**A quick guide on curriculum development**

The three readings provided (AMEE Guide, Bandaranayake & Newble, et al) offer some suggestions as to

* who should participate in developing a core curriculum?
* how a core curriculum can be developed (various methods)?
* criteria for developing a core curriculum.
* importance of periodic reviews of what is core

Given the current pressures we are all working under, we have distilled from these 3 readings key criteria and questions to guide our selection of **‘what is core’**, as follows:

1.Do the **Exit Level** Learning Outcomes or Competences for this **Programme or Qualification (at undergraduate- or postgraduate levels):**

1.1 Address the most common health issues and conditions that our graduates will have to work with in their professional practice upon graduation, as developing health care professionals?

1.2 Take account of what students **MUST KNOW AND DEMONSTRATE** for practice in relation to those health issues or conditions, in contrast to **WHAT THEY NEED TO RECOGNISE FOR REFERRAL PURPOSES**?

1.2.1 MUST KNOW refers to the knowledge; and DEMONSTRATE refers to skills and values. This applies to all relevant sections below.

2.Do the **Course** Learning Outcomes or Competences align with the Exit level Learning Outcomes or Competences?

3. Do the Course Learning Outcomes or Competences distinguish between **MUST KNOW AND DEMONSTRATE** and **WHAT THEY NEED TO RECOGNISE FOR REFERRAL PURPOSES in clinical years?**

3.1 An assumption is that curriculum is designed ‘backwards’ from the EXIT LEVEL OUTCOMES or COMPETENCES, that is, courses in the preceding years that make up the programme or qualification are designed to serve as building blocks to achieve the EXIT LEVEL OUTCOMES OR COMPETENCES.

3.1.1 A major implication is that all courses need to ***select only the knowledge, skills and values that are relevant and appropriate as a building block*** in the sequence of year levels to enable the achievement of the EXIT LEVEL OUTCOMES OR COMPETENCES of the Programme or Qualification as a whole;

3.1.2 Electives or Special Studies Modules can be designed as courses that AUGMENT and BROADEN the knowledge, skills and values, if the credit load for that Higher Educational Qualification Framework Level permits, for example, Health and Rehabilitation Professional Qualification Credits are a minimum of 480 credits plus the hours required by the Accrediting Professional Body; Bachelor of Sciences Honours are a minimum of 120 credits; a Postgraduate Diploma, 120 credits; MMed, 180 credits; and for the MBChB a minimum of 480 credits plus the hours required by the Accrediting Professional Body. However, MBChB being a 6-year programme averages between 720 and 980 credits, depending on the Faculty of Health Science in which it is located.

4. Are the Course Learning Outcomes or Competences **feasible** for this particular year level, that is, have students had adequate preparation theoretically and practically at previous year levels?

5. Do any other courses have similar or overlapping Learning Outcomes or Competences? If so, how can we rationalise between the courses with overlapping outcomes?

5.1 What changes to assessments need to be made to take account of overlaps and similarities with other courses?

5.2 Are there opportunities to integrate assessments across courses as a means to rationalise the amount of assessments versus administering individual assessments for each course separately?

6.Are our Assessments aligned with our Programme Level and Course Level Learning Outcomes or Competences?

7. Does our Assessment Weighting take account the weighting of topics related to MUST KNOW AND DEMONSTRATE in contrast to WHAT THEY NEED TO RECOGNISE FOR REFERRAL PURPOSES?

8. For **Emergency Remote Teaching,** have we clearly distinguished between Theory Learning Outcomes or Competences that can be addressed online, in contrast to Practice/Practical/Clinical Learning Outcomes or Competences that can only be addressed in contact mode?

8.1 Have the ways in which we have revised our courses and resourced them for this emergency remote teaching context taken sufficient account of ALL our students’ learning needs, irrespective of where they are and the conditions under which they are living and learning?

9. Does our Assessment Weighting take account of the Theory-Practice/Practical/Clinical Learning division within the course?

10. What are the most appropriate assessments? See the *Assessment Lessons* in the ‘Emergency Remote Teaching’ resource on VULA.

**References**

* Brauer, D. G., & Ferguson, K. J. (2015). The integrated curriculum in medical education: AMEE Guide No. 96. *Medical teacher*, *37*(4), 312-322.
* Newble, D., Stark, P., Bax, N., & Lawson, M. (2005). Developing an outcome‐focused core curriculum. *Medical Education*, *39*(7), 680-687.
* Bandaranayake, R. (2000). The concept and practicability of a core curriculum in basic medical education. *Medical Teacher*, *22*(6), 560-563.
* Harden, R. M. (1999). AMEE Guide No. 14: Outcome-based education: Part 1-An introduction to outcome-based education. *Medical teacher*, *21*(1), 7-14.
* Smith, S. R. (1999). AMEE guide no. 14: outcome-based education: part 2-planning, implementing and evaluating a competency-based curriculum. *Medical teacher*, *21*(1), 15-22.