of progress towards graduate outcomes through learning reports, and the employment of learning coaches for students. An ongoing cycle of evaluation of the assessment systems is embedded in the new assessment approach.

In August 2014 funding was approved and a project management group was established to develop the Centralised Assessment Data Management System, an assessment database system that will serve as a repository for student assessment data, and will be connected to, and aligned with, the Online Curriculum Framework (hosted in the University web-based Learning Content Management System, also known as FLEX) being developed within the School. The School expects that the assessment database will be completed and implemented at the end of 2015. The intention is that students and staff should be able to explicitly link learning outcomes, curriculum content and assessment.

In 2015, the focus is on preparing for programmatic assessment with implementation in 2016 for students entering Year 1, and then progressively until fully implemented across all years of the program in 2019. The implementation plan remained under discussion, and may be modified to introduce it to both Years 1 and 3 in 2016 given

concerns from students in later years of the program that they may miss out on educational benefits if the program were rolled out in the intended year-by-year fashion. The final implementation plan, and its evaluation, should be included in future progress reports.

There was significant support for the change amongst most staff and students, however some Northern Territory clinicians expressed concern regarding adequate resourcing and time demands. The team commends the School on its detailed review of existing assessment methods, its thorough implementation plans for programmatic assessment for learning, and its plans for ongoing quality assurance in assessment. This change is firmly based on evidence from current educational literature and demonstrates an admirable focus on formative assessment, meaningful student feedback, and whole-of-program assessment.

Assessment and progression requirements are outlined in Statement of Assessment Methods forms for each course topic, and in the program's Exam Board Guidelines. These are available to staff and students via Flinders Learning Online.

The Statement of Assessment Methods documents include topic and workload expectations, details of assessment activities, and assessment alignment with learning outcomes of the topic. They are posted on Flinders Learning Online during the first few weeks of each semester.

The Exam Board Guidelines apply to the Year 1 and 2 Board, and the Year 3 and 4 Board. The guidelines define the composition and function of the Board, the process for determining results and grades, and rules for student progression and supplementary assessment. The team commends recent changes to the guidelines with respect to the explicit support for students who have failed examinations, including how and when they will be informed and who will provide student support.

The University has Student Related Policy and Procedures on Review of Student Progress that are implemented via the Faculty Student Progress Committee. The policy is available on the University website. This did not appear to be clearly understood by all staff, with confusion among some Northern Territory clinicians regarding University policy in determining student progress and appeals. For example, clinicians were baffled when students they had failed continued to progress in the program (not understanding the authority of exam boards to overturn pass/fail decisions nor the student appeals process). Clinicians were also confused by the University policy of only allowing students to repeat the failed subject, particularly when they felt the student would benefit from repeating the entire academic year. The team recommends the School address communication with staff around assessment outcomes in this regard.

The program contains numerous formative assessment opportunities which are not compulsory and were variably utilised by students. It was a concern that there was no compulsory knowledge-based formative assessment throughout the program (particularly in Years 1 and 2). The onus is then primarily on students to approach staff for assistance after formative assessment. Quizzes will be compulsory from 2015 and

the School was determining whether the formative practice examination would also become compulsory in 2015. The team believed that formative assessments of clinical knowledge would be further strengthened with the introduction of programmatic assessment in 2016, and with the introduction of a progress testing pilot program in all years in 2015. However, review of this area for students who will not benefit from this development is recommended.

The School will need to engage in clear student communication as it moves from year-level appropriate assessments to end-of-course standard assessments. The move from the non-graded pass arrangements in Years 1 and 2 of the current assessment program to tests delivered at a final year standard is likely to provide challenging feedback for participating students.

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.

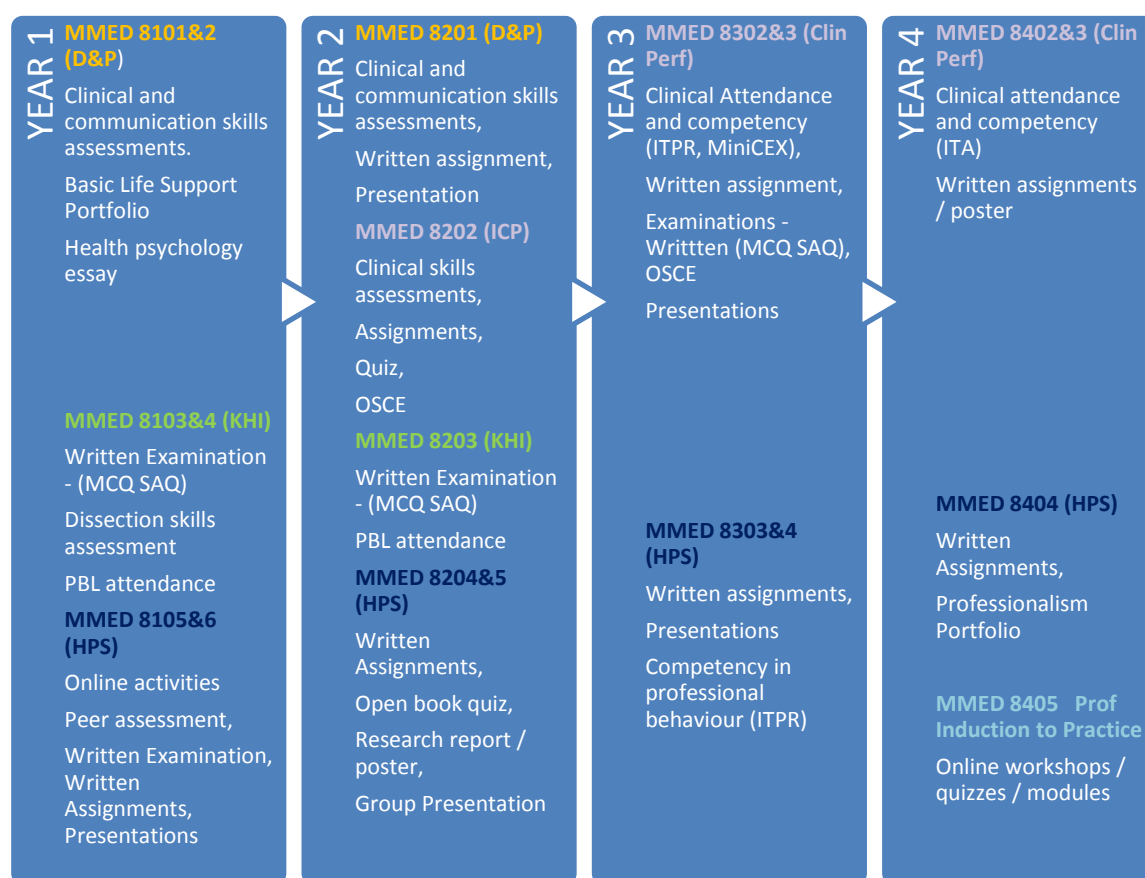
5.2.3 The medical education provider uses validated methods of standard setting.

The School uses a combination of assessment methods throughout the program designed to test both clinical skills and application of knowledge. The School's assessment review and staff / student feedback showed some criticism of the relative weighting of these two important areas, which is being addressed with the changes to programmatic assessment for learning. An overview of the summative assessments is shown in Figure 8.

Multiple-choice questionnaires (MCQ) and short-answer question (SAQ) exams are used in summative written examinations and supplementary assessments. Assignments are required in all years of the program. Standardised and real patients are used in clinical skills assessments. In-training progress reports / in-training assessments, Mini-CEX, and clinical practice assessments are used to gauge clinical skills. Group presentations, tutorial participation, oral presentations, and elective reports fill-out the assessment mixture used throughout the program.

In light of the assessment review, changes to assessment will remove barrier examinations in favour of more regular assessment of clinical knowledge, and will strengthen existing clinical skills assessments such as objective structured clinical examinations (OSCE) with feedback directed to practice domains, Mini-CEX (improved assessor training will be required) and in-training assessments and progress reports. The team considered there could be further improvement in the clinical assessments used in Years 3 and 4 (see Standard 5.3).

Figure 8: Overview of summative assessments 2014



It is likely that the implementation of learning coaches with programmatic assessment will significantly improve the students' development of personal learning plans and their skills in self-assessment. However, busy clinical staff had concerns regarding the time available to them for this role.

Years 1 and 2 assessments are designed by the teaching teams and reviewed by the topic coordinators. The Year 3 assessment retreat is used to create Year 3 OSCE, MCQ and SAQ assessments to a test blueprint and linked to the discipline common conditions. Year 4 assessment is aligned to the Flinders Medical Graduate Outcomes.

The School noted in its submission that blueprinting at a program level was underdeveloped. The new Centralised Assessment Data Management System (under development, refer to Standard 5.1) is planned to link with the Curriculum Outcomes Framework (also being developed), and these will improve mapping of content, longitudinal mapping and blueprinting of curriculum. This will also be useful in encouraging long-term retention of knowledge learnt in pre-clinical years.

Methods of standard setting (Angoff, Borderline and Cohens) are applied to appropriate assessment methods in line with current educational best practice.

The Cohen method for standard setting has recently replaced an absolute standard of 50% for Year 1 and 2 assessments. The School considered it provided advantages through compensation for variation in difficulty between exams, and no requirement

that a certain proportion of students should fail. It was implemented as the standard setting method after staff undertook a retrospective study using previous examination results to compare the Cohen and absolute standard methods. In Year 3 the Angoff method is used for the written examination (MCQ & SAQ) and is undertaken at the Year 3 assessment retreat.

The Borderline method is used for the OSCE. A global score is given in addition to a performance score using a multiple item checklist. The mean score of the borderline students becomes the pass score for the test.

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.

The team noted positive student comments about the feedback received in the Structured Clinical Instructional Modules (SCIMs), communication skills training, general practice placements and anatomy tutorials. The Flinders University Rural Clinical School program also provides students with excellent clinical skills feedback.

The team found that the non-compulsory formative assessments of clinical knowledge did not facilitate feedback for students (refer to Standard 5.1), and there was also limited feedback to students following summative assessments. The team welcomes the School's planned changes in assessment which should facilitate improved assessment feedback, though alternative feedback measures will be necessary for students remaining under the existing assessment structure.

The team suggest that the assessment of student learning in the problem-based learning (PBL) sessions be reviewed. The PBL feedback was more focused on student attendance, group interaction and generation of hypotheses rather than acquisition of knowledge (or accuracy of hypotheses).

With the introduction of Advanced Studies, new processes were under development for the assessment of competencies related to research skills for Year 2 in 2015 and Year 3 in 2016. Subsequent to the visit, a satisfactory process for assessment of competencies related to research skills for Year 2 was implemented in 2015. Evidence of the finalised assessment of competencies for Year 3 will be required. The intention to instigate processes for early detection of under-performance in both research and coursework streams is commended and finalised information on these developments is required.

The team considered that there could be improvements in defining the marking criteria for assessment, the quality of feedback and marking turn-around time for assignments in some topics. Students identified Health Professions and Society in Year 2, and

Knowledge of Health and Illness for students in the Northern Territory, and Year 4 clinical audit assignments as examples.

The newly developed guidelines for directed terms for students seen to be at risk in Year 3 or Year 4 were acknowledged. These clarify the requirements for staff when communicating student performance information to subsequent supervisors and demonstrate a real attempt to balance the need for student confidentiality with assistance for students needing extra help in learning.

The efforts of the Northern Territory Medical Program in implementing the Acting to Support Students Staying on Track (ASSIST) pilot were notable and the program evaluation will be of interest (refer to Standard 7.3).

The team acknowledged both the educational strengths and the vulnerabilities of the current policy permitting part-time study within the program. It is a challenge to maintain a balance between meeting students' sometimes complex social and personal needs while adequately addressing difficulties in knowledge and skill retention, and in equivalent clinical experiences to provide a context for learning, while ensuring that overall graduate outcome standards are achieved.

OSCE checklists are currently under revision with a plan to standardise reporting of assessment domains, allowing students to receive useful feedback after these assessments.

The team considered that feedback to supervisors and teachers on student cohort performance was an area for significant improvement and recommend that feedback on cohort performance be widely communicated to all teachers. Feedback to academic staff with university appointments and those staff members with committee representation at Flinders Medical Centre appeared extensive, but supervisors and teachers who are located away from the central university campus, particularly those who do not have a University appointment, appeared to receive much less information about cohort performance and in general found communication with the University challenging.

The Centralised Assessment Data Management System was considered by staff to have the potential to significantly address the need to better close the loop on the feedback cycle. However, the team recommend that feedback on cohort performance be widely communicated to all teachers, including those without university appointments and those with casual and sessional teaching commitments. This should also be a mechanism to highlight learning and assessment goals for the next cohort of students.

University and Faculty policy in the area of underperforming students are clear, and the quality of decision making around student progression is high.

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.

The team was impressed by the regular review of assessment practices within the school. The School's Assessment Standing Committee's role included a process for ongoing evaluation, review and renewal.

The School commenced item banking in 2013, and along with the development of the Centralised Assessment Database Management System, this will allow psychometric data from assessment items to play a more significant role in development of assessments in future years. The curriculum database will likewise improve capacity for blueprinting and is expected to deliver significant dividends upon completion.

The team noted the efforts to ensure consistency in assessment practices, processes and standards. The involvement of main campus staff at rural and NT sites in reciprocal visits for training and assessment tasks is considered an important part of work towards this standard. The process of double-marking and reciprocal marking of SAQ questions and assignments, and use of common written exam papers at different sites, is likewise an important step. The contextualisation of assessment items (e.g. using local health service forms in OSCEs at the various sites) as a way of ensuring one group of students are not advantaged to the detriment of others was acknowledged, as was the regular review of assessment outcomes to detect site specific differences.

Ensuring consistency across all sites in clinical assessment was an area for improvement. Year 3 clinical skills teaching and in-training progress reports were dependent on clinical supervisors and the effectiveness of both the Year 3 In-training progress reports and Year 4 In-training assessments were assessor-dependent.

Achieving reliability with Mini-CEX assessments was a particular challenge in the current summative assessment portfolio and the team became aware that some staff were unsure of appropriate standards and the purpose of this assessment. The team consider any approach to rectify this should be particularly directed towards adjuncts, non-University affiliated clinical staff and to non-hospital based staff, delivering education locally, including at remote and community sites, and a time that staff can attend, which may well be outside business hours for those in private practice in particular.

The procedure for clinical skills sign-off may benefit from review, as some NT students reported it possible to complete the program without achieving competence in certain skills. They also noted that the lack of a specific requirement to attend a certain number of deliveries means that students obliged to meet such requirements, sharing the same hospital placements, may receive preferential access to such clinical opportunities.

Students perceived significant variation in standards expected in written assignments and frequent contradiction between descriptive comments and grading received. Clarified criteria for assessment of assignments should significantly help in this regard.

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 the 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.

The School has a strong commitment to monitoring, evaluation and feedback, ensuring that existing practises are reviewed and evaluating innovations for efficacy and practicality.

The program is subject to strong University level monitoring and reporting structures, including the 2009 University-wide Course and Curriculum Restructure and Renewal (C2R2) program. This review led to significant changes in the unit/topic level structure of the program. These changes have generally been well received, and the challenges of ensuring compatibility between this mandated approach and the School's philosophy of curriculum integration have been identified and largely met.

The Research and Evaluation Expert Reference Group, which reports to the Medical Course Committee, has oversight of activities regarding students and staff for both program monitoring and research purposes. One of its responsibilities is the management of potential burden on students from participation in surveys. The appointment of a lead academic to the position of Evaluations Coordinator is a positive move. The Group is working with the Board of Studies to develop a quality assurance framework to assist with program evaluation and the team encourages the School in developing a comprehensive program evaluation plan.

The School uses structured feedback and monitoring to evaluate its educational initiatives. Evaluation had been used to further develop the Longitudinal Training at Flinders model in Adelaide and Alice Springs, and a formal evaluation process led to the introduction of a support program for students admitted to the program through the Indigenous Entry Stream.

The School had strong processes and systems in place for monitoring student academic progress, and this will be further strengthened with the introduction of programmatic assessment for learning. As expected, the School had an evaluation process in place to accompany these innovations, and evaluation outcomes should be included in future progress reports.

Student concerns over the lack of timely review of some curriculum content had been noted by the School, and processes put in place to address these issues. The outcome of these reviews was awaited, for example with respect to PBL content in Year 1 and 2, and on-line lecture content in Year 3.

There are opportunities for improved handling of student feedback, and feedback from non-university staff who teach in the program. Some evaluation processes were regarded as ad-hoc, and reactive to particular innovations or concerns. Student concerns regarding the early identification of struggling students are likely to be allayed with the assessment changes.

There are a number of tools used by the University and the School to collect feedback from students and staff. The main instrument used by the University, the Student Evaluation of Teaching (SET) had a modest completion rate in the clinical years. The University had provided the School with the opportunity to adapt and modify some of the questions of the SET instruments to be more relevant to the student experience, but this seemed unlikely to adequately address the challenge. It was recognised that this is a problem for many medical programs in the clinical teaching years, and the student cohort did not regard the SETs as a particularly effective means of giving feedback to the School. The team considered that a procedure and appropriate indicators for program evaluation in Years 3 and 4 is required.

The School uses additional instruments in an attempt to improve the quality of feedback. High frequency problem-based learning feedback is provided by Student Evaluation of Learning Feedback Sheets ('blue sheets'), though data from the student body indicated that many students did not feel that the "loop was closed", and would welcome greater transparency in the processes around the data collected from the blue sheets.

There are a number of instruments used in the clinical years (particularly within the Rural Clinical School) to seek student feedback; again, there may be an opportunity to further improve transparency in the processes around this data. NT students raised concern around the anonymity of surveys, given the small cohort size.

There was significant student representation at School committee level. The team applauds the efforts of the student body and School for fostering an environment where constructive feedback can inform improvement in the program. However, as identified in the student submission, wider dissemination of these improvements appeared to be problematic. It was not clear to some student representatives what information from the committee meetings was confidential and what was for dissemination. There has also been a shift in how students access information, such that social media may be more effective than publication of minutes/key decisions on a web page. The team recommends that the School review its processes for communicating with students and advise how these have been improved.

The School has extensive links with national and international medical, academic and education programs, and has regularly taken advantage of the opportunities these

links provide to evaluate and review many aspect of the program. It is a member of the Australian Council for Educational Research, a founding member of the international Consortium for Longitudinal Integrated Clerkships, and of the Training for Health Equity Network. In licensing six other medical programs to use its curriculum, its analysis of each school's context has informed the program's ongoing improvements. In assessment, the School compares itself with other medical schools through involvement in the Australian Medical Schools Assessment Consortium (AMSAC) with use of their MCQ items in Year 3 assessments, the IDEAL database (the School is a member of the IDEAL consortium), and through external observers at OSCEs (who are asked to provide comment on consistency across streams and within stations).

In the area of student exchange, the School intended to reduce the number, and increase the depth, of its relationships with partner organisations.

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 committee responsible for student selection, curriculum and student support.

The School has comprehensive mechanisms in place to review the performance of student cohorts, and presented strong evidence that the various programs have equivalent academic outcomes. In a diverse program such as this, it is essential to have a regular structured framework to document, understand and respond to variations in student performance and the team was pleased to see such a system in place. The School made changes in response to the performance of the early NTMP cohorts and continuing comparative course outcome data for this group will be required.

The School participates in the Medical Schools Outcome Database (MSOD) project, and is participating in a number of projects related to graduate outcomes, often at exit or close to exit from the program. The participation in the THEnet (Training for Health Equity Network) graduate outcome study is particularly interesting. Any correlations between academic outcomes and intern evaluation would be of interest.

The team was pleased to receive details of a planned graduate outcome survey focussed on career pathways for alumni, including a comprehensive alumni database.

The School has a comprehensive system in place for ensuring that student characteristics (and outcomes) feed back into the selection process. The team noted with interest the 'Validity of common selection criteria in predicting academic and clinical performance in medicine' project, a research project funded by the GAMSAT consortium. A summary of the findings and recommendations, and their implementation, would be relevant to include in future progress reports.

Changes proposed to selection criteria were evidence based, and the School plans to review these after implementation.

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.

There is a formal process in place for the reporting of all academic performance outcomes of students. This data is reported to the Medical Course Committee which has representation from academics and students.

As with assessment feedback on student cohort performance (Standard 5.3), it was noted that clinicians not formally attached to the University have less access to outcome evaluation results and there may be an opportunity for the School to improve its communication in this area.

The School has strong links with relevant stakeholders across all sectors, including University, Health Service, community (urban, regional and remote) and Government (Local, State and Federal) sectors. Evaluation results are made available to these stakeholders and the discussions fed back to the Medical Course Committee.

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.

The School has a stable and prescribed intake of 111 Commonwealth supported places. Prior to 2011, the School had 111 Commonwealth supported places and up to 30 places available for international students. From 2011, the School has had 111 Commonwealth supported places (25 of which are double-degree entry), 24 NT bonded industry supported places (12 of which are double-degree entry), and up to 30 places for international students. As the number of international students enrolled varies from year to year, this results in a cohort size of between 155 and 165 places. Figure 9 displays the 2014 student place types.

Figure 9: Student place types, 2014

Student place types	Quota
Commonwealth Supported Places (CSP) – Adelaide MD (86) which includes Bonded Medical Places – Adelaide (28) and Medical Rural Bonded Scholarships (MRBS) – Adelaide (4) Bachelor of Clinical Sciences/MD (25) which includes Medical Rural Bonded Scholarships (MRBS) – Adelaide (1)	111
Full Fee Paying (Industry Sponsored) – Northern Territory Medical Program, Darwin MD (12) CDU/Flinders Bachelor of Clinical Sciences/MD (12)	24
Full Fee Paying International – Adelaide	30
TOTAL STUDENT PLACES (ALL TYPES)	165

The School developed infrastructure in SA and the NT to support the increased student numbers, and the team found that there were adequate clinical placements with supervision available for all students.

The School has set quotas for its student cohort in alignment with the School's values and vision and as a result has increased the proportion of students from rural, Aboriginal, and humanitarian visa backgrounds.

The Indigenous Entry Scheme was introduced in 2010 in addition to the School's existing formal sub-quota of up to five places for Australian and Torres Strait Islander peoples using the GEMSAS application process for graduates, though the School advised that all Indigenous students admitted since 2010 have done so through the Indigenous Entry Scheme. The Indigenous Entry Scheme graduate entry pathway has an upper limit of 10 students in South Australia and 12 in the Northern Territory Medical Program. The undergraduate pathway is available to Indigenous students in South Australia and there is no upper limit on places. In the NT, there is a sub-quota of 2 places for Indigenous students in the Charles Darwin University / Flinders double degree (from a total of 12 places). Details on the Scheme are at Standard 7.2.

The number of students admitted through the Indigenous Entry Scheme since 2010 are shown:

	2010	2011	2012	2013	2014	2015
SA	0	4	2	4	3	0
NT	-	8	2	4	1	1
Total	0	12	4	8	4	1

The School is encouraged in its efforts to attract and retain Indigenous students. The role of the School's NT based Aboriginal and Torres Strait Islander Advisory Committee includes a focus on developing Indigenous students' interest in science and health careers early in their schooling across the Territory.

The School has developed and extended its program into the Northern Territory to educate and retain medical practitioners locally and is to be applauded for this. From 2011, the full program has been offered in the Northern Territory. The funding agreement with the NT Government continues to prioritise admissions for the 24 industry-sponsored NT bonded scholarship places, giving preference first to NT Indigenous residents, then NT non-Indigenous residents, then non-NT Indigenous residents, and finally non-NT and non-Indigenous residents.

The School confirmed that students who fail a year (or in some documented cases, multiple years) can continue in fully-funded places on an ongoing basis if they remain enrolled in the program.

There is a formal 25% rural student sub-quota of the total number of Commonwealth supported places, bonded medical places and medical rural bonded scholarships, and the School has retained the sub-quota of four places for the Parallel Rural Community Curriculum for rural students to spend the whole of Year 3 in the Riverland. The rural student sub-quota has been met each year since 2012.

The School trialled a humanitarian visa sub-quota of one to two students for admissions in 2014 as potential applicants were unlikely to be competitive given the GAMSAT cut-off for non-sub-quota positions. The School advised subsequent to the visit that a permanent sub-quota of four humanitarian visa places was approved for 2015. The team encourages the School in its consideration of this underserved group and its suggested consideration of extending to other communities and populations of need.

The international student sub-quota will remain at up to 30 students per year. The School had converted 10 of its graduate entry places to undergraduate entry double-degree places from 2015, and from 2017 the international student graduate-entry intake will drop to 20 to accommodate the 10 international students transitioning from the Bachelor of Clinical Sciences into the MD. Prospective international students are advised in briefings that there is no guarantee of an internship, and formal contracts with international students state that internship is not guaranteed.

The School ensures support for students on its targeted-access schemes; with excellent supports in place for rural and Indigenous students. The School is encouraged to develop appropriate additional support for other groups of students including international students, who may benefit from orientation to key issues in cultural safety and health service provision in Australia.

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.

Students can be admitted into the medical program in both South Australia and the Northern Territory via the graduate entry pathway, or the undergraduate double-degree.

The graduate entry selection process is hosted by the Graduate Entry Medical School Admissions System (GEMSAS) for all graduate entries except the Indigenous Entry Scheme. Three criteria are used in the admissions process: a weighted GPA from a previous undergraduate degree, results from the Graduate Australian Medical School Admissions Test (GAMSAT), and a semi-structured interview. Interview offers are primarily based on the GAMSAT score, with subsequent place offers based on equal weighting of the GAMSAT score, weighted GPA and interview score. The weighted GPA is based on grades from the final three years of the undergraduate study as the School

considered that rural and other low-SES background students may perform better in the final years, likely predicting their performance in the MD.

The GAMSAT cut-off in 2014 was 67 for non-sub-quota applicants, having risen steadily from 60 in 2010. Some students with GPAs of at least 6 in every year of undergraduate study and who do not make the GAMSAT cut-off are selected for interview. For the rural, Indigenous and humanitarian sub-quotas, applicants are automatically considered if eligible. Interviews are semi-structured with a panel of three interviewers, assessing qualities identified through consultation with the School and community. While the application system is managed via GEMSAS, final offers of places are made by the University.

The PRCC rural sub-quota has an additional process whereby autobiographical statements are ranked by a Community Liaison Committee in the Riverland. The School then offers interviews to the top seven or eight ranked rural applicants who also preference Flinders PRCC sub-quota with GEMSAS. The rural interview panel is comprised of rural academics, professional staff, students and community members. The School is commended on the outcomes of its PRCC rural sub-quota recruitment, given that over 95% of students selected in this targeted mechanism in the last 15 years have chosen a rural medical career on graduation.

The undergraduate entry Bachelor of Clinical Science / MD double-degree pathway is available to school leavers in Adelaide or Darwin, with an ATAR of at least 95 or 90, respectively being considered competitive due to the large numbers of students applying for these places. Ranking for offer of places combines the ATAR score (90%) with a UMAT-derived score (10%). Students completing the BCSi/MD with Charles Darwin University (CDU) apply to CDU via SATAC. Once they have completed the CDU Bachelor of Science they must be approved for an offer using Flinders admissions approval processes. The BCSi/MD pathway has proved popular with over 800 applications recently received for 12 places in Darwin, likely due to the guaranteed medical program entry and employment as an intern. In Darwin, there is also a domestic lateral transfer into the BCSi/MD if any initial students withdraw, to ensure that 12 students remain. Northern Territory residency students at CDU with a GPA of 5.5 or above in specified relevant courses are considered. In Adelaide from 2015, a pathway for international undergraduate students meeting requirements are ranked on ISAT scores and interviewed face-to-face or via Skype.

The international student minimum IELTS score was raised in 2014 for medical students from 6.0 to 7.0 in each sub-band. The School considered that students will complete the program with a higher level of English competency so should be able to score 7.5 if they secure an internship.

An MD Admissions review group undertook a review in 2013/14, as a sub-committee of the Medical Course Committee, to evaluate the admissions policies for all entry pathways into the program. Its report was unavailable at the time of the visit. A separate research project had been undertaken (the Solomon project) to inform the

Admissions Review. The final report was not yet complete, though preliminary results were presented in relation to student performance across sites. The team understood the School may be considering some type of prerequisite for biomedical sciences, and a weighted GPA minimum. The team recommends the recommendations of the Admissions review, and subsequent policy changes, be included in future progress reports.

The team was pleased to note the detailed review of the Indigenous Entry Scheme cohort in response to early concerns about its academic performance. Key features of the Scheme are that graduates apply direct to Flinders instead of GEMSAS, the application requires more education, work and community service information, and short-listed candidates are interviewed by a panel including an Indigenous interviewer. Applicants for both Adelaide and Darwin are then offered a two-week on-site Preparation for Medicine Program in Darwin, and from 2012 this has been followed by a ten-week online science review course ('FUELS' – Flinders University Extended Learning in Science) and MCQ exam. Applicants are then considered on a case-by-case basis for admission.

Preliminary findings from the Solomon research project identified significant differences in outcomes between Adelaide and the NTMP based on variables likely to impact performance, including being an older cohort, lower weighted GPA, lower GAMSAT Section 3 scores, with a longer time since graduation, and more students with non-science backgrounds.

The revision of selection criteria into the NTMP program from 2012 onwards appears to have been effective in recruiting students with appropriate skills to successfully meet the requirements of the program. Indigenous student selection changes have included requiring a weighted GPA of 5, an online science program, and increasing the pass mark for the Preparation for Medicine program exam and FUELS to 65%. To improve retention, the School had also made changes in academic and financial support for these students in the program, and enhanced early identification of borderline academic performance (and subsequent counselling). This is taking place in a complex trans-cultural environment and the School has increased its cultural support for these students.

The team noted some concern in the NT that selection into the NTMP for Indigenous NT students relies on permanent residency in the NT for at least two years out of the last six, or a total of at least five years since commencing primary school. NT Indigenous students who have studied interstate may be excluded from applying as a NT local. The School advised that this policy is the remit of the NT Government. The team encourages the School in seeking revision of the current restrictions on eligibility for these places as it would be expected that students with demonstrable family linkage with the NT would be desirable regardless of where they complete their schooling.

The overall NTMP 2011 cohort of 24 has had 8 students progress to final year in 2014, with a small number repeating some years. The NTMP 2012 cohort of 24 had 22 pass

Year 1 with 19 progressing to Year 3 in 2014, and the 2013 Year 1 cohort of 26 had 23 students pass that year. The improved progression of the NTMP cohorts is a positive sign that the changes to selection criteria are working. The School is encouraged in its efforts to counsel students who are repeatedly not meeting course requirements regarding their potential to meet graduate outcome requirements and consider exit pathways in accordance with University rules. The outcomes of the NTMP cohorts should be included in future AMC reports.

The School has satisfactory policies on the admission of students with disabilities and students with infectious diseases, including blood-borne viruses.

The team was satisfied that information about the selection processes is available publicly on the Flinders website. Mechanisms for appeals can be accessed first via the GEMSAS appeals process, or for any other requests, applicants can write a letter to the executive officer of the Admissions Committee. The undergraduate pathway entry process and appeals process for both Flinders and CDU is available on the Flinders 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:

- o students with disabilities and students with infectious diseases, including blood-borne viruses*
- o students with mental health needs*
- o 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.

The School is commended for its wide range of student welfare supports available at all sites, including at its rural and remote sites. Students have access to University-wide supports for health, counselling and disability services, academic skills, mentoring, careers advice and emergency financial assistance.

The School additionally provides medical students with a dedicated counselling service by appointment, located in Adelaide and available via telephone for remote students. In the NT, there is a similar arrangement and NT students can also access a private counselling company out-of-hours. Students in rural-placements are provided with details of doctors and private psychologists available to see medical students, and orientation and wellbeing programs are offered.

As noted at Standard 7.2, the University has policies and support for students with disabilities, mental health needs and infectious diseases. The School has carefully considered its processes for supporting students at risk following a student suicide in 2011. The staff have supported student-led seminars on mental health and wellbeing, and the School's Admissions Review is considering how different selection approaches can also reduce risk.

The School is piloting a program called Acting to Support Students in Staying on Track, known as 'ASSIST', in the NTMP. This program seeks to proactively identify students, at an early stage, who may be at risk of academic underperformance or misconduct, and offer support and remediation. The team noted that there is consideration of rolling this program out across the School.

The creation of an Elders program throughout the University, to support all staff and students is important to ensure Aboriginal world views are privileged at all levels of the School.

Some students reported feeling culturally unsafe at times in the School. The cultural safety training, which is strongly supported by the School leadership, needs to engage all staff and students. The team encourages the School to coordinate this initiative using the expertise of its Indigenous staff in South Australia and the Northern Territory.

There are comprehensive learning supports in place for Indigenous students. All Aboriginal students have ITAS tutoring to assist with studies. In South Australia, the Poche Centre at the main campus works closely with the Centre for Indigenous Adult Education providing students with access to services including advocacy, cultural support, and scholarship assistance. Support initiatives include a study buddy system with non-Indigenous students keen to assist their Aboriginal peers; the black coffee club which meets a couple of times a month for informal social and academic support; and the FAME Indigenous mentoring group that places Indigenous students with a mentor in private practice for the life of the program, allows ready access to their mentor and access to a future employer. There are also mentors in the program who support Indigenous students.

In the NT, there is extensive Indigenous student support available if needed, coordinated by the Indigenous Transitions Pathway team. All Indigenous students receive a bursary and have access to emergency funds for accommodation and relocation costs. There is academic support including access to laptops, tablets, apps and text-books. Students also receive a mentor, and receive extra tuition at exam time and post-exam feedback.

The current provision of extra time for Aboriginal students to complete the Year 2 Structured Clinical Immersion Modules was contentious, with some staff and students considering that no extra time should be allowed to complete a core professional competency such as a consultation. The School is encouraged to engage in further discussion on this matter with the aim of achieving a wider consensus.

The team encourages the School to manage potential conflicts of interest for support staff, which may arise through their involvement in multiple roles in a relatively small jurisdiction. The team encourages the School to ensure that no support staff have a conflict or perceived conflict of interest in discharging their duties.

Some students noted that reporting lines in the NT regarding program information could be clearer. The School advised that there are clear reporting lines for students, however some students reported confusion or slow responses and the team recommends that the School continue to reinforce correct reporting lines with students and manage student concerns.

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.

The School's Professional Behaviour and Medical Registration Committee, chaired by the Assistant Dean, Student Affairs, reports to the relevant year examination board. It considers referrals of students with problems of impairment and/or professional behaviour aiming to remediate in the case of behavioural or professional issues, though if concerns persist, the Committee reports to the relevant examinations board.

A professional behaviours interview is held with a group of three staff, selecting people who are not conflicted. The student is encouraged to bring a support person of their choice.

The School advised that it is working through challenges regarding early identification of students, including the effective transfer of information between academic supervisors regarding students who need extra support but who have not crossed the referral threshold to the Committee, and improving remediation opportunities for these students; and an appropriate exit degree for students who are academically competent but who fail the professional behaviour domain repeatedly.

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.

There is good student representation on the course committees, the year committees and the admissions committee.

The main student society is the Flinders Medical Student Society of which all MD and BClinSc students are members. Its activities may be academic, community or socially based and it caters for both younger students and mature students with families. The

Society also has a chapter in the NT. There is also a surgical society, a general practice network, a health and human rights group, and a rural health society.

Some Indigenous students did not feel 'heard' or included in some of the Student Society meetings, and were not always able to properly represent the broader student body, in part due to the number of meetings and also around the issue of representation. The team understood that the School was working to improve this with the student representatives.

Overall, the School showed evidence of taking its students' views seriously, though students across the program at times commented that the School could engage with them more effectively.

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.

The University holds insurance covering professional indemnity and medical malpractice for all enrolled students. Students on overseas placements remain covered, including Canada and North America for public liability, professional liability and medical malpractice insurances.

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.

The geographically dispersed nature of the program provides particular challenges. These had been clearly identified by the leadership of the program, and much progress had been made since the 2010 AMC visit.

The completion of a number of key teaching and learning facilities, and the provision of high-standard affordable housing for students in the Northern Territory program, was noted. Students in the NT, Adelaide and rural programs reported feeling well-supported and safe in their environments. The provision of quality simulation facilities (both high and medium fidelity) to all sites was impressive.

The physical facilities on most of the campuses are of a high standard; the new facilities in Darwin and Nhulunbuy are particularly commended. The investment made by the University at the Repatriation General Hospital was noted, including the exciting clinical and research rehabilitation facility. There are also excellent new Rural Clinical School facilities now in operation at Mt Gambier, Victor Harbor and Murray Bridge.

There are challenges at the Flinders Medical Centre (FMC) and the Renmark campus of the Flinders University Rural Clinical School. At FMC, renovations are underway in the clinical skills areas, as the incompletely renovated areas do not provide the level of sound insulation and privacy required for clinical skills teaching. When complete, it will be a significantly improved teaching environment.

The new University Health Science Lecture Theatre complex on the Flinders main campus contains superb PBL rooms; however the PBL rooms in the older clinical sciences area are inadequate. Audio-visual facilities in the older PBL rooms (in the FMC main building area) were outdated, as students advised that PowerPoint presentations could not be presented on the TV monitors in these rooms. Refurbishment of these rooms to modernise the audio-visual resources is important.

There is considerable scope to improve the student common room facilities at FMC. The small room is shared by students from a number of health science programs and is crowded, lacks adequate lighting, and is sparsely furnished. The provision of an adequate student common room facility at the FMC campus will be an important improvement in the physical amenities for students.

At the Renmark campus of the Rural Clinical School, students had concerns regarding their learning facilities and the team supports the planned renovations there. Students also commented regarding the lack of a general student area at the Repatriation General Hospital (Daw Park) in Adelaide.

The School had built a new dedicated Indigenous cultural space at the Royal Darwin Hospital campus. At the Charles Darwin University campus, the notional students' area is available for use by all students and the School was surveying Indigenous students about how and if they wish to implement a separate area.

There is an excellent standard of student accommodation in rural and remote sites, accompanied as it is by the close pastoral and academic support from University academic and professional staff.

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.

The superb videoconferencing facilities and related technical support were commended by the team. This technology was in constant use during the team's visit, and performed (with rare exceptions) excellently. The AV staff were very capable, and gave the team confidence that the student experience using video-/tele- conferencing for interaction and learning would usually be as rich as possible.

There were innovative examples of the use of ICT, particularly with the provision of anatomy teaching between Flinders and Darwin.

The further deployment of wireless internet access to all student sites will be welcomed, as students increasingly wish to bring their own devices to clinical and study areas. There were some understandable challenges in some remote and regional areas. Students in rural areas are supplied with 3G or 4G dongles for internet access in their place of accommodation. This solution was not always adequate for high bandwidth applications, and the installation of high-speed internet in student accommodation would be welcome. The team noted comments from students regarding videoconferencing difficulties at the Kangaroo Island site.

There were concerns regarding delays in staff log-on's at some remote and rural sites. This was thought to relate to the location of staff log-in profiles, and may be ameliorated by the storage of these profiles at multiple sites, rather than just at the Flinders main campus. This was understood to be a Flinders University ICT policy issue, and resolution of this issue would be welcome.

The technical and educational expertise in the area of eLearning is impressive, and enhancements to the student learning portal, Flinders Learning Online, were noted. As noted at Standards 2 and 5, the Online Curriculum Framework and the assessment

database (both under development) will be integrated with the University web-based Learning Content Management System in 2015, and a report on the progress of this important process will be required.

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.

The team commends the quality of staff at the Flinders University campus medical library. There was a high standard of service provision and resourcing, and students commented that they found the library staff supportive and welcoming. There were adequate reference materials available, and the ICT was well-used to provide these resources to all sites of the program. There is a flexible delivery service, allowing copies of articles and books not in the collection to be delivered outside metropolitan Adelaide.

The library facilities in the NT were of a high standard, with the Royal Darwin Hospital library being an excellent resource. Students were also pleased with facilities provided at Gove, Katherine, Tennant Creek and Alice Springs hospitals. Students did, however, comment on the limited access available at Charles Darwin University during its semester break when Flinders MD students are still in their examination period. The School has subsequently advised that this issue has been addressed.

At Flinders Medical Centre, the team noted increasing pressures on quiet study spaces in the Library and the re-zoning of existing space within the Library to quiet space during the examination period. Unfortunately, a number of the program's examinations are outside the usual university examination period, when these additional spaces are not available, making quiet spaces hard to find. The plan to construct additional quiet study spaces in the Library is welcomed.

8.3 Clinical learning environment

8.3.1 The medical education provider ensures that the clinical learning environment offers students sufficient patient contact, and 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.

The clinical learning environments provided by the program are generally of a high standard and provide students with both breadth and depth of experience. Students and staff (both University and non-University) provided positive feedback on the learning

and clinical opportunities available to students. There was adequate clinical exposure for students at all sites and in all the clinical placements. While not all students may encounter every discipline or clinical context there were opportunities for all students to have adequate clinical experiences to achieve the required learning objectives.

Students in Year 1 attend an 'introduction to the ward' session in their first tutorial, and later attend the theatre recovery area for airway management experience. In Years 1 and 2, students visit the wards, both with tutors and in pairs to see patients. In Semester 2, Year 2 students have a 3-4 week ward placement in the Structured Introduction to Clinical Performance course. The change in 2013 from 2 x 2 week rotations in this course caused some unease amongst students, and it will be important to monitor student feedback and performance in this area.

The team was impressed with the care taken in student placement allocation, particularly for students allocated to rural or remote placements with the perceived difficulties of isolation or educational disadvantage. The program has excellent processes in place to support students allocated to these rural or remote placements. The cohort size allows the program to tailor, to some extent, students' rural and remote experience to meet their educational and personal needs. Every effort is made to place students with nominated classmates, and sites are selected for particular students based on detailed information acquired at interview prior to allocation. The professional staff at rural and remote sites are fully aware of their students' academic progress, and provide venues for students to meet discuss and resolve issues.

The NTMP is the agreed placement coordinator for all students who undertake clinical placements in the NT. This agreement does not compromise Flinders student places. The JCU student numbers will decrease as the number of Flinders NT students increase.

In Year 3, students are immersed in a wide range of clinical settings (refer to Standard 3.3) and in Year 4, students undertake seven six-week clinical placements. In a complex and diverse program such as the Flinders MD, it is inevitable that there will be differences in opportunities between clinical sites, making it impossible to deliver identical programs at every site. The School provides an outstanding range of experiences to its students, with program equivalence defined across settings. However, continuing emphasis on this equivalence is vital for the success of the NT program as the team noted some disquiet around this issue from students.

There are varied opportunities for students to undertake clinical attachments that will expose them to working with Aboriginal and Torres Strait Islander patients. The NT program has clearly defined teaching sessions for Year 3 and an excellent range of deeply integrated opportunities in Aboriginal health in rural and remote clinical placements. Many students have the opportunity to undertake a term in Year 4 in the Northern Territory. Adelaide has a far smaller Indigenous population, and there appear to be no Indigenous health placements available. It may be more difficult for students in the Adelaide program to appreciate the holistic content of the Indigenous patient's

experience of the health system. The team encourages the School to increase Indigenous health placement opportunities for students in southern Adelaide.

There is a sound collaborative relationship with the University of Adelaide, both in the setting of student teaching in the Barossa Parallel Rural Community Curriculum and in dealing with new development in the medical research precinct in Adelaide.

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.

Each major clinical site has an academic coordinator responsible for ensuring student learning outcomes are met in the clinical placement. Each sub-site has a supervisor or clinical educator responsible for students, who reports to the academic coordinator.

The level of engagement of clinicians in student supervision was pleasing. These clinicians play a central role in teaching, assessing and caring for students and the team was impressed with their enthusiasm and expertise. At a number of sites, non-clinical and professional staff had significant roles in student welfare and mentoring, and their involvement enhances the students' clinical experience.

While the School's outreach to its clinician partners overall was inclusive and supportive, a dispersed program provides significant challenges to ensure consistent and complete communication of expected learning outcomes and assessment standards. Clinicians who are neither staff nor adjunct members of the Faculty (and they comprise a significant fraction of the supervisory teams) were found to have less communication with the Faculty on matters of curriculum, assessment and feedback. There is scope for improving communication with this group, particularly in the areas of curriculum and assessment (see Standards 3.4 and 5.3).

Students reported that they were clear about their professional responsibilities from an early stage, and understood their scope of practice and felt safe in declining to operate outside that scope.

The establishment of the Prideaux Centre provides staff with exciting opportunities to improve their teaching and supervisory skills in a world-class academic environment. The offerings of the Centre may provide a means of building on the relationships with 'non-University' staff mentioned above. The outstanding library and ICT infrastructure is another attraction for staff without university affiliation, and the team was pleased to

hear of a number of clinical teams who are encouraging registrars to apply for adjunct appointments at the University.

The School has a close relationship with its general practitioner supervisors. There are formal feedback mechanisms in place, and student comment is appropriately and sensitively handled. As noted at Standard 5, improved student feedback to adjunct and non-university staff at teaching hospitals is recommended.

The School includes clinical supervisors in its workshops, allowing supervisors to meet a number of times a year and contribute to curriculum and assessment. Supervisors can access the School's Master of Clinical Education training.

The team was concerned by consistent comments from clinical staff (particularly at teaching hospitals) in South Australia and the Northern Territory regarding the decreased time available for teaching and research, given the increasing financial and workload pressure on health services. This has an impact on supervision, teaching time and student experience. The School is encouraged to continue discussions with health services on how to effectively implement their expressed high-level commitment to supporting teaching and research. There may be scope for including teaching and research KPIs in health service evaluation of clinicians. SA Health acknowledged the fiscal challenges it is currently facing, but stated that its commitment to supporting the education of its future staff was unwavering. The program is encouraged to monitor the time available for teaching and research across its academic and adjunct staff, and report any significant changes in routine progress reports to the AMC.

There is a formal position description for all Faculty staff contributing to the program, and an overarching University document around workplace-based teaching. As ever, there are challenges in the formalisation of responsibilities of clinicians who have no adjunct or staff appointment to the University. The team noted that senior clinicians in the Units or practices usually do have such formal appointments, and take it upon themselves to communicate with their colleagues not in such arrangements.

Appendix One Membership of the 2014 assessment team

Professor Pete Ellis (Chair) BMBCh, MA, PhD, FRANZCP

Head, Department of Psychological Medicine, Associate Dean Medical Education, University of Otago, Wellington

Professor Naomi Trengove (Deputy chair) BSc (Hons), PhD

Dean, School of Health Sciences, The University of Notre Dame Australia Fremantle

Professor Amanda Barnard BA (Hons), BMed (Hons), FRACGP

Associate Dean, Rural Clinical School, The Australian National University

Associate Professor Lisa Jackson-Pulver AM MPH, GradDipApp.Epidemiology, PhD

Chair Indigenous Health / Professor / Public Health, Director, Muru Marri Indigenous Health Unit, School of Public Health and Community Medicine, Faculty of Medicine, The University of New South Wales

Dr Anna Ryan MBBS, B.App.Sc (Clin), BChiro.Sc, Dip.Acu, Grad Dip VET, Grad Cert Uni Teaching

Clinical Supervisor and Senior Lecturer University of Melbourne Austin Clinical School

Associate Professor Christopher Wright MBBS, FRACP, FCICM

Academic Coordinator, Years 3 – 5, Medicine Nursing and Health Sciences, Clayton, Monash University

Ms Stephanie Tozer

Manager, Medical School Assessments, Australian Medical Council

Ms Fiona van der Weide

Accreditation Administrator, Australian Medical Council

Appendix Two Groups met by the 2014 assessment team

Senior Leadership

Vice Chancellor

Executive Dean, Faculty of Medicine, Nursing and Health Sciences

Dean, School of Medicine

School of Medicine Executive

Associate Dean, Flinders Health Care and Workforce Innovation

Associate Dean, Flinders Medical Science and Technology

Associate Dean, Flinders Northern Territory

Associate Dean, Flinders Southern Adelaide Clinical School

Associate Dean, Flinders University Rural Clinical School

Associate Dean, Medical Course

Associate Dean, Research

Associate Dean, Teaching and Learning

Business Development Manager, Faculty MNHS

Executive Officer, Flinders University, Rural Clinical School

Executive Officer, School of Medicine

Manager Business Operations, Faculty MNHS

Manager, Flinders Northern Territory

Manager, School of Medicine

School of Medicine staff

Academic Coordinator, Parallel Rural Community Curriculum (PRCC)

Advanced Studies Coordinator (Chair)

Assistant Dean Alumni

Associate Deans of the School of Medicine Academic Units

Chair Admissions Committee

Chair, Examination Boards

Chair, NT Course Development Committee and Director, Clinical Education, Flinders NT

Course Coordinator, Bachelor of Clinical Sciences/MD program

Director Pre-Clinical Education, Flinders NT

Head, Year 3

Head, Year 4

Head, Health Professional Education

Head, Year 1 and 2

Manager, Learning Technologies Unit

Manager, Medical Course Administration

Medical Course Deputy Director

Medical Course Director (Chair)

President, Flinders Medical Student Society

President, Flinders Medical Student Society NT

School of Medicine Committees and Groups

Aboriginal and Torres Strait Islander Advisory Committee

Admissions Committee

Assessment Committee

Clinical Placement Allocation Group

Clinical Skills and Simulation Unit

Department of General Practice

Discipline Leads

Health Professional Education Unit

Indigenous student support Group

Interprofessional Learning Group

Learning Technologies Unit

LIFT team (FMC & Alice Springs)

Medical Course Committee

PBL tutor representatives

Poche Centre for Indigenous Health Adelaide

Prideaux Centre (Research for health professional education)

Research & Evaluation Expert Reference group

Student well-being group

Year 1 and 2 Committee

Year 3 and Year 4 Committee

Medical Students

Flinders Medical Students Society

LIFT program students

PRCC program students

Student representatives from all clinical sites

Student representatives from Years 1 – 4 of the program

Stakeholders

Northern Territory Health – Chief Medical Officer
Pro Vice Chancellor, Charles Darwin University
South Australian Health and Medical Research Institute
South Australian Indigenous Advisors and Elders advisory group
Southern Adelaide Local Health Network – Chief Executive Officer
Southern Adelaide Local Health Network – Director of Medical Services
Vice Chancellor, Charles Darwin University

Clinical sites

Northern Territory Medical Program

NTMP Committees and Group

Northern Territory Course Development Committee
Northern Territory Medical Program Education Team
Northern Territory Medical Program Indigenous Transitions Pathway
NT Poche Centre for Indigenous Health
NT Remote Clinical School Alice Springs

Royal Darwin Hospital

Royal Darwin Hospital Clinical Teachers
Royal Darwin Hospital Management, Director of Medical Services and Education –
Acting Executive Director Medical Services
Royal Darwin Hospital Medical Advisory Committee
Palmerston GP Super Clinic
Chief Executive Officer Flinders Charles Darwin Health
Clinical Teachers
Palmerston GP Super Clinic management

Flinders Medical Centre

Southern Adelaide Clinical School Staff
Teaching Clinicians

Onkaparinga Clinical Education Program (OCEP) / Noarlunga Hospital

Academic Coordinator OCEP Program
Noarlunga Hospital Clinical Teachers and General Practitioners
OCEP Administration staff
OCEP School teaching staff

Parallel Rural Community Curriculum (PRCC)/ Flinders University Rural Clinical School (FURCS)

Clinical Educators

Director of FURCS

GP Teaching staff

Mount Gambier District Health Services – Specialists and Clinicians

PRCC Academic Coordinator

PRCC administration staff

Repatriation General Hospital

Clinical Teachers

Southern Adelaide Clinical School Staff

Student facilities and ViTA Building

