General Internal Medicine Portfolio Pathway evidence map

A practical planning sheet for senior doctors mapping GIM Portfolio Pathway evidence against the GMC SSG. Use this with the live GMC guidance, not instead of it.

1. SSG evidence numbers to plan around

Evidence	What to gather	Planning note
ACAT	6 ACATs to level 4. Each ACAT should include at least 5 cases.	Prioritise acute unselected take and ward-round new-patient presentation.
OPCAT	2 OPCATs to level 4.	Useful for clinic, ambulatory and long-term condition evidence.
CbD / mini-CEX	8 further SLEs, mixed across different aspects of GIM.	Avoid eight versions of the same narrow clinical problem.
Procedures	DOPS or senior GIM structured report for procedural competence.	Map each procedure to logbook, DOPS and direct consultant observation.
QIPAT	1 completed QI or audit project in the last 5 years WTE.	Show completion, change and reflection, not just project participation.
Patient survey	Approx. 15 patients, plus reflection, or equivalent alternative evidence.	Collect while in a post with relevant patient-facing GIM work.
MSF and MCRs	MSF approx. 12 colleagues. 4 MCRs in last 12 months WTE.	Include medical and non-medical colleagues who know current work.

2. Procedure gap check

Procedure	SSG level / proof route	Your evidence
Advanced CPR	Leadership of CPR team.	DOPS / ALS evidence / MCR / simulation.
DC cardioversion	Unsupervised competence.	DOPS / logbook / consultant confirmation.
Temporary pacing	Skills lab or satisfactory supervised practice.	Simulation, supervised practice, course evidence.
Central venous cannulation	IJ or subclavian. Skills lab or supervised practice.	Logbook / DOPS / supervisor report.
Femoral or IO access	Access to circulation for resuscitation.	Simulation or supervised practice evidence.
Pleural aspiration	Fluid and pneumothorax. Fluid aspiration should follow BTS ultrasound expectations.	DOPS / ultrasound-supervised evidence.
Intercostal drains	Pneumothorax or effusion. Skills lab or supervised practice.	DOPS / supervised practice / procedure log.
NG tube, ascitic tap, LP	Unsupervised competence where specified.	DOPS and logbook evidence.

3. Evidence your post must generate

Evidence area	What the post needs to produce	Risk if missing
Employment letters	Dates, title, grade, type of employment and WTE percentage matching the CV.	Assessors cannot trust the timeline or level of responsibility.
Job descriptions	Department structure, title, clinical and non-clinical commitment, teaching role.	The role looks senior but the duties are unclear.
Rotas	Samples from the last 3 years showing weekly clinical and non-clinical work.	No proof of acute take, clinic, wards, admin, governance or teaching pattern.
Appraisal	Annual appraisal, revalidation portfolio, review by clinical director or line manager.	No evidence of ongoing evaluation in a non-training post.
Consultant observation	ACATs, OPCATs, MCRs, DOPS and structured reports from direct observers.	Evidence becomes self-reported or generic.
Breadth evidence	Acute take, inpatient continuity, clinic, referrals, MDT discharge, deterioration and end of life care.	Portfolio looks too narrow for GIM.

4. 90-day action plan

Window	Action
Days 1-15	Map every GIM CiP and SSG evidence type. Mark solid, partial and missing evidence.
Days 16-30	Book consultant-observed ACATs, OPCATs, procedure DOPS and first MCR conversations.
Days 31-60	Collect breadth: acute take, clinic, referral work, discharge planning, deterioration and end of life cases.
Days 61-90	Review whether your current post can keep producing evidence. If not, fix the job fit before the portfolio stalls.

Use this sheet as a live working document. The strongest GIM applications usually show breadth, recent consultant observation, cross-referenced evidence, and a post that genuinely produces the documents the SSG asks for.