Clinical Radiology Portfolio Pathway Evidence Map

Use this as a working checklist before uploading documents. Always check the live GMC Clinical Radiology SSG.

1. Evidence numbers and timing

Evidence	Planning number	What to check
Uploads	Usually no more than 150 documents	Keep evidence relevant, grouped and cross-referenced.
Reports	60 minimum, usually no more than 150	Personally generated, dated, anonymised and institution-identifiable.
Reporting numbers	Last 3 years	Break down by body system, modality, primary/secondary reporter and workload type.
Rotas	2 to 3 recent months	Show emergency, elective, adult, paediatric, procedural, cross-sectional and fluoroscopy activity.
Appraisal	Most recent year plus 3-year coverage	Add evidence that any development points were addressed.
MSF/patient feedback	At least 1 structured round	Unselected feedback carries more weight than testimonials or thank-you notes.
MDT	6 consecutive months	Record dates, role, imaging type, number of cases and outcome decisions.

2. Reporting breadth

Body/system area	Evidence prompt
Breast / cardiac / thoracic	Mix normal and abnormal reporting, urgent and routine where relevant.
GI, HPB and uroradiology	Include CT, US, fluoroscopy and contrast study context where available.
MSK and neuroradiology	Avoid being too narrow; include common and acute work, not just specialist cases.
Paediatric and O&G;	Show safeguarding, consent and age/patient-specific imaging judgement.
Vascular and basic procedures	Include image-guided biopsy, drainage, vascular access, catheter/wire and fluoroscopy awareness.

3. Job-fit evidence

Document/opportunity	Why it matters
Workload statistics	Assessor can compare report selection with real reporting activity.
Peer review/discrepancy meetings	Shows quality assurance, learning, insight and governance.
On-call/emergency work	Shows ability to support acute unselected imaging and urgent intervention decisions.
MDT work	Shows integration of imaging, clinical question, pathology and onward decisions.
Procedural exposure	Shows basic image-guided procedure knowledge or practical skill.
Clinical director referee	RCR guidance says one referee should be clinical lead or clinical director from current post.

4. Next 30 days

• Create a report index by body system, modality, emergency/routine status and CiP.

• Ask for three years of reporting numbers before choosing the final 60 to 150 reports.

• Identify areas with weak breadth: general ultrasound, body CT/MRI, MSK, paediatrics or basic procedures.

• Ask your clinical director, subspecialty lead and MDT/on-call colleagues whether they can support structured reports.