SIMtegrated Care Mapping

This document provides a structured mapping of our 4 clinical simulation scenarios to the UK Foundation Programme Curriculum (2021). It also aligns each scenario to the relevant Foundation Professional Capabilities (FPCs) for both FY1 and FY2 doctors.

Each scenario has been analysed in terms of its clinical content, teamwork requirements, and the expected behaviours of foundation doctors at different stages of training.

The mapping identifies the specific FPCs that are most applicable to the learning outcomes of each simulation scenario. All scenarios also contribute to the development of the three Higher-Level Outcomes (HLO's) of the Foundation Programme:

• HLO 1: An accountable, capable and compassionate doctor

• HLO 2: A valuable member of the healthcare workforce

• HLO 3: A professional, responsible for their own practice and development

This is due to their integrated focus on clinical knowledge, multidisciplinary collaboration, communication, ethical practice, and self-directed learning—ensuring each scenario not only builds technical proficiency but also supports holistic professional growth.

1	Managing the transition of care for a patient with complex long-term conditions requiring multidisciplinary collaboration, medication optimisation, discharge planning and community follow-up.

FY1	FY2
• **FPC1** – Clinical assessment and interpretation of clinical information from multiple sources. • **FPC4** – Communicates effectively with patients regarding treatment, ongoing care and follow-up. • **FPC5** – Contributes to safe discharge, prescribing, monitoring and handover processes • **FPC6** – Works collaboratively with pharmacy and multidisciplinary colleagues	• **FPC3** – Formulates and adjusts management plans for patients with complex needs. • **FPC4** – Leads shared decision-making and management discussions. • **FPC5** – Oversees continuity of care across healthcare settings. • **FPC6** – Coordinates multidisciplinary input and escalation plans.

2	Supporting discharge and ongoing management of a patient with a long-term condition, addressing medicines optimisation, patient understanding, self-management and continuity of care between healthcare settings.

FY1	FY2
• **FPC1** – Clinical assessment and review of patients with long-term conditions across care settings. • **FPC4** – Communicates effectively with patients and carers, adapting communication to individual needs. • **FPC5** – Supports safe prescribing, medicines reconciliation, monitoring and discharge planning. • **FPC6** – Works effectively with pharmacists and other healthcare professionals.	• **FPC4** – Facilitates shared decision-making and promotes self-management. • **FPC5** – Ensures safe transition of care and appropriate follow-up arrangements. • **FPC6** – Coordinates multidisciplinary care to address ongoing healthcare needs. • **FPC10** – Contributes to education and empowerment of patients in managing long-term conditions. [

3	Managing a patient with complex physical, psychological and social needs, requiring risk assessment, safeguarding, multidisciplinary working and coordinated transitions between care settings

FY1	FY2
• **FPC1** – Undertakes clinical assessment and recognises factors contributing to vulnerability and deterioration. • **FPC4** – Communicates sensitively with patients, carers and other professionals in challenging circumstances. • **FPC6** – Works effectively within multidisciplinary teams to coordinate patient care. • **FPC11** – Recognises ethical, legal and safeguarding responsibilities in clinical practice	• **FPC2** – Prioritises and manages care for patients with urgent and complex needs • **FPC4** – Leads difficult conversations and shared decision-making discussions. • **FPC6** – Coordinates care across healthcare teams and services. • **FPC11** – Applies ethical, legal and safeguarding principles when managing risk and planning ongoing care.

4	Coordinating care for a patient with frailty, multimorbidity and increasing care needs, requiring holistic assessment, medication review and safe discharge planning.

FY1	FY2
• **FPC1** – Performs holistic assessment of patients with complex health needs and functional decline. • **FPC3** – Contributes to care planning that takes account of medical, functional and social factors. • **FPC5** – Promotes safe prescribing, medication review, handover and discharge processes. • **FPC6** – Works collaboratively with multidisciplinary teams to support patient care.	• **FPC3** – Leads development and adjustment of management plans for patients with multiple comorbidities and complex needs. • **FPC5** – Oversees continuity of care and safe transitions between healthcare settings. • **FPC6** – Coordinates multidisciplinary input to optimise patient outcomes. • **FPC11** – Applies ethical and legal principles when assessing capacity, risk and best interests.