

NHS England Consultation on Mechanical Thrombectomy for acute ischaemic stroke

Specialised Services clinical commissioning policies and service specifications

Would you like to comment on a service specification, or clinical commissioning policies?

Service specification

Service specification

Please indicate which service specification you would like to comment on:

Neurointerventional Services for acute Ischaemic and Haemorrhagic Stroke

Does the impact assessment fairly reflect the likely activity, budget and service impact?

Yes

If you selected 'No', please tell us what is inaccurate?

Does the document describe the key standards of care and quality standards you would expect for this service?

Yes

If you selected 'No', what is missing or should be amended?

Please provide any comments that you may have about the potential impact on equality and health inequalities which might arise as a result of the proposed changes that we have described?

For mechanical thrombectomy (MT) to be effective it needs to be available to patients within a very short time frame. This means there has to be a robust service available in all regions both in and out of hours. With the exception of one or two centres which have recently implemented such a service this is not yet the case. The current numbers of Interventional Neuroradiology (INR) consultants available to deliver the service, and the time involved in training new INR consultants or retraining consultants in other allied fields, make achieving implementation within the proposed timescale unlikely. The longer the phased implementation plan takes, the longer there will continue to be wide variability in the service available to patients. *See below for more detail.*

Are there any changes or additions you think need to be made to this document, and why?

The RCR is fully in agreement with the need for personnel delivering MT to be well trained and audited, and that there is a need for an agreed national standard. We believe that the "*Standards for providing safe acute ischaemic stroke thrombectomy services*" which are quoted in the service specification, accurately represent the ideal situation in the long term. However, the prescriptive nature of the standards could be restrictive in the short term, potentially delaying the implementation of the 24/7 service.

We believe there needs to be some flexibility in the training of other clinicians who might deliver the service (e.g. Interventional Radiologists), as different doctors from different backgrounds will require different levels of training and experience to become competent. The number of procedures that trained consultants will be required to perform each year to maintain competence is felt to be too

high in the early years of implementation. How many patients a centre is receiving as it ramps up its service will affect the speed at which clinicians in that centre are signed off and by extension increase the amount of time it takes for centres to reach full 24/7 service delivery. While national standards are required, local factors should also be taken in to account and trusts should have the authority to sign-off on the delivery of what is safely possible in their location, with the experience and workforce at their disposal.

A two-year time-frame for training consultants in allied fields would be appropriate for some clinical specialties, but Interventional Radiologists (IRs) could be trained up to support an INR-led service in less time. IRs already perform a wide range of image guided, minimally invasive procedures for many organ systems. These procedures often have a number of similarities and transferrable skills with the MT procedure. In addition, IRs have a strong (and formally assessed) expertise in imaging, including the brain and CT angiography, having followed the same curriculum in core radiological skills as INRs. There is evidence from the USA and Europe that such transferable skills can be used without prescriptive training or practice requirements (*Interventional Stroke Treatment in Germany is a Joint Effort Between Neuro- and General Interventional Radiologists. Berlis A, Weber W. Cardiovasc Intervent Radiol. 2016 Nov;39(11):1539-1540 and Interventional Radiologists and Endovascular Therapy for Acute Ischemic Strokes. D Sacks. J Vasc Interv Radiol 2017 ; 28 : 1137-40.*). In-house training at the neuroscience centres, simulator training and practice, mentoring by INRs, clinical governance and local job planning could be used to rapidly upskill IRs and these options are already being considered by an RCR-led cross-specialty working group. However, if the training standards referenced in Section 5 of the Service Specification Annex are adopted as currently written without any in-built flexibility, this could hinder such initiatives from being used to address the urgent workforce need.

Even if IR consultants or consultants from other allied fields are trained up to help to deliver the service, the RCR strongly believes that all MT services must be INR-led and that all efforts must be made to increase the INR workforce to ensure full coverage in the future.

For the neuroscience centres to deliver a 24/7 MT service that is staffed safely and sustainably, the number of INR consultants in the UK will need to double over the next five years. The current number of trainees following the INR pathway will not come close to meeting that need. The number of INR training posts therefore needs to rapidly expand but there is currently no central funding for this and the severe shortages in the wider radiology workforce, and the inadequate provision of additional training places to address this will further hamper any effort to increase numbers.

In addition to the shortage of training posts that needs to be addressed there is also an issue around attracting newly qualified doctors, radiology trainees and doctors from other specialties to a career in INR. Doctors providing MT services will be making a career-long commitment to providing 24/7 cover on 1/5 rotas, working in a demanding, high stakes environment. While such a career can be interesting, exciting and hugely rewarding, in an under-resourced setting it can also be fatiguing, stressful and potentially bad for physical and mental health. Unless there is high-level engagement to address the factors that discourage recruitment to the sub-specialty there is a significant risk that INR, and by extension MT training and delivery, will fail to expand sufficiently to meet clinical need.