

THE SOCIETY FOR
VASCULAR TECHNOLOGY OF
GREAT BRITAIN AND IRELAND

NEWSLETTER

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Winter 2021



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Article from the SVT President

Hello and Happy new year to all SVT members. Although this festive period was different to the usual, I hope you all had a happy and relaxing time and are rested and revitalised for the new year ahead.

I hope you all enjoyed the SVT annual scientific meeting we held back in November. Although it suffered from some minor technical issues at times, I feel that it still provided you all with good accessible content that was educational and informative. If you registered for the conference you can still access the talks via the online portal and re-watch any time.

Many congratulations to Amine Turay on winning the best scientific paper award for his talk on DVT and also to Andrew Pellew-Nabbs who was the recipient of this year's scientist of the year award.

I would also like to take this opportunity to thank all my committee members for their hard work over the year and especially at the conference, I could not wish for a better team to work with.

We are still (tentatively) planning this year's ASM as a traditional meeting in Manchester, however as I'm sure you're aware this will be reviewed regularly and could change if restrictions in social distancing and travel remain.

The SVT constitution changes that were proposed at the AGM are now open for voting on by ordinary members. Please see the SVT website for details of the vote. If you are eligible to vote you should have received an email with the link to vote on the 5th January. Voting is open till the 13th Feb. After this date the votes will be counted and the changes passed following a simple majority. I encourage all ordinary members to cast their vote.

The year gone by presented numerous challenges that I had not thought possible when I took the reigns as president back in the non-Covid days of November 2019. This meant a lot of the plans I had for the society needed to be put on hold this year however with the distant hope of normality on the horizon I am determined to push ahead with our plans in the coming year.

- In the next 12 months, I aim to produce a survey on workforce planning which will hopefully give us an idea of any potential future issues regarding staff levels.
- Following the success of online zoom/teams based virtual meetings this year we are looking to utilise this technology for future study days and revision sessions.
- RSI is, as always, a major risk factor in our profession and the last survey on this was a number of years ago so I plan to produce another RSI survey plus provide online resources for our members.
- The SVT RadAid global health initiative will launch in 2021
- Mental health and wellbeing is an important aspect of overall health and following the year's events is as important as ever. I look to increase the resources we offer for our members to help with any of these issues and potentially offer training.
- I aim to increase the promotion of IQIPS accreditation and work with the accreditation board to help more vascular departments achieve the standards necessary.

Many thanks for all of your hard work and dedication to the profession and here's so to brighter and less locked down 2021.

Many thanks

Lee Smith

SVT President

BioAcoustic technologies from Siemens Healthineers offer solutions in ultrasound diagnostics

Over the last two years, Siemens Healthineers has introduced a new portfolio of ultrasound systems designed to optimise image quality with no compromise.

An important design goal for the ACUSON Sequoia™ system was to introduce an ultra-premium ultrasound system that meets and exceeds demanding requirements in key critical clinical capabilities:

Breakthrough B-mode, colour flow Doppler, and spectral Doppler image quality to reduce operator dependence and provide consistently high exam quality across operators in an ultrasound lab or department. The result being a user experience to enhance productivity in very busy labs.

InFocus Coherent Image Formation

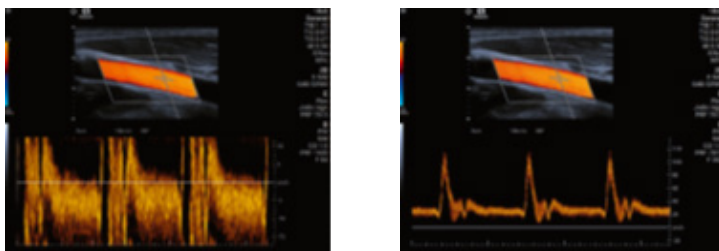
InFocus coherent image formation automatically focuses the image at all depths without compromise in frame rate and exploits high beamformer output capacity, which increases image uniformity compared to prior systems. This secondary beamforming enabled with InFocus, physics-based delay, phase and amplitude corrections can be made across transmit events to significantly sharpen the image and improve spatial and temporal resolution beyond what is typical for a given transducer frequency.

AutoTEQ Technology

The image former of the ACUSON Sequoia system also provides significant benefits to the Doppler workflow. Its new AutoTEQ™ tissue

equalization technology automatically optimizes relevant parameters so that operator adjustments are kept to a minimum.

Several acquisition parameters such as gain, velocity scale, wall filter, AutoTEQ and other post-processing parameters can now be adjusted on a frozen sweep before images are saved to PACS.



AutoTEQ Off

AutoTEQ On

Fig.1 Workflow automation with Doppler AutoTEQ reduces user interaction and improves exam consistency.

Auto Flash Artifact Suppression

Auto Flash Artifact Suppression is a **Siemens Healthineers proprietary technology** that detects and prevents artifacts associated with transducer and patient motion and enhances colour imaging sensitivity when no motion is detected. It is integrated into the platform architecture of the ACUSON Sequoia system and, as such, can support higher image quality and greater diagnostic certainty without adding additional steps to the clinician's workflow.

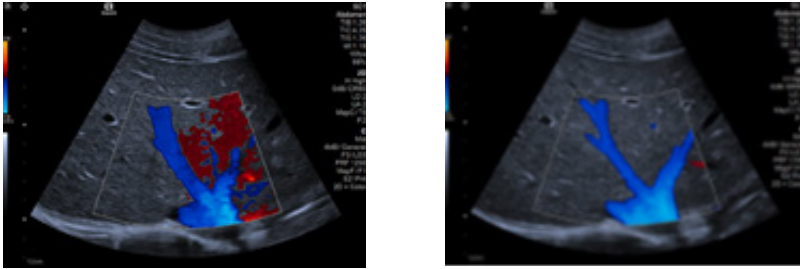


Fig.2 Conventional colour Doppler image with motion artifacts (left). Same patient (right) with Auto Flash Artifact Suppression technology.

Slow flow State

Colour Doppler technology can allow a user to determine presence or absence of blood flow as well as direction information and velocity. However, small, weaker signals can be lost from the surrounding signal clutter or rejected as noise by filters within the system which remove this information altogether. Slow flow uses an intelligent algorithm combined with smart system filters to detect and separate the weaker signals offering PRF between 250 and 800 Hz. Once detected, these signals are amplified and used to help improve smaller, low flow vessel visualization, as well as visualize these challenging vessels further into the tissue being imaged.

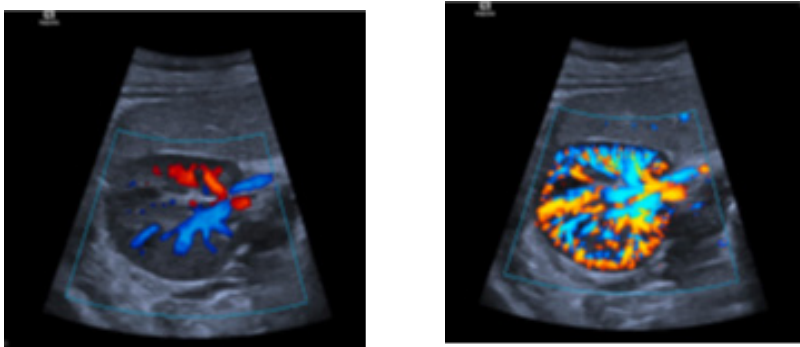


Fig 3. Image of the kidney using conventional colour Doppler (left) and Slow flow Doppler (right).

Deep Vascular Transducer

The new 7L2 single crystal linear deep vascular transducer is designed for peripheral vascular imaging cases with low Doppler frequencies for high-flow states and sensitivity at depths up to 20cm.

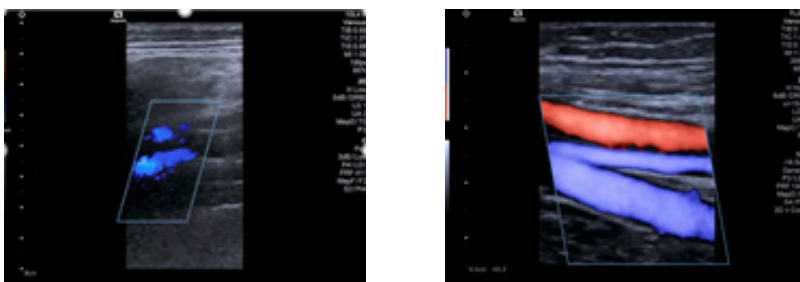


Fig4. The 7L2 transducer provides 58% deeper C Mode penetration*

For further information, please contact ultrasound.gb.team@siemens-healthineers.com or visit <https://www.siemens-healthineers.com/en-uk/ultrasound>

2020 – the year that never was

2020...what a year! It started off with such good cheer.

A toast to welcome the year with chorus, another decade now lay before us.

But if we knew then what we know now, a different demeanour we would endow.

A virus was found in Wuhan city, so far from us, we just felt pity

for the people there who had been affected, it won't come here, we all expected.

And then the news, it started spreading, across to Europe it was heading.

But even then I did not fear, still far from me, but I was wrong my dear.

What was the name of this strange beast, which spread its way from the East.

Corona Virus was what they said, and now a name that's in our head.

We watched with angst just like the rest, as this new virus headed west.

Italy first with cases rising, we watched the news and not surprising,

it spread to France and very soon, the UK news was filled with doom.

By March 13th it was a beast, Europe's cases had increased

The numbers now were even more, than China reported just months before.

The science world was now perplexed, their many brains now were flexed

To find the answers for a cure, that's what we needed that's for sure.

And so the country rallied round, just like the war the oldies found,

As a nation we went into 'lockdown', but being British we won't be knocked down.

Many had to work from home, a concept some had never known

Schools closed and as a nation, we worried about the education

of our children, schooled at home, their little minds were free to roam.

Their fitness sorted by Joe Wicks, with households getting their fitness fix.

Charing Cross Symposium

The next Charing Cross Symposium will be live streamed on 19–22 April 2021 (Monday to Thursday) from London, UK, with the theme “Vascular and Endovascular Controversies Update”.

The symposium will offer:

- Two-day Aortic programme (Abdominal and Thoracic Aortic)
- Two days of Peripheral programme (Proximal Disease and Severe Disease/ileg)
- Two days of CX Venous and Lymphatic programme
- Acute Stroke session
- One day of Vascular Access programme
- Vascular Trauma session

We would like to offer a 50% discount on registration to all members of the Society of Vascular Technology of Great Britain & Ireland who would like to attend CX 2021 – Digital Edition. These discounted early bird fees apply until midnight of the 21st March, 2021. To apply the discount please visit <https://www.cxsymposium.com/cx2021/registration/> to select your registration and apply coupon code svt-cxde at the checkout. If you wish, the CX team can communicate this offer to your members via email, or alternatively you can share this email with them.

Finally, we are keen to publish the latest news from the Society for Vascular Technology of Great Britain and Ireland in Vascular News and Venous News that are distributed to 20,000 vascular specialists. If you would like to sign up to receive these newspapers, please complete the online form at <https://bibapublishing.com/subscriptions/>



Letter to the Editor - STP's trainee perspective

From the perspective of someone who is now applying for the AVS practical exam having completed the STP several years ago, I do think the AVS still holds a crucial place in the certification of what one might call a “qualified” vascular scientist.

I also however, feel that that the debate surrounding AVS, whilst a worthwhile regular reflection on whether it reflects current practice, often quickly becomes tribal and divisive with little room for discussion.

There is no doubt in my mind that almost all vascular ultrasound practitioners in the UK would agree that the stringent requirements necessary to obtain AVS ensures that whomever holds the qualification is extremely competent. The AVS qualification therefore acts as a nationally accepted currency, a known and recognised quantity of competence that reassures a potential employer of what they can expect.

However the debate is clearly in the suggestion that the reverse is true; the omission of AVS therefore makes you incompetent, or “unqualified”. This suggestion, which many consider to be rude or insulting, is one of the reasons this debate can become so divisive or emotive.

Some individuals continue to train via the AVS and STP pathway in centres where the access to varicose veins are extremely low. These can be individuals who are extremely experienced and competent in all other aspects of vascular ultrasound, but who will never obtain AVS without further time at another hospital. Other than planning for future employment in a different trust, what incentive do these otherwise competent individuals have to pursue AVS?

A counter argument would be that without external assessment via the theory and practical exams, what is believed to be self-competence might actually be bad practice, habits and incorrect knowledge. This may not necessarily be true, but the potential for harm without peer review is so great, that it is this reason at least for me why I feel the AVS not only has a place, but a duty in ensuring safe and competent national practice.

There is considerably more depth to this debate which I have not attempted to dive into, however my opinion is that the AVS most certainly still holds a place as a sign of verified competence which all self-conscious vascular practitioners should aspire to. However I also feel there should be more acceptance and understanding on why potentially competent individuals may not wish to pursue the AVS qualification, and how this does not necessarily make them “unqualified” without it.

Lastly, I would like to add a brief comment to the AVS/non-STP/“traditional” training route v STP debate. Having personally completed the STP and observed my colleagues training on the AVS pathway over the past two years, it is plain to see that the AVS route is superior in advancing practical scanning skill, purely due to the uninterrupted time to practical experience trainees can commit too. However it is also clear that the structure of the STP is superior in advancing academic judgement and knowledge in a timelier manner when compared to the practical focused AVS route. I believe all of the above is fairly agreed upon.

Few would deny that the job is almost entirely practically scanning in nature, hence why many feel the AVS is superior as it fast tracks progress in this domain. However the delay in practical experience via the STP route is quickly compensated after several years post-graduation, leaving both trainees in the same position having just taken different routes to get there. Furthermore, what is often not highlighted enough is the need for academic experience if we wish to develop our profession. Not only is this important to allow us to participate and lead our own research to improve our services, but also to maintain interest in our field of expertise.

The opening paragraph to this article highlighted that the number of AVS staff is approximately 260 and has remained stable over the past several years, despite a regular new influx of trainees. The elephant in the room is that this could and likely is partially related to a declining interest for the job once practically competent. All careers require frequent stimulation if they want to preserve the expertise of the senior and experienced staff, and the only way to succeed in this is to provide extra avenues to explore; whether this be management, professional committees, or research. In conclusion, I feel that both training schemes should co-exist and offer different advantages in different time frames, but having the exposure and encouragement to engage in research might go somewhere towards reducing AVS staff who leave the professional and subsequently increasing AVS total numbers.



Good infection prevention practice - using ultrasound gel

Background and purpose of this communication

Contaminated ultrasound gel has been associated with outbreaks of infection in various settings and or identified as a potential vector for infection.^[1-9] Standard ultrasound gel is not produced as a sterile product. Ultrasound and ultrasound guided procedures are conducted routinely both in radiology and clinical areas, including use in high dependency care and among patients with immunosuppression. There is currently little available guidance on good practice in use of ultrasound gel for the UK setting.

This document provides interim guidance on the safe use of ultrasound gel to reduce risk of transmission of infection. It has been in part adapted from guidance produced elsewhere and should be considered in the wider context of standard infection prevention and control precautions.^[10,11]

Which type of ultrasound gel to use

Sterile ultrasound gel **must** be used in the following circumstances:

- for invasive procedures, i.e. any ultrasound guided procedure which involves passing a device through tissue such as intravenous line insertion or fine needle aspirate
- where there is contact with non-intact skin
- where there is contact with mucous membrane (e.g. for transrectal or transvaginal procedures)
- for examinations on immunocompromised, neonatal intensive care or critically ill hospitalised patients (such as in in high dependency settings)

Non-sterile ultrasound gel may be used in the following circumstances:

- during low risk, general examinations on intact skin

Safe use of ultrasound gel

For use of sterile ultrasound gel:

- ensure that only unopened sachets/containers that are labelled as 'sterile' are used.
- sterile gels are single use only and once opened must not be reused, either with other patients or stored and reused with the same patient

For use of non-sterile ultrasound gel:

- we recommend use of pre-filled bottles in preference to re-filling reusable bottles
- remove gel from skin after the procedure using a clean paper towel/tissue/wipe and clean/cleanse the skin using patient skin wipes or equivalent
- nozzles of bottles should not come into contact with the patient, staff or instruments
- if the nozzle comes into contact with the patient's skin/tissue the bottle should be discarded

General principles:

- ensure to check and only use products within their expiry date and discard any product that has exceeded expiry or has exceeded the manufacturer's recommended time after opening

Practice when using reusable ultrasound bottles

Re-filling (non-sterile) reusable ultrasound gel bottles

The use of pre-filled bottles is preferable. Where refilling of reusable bottles is carried out, the following should be adhered to:

- ensure to check the expiry date of the bulk container- only use products within their expiry date and within the manufacturer's recommended time after opening
- reusable bottles must not be used beyond the expiry date of the bulk container; i.e. reusable bottles should be discarded and new bottles used when the bulk container is replaced. No attempt should be made to disinfect the inside of bottles to extend their use life
- label on the bottle the date that the reusable bottle was re-filled. Discard the bottle and contents if the period since last re-fill exceeds one month
- avoid touching the openings of the dispensing container and the bottle
- reusable bottles should be filled with a dispensing device, such as a pump
- bottles should not be re-filled until they are empty (or as near to empty as practical)
- discard all containers, bottles and or gel pumps that show any sign of damage or if visibly soiled

Warming of gel

Where warming of gel is performed the use of dry heat is preferable to use of water. Gel bottles should be kept upright in warmers and not inverted

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11. NHS, National Services Scotland. National Infection Prevention and Control Manual. <http://www.nipcm.hps.scot.nhs.uk/chapter-1-standard-infection-control-precautions-sicps/#:~:text=1%201.1%20Patient%20Placement%2FAssessment%20for%20infection%20risk.%20...,and%20Body%20Fluid%20Spillages.%20...%20More%20items...%20>

Does a “qualified” Vascular Scientist need the AVS qualification?

Conversations at a recent Professional Standards Committee meeting prompted submission of this article to the Newsletter. We were considering what constituted a “qualified” Vascular Scientist and realised that in the year 2020, there isn’t a single answer to this question. This led to more questions: What has changed? Does this matter? What are the implications for the current and future workforce? Why are there so few AVS? Why can’t we recruit to AVS posts? Our aim in writing this article is promotion of discussion. These are personal views on the issue and should not be interpreted as the official view of the SVT.

The SVT developed the current qualification of “Accredited Vascular Scientist” or “AVS” in the mid-1990s and the aim of this rigorous accreditation process was, and still is, “to ensure individuals are able to achieve and maintain high standards of diagnostic vascular investigations for the benefit and safety of patients”. The AVS qualification is recommended by the SVT for all individuals practising vascular ultrasound in the UK 1.

However, this is not the only training route available. We now have the National School of Healthcare Science Scientist Training Programme which includes training in Vascular Science 2. Its graduates are eligible for registration with the HCPC as Clinical Scientists, providing employers assurance around standards for its registrants 3 . There are also many standalone training courses including University based Postgraduate Certificates, Diplomas and Masters level qualifications. The practical content of these is variable and many Vascular Departments will only consider employing graduates with qualifications from a CASE-accredited course 4. CASE is the Consortium for Accreditation of Sonographic Education and this organisation accredits ultrasound courses with the help of members of various professional bodies including the SVT.

The current number of AVS staff, including honorary members is around 260. This figure remains fairly static, with no significant increase in the numbers of clinically active AVS year on year. This year with the challenges of Covid-19, we have been unable to complete the practical exams as usual, so the number of new AVS’s may not compensate for those retiring/lapsing.

So we thought it may be helpful to address the question of “Do we need AVS?” both from the perspective of a Head of Department who employs staff and also a trainee who is navigating their way through the various trainee routes in the hope of securing a post as a “qualified” Vascular Scientist..

Head of Department’s perspective

As an employer, and supporter of the AVS qualification, our departmental requirements for a Band 7 “qualified” post have always been AVS. Our STP graduates have been encouraged to gain AVS as have our “in-house” trainees. I feel that AVS assures us of a high level of theoretical understanding and practical skill gained through completion of over 2000 scans during at least 3 years full-time vascular scanning. During recruitment, this level of experience together with demonstration of skills at interview, assures me that a candidate meets the requirements for one of our band 7 posts. This view that Band 7 requires highly specialist expertise is reinforced when I consult the NHS national job profiles (see Healthcare Scientist job profile https://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/Healthcare_Science_Generic.pdf)

However, our experience at Portsmouth has been that it is very difficult to recruit anyone with AVS to a band 7 position, even with the added attraction of a recent additional Recruitment and Retention payment. We have easy access to National parks, airports, ferries to Europe, outlet shops, historic cities as well as beaches and a warm micro-climate – why wouldn't you want to relocate to the South Coast?

So, I started to wonder if our expectations were out of date and inconsistent with the current job market for qualified vascular scientists. I contacted other Heads of Department to ask what their criteria were for band 7 posts and had replies from 17 Vascular Labs. A simple summary of their current Band 7 criteria is given in the table below.

AVS?	This is the ideal gold standard for all 17 labs but acknowledged as not easily achievable
STP graduate?	15 said Yes (3 with use of Annex 21*/local sign-off), 1 said No
Vascular MSc?	5 said Yes, some centres only if locally trained, 1 said No
Radiology qualifications?	3 said Yes if can scan Vascular modalities independently
Overseas qualifications?	1 said Yes
PgCert?	2 said Yes
Equivalence to STP?	3 said Yes

*Annex 21 can be used where there will be a significant change in skills during a training period and enables pay to be determined as a percentage of that for qualified staff 5 .

Some labs use a combination of the above qualifications with local sign-off for Band 7, particularly arterial and reflux sign-off for STP graduates, with some only giving Band 7 to their own locally trained STP graduates. Some labs focus wholly on local sign-off and skills and don't require specific qualifications. Many labs have additional criteria including performance management linked to salary/band with use of gateways aligned to levels of competency. Some use clauses in contracts to assure progression in salary on achievement of goals (e.g. AVS) and some use a decrease in salary/band or end of contract for non-achievement of goals within a specified time frame.

Some labs offer a salary incentive for achievement of AVS, for example additional R&R (Recruitment and Retention 6) or payments of up to 15% in additional salary. One lab differentiates between scientists and advanced practitioners using national NHS job profiles 7 .

Despite AVS being at the top of the wish list, there is widespread acknowledgment that this now appears to be an unrealistic expectation. Acknowledgement that Agenda for Change banding criteria needs to be aligned to market forces, appears widespread in the attempt to attract candidates for vacant posts. Allocation to a particular band or pay point is now less dependent on what were previously considered "essential" qualifications and skills, and this widespread practice has, I believe reduced the necessity for trainees to achieve AVS.

In my survey, all Heads of Department stated that AVS was their gold standard for Band 7, but in practice do not appear to be insisting on this qualification. I believe that those of us with responsibility for recruitment, need to carefully consider how we can reverse the trend of awarding "qualified" Vascular Scientist Band 7 posts without including a requirement for candidates to achieve AVS. We have a duty to ensure that clinical experience and the ability to act autonomously within professional responsibility match the requirements of the Agenda for Change role descriptors for the banding we are allocating.

I believe that we can only redress this supply and demand inequality if we act in unity. A unified approach will ensure that pressures to “match” what other departments are offering will be minimised and will allow us to encourage a renewed emphasis on the importance of AVS. Achievement of the required scan numbers will require managers and staff to proactively forward plan and arrange visits to other units as required. And the advice of Human Resources departments will help us to consistently implement banding allocations and establish and evaluate progress towards clearly documented expectations.

Recent trainee’s perspective

As a trainee through the ‘old’ (non-STP) route, I can see the benefit of AVS status. It demonstrates the ability to perform a wide range of vascular scans with sufficient experience demonstrated and is a peer assessment of competence. However, with the rising number of Vascular Scientists coming from an STP background, I can understand the reluctance for trainees, obliged to become HCPC registered, to fulfil this additional requirement, particularly if their Trust is satisfied with HCPC registration. So why bother? In some Trusts there is a financial incentive for STP trainees; the lure of a higher banding or a bonus of some kind. But for many trainees HCPC registration is all that is required to secure that higher wage. As the ‘on the job’ training becomes less accessible, particularly for graduates expecting entry at a band 5 or 6 level, and the STP route appears to be the main point of entry into vascular ultrasound, will the AVS requirement become defunct?

Certainly, many trainees struggle to obtain numbers of particular scans, the classic example being varicose veins, although the division of services within imaging departments can be variable meaning there can be a shortfall for many trainees of multiple scan types. Many AVS members happily offer up their centre for trainees to attend and train at, but the ability to do this also lies with the support of the Trust. If the Trust isn’t invested in AVS accreditation, and have a busy clinical service to run, they may not support the trainee taking time away to train in scan types that provide no direct benefit to the Trust.

However, the HCPC training has a minimal set of standards in regard to scanning, and unless a trainee is invested in by their particular training lab, they may graduate as a Clinical Scientist being able to confidently scan only carotids, DVTs and AAAs. As we know, this is a significant part of routine work but by no means the only scans we are required to perform. Conversely, some smaller vascular ultrasound units will only need to perform a small subset of scans, so do we alienate these members because they may never achieve accredited scientist status?

This debate is not new, but the change is the desirability for HCPC registration for all, and the development of ‘equivalence’. So how do we move forward to a point where AVS and HCPC registration can go hand in hand? Perhaps mapping the AVS theory exams to the STP curriculum, and then waiving the necessity for STP trainees to sit these exams as well, at least for the physics element? I am not sure of the way forward, but I do think there needs to continue to be an incentive for trainees to achieve AVS for the SVT to continue to thrive.

Conclusion

There is a lot for us to consider and discuss in terms of our training routes and what we consider to be a “qualified” vascular scientist. We understand that the Education Committee are in the process of mapping STP equivalence against our AVS qualification and are also surveying opinion from members around the scan requirements for the AVS

qualification. We encourage you to fully participate in these forums for discussion, as they are vital to ensure AVS is retained as an achievable robust qualification which is valued in the workplace as we continue our journey towards registration for our profession.

Alison Charig, Head of Vascular Assessment Unit, Portsmouth Hospitals University Trust.

Ellie Blaxland, Vascular Scientist, Cardiff and Vale, University Hospital Wales.

References and Links

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CPD Questions

To keep CPD opportunities available as the pandemic continues the on-line CPD questions will now be available for the full CPD year they are released in apart from the Summer questions which will span both the current and the next CPD year to allow for their 3 month availability.

To clarify for the next CPD year 2020-2021.

The Summer 2020 questions will remain available until 31st August 2021.

The Autumn 2020 questions will be released on 1st November and will be available until 31st August 2021.

The Winter 2021 questions will be released on 1st February and will be available until 31st August 2021.

The Spring 2021 questions will be released on 1st May and will be available until 31st August 2021.

The Summer 2021 questions will be released on 1st August and will be available until 31st August 2022.

SVT CPD Online Question Officer.