

***The Society for Vascular Technology of  
Great Britain and Ireland***



**The Accreditation Document**  
**Attaining & Maintaining Registration as**  
**an Accredited Vascular Scientist (AVS)**

**2012**

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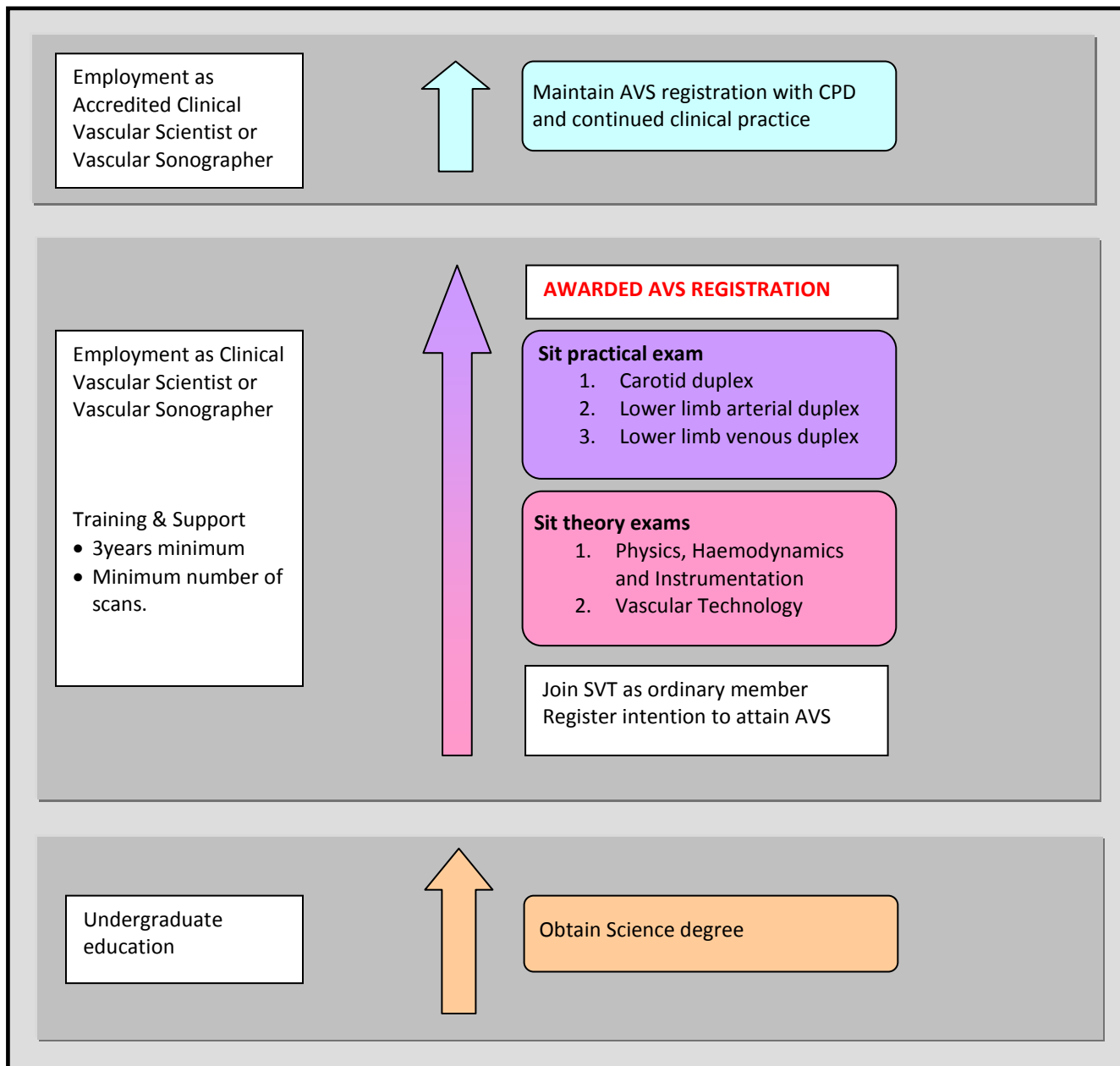
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# 1 – Introduction

The aim of the SVT Accreditation process is to ensure the achievement and maintenance of high standards of diagnostic vascular investigations for the benefit and safety of patients. Accreditation as a Clinical Vascular Scientist (AVS) is recommended for all individuals practising vascular ultrasound in the UK or Ireland and is aimed at the **ADVANCED SCIENTIST with a minimum of three years** full-time postgraduate experience (or part-time equivalent) in a **range of key diagnostic vascular investigations**. The accreditation process can be summarised as follows:



## 2 - Academic Requirements

- Applicants for AVS will be expected to hold a relevant **science degree** prior to accreditation training.
- The Society will consider equivalent professional qualifications or experience (e.g. radiography).
- Qualifications below degree level may be considered on individual merit in the case of those entering the profession before 2001.

**How do I apply for ordinary membership of the SVT?** The application form for new membership is available on the society website

## 3 - Training and support

The SVT recognises that Clinical Vascular Scientists work in a variety of clinical settings. They may be employed as lone practitioners, as part of a large team, in dedicated vascular studies units or in general radiology departments. They may be specifically employed as a supernumerary trainee with well structured academic support and broad clinical training or they may be employed as a permanent member of staff expected to “learn on the job” with little educational support and unfocused clinical training.

It is the responsibility of the applicant to ensure that they have the appropriate support and guidance (from an experienced AVS) and be able to gain sufficient clinical experience in all of the core modalities before embarking on the route to AVS. Supplementary academic support may be obtained from a higher education establishment (e.g. by studying for an MSc Medical Ultrasound).

It is also the responsibility of the applicant to ensure there is a suitable record of each type of diagnostic vascular investigation carried out. This record may be part of PACS, a department database or an individual’s logbook but it must be in a format that contains enough information to breakdown the clinical activity into the compulsory and optional elements of the **Core Modalities** (the elements and numbers required are detailed in appendix 1).

### The Core Modalities required for eligibility for AVS registration are

- Core Modality 1 – Carotid Duplex
  - Compulsory element – carotid/vertebral duplex
- Core Modality 2 - Peripheral arterial duplex
  - Compulsory element – aorto/iliac/femoral/calf arterial duplex
- Core Modality 3 - Peripheral Venous duplex
  - Compulsory element – lower limb varicose vein and deep vein duplex
- Core Modality 4 – ABPIs (including exercise testing)

## 4 - Theory Exams

- Applicants for the theory exams must be a member (ordinary or associate) of the SVT.
- There are two theory exams
  - Vascular Physics, Haemodynamics and Instrumentation
  - Vascular Technology
- Candidates may choose to sit both exams in the same year or in different years.

Each theory exams lasts 2½ hours and consists of 100 Multiple Choice Questions (MCQs).

The pass mark for each examination is 70%. Each question has only one correct answer and there is no negative marking.

The theory exams are held in **May** each year in both London and Dublin with results available in late June.

There is a re-sit exam in September (but only for those candidates unsuccessful in May of that year) and results are available in October.

There is no limit on the number of times a candidate may apply to re-sit a theory exam.

A successful pass in a theory exam is valid for 5 years (with respect to eligibility to sit practical exam).

There is a detailed syllabus and reading list for each exam on the SVT website.

**How do I apply for the theory examinations?** The registration form for the May theory exams is available on the society website between Dec and Feb of each year.  
For those candidates unsuccessful in the May exam the registration form for the September re-sit is available June and July each year.

The theory exams are aimed at individuals who have been practising diagnostic vascular investigations for 2 years however this length of experience is not mandatory. Candidates with well structured academic support may find they have confidence to sit the theory exams earlier. However remember the practical exam must be taken within 5 years of the passing the theory exams.

The theory exams are aimed at clinical vascular scientists aspiring for AVS. However they are open to any SVT member to sit at any time e.g. vascular researchers, nurses or surgeons wishing to test their theoretical knowledge.

The SVT runs a two day course in September/November for trainees covering both basic physics and technology theory and practical techniques. There is also an exam revision course each year in February/March held in London and is aimed at helping candidates in their final exam preparation.

## 5 - Practical Exam

### Applicants for the practical exam

- Must be an ordinary member of the SVT (see website for details of membership types).
- Be **currently employed in the UK or Ireland** to perform vascular diagnostic investigations.
- Have been employed in the UK or Ireland to perform vascular diagnostic investigations **for at least 6 months** prior to applying to sit the practical exam.
- Have a Science degree.
- Have passed both theory exams in the last 5 years.
- Have performed **at least 600 scans in each of the 3 core duplex modalities** (including a minimum number of compulsory elements) and **200 ABPIs**. *See appendix 1 of Accreditation for details of qualifying scans.*
- Have at least **3 years full-time diagnostic vascular scanning experience** (or part-time equivalent) in each core modality. *See Appendix 2 of Accreditation Document for full details.*
- Have carried out at least 25 scans from each of core modalities 1-3 in the preceding 3 months prior to applying to sit the practical exam.
- Must provide a reference from their line manager and a vascular surgeon.

The practical exam consists of 3 patient examinations and a *viva voca*

- A bilateral carotid and vertebral duplex examination (from Core Modality 1 – Carotid duplex)
- A single full-leg (aorta-ankle) arterial duplex (from Core Modality 2 - Peripheral arterial duplex)
- A single full-leg (groin-ankle) varicose vein and deep vein scan (from Core Modality 3 - Peripheral venous duplex)
- Viva Voca – covering clinical protocols, understanding of machine and service development.

**For the purpose of a standardised accreditation process the minimum scope for each scan is defined by the SVT, irrespective of local protocols.**

**Details of the minimum scope for each of the core modality scans can be found in appendices 3, 4, 5 & 6.**

Please note that local protocols and copies of recent reports must be available to examiners on the day of the practical assessment.

The practical exam may be taken at any time of the year, is taken in the candidate's place of work and is expected to last 3-5 hours.

There will be two examiners (both current AVS: registered for at least 1 year)

- one internal examiner appointed by the candidate
- one external examiner appointed by the SVT

Two external examiners may be appointed if there is not a suitably qualified or experienced internal examiner.

There is no limit on the number of times a candidate may apply to resit the practical exam however it must be taken within 5 years of passing the theory exams and at least 6 months after a previously failed practical exam.

**How do I apply for the practical examination?** The application form for the practical exam is available on the society website at all times of the year.

Successful completion of the practical exam entitles the candidate to be registered and use the term

## **Accredited Vascular Scientist (AVS).**

However AVS only remains valid with successful upkeep of CPD and clinical competency

## **6. Continued Professional Development (CPD) and maintaining AVS status**

The AVS award only remains valid under specific conditions. The AVS must

- **Condition 1** - be a current paid-up Ordinary Member of the SVT.
- **Condition 2** - maintain clinical competency by performing a minimum of 100 scans per annum in each of the 3 core duplex modalities, keep appropriate record of numbers and register numbers before the end of September
  - Core Modality 1 – Carotid duplex
  - Core Modality 2 - Peripheral arterial duplex
  - Core Modality 3 - Peripheral venous duplex
- **Condition 3** - accrue a total of **30 CPD points** summed from the **previous 3 years** (i.e. average 10 points per year) and register points before the end of September every year.

The time period for accruing CPD and maintaining clinical competency coincides with the membership year i.e. 1<sup>st</sup> September to 31<sup>st</sup> August. Newly registered AVS must start collecting CPD points immediately and **submit data in the first September following their practical exam**. Newly registered AVS will be awarded 10 points for each of the last 3 years to ensure their 3 year rolling average is not disadvantaged at the start. Newly registered AVS may also include CPD points obtained at conferences and study days during their training period.

It is the personal responsibility of each registered AVS to keep records of their CPD activity (e.g. certificates, programmes, course notes) and their clinical activity (e.g. using PACS, departmental database or personal logbook). **Each year the SVT Education Committee will randomly select 10% of AVS for a detailed inspection of CPD and clinical activity.**

### **AVS at risk**

If conditions 1 to 3 are not met before the end of September then AVS registration will be considered “at-risk”.

If conditions 1 to 3 are not met before the end of December **AVS registration will be suspended.**

### **Suspension of AVS registration**

Following suspension if conditions 1 to 3 are met before the end of March then AVS registration will be reinstated (but there will be an additional late registration penalty fee)

If conditions 1 to 3 are still not by the end of March then AVS registration will remain suspended until

- Conditions 1 to 3 are met
- The practical examination is retaken and passed
- The re-registration penalty fee is paid

If AVS registration is suspended for 5 years or more then both theory and the practical exam will have to be retaken and all conditions met before AVS can be reinstated.

**How do I register my CPD points and clinical competencies?** The CPD form is available on the SVT website throughout the year

Useful tip: If you happen to accrue more than 30 points in a single year it is not necessary to record this additional activity on your CPD record as it will never be needed. Keep it simple!

Exceptions and exemptions may apply due to sabbaticals/ maternity leave / illness for up to 1 year. Applications will be considered on an individual basis. Other exemptions may be considered based on individual merit. Please contact the CPD coordinator for advice.

## Appendix 1: The Core Modalities and Required Numbers

A minimum number of diagnostic vascular investigations is required and must be achieved by direct hands-on experience of **appropriate patient referrals**. At least 3 years full-time experience (or part-time equivalent) in each of the **compulsory elements** of the core modalities is required (even if the minimum number is reached sooner).

### The Core Modalities required for eligibility for AVS registration are

- **Core Modality 1** – Carotid duplex **MINIMUM 600**
  - Compulsory element – Carotid/vertebral duplex **MINIMUM 500**
- **Core Modality 2** - Peripheral arterial duplex **MINIMUM 600**
  - Compulsory element – aorto/iliac/femoral/calf arterial duplex **MINIMUM 300**
- **Core Modality 3** - Peripheral venous duplex **MINIMUM 600**
  - Compulsory element – lower limb varicose vein and deep vein duplex **MINIMUM 400**
- **Core Modality 4** – ABPIs (including exercise testing) **MINIMUM 200**

The SVT strives to be as flexible and inclusive as possible and take into account the variety of clinical settings and changing workload of candidates aspiring to AVS. As such each Core Modality is split into **compulsory** and **optional** elements. The optional elements can be used to boost the numbers in each core modality up to the limits outlined in the table below. The general expectation would be for the number of scans to increase during the training period. For example: 100 scans in year 1, 200 in year 2 and 300 in year 3, in each modality. The majority of the scans must demonstrate pathology rather than be “normal”.

The 3 compulsory elements of Core Modalities 1, 2 & 3 will be assessed in the practical examination.

Core Modality 1		Core Modality 2		Core Modality 3		Core Modality 4		
Carotid duplex	Required numbers	Peripheral arterial duplex	Required numbers	Peripheral venous duplex	Required numbers	ABPIs	Required numbers	
Compulsory Elements	Bilateral Carotid Duplex (ex. f/up scan)	Min 500	Single leg arterial (aorta-TPT)	Min 250	Single leg VV scan <i>(Must include: Primary vv Recurrent vv)</i>	Min 400	ABPIs - bilat <i>(Must include: ABPI pre+post Exercise - bilat)</i>	Min 150
			Full single leg arterial (aorta-ankle)	Min 50		<i>Min 50 Min 100</i>	Min 50	
Optional Elements	Intraoperative carotid duplex	Max 50	Single leg segment duplex (iliac only/ femoral only/ calf only)	Max 300	Vein map (pre bypass)	Max 50	Toe pressures - single	Max 50
	Follow-up carotid	Max 50	Graft scans	Max 150	DVT arm	Max 50		
	TCD imaging	Max 50	Upper limb arterial	Max 100	DVT Above knee	Max 50		
			Thoracic outlet duplex	Max 50	DVT calf	Max 50		
			EVAR surveillance	Max 50	Pre-op vv mark	Max 50		
			Renal artery	Max 50	Intra-op vv scan	Max 50		
			True aneurysm scan	Max 50				
			False aneurysm scan	Max 50				
			Fistula surveillance	Max 50				
Total	Minimum	600	Minimum	600	Minimum	600	Minimum	200

## Appendix 2: Calculating the number of years experience

A minimum of 3 years clinical experience and responsibility in diagnostic vascular investigations is required before the practical examination can be taken.

The **minimum of 3 years** clinical experience is based on **37.5hrs per week** employed as a clinical vascular scientist or vascular sonographer. Within these full-time hours there is the expectation that this will involve scanning patients on average 8 out of 10 sessions per week. It is expected that the remainder of the time will be spent doing structured reading, attending training courses, attending university etc.

Clinical vascular scientists or vascular sonographers working part-time must pro-rata their hours accordingly e.g. an individual working **22.5hrs per week in vascular ultrasound will take 5 years** before eligible for the AVS practical examination even if they acquire the requisite number of scans in the core modalities sooner.

$$\text{Years} = \frac{37.5}{A} \times 3 \quad A = \text{number of hours worked in diagnostic vascular ultrasound}$$

The SVT recognises that some of the skills required for an AVS can be obtained by **non-vascular ultrasound scanning**. Skills such as ultrasound technology, use of the machine, scanning techniques, artefacts, image interpretation, hand-eye coordination, patient care and reporting. Sonographers working part-time in vascular ultrasound and part-time in another ultrasound specialty may have their non-vascular ultrasound experience credited towards their qualifying years at a value of 75% - **providing they are fully responsible for reporting the scans**. E.g. a sonographer who works 10 hours per week in general ultrasound can have this counted as 7.5hrs for the purpose of calculating qualifying years.

$$\text{Years} = \frac{37.5}{A + 0.75B} \times 3 \quad B = \text{number of hours worked in non-vascular diagnostic ultrasound}$$

Example jobs	Example Weekly Hours	Minimum qualifying years before eligible
Clinical Vascular Scientist or vascular sonographer	37.5hrs vascular	<b>3yrs</b>
Clinical Vascular Scientist <i>part-time</i>	20 hrs vascular	$(37.5/20) \times 3 = \mathbf{5.6yrs}$
Clinical Scientist <i>Part-time vascular / part-time radiotherapy</i>	18.75hrs vascular 18.75hrs radiotherapy	Only vascular ultrasound counts 18.75hrs $(37.5/18.75) \times 3 = \mathbf{6yrs}$
Sonographer <i>part-time vascular / part-time general ultrasound</i>	15hrs vascular 22.5hrs general ultrasound	General ultrasound counts at 75% $37.5 / (15 + (0.75 \times 22.5)) \times 3 = \mathbf{3.5yrs}$
Radiographer <i>part-time vascular / part-time ultrasound / part-time X-ray</i>	15hrs vascular 7.5hrs general ultrasound 15 hrs X-ray	Ultrasound hours count i.e. 22.5hrs $(37.5 / (15 + (0.75 \times 7.5))) \times 3 = \mathbf{5.5yrs}$

Other types of ultrasound, physics or physiological measurement work may be credited towards the qualifying years at the discretion of the education committee. If you are unsure how your experience or hours may count please contact the Chair of the Education Committee for clarification.



## Appendix 3 – The minimum scope of the scans

With significant changes to scientific careers in the NHS it is important for the SVT to demonstrate that it has a robust and standard process of assessing the skills and clinical competencies of members. Candidates will no longer be able to choose what they are examined in.

The practical exam consists of 3 patient examinations and a *viva voca*

- A bilateral carotid and vertebral duplex examination (from Core Modality 1 – Carotid duplex)
- A single full-leg (aorta-ankle) arterial duplex (from Core Modality 2 - Peripheral arterial duplex)
- A single full-leg (groin-ankle) varicose vein and deep vein scan (from Core Modality 3 - Peripheral venous duplex)
- Viva Voca – covering clinical protocols, understanding of machine and service development.

The minimum scope for each of the core modality scans is outlined in appendices 4, 5 & 6 and sets out the basis upon which the candidate will be assessed. It is recognised that they may differ from the local protocols normally followed in any particular department. They are given in order to ensure that a uniform standard of assessment is performed for each candidate, no matter which department they are in, and are designed to include all the features of scan performance that a candidate achieving accreditation should be able to perform if required to do so.

### Patient Selection

The 3 scans must be clinically appropriate referrals.

A patient's consent to be part of the examination process must be acquired in advance.

During all scans it is important to remember the privacy and dignity of the patient particularly in light of the additional people present in the room.

The patients should be positioned appropriately for each scan being performed.

### Equipment

A duplex ultrasound scanner with the appropriate range of probes for the examinations.

Minimum requirements: Linear array 5-10MHz and Curvilinear array 2-5MHz

### Image Recording

In order for the Assessors to be able to fully discuss the examination and report with the candidate after the patient has left the room, it is necessary to have images of the examination available. Therefore whilst it may not be the usual practice of a department to routinely record images and waveforms **for the purposes of this exam a recording of the images and waveforms should be available** for discussion with the final report. This may be in the form of hard copy or as a set of stored images available for viewing on the scanner. If you do not normally record images, you may find it helpful to practice doing so before the assessment takes place so you do not forget on the day.

### Reporting

Using the in-house reporting system a full written report (with diagrammatic representation when used) will be expected.

## Appendix 4 - A bilateral carotid and vertebral duplex examination

- The scan must be a diagnostic referral for a carotid duplex investigation.
- The patient must be >50yrs with appropriate carotid territory symptoms.
- The patient must be a new referral with no previous carotid duplex.

The examination should cover the arterial supply to the head from the common carotid artery (CCA) to the distal internal carotid artery (ICA) and include the proximal external carotid artery (ECA), vertebral artery, proximal subclavian artery and the brachiocephalic artery on the right.

- The CCA, bifurcation, ICA origin and ECA origin should be identified in B Mode using the transverse and longitudinal plane. The presence of any disease should be identified.
- Colour and spectral Doppler should be used appropriately to assess flow in the brachiocephalic, proximal subclavian, CCA, ICA, proximal ECA and vertebral.
- Identification and differentiation of the ECA and ICA should be clearly demonstrated with spectral Doppler.
- Peak systolic velocities and end diastolic velocities must be measured and documented in the distal CCA and proximal ICA and at any areas of flow disturbance.
- Direction of flow must be identified in the vertebral artery.
- The anatomical location of any haemodynamically significant lesion should be documented.
- Basic plaque characteristics and the length of any lesion should also be documented.
- The quality and patency of the ICA lumen distal to any disease should be documented.
- Any limitations of the scan must be documented.

Whilst stenoses may be graded and reported using local criteria, if this differs from the recommended criteria below you will be expected to justify your local protocol and understand and explain the implications of the differences.

### Recommended carotid grading criteria

Percentage Stenosis (NASCET)	Internal carotid peak systolic velocity cm/sec
<50	<125
50-69	>125
70-89	>230
>90 but less than near occlusion	>400
Near occlusion	String flow
Occlusion	No flow

## Appendix 5 - A single full-leg arterial duplex

- The scan must be a diagnostic referral for a full-leg lower limb arterial duplex. If the referral is just for a limited duplex (e.g. femoro-popliteal duplex) then the referrers and patient's approval must be sought to extend examination to full leg for purposes of the exam.
- The patient must have significant arterial disease. For the purposes of the examination this is defined as a resting ABPI < 0.8 or a post-exercise ABPI of < 0.6 which must be established prior to booking the patient for the exam.
- The patient must be a new duplex referral with no previous lower limb arterial duplex.

The examination should cover the arterial supply in the leg from the distal aorta to the ankle including the common iliac, external iliac, internal iliac origin, common femoral artery, profunda artery origin, superficial artery, popliteal artery, tibio-peroneal trunk, anterior tibial artery, posterior tibial artery and peroneal artery.

- The aorta should be identified in B Mode using the transverse and longitudinal plane. Anterior-posterior diameter measurements should be taken. The presence of any disease should be identified.
- Colour and spectral Doppler should be used appropriately to assess flow in all of the lower limb arteries.
- Peak systolic velocities must be measured and documented at appropriate intervals particularly near a stenosis.
- The anatomical location of any haemodynamically significant lesion should be documented.
- The degree of narrowing and/or length of occlusion should be documented.
- Any limitations of the scan must be documented.

## Appendix 6 - A single full-leg varicose vein and deep vein scan

- The scan must be a diagnostic referral for a varicose vein duplex.
- The patient must have significant visible varicosities.
- The patient must be a new duplex referral with no previous lower limb venous duplex

The examination should cover the deep and superficial venous supply in the leg from the groin to the ankle including the common femoral vein, the profunda vein origin, superficial femoral vein, popliteal vein, tibio-peroneal trunk, anterior tibial veins, posterior tibial veins, peroneal veins, gastrocnemius veins, soleal veins, long saphenous vein, short saphenous vein, relevant perforators and branches.

- All the deep veins (including calf veins) should be assessed for deep venous thrombosis using transverse B Mode compression
- The femoral and popliteal deep veins should be assessed for reflux using colour and spectral Doppler at appropriate intervals.
- The superficial veins should be assessed for superficial thrombophlebitis.
- The superficial veins and varicosities should be assessed for reflux with the source of reflux identified.
- Any limitations of the scan must be documented.