

THE SOCIETY FOR
VASCULAR TECHNOLOGY OF
GREAT BRITAIN AND IRELAND

NEWSLETTER

Issue 94 Autumn 2016

Welcome to the Autumn 2016
edition of the SVT Newsletter...

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As always I would like to extend my thanks to those who have contributed to this issue. I would also like to take the opportunity to say how honoured I am to have been given the role of vice president over the last year and how much I'm looking forward to my year as president. I appreciate the illustrious company I join in having this role and plan on making a positive impact to the SVT during this time.

Don't forget, the Newsletter is continually looking for original contributions, so please email me any case studies, reviews, your experiences or any comments that you think would be of interest to

members of the society, contributions may also be eligible for CPD points. I would also welcome any comments on articles published in this edition.

As always a £25 prize is offered to the individual chosen for sending in the article or letter of the month. The prize this issue is awarded to Dr Toni Cooper.

The next Newsletter will be the Winter Issue, and the closing date for receiving articles will be 6th January. Look forward to seeing all of you who can make it to Manchester!

Helen Dixon, Newsletter Editor
newsletter@svtgbi.org.uk

DATES FOR THE DIARY 2016/17

VS ASM, Manchester Central Convention Complex
30th November – 2nd December

SVT ASM, Manchester Central Convention Complex
1st December

BMUS ASM
7th-9th December, York

SVT Fundamentals Study Days
26th-27th January,
Addenbrooke's Hospital,
Cambridge

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The Vascular Societies'
Annual Scientific Meeting
in conjunction with the Vascular Society of Great Britain and
Ireland, the Society of Vascular Nurses, and the Society for
Vascular Technology of Great Britain and Ireland. **2016**

30 November – 2 December
Manchester Central Convention Complex

The Vascular Societies Annual Scientific Meeting encompassing the **Vascular Society**, **Society of Vascular Nurses** and the **Society for Vascular Technology** into one single integrated event will take place from the 30 November – 2 December at the Manchester Central Convention Complex.

The conference will take place in the iconic Manchester Central Convention Complex (MCCC), which is located in the heart of the city. Being located in the centre of the UK, Manchester has excellent transport links to the rest of the UK and further afield.

SVT Workshop on Renal and Visceral Duplex Imaging Wednesday 30th November 13.00-17.00

This workshop will include lectures and a demonstration on scanning renal and visceral vessels and an overview of abdominal scanning. There will also be a hands-on session with experienced tutors available.

SVT ASM Thursday 1st December

The Annual Scientific meeting of the SVT will be held on Thursday 1st December, the full programme is available at:

https://www.vascularsociety.org.uk/_userfiles/pages/files/Annual%20Meeting/Documents/Programme/21_10_16v2%20ASM%202016%20programme.pdf

SVT Welcome Reception

As usual the SVT will be hosting a drinks reception for all members on the evening of Wednesday 30th September.

The reception will be held at The Rain Bar and starts at 7pm.

<http://www.rain-bar.co.uk/>

Royal Eye Hospital Carotid Referral Audit 2013 & 2014

Dr Toni Cooper, PhD, AVS, Central Manchester University Hospitals

Introduction

In 2007, a referral protocol was agreed between the vascular lab and the ophthalmology consultants to try and improve the carotid artery duplex service with a view to categorising urgent and routine referrals in accordance with stroke guidelines. Please see below:



Urgent	Routine
Amaurosis Fugax	Optic Neuropathy
Branch/Central Retinal Artery Occlusion	Ocular Ischaemia
Intermittent monocular loss of vision	Rubeosis
Homonymous Hemianopia	Retinopathy
Emboli	Glaucoma
	Blurred vision

This referral criterion was reviewed and audits were performed in both 2013 and 2014 to review the number of referrals from the eye hospital for a carotid artery duplex and the incidence of patients with potentially operable carotid artery disease.

Methods

All patients were referred as an outpatient from an ophthalmology clinic or from the emergency eye centre and met the suitable criteria for an extracranial carotid artery duplex assessment.

According with lab protocol urgent scans were performed within 1-week of the onset of symptoms and routine within 4-weeks. Patients presenting with urgent symptoms in the last 2 days will have a scan within 24 hours.

All Doppler ultrasound assessments assessed bilateral common (CCA)/bifurcation, internal (ICA) and external (ECA) carotid arteries as well as vertebral and subclavian arteries.

The presence of carotid disease in the CCA/BIF, ICA and ECA was documented and graded using the SVT guidelines in accordance with NASCET methods for grading. The symptoms of the patient were also documented and compared.

Results

There has been a slight decrease in the number of referrals between 2013 (n=289) and 2014 (n=280).

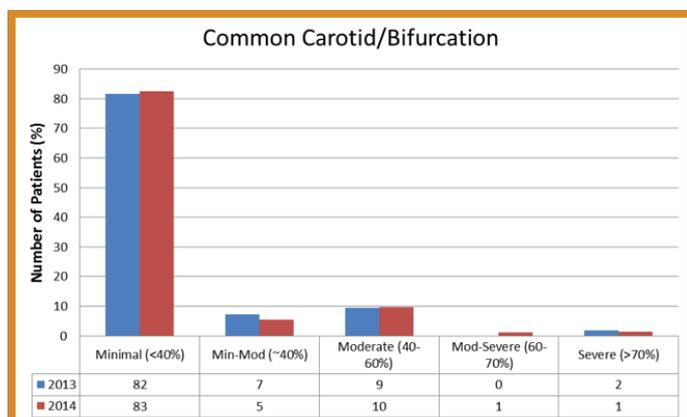


Figure 1a. Comparison of severity of disease in the Common Carotid Artery/Bifurcation.

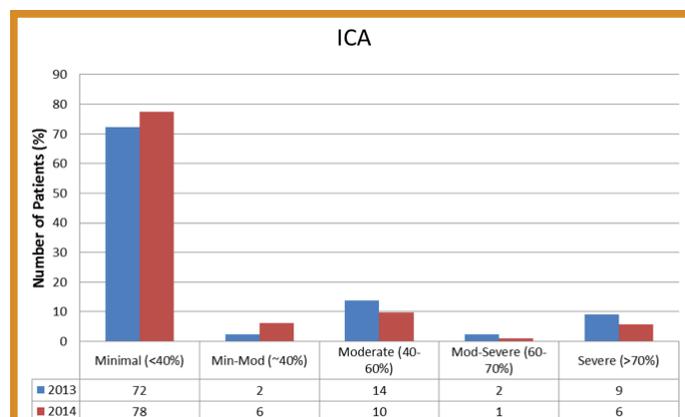


Figure 1b. Comparison of severity of disease in the Internal Carotid Artery (ICA).

There is a significant increase between 2013-2014 in the number of patients with min-mod (~40%) disease in the ICA ($P < 0.05$). However, there was decrease between 2013 and 2014 between the numbers of patient with severe (>70%) disease in the ICA. This was not significant ($P > 0.05$). Results also showed a significant increase in patients with minimal disease (<40%) in the ECA ($P < 0.05$).

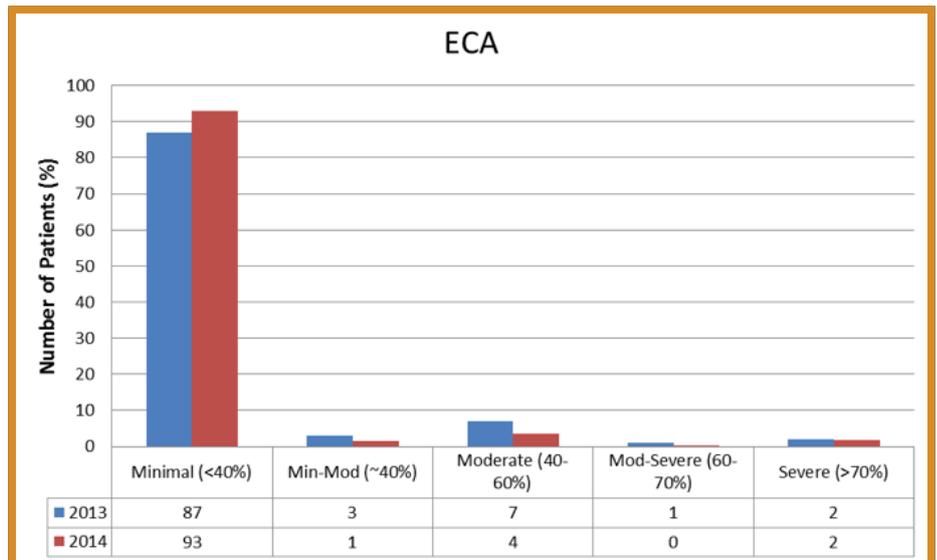


Figure 1c. Comparison of severity of disease in the External Carotid Artery (ECA).

Comparison of presenting symptoms for suspected TIA between 2013 and 2014

- There is a significant decrease in the absolute number of patients presenting with branch retinal artery occlusion (BRAO) ($P < 0.05$).
- There is a decrease in the number of patients presenting with blurred vision, whilst there was an increase in number of patients with bilateral vision.
- There is no change in the number of patients presenting with amaurosis fugax.

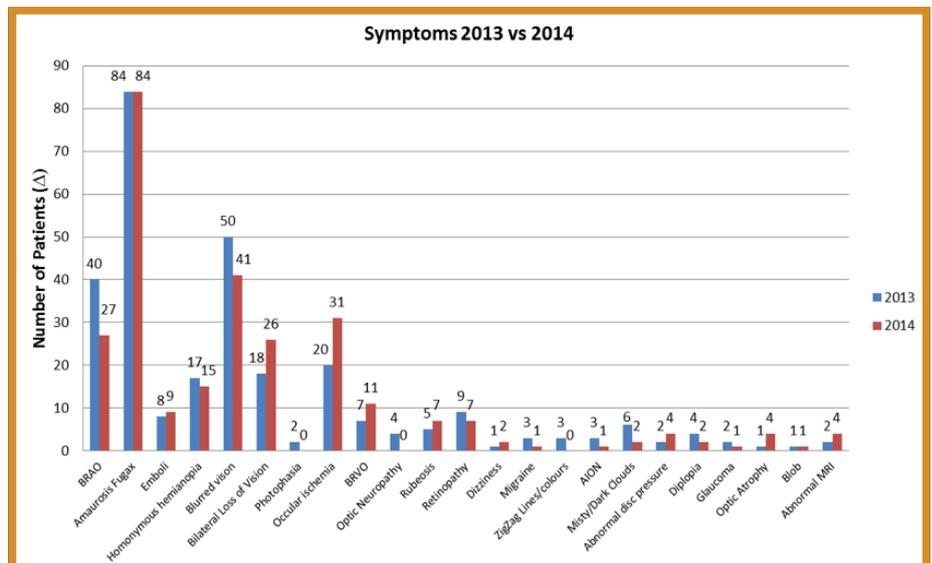


Figure 2. Comparison of presenting symptoms for suspected TIA between 2013 and 2014

Symptoms versus Severity of Disease: 2013 and 2014

The severity of disease in the CCA/ BIF and ICA arteries was grouped and compared with the patients referring symptoms. Disease in the ECA was excluded as it would not require urgent surgery.

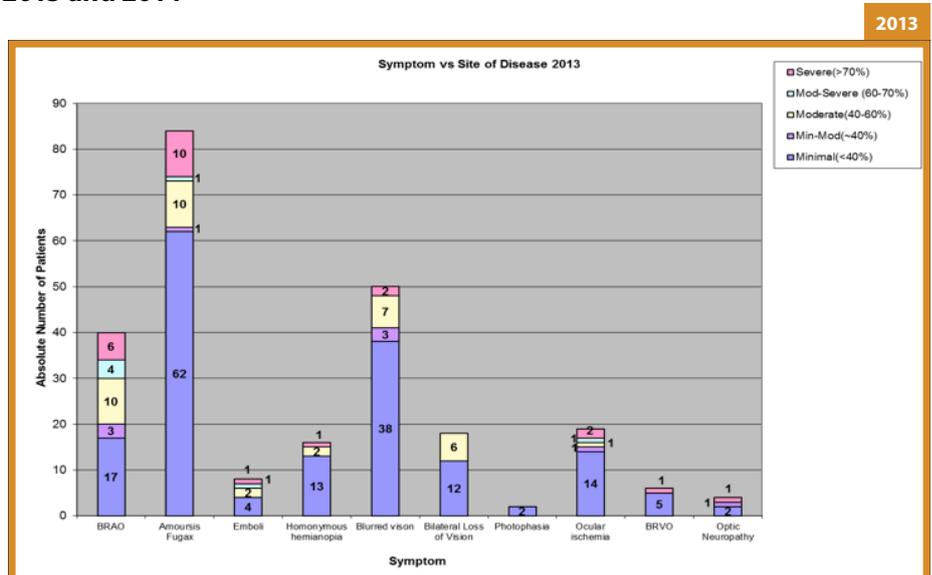


Figure 3a. Presenting symptom versus severity of disease in CCA/CCA bif and ICA.

2014

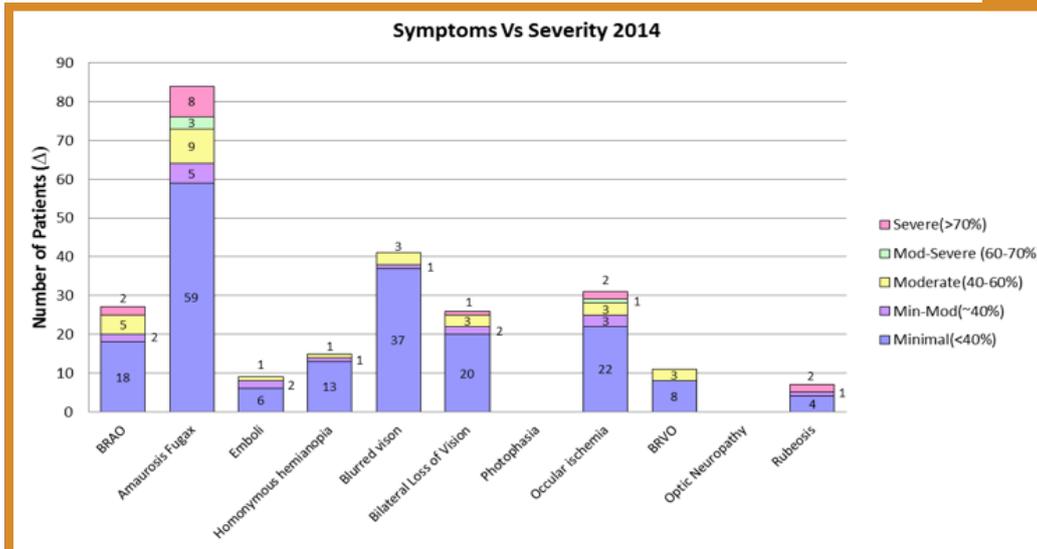


Figure 3b. Presenting symptom versus severity of disease in CCA/CCA bif and ICA continued.

2013

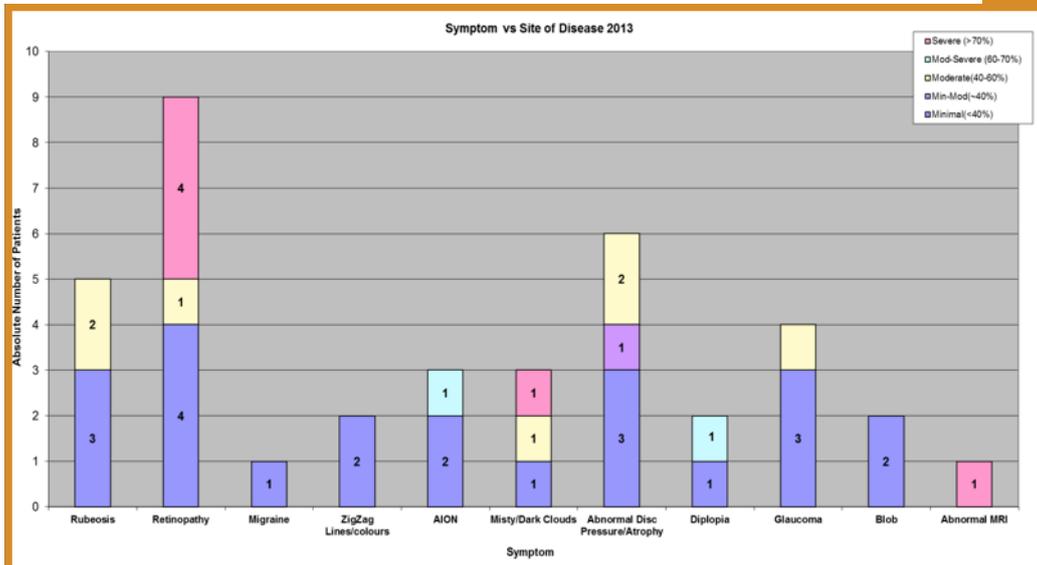


Figure 3c. Presenting symptom versus severity of disease in CCA/CCA bif and ICA.

2014

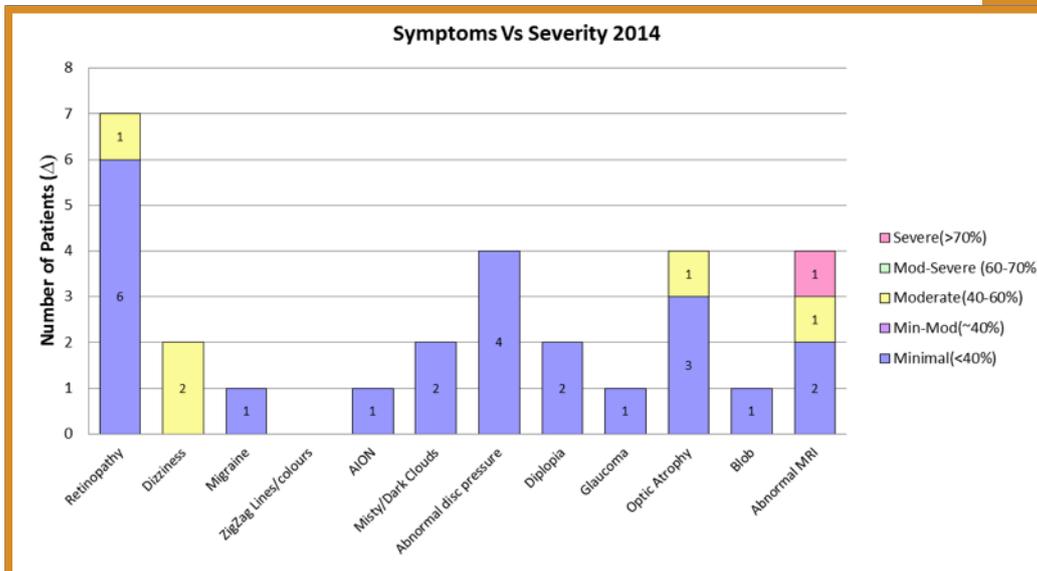


Figure 3d. Presenting symptom versus severity of disease in CCA/CCA bif and ICA.

- In 2014, only 11 patients presenting with amaurosis fugax were found to have potentially operable carotid artery disease. 59 patients had minimal or no disease. There was no significant change compared to 2013.
- There was also a slight decrease in the number of patients presenting with severe/mod-severe disease in the ICA/CCA bifurcation between 2013 and 2014.

Conclusion

- The majority of carotid disease detected in the CCA BIF and ICA was minimal (<40%). There was no change compared to 2013.
- In 2013, 13% of patients (n=38) presented with potentially operable carotid artery disease in the CCA bifurcation/ICA. However, this decreased to 9% in 2014 (n=26).
- Amaurosis fugax remained the most common referral reason for

- a carotid artery scan from the eye hospital. 21% of these patients (n=121) had minimal disease in both 2013 and 2014. Only 4% of patients (n=22) had potentially operable carotid artery disease. Figures 3a-3d.
- Referral patterns remained similar for both 2013 and 2014. Future studies aim to compare these results to referrals received from the one-stop TIA clinic run by the Stroke consultants at CMFT.

The Development of a Vascular Ultrasound Quality Assurance Programme

Penny Gill and Catherine Rogan, Senior Vascular Scientists, Queen Alexandra Hospital, Portsmouth Hospital Trust

The vascular ultrasound department at the Queen Alexandra Hospital in Portsmouth has achieved IQIPS accreditation this year; we are the first NHS Vascular unit to have accomplished this. One of the many requirements that were met in order to achieve this was the implementation of a quality assurance programme.

IQIPS is now a CQC approved scheme, Professor Sir Mike Richards CBE; the chief inspector of hospitals released a policy statement which expressed his support for accreditation and the importance it plays in improving the quality of healthcare.

At present there is not a vast amount of information detailing this process or providing guidance. Many vascular scientists that we consulted on the subject had an ad-hoc programme where the main focus was on auditing of scanning and scan results rather than a comprehensive QA assessment of ultrasound machines and transducers. We thought it may be helpful to other vascular departments, if we shared our experiences.

The first step was to assign two quality assurance leads to implement and develop the programme. Our staff rota and clinical work load were rearranged and time was given to the QA leads to start developing the necessary checklists and time to use the ultrasound machines.

We developed our programme based on BMUS guidelines published in the journal ULTRASOUND in 2013. <http://ult.sagepub.com/content/early/2013/11/29/1742271X13511805>

The aim of the BMUS guidelines was to collate the information available and to make it available for sonographers in the one place. In addition to this paper,

one of the QA leads attended several quality assurance courses. One of the courses was organised by BMUS and was very informative, this course provided very useful information regarding what is required to run a robust QA programme and the specific tests which should be performed. Another useful course is run by the college of radiographers called 'Delivering a quality ultrasound service'; details of these courses are available on their website. We also purchased a book produced by the Institute of Physics and engineering in medicine (IPEM) called 'Quality Assurance Of Ultrasound Machines' this book provides information on a variety of issues including, image quality, acceptance tests, references and standards.

In our department, our Vascular Assistant is tasked with checking a number of details before setting up our scanning rooms and turning on the machines. It was decided that we, as Vascular Scientists, using the machines and signing reports based on the images produced should also have a basic check-list after using the machine for their first scan in the morning. This check list covers, B-Mode, colour, spectral Doppler, transducers and the machine controls and is signed to confirm that the machine is operating to expected limits.

Following on from this and with guidance from the BMUS paper, two additional QA checklists were created. Our level 2 QA checklist was more robust and assessed the transducers for reverberation and shadows and/or streaks and confirmed that the Grey-scale images were satisfactory. The transducers and cables were also checked for wear and tear and any faults or damage. We decided that this would be performed weekly, but on reflection determined that a monthly check was actually sufficient.

A further more in-depth assessment is also carried out on a monthly basis. The system is checked for air reverberation, element drop-out and electronic noise assessment. In addition the clinical engineering department service the machines every six months. The service comprises of back-up of software, a filter clean, brake check, hoovering dust from inside the machine and a B-mode axial resolution check using a phantom.

Coinciding with these check-lists, comprehensive guidelines have also been created so that any member of

the scanning team can perform the QA assessments.

During our daily checklist, our linear transducer was found to have what appeared to be superficial wear on the lens with accompanying element drop-out, this was noted and after consultation with the clinical engineering department it was decided that the transducer was no longer fit for purpose and had to be condemned, our curvilinear transducer was also faulty and was replaced, this early intervention and flagging up of issues helps to prevent any delay in clinical throughput and

interruption to our busy workload. Our checklist incorporates a visual inspection of the transducer and the cables so that any ingress of gel, damage to the transducer face etc. can be identified early on and monitored.

The programme has already proved invaluable and the department can only continue to benefit from early intervention where problems are pinpointed and dealt with promptly thus avoiding any interruptions to the provision of our service.

VAU - Daily Machine Performance Checklist Room

Modality	Mon	Tues	Wed	Thurs	Fri		Mon	Tues	Wed	Thurs	Fri
B-Mode satisfactory											
Colour satisfactory											
Spectral Doppler satisfactory											
Transducers satisfactory											
Controls satisfactory											
? Issue with any modality *											
Modality	Mon	Tues	Wed	Thurs	Fri		Mon	Tues	Wed	Thurs	Fri
B-Mode satisfactory											
Colour satisfactory											
Spectral Doppler satisfactory											
Transducers satisfactory											
Controls satisfactory											
? Issue with any modality *											

* Perform level 1&2 QA testing

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Figure 1: Example of one of our checklists

bubbles

Lila Elliott, North Bristol NHS Trust

Echo color Doppler Ultrasound: a valuable diagnostic tool in the assessment of arteriovenous fistula in haemodialysis patients.

Anna Mudoni, Francesco Caccetta, Maurizio Caroppo, Fernando Musio, Antonella Accogli, Maria Dolores Zacheo, Maria Domenica Burzo, Maurizio Gallieni, Vitale Nuzzo (2016) *Journal of Vascular Access*, 17 (5), pp. 446-452.

Monitoring and surveillance of vascular access plays a key role in identifying any dysfunctions. A reliable and durable vascular access is a critical requirement to improve the long term survival and quality of life in haemodialysis patients. Through close monitoring of vascular access sites, the adequacy of dialysis can be maintained as well as reducing economic costs associated with failing access. Vascular access failure continues to be one of the most common causes of morbidity in haemodialysis patients.

Over a period of five-years, Mudoni et al. (2016) developed a study protocol for monitoring arteriovenous fistula (AVF) both pre and post operatively. For the preoperative assessment the study focused on the use of colour Doppler ultrasound (CD-US) for the evaluation of cephalic and basilic veins to include; analysis of the walls, patency, internal diameter, distensibility and the presence of tributaries. The arteries were assessed for diameter, walls and functional ability of the artery to dilate using the active hyperaemia test.

The study found that veins with a small diameter (<1.6mm) were associated with higher risk of early failure rates. The preoperative assessment has led to increased numbers of vascular access interventions particularly for those who required complicated procedures

in which central venous cannulas are used, for patients with pacemakers, and risk factors such as central vein stenosis or to previous failures. Mudoni et al. reported a reduction in complications in those patients who received a preoperative CD-US but not a reduction in early failures. The AVF surveillance using CD-US included assessment of the arterial inflow, anastomosis and venous side for stenoses (but not volume flow). Flow was measured 2 cm above the elbow crease in the brachial artery for both upper and lower arm AVF; this site was chosen based on guidelines from the K/DOQI(1) based on the assumption that as a relatively straight segment it is easy to reproduce, has laminar flow and is incompressible (unlike the venous outflow). Ultrasound assessment in this department was always carried out in the presence of abnormalities of the AVF function such as; difficulties needling, increased venous pressures, prolonged bleeding post dialysis, high circulation and inadequate KT/V(2).

This study reported that in native AVF, more than 85% of cases of thrombosis are due to the presence of stenosis. The most common site for stenosis (~50%) are juxta-anastomotic. Stenoses are the most common complication of AVF and responsible for the reduction of the AVF volume flow.

After five-years experience, Mudoni et al. (2016) conclude that CD-US should have a crucial role in the interdisciplinary cooperation in AVF monitoring because it provides a detailed picture of the vascular anatomy, it has high sensitivity for stenosis, and it provides indications and quantitative measurements of blood flow, which can be considered an important prognostic value for the dialysis adequacy and, consequently

an effective early predictor of thrombotic risk.

Despite its strengths, this study concludes that CD-US should not replace a clinical examination but that should be a crucial part of an integrated vascular access management program.

1. The National Kidney Foundation produces clinical practice guidelines through the NKF Kidney Disease Outcomes Quality Initiative (NKF KDOQI)
2. Kt - represents the volume of fluid completely cleared of urea during a single treatment, V - is the volume of water a patient's body contains. Therefore, Kt/V compares the amount of fluid that passes through the dialyzer with the amount of fluid in the patient's body.

Does pre-and post-angioplasty Doppler ultrasound evaluation help in predicting vascular access outcome?

Maria Guedes-Marques, Pedro A.Maia, Fernando Neves, Anibal Ferreira, Joao Cruz, Dulce Carvalho, Carlos Oliveira, Carlos Barreto, Telmo Carvalho, Pedro Ponce, (2016 Sep 24) *Journal of Vascular Access*, doi: 10.5301/jva.5000604.

A mature a functional arteriovenous fistula (AVF) is considered the best vascular access modality and should be monitored regularly. Doppler ultrasound (DU) has been increasingly recognised as a valuable tool and angioplasty is the first-line modality for treating stenosis related access dysfunctions (Haage et al., 2006). This prospective observational study set out to determine how post-percutaneous transluminal angioplasty (PTA) access blood flow improvement predicts vascular access outcome. Secondary end points were to compare DU and angiography

diagnostic accuracy in detecting stenoses, as well as to determine how other clinical factors could also predict outcome.

All chronic haemodialysis patients who were receiving dialysis via functioning vascular access (AVF and AVGrafts) and underwent a PTA procedure for a VA-related venous stenosis over a two month period. A total of 54 patients were included in the study, the most common type of access were AVGs (53.7%) followed by AVFs (42.6%); three patients has a PTFE interposition graft.

The initial ultrasound assessment detected 85 stenoses; the majority of stenoses in grafts were located in the vein/graft anastomosis and post-

anastomosis for AVFs. Optimal post PTA result was defined by a residual stenosis of 30% or less and a good flow determined by DU. Secondary patency until new intervention of both fistulas and grafts was 83% at the first trimester follow-up and dropped to 63% at six months. This confirmed that fistulas have a better patency than grafts, which were three times more likely to fail.

This study demonstrated that DU correlated highly with angiography and although was less accurate for central lesions. Despite this, Guedes-Marques, et al. (2016) concludes that DU has a key role in vascular access surveillance and dysfunction diagnosis, as it is the only

examination that bases decisions on a morphologic and haemodynamic assessment. They go on to state that angioplasty is a safe and effective tool in preserving vascular access function; however, restenosis due to accelerated neointimal hyperplasia is higher and its long-term success can't yet be predicted by anatomic or haemodynamic factors.

Reference

Haage, P., Gunther, R.W. (2006) Radiological interventions to maintain vascular access. *European Journal of Vascular and Endovascular Surgery*, 32 (1), pp. 84-89.



FUNDAMENTALS OF VASCULAR ULTRASOUND

2 DAY STUDY EVENT - 26th -27th January 2017
Addenbrooke's Hospital, Cambridge

Both days

£120 SVT members/ associate SVT members

£150 non members

1 days

£70 SVT members/associate members

£90 non members

A 2 day course designed to give a basic overview of vascular technology, suitable for trainees preparing for the SVT exams and anyone interested in vascular ultrasound

Topics to include: ultrasound physics, haemodynamics, vascular disease and vascular imaging techniques, taught as a mixture of lectures and hands on ultrasound workshops

Booking forms and provisional timetables to be posted on the SVT website at a later date

Please contact: edmund.ramage@addenbrookes.nhs.uk

CPD Questions

Summer 2016

Questions 1 – 6 are taken from the paper:

'Pitfall of vertebral artery insonation: Bidirectional flow without subclavian artery pathology'. Susanne Johnsen, Stephan J Schreiber et al. *Perspectives in Medicine* (2012) 1, 449 – 451.

Questions 7 – 12 are taken from the paper:

'Analysis of Doppler blood flow waveforms of cerebral arteries and common abnormal findings'. Shu-Yi Chen, Hung-Ti Hsu. *Journal of Medical Ultrasound* (2014) 22, 3 – 6.

Both papers are open access online.

Questions

1. Describe how grade 1, 2 and 3 subclavian stenosis affect ipsilateral vertebral artery flow?
2. What were the diameters of the right and left V2 segment of the vertebral artery in case 1?
3. What anatomy did CT angiography demonstrate in case 1?
4. Name 2 variations of the vertebrobasilar circulation that were found in both cases?
5. What 2 measurements are stated to be mandatory/included in the examination to avoid the pitfalls mentioned?
6. Name 1 artery of the Circle of Willis NOT mentioned in this article?
7. Name 1 situation in which retrograde blood could be observed?
8. What is the contraction acceleration phase?
9. How is PI calculated?
10. What RI value represents high resistance?
11. Give 1 example of a hyperdynamic state?
12. What does pulsus tardus represent?

Submission deadline: **January 31st 2017**

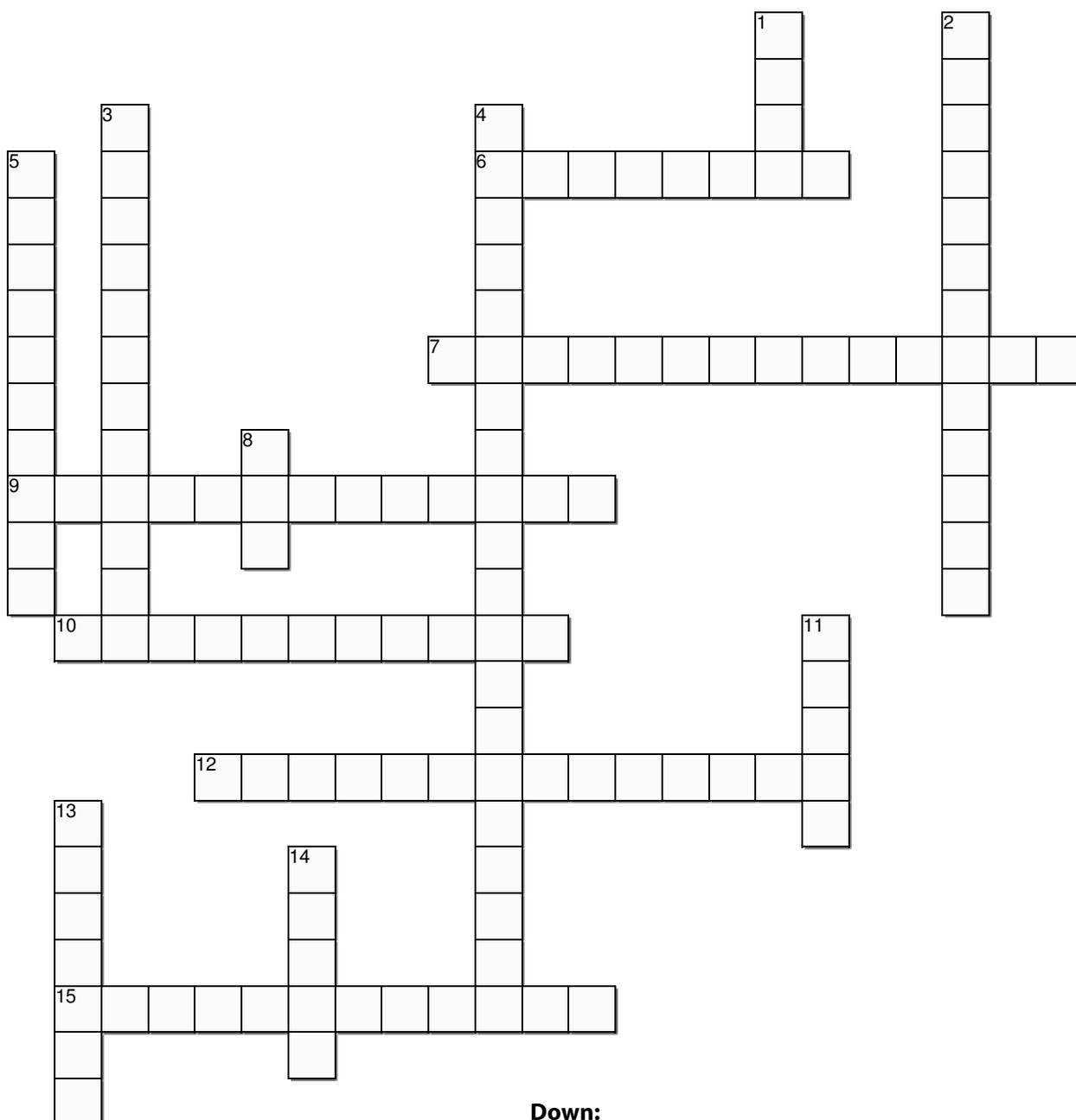
Please forward answers to alison.dumphy@ivs-online.co.uk including your full name and SVT membership number.

Answers: Spring 2016 Newsletter

1. 38.7%
2. Higher blood flow rates, lower rates of infection, thrombosis, septicaemia and central venous stenosis.
3. 64.7%
4. Infection, malignancy, recently created AVF and patients with temporary non-tunneled catheters.
5. Diabetics.
6. $p < 0.05$
7. Stenosis, atheromatous plaque, aneurysm, pattern of blood flow and distal ischemia.
8. S.Aureus, Pseudomonas and Klebsiella pneumoniae.
9. 14.28%
10. Decreased blood flow rates. Re-circulation of blood.
11. Multi-centre study.
12. Lower infection rates, longer dwelling time.
13. $Q = VA (r2)$



Colour & Power Doppler



Across:

6. This can occur in the presence of high mean Doppler frequencies.
7. Colour control that affects the insonation angle.
9. Colour control that affects frame rate.
10. Advantage of Power Doppler over Colour Doppler.
12. Difference between the emitted wave frequency from the transducer and the reflected wave frequency.
15. The maximum frequency that can be unambiguously detected for a particular sampling rate.

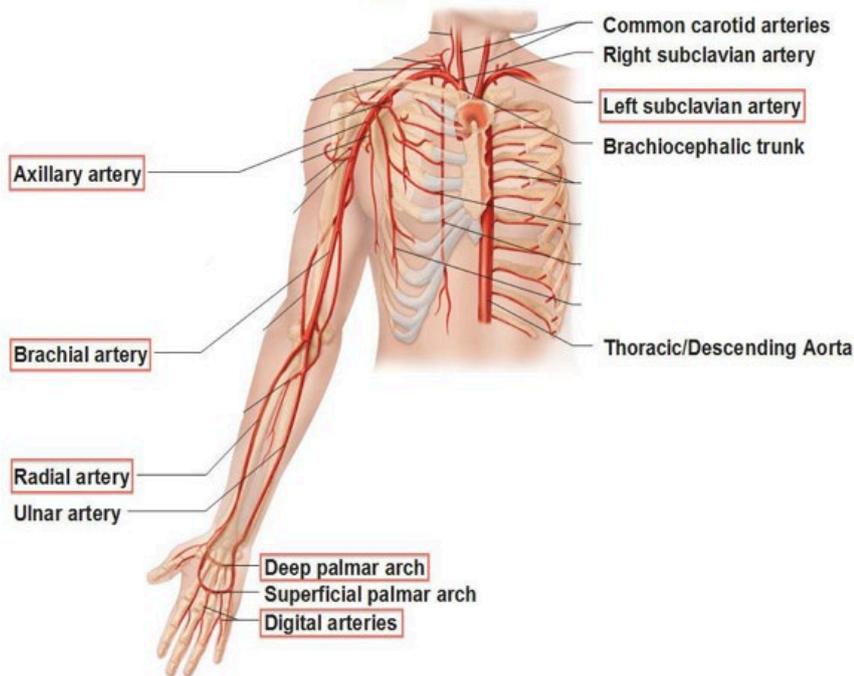
Down:

1. Colour control providing amplification of all the received echoes.
2. Type of crystal in an ultrasound transducer.
3. The target area that the blood cell velocities are derived from.
4. The processing technique used to derive the Doppler Shift.
5. Device used to generate and detect ultrasound.
8. The number of pulses of ultrasound transmitted per unit time.
11. Unit of frequency equal to one cycle per second.
13. Type of flow in which the fluid particles move along in smooth paths in non-mixing layers.
14. Colour and Power Doppler artefact.

Upper Limb Study Day 2017

An upper limb study will be held in Ireland in 2017. The study day will be open to all members. **Further information will be posted on SVT website**

Arteries of the Upper Limb and Thorax



Would you like to be more involved in the SVT?

The SVT relies on the good will and dedication of its members to support and promote the development of our profession. Although we are a relatively small society we have always been extremely fortunate to attract new enthusiastic and willing volunteers every year to help run and influence our society. This continual cycle of refreshing our committees and working groups ensures that there is always an assortment of opinions, skills and knowledge leading our profession into the future.

SVT roles are wide and varied; they may be very specific organisational tasks such as arranging practical examiners and recording exam results or a more responsive role such as reviewing new NICE guidelines or surveying members on a particular topic.

Typically members attend 3-4 meetings per year in London (expenses are paid). Being involved is interesting, great team work and a really fantastic opportunity to make new contacts and learn from colleagues. You will also be awarded CPD points for being on a committee. Committee members do not require full accreditation but we do ask that you have passed the theory exams and are preparing to sit the practical.

If you are interested in taking on a role or would like any further information please contact me on: h.dixon@nhs.net.

Helen Dixon, SVT Vice President.

Executive Committee Meeting Summary

October 2016

Conference

The ASM workshop was discussed and the format will include lectures and a 'live' demonstration of renal, visceral and abdominal scanning. Philips will supply the machines for the afternoon. All items for the workshop booklet and ASM programme to be submitted for the 7th November as this is the deadline for publishers.

Venue for the SVT welcome drinks reception is still to be confirmed and members will be sent this information in an email nearer the time.

There were 21 abstract submissions to the scientific section of the ASM and 6 trainee submissions. There were some minor issues with the online scoring system but these were resolved by Dominic and Fitwise. Voting procedures for the best paper and best student proposal were discussed.

Website

The new website receives 50-60 hits per day from around the world including UK, USA, India and Porto Rico. The online CPD program is almost ready. This is a link to a separate website to access the activity and can use questions, videos, links, MCQ's and True/false questions. The pass rate can be set as required eg. No. of points. A certificate can be sent to member locker for CPD record. TG suggested having a patient area of the website to provide information and leaflets – or links to CF leaflets. This is to attract more visitors to the site and raise awareness of vascular disease.

A meeting is to be arranged between Steve Walmsley (Capability Cloud) and all SVT officers using the admin side of the website to give training on how to use it.

Research Committee

The SVT research committee met on Monday 18th July, all members attended and work to be carried out by the committee divided up between the members. The committee has produced documentation for applying for SVT research grants including application form and guidance. The committee has also produced and uploaded new content for the research pages of the website. The committee continues to maintain links with Vascular research groups and feeds back to the committee.

Education committee report

The education committee met on 15th September. The education committee fed back to the executive committee with questions regarding the new system for the SVT exams, website changes and the use of the website for online CPD exercises. The resit exams were held on the 5th September, 9 members sat the Physics paper and 5 the Technology. The committee reviewed the papers 5 questions were removed

from the physics paper marking. The pass rate was 60% for the Technology paper and 22% for the Physics. The exam certificates will be applied to each members web account and an email sent to alert members of how the results have been issued. The fundamentals days will run in late January and the SVT will also be running a study day in Ireland next year on upper limb/fistula scanning. The tutorial dates will be held at the end of March and will include information about the new electronic delivery of the exams. Tutors are also required for some areas of the syllabus.

The trainee breakout session at the ASM this year will include a talk from a graduate of the STP scheme on gaining SVT accreditation, a Q&A session on equivalence and a TCD talk.

Newsletter

Future editions of the SVT newsletter will be sent to members as a web-link to the SVT website.

Treasurers report

End of year Income/expenditure report has been submitted, this will be included in the AGM programme. An application has been submitted for a business account which will enable card payments and BACS transfers to be made for expenses etc. A direct debit facility will also be set up.

Membership

For the new membership year we currently have 490 members listed with 3 pending. Of these 86 are yet to pay, either in full or their payment shortfall. We therefore have 404 fully paid up members. Numbers correct as of 4th October 2016. Fully paid members have both a receipt and certificate of membership in their locker.

The normal system for reminders of expiring memberships to members was not activated by the system this year. This was apparently due to the database inheriting membership expiry dates rather than producing them itself as members joined. In future a reminder will be sent out weekly for the four weeks prior to expiry. An email is not automatically sent once it has expired. Capability Cloud has said that feedback from other Societies state that this is sufficient.

There have been some minor technical issues with the new database/website which have been resolved quickly. Communication on the whole with the website company has been good.

PSC

Code of conduct - SVT code of conduct has been uploaded to the website.

SVT complaints procedure and proforma - the draft is completed however following discussion with WT at SCoR a right to appeal section needs to be added.

Constitution - Point 9 changed – will need vote by membership.

Professional Performance Guidelines - Most Performance guidelines have been uploaded now, on-going development of the TCD document.

Service Specifications - We are currently reviewing all of the service specifications documents, references and links need updating and changing.

NICE - No current updates. AAA Guidelines and Diagnostic imaging

guidelines in development.

IQIPS - Level A specific domains for Vascular have been developed by PSC and submitted. Numbers from IQIPS: 13 services enrolled in the programme using the SAIT (up from 9. Still only one service accredited. Average time from UKAS application to accreditation is around ~12 months (based mostly on data from other specialties).

Vascular Society

TG attended the Open Council meeting on Friday 9th Sept at NCVO in London. Major items discussed were recruitment into vascular surgery and raising profile and awareness of profession.

BMUS

Meeting on 28th Sept. EW unable

to attend. Awaiting minutes. Steve Rogers and Tracey Gall are continuing with organising the ASM vascular stream and carotid workshop.

AOB

SVT formal regalia designs were displayed for the exec at the meeting and a vote taken to decide on the design for the presidents and past presidents medals.

TG attended the ESVS in Copenhagen to speak on vascular scientist training in the UK and help with the workshop. We hope to be asked to support this session next year in Lyon.

Committee Members 2016

EXECUTIVE

President

Tracey Gall

Past President

Tanyah Ewen

Vice President

Helen Dixon

Membership

Sara Causley
membership@svtgbi.org.uk

Website & Job Adverts

Lee Smith
website@svtgbi.org.uk

Newsletter

Helen Dixon (acting)
newsletter@svtgbi.org.uk

Treasurer

Tanyah Ewen (acting)
treasurer@svtgbi.org.uk

Conference Secretary

Dominic Foy
conference.secretary@svtgbi.org.uk

EDUCATION

Chair

Siobhan Meagher
siobhan.meagher@luht.scot.nhs.uk

Exam Registration

theoryexam@svtgbi.org.uk

CPD Coordinator

Shakila Chowdhury
cpd.avs@svtgbi.org.uk

Assistant CPD coordinator

Julia Habens
cpd.avs@svtgbi.org.uk

Study Day Coordinators

Edmund Ramage & Davinder Virdee

Newsletter Questions

Heather Griffiths
heather@vascularsolutions.co.uk

Theory Exam Officer

Sophie Harrison
theoryexam@svtgbi.org.uk

Technology Exam Officer

Naavalah Ngwa-Ndifor
Naavalah.Ngwa-Ndifor@bartshealth.nhs.uk

Physics Exam Officer

Caroline Dainty
carolinedainty@nhs.net

Practical Exam Officer

Anne Delossantos
practicalexam@svtgbi.org.uk

Trainee Network

Ria Sharpe
ria.sharpe@uhl-tr.nhs.uk

STP Graduate Representative

Laura Scott
laurascott8@nhs.net

PROFESSIONAL STANDARDS COMMITTEE

Chair

Matthew Slater
matthew.slater@addenbrookes.nhs.uk

Members

Mary Ellen Williams
Richard Craven
Lila Elliott
Alison Charig

RESEARCH COMMITTEE

Chair

Richard Simpson
richard.simpson@nuh.nhs.uk

Members

Steven Rogers
Laura Scott