GUIDANCE on TRAINING PROVISION in VASCULAR INTERVENTIONAL PROCEDURES

To support the curricular requirements of vascular surgery trainees.

This document has been produced as a replacement for previous iteration dated September 2016 and is the result of the introduction of the 2021 versions of both the Interventional Radiology and Vascular Surgery curricula. Henceforth, use of the 2016 document should cease.

INTRODUCTION

Interventional Radiology (IR) gained subspecialty status in 2010. This means that delivery of IR training is the responsibility of the Royal College of Radiologists (RCR). The IR curriculum has been approved by the GMC and forms part of the Clinical Radiology curriculum, with additional interventional and clinical competencies in practice. The British Society of Interventional Radiology (BSIR) is a Special Interest Group within the RCR, with direct input into the RCR IR Committee for matters pertaining to IR service.

Vascular Surgery (VS) became a Surgical specialty, independent of General Surgery in 2012. The VS curriculum is based on the Joint Committee of Surgical Training (JCST) template. Since 2012 when the first curriculum was agreed it has become apparent that it's delivery has created some difficulties for trainers and trainees which could not be resolved with subsequent curriculum updates. The development of the new (2021) curriculum, aimed at expectations of a day one consultant, have changed the technical skill requirements, and replaced them with objectives for the higher-level outcomes. This does not mean that they may not wish to obtain (or have a planned post that requires) a higher level of experience and skill, but that will relate to local service requirements and delivery rather than be a requirement for satisfactory completion of training. The curriculum has been approved by the GMC and both BSIR and RCR were involved its development, highlighting benefits of collaborative working.

The vascular surgery curriculum can be found in full at: https://www.gmc-uk.org/education/standardsguidance-and-curricula/curricula/vascular-surgery-curriculum.

The VS curriculum contains vascular radiology and imaging objectives within the syllabus focussed upon the delivery of the acute vascular surgery service. The indicative level for the day one consultant vascular surgeon, in the absence of IR availability, is that they can perform simple inflow and outflow (iliac and superficial femoral artery stenosis) angioplasty in an emergency, to avoid the need for more invasive open alternatives. VS trainees also need to be competent in reviewing images of the vascular system to enable them to make appropriate initial management decisions based on upon that image interpretation. Formal scan assessment and reporting will remain the remit of radiology

There must not be direct competition with IR trainees. Post CCT fellowships may be the place to consider these activities, particularly if there is an identified service need for the additional expertise, but again should not be detrimental to either trainee group. It was agreed that to mandate a core requirement of such advanced skills for all VSs was not realistic or desirable, as it would lead to unnecessary pressure on trainees in VS, and a threat to the ability of IRs to be fully competent at these at CCT.

The delivery of training should be a matter for local discussion, preferably with plans made prior to trainee appointments, and certainly with mutual respect for both sets of trainees and for the service delivery.

VASCULAR SURGERY TRAINING PROGRAMMES

Vascular surgery training programmes were established by the Vascular Surgery SAC approved by the GMC and with quality control provided by the JCST. It was agreed (between the Vascular SAC, RCR and BSIR) that all applications for vascular surgery training programmes should have the support of the local training programme directors (TPDs) for both vascular surgery and clinical radiology, to be clear that there was capacity for the IR aspect of the training. This support was obtained in 2012 for the existing training programmes and for any new placements such support should be obtained prior to the appointment to training posts, to ensure that capacity exists to deliver training that does not compromise IR training.

Competency in endovascular skills (including aspects of EVAR) and image interpretation is assessed throughout training, in common with all aspects of the curriculum by the new Multiple Consultant Report (MCR)assessment with progression then being assessed by the ARCP process. It is reasonable for IR trainers to become Clinical Supervisors (CS) and to assess trainees through appropriate procedure-based assessments (PBAs) for index procedures and input into the MCRs.

IMPACT ON IR TRAINEES

The primary responsibility of radiology training programs is to deliver IR training and to ensure achievement of competencies in full as stated in the IR curriculum. This includes aortic, vascular and non-vascular training. Radiology training programs should provide training to vascular surgeons by collaboration with vascular surgery and so ensure that there is no detriment to the training of radiology trainees.

Failure to attract and train IRs will have a negative impact on a wide group of patients, not just those with vascular diseases, in both the short and long term. Any reduction in training opportunities for IR trainees reduces the potential for them to achieve competence in other aspects of intervention vital for the provision of 24/7 services such as haemorrhage control, treatment of sepsis, delivery of interventional oncology and stroke services.

Training programmes should be encouraged to agree reciprocal arrangements whereby vascular surgery units provide training in arterial exposure, ward round, diabetic foot management and out-patient decision making skills to IR trainees. This may be of limited potential where IRs already deliver this training, but mutual collaboration may benefit both groups of trainees, by exchanging clinic or list time, to promote more flexible and inclusive training/working practices. Local vascular surgical and clinical radiology TPDs and IR/VS trainers should meet to determine how these aspects can be incorporated into the local IR training programme.

It is in the interests of both specialties, and patients, that a collaborative approach is taken to the VS/IR service and training. It is recommended that Heads of Schools and TPDs from vascular surgery and clinical radiology (IR representatives) establish formal cross-specialty training agreements with their Deans, defining the extent, arrangements and capacity for this collaborative training.

SUGGESTED ACTIONS IN THE EVENT OF PROBLEMS

If the demands for VS training are putting at risk the training of interventional radiologists in any programme or if the endovascular component of the vascular surgery curriculum is not being delivered, the following actions are suggested for the clinical radiology Heads of School or TPDs:

- Talk to the vascular surgery TPD and Head of School of Surgery. A mutually respectful and cooperative way of working together, with regular dialogue, is clearly the ideal way to avoid/solve problems
- Highlight to the Vascular SAC Liaison member and the regional IR lead.
- If this fails, the issue should be escalated for discussion through the training hierarchy. Initially the local Post-graduate Dean, but, if necessary, the lead dean for the speciality. Request a Deanery visit.
- Inform the RCR via qatraining@rcr.ac.uk and/or BSIR council@bsir.org. The RCR and BSIR hold regular discussions with the VS, and it is useful to be aware of what is happening in practice around the country. If necessary, matters can be raised at a national level with the GMC. Equally we would welcome hearing about good practice and solutions to problems.
- If there is a negative impact on the service, and/or patients are at risk, take this to the trust governance system via Clinical Directors for Radiology and VS as well as Trust education and training body