The Royal College of Radiologists

THE ROYAL COLLEGE OF RADIOLOGISTS (RCR)

Response to:

NHS England Consultation on Specialised Vascular Clinical Commissioning Service Specification

- The consultation document does not contain any mention of the RCR's *Provision of Interventional Radiology Services* (1) document. This is important as it deals with many of the issues around how services are configured to provide optimal care for patients with vascular and non-vascular disease by interventional radiology (IR). In addition to having the availability of the surgical teams, there should be availability of interventional radiologists, nursing and radiographers to provide a 24/7 service with investment in these services. 24/7 emergency cover is required regardless of whether the site is an arterial centre or not with clear protocols/pathways for both. There needs to be good collaborative working relationships between the vascular and interventional teams to provide the best patient focused care.

- There is very little (and late) mention of the issues around managing diabetic foot problems, and prevention of amputations. There should be regular MDTs which should include diabetologists, surgeons, interventional radiologists and podiatrists, as well as considering specialised nursing and physiotherapy.

- Trauma remains outside this document, but the provision of a vascular and a trauma service requires specific IR support.

- Vascular access constitutes an increasing proportion of work for vascular specialists beyond just renal and needs to be included within scope of practice and service delivery.

- Abdominal aortic aneurysm (AAA) numbers assume that surgeons only are involved in AAA repair, which is not correct.

- The list of registries is out of date. BIAS is now closing and should be removed. NVR is now being used. There are set outcome measures for surgery and similar measures of IR should be included i.e. from the RCR *Provision of vascular services* document and from the Society of Interventional Radiologists (SIR) and **Cardiovascular and Interventional Radiological Society (**CIRSE) quality standards.

- There needs to be greater emphasis on the importance of day case and other IR procedures at non-arterial centres. These can offer a wider range of interventions as well as a clinical vascular service on site. These can be performed without onsite cover by surgery particularly for simpler procedures as is the case for coronary angioplasty (1). There may be opportunities to move some work out to the non-hub centres to partly counterbalance work moving into the main arterial centre and avoid overloading the hub. This will also help maintain core skills in the non-arterial centre to support on call.

- In emergency cover, it may be more appropriate for the call to be to an interventional radiologist, so there needs to be a method for this referral. In addition it may be

necessary for both an IR and a surgeon to transfer to the patient, or the patient to be transferred to the arterial centre, where the equipment is available.

- It needs to be remembered that vascular IR offers much more than that considered in more traditional vascular surgery (e.g. control of bleeding, obstetric care etc).

- We support the key role of the MDT co-ordinator to ensure patients are not lost in the system during transfer. They should be discussed in a timely fashion with the relevant clinical information, imaging and ensuring the patients have an agreed action plan from the MDT.

Reference

1. Provision of interventional radiology services - BFCR(14)12 , 2014, Royal College of Radiologists, London.

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