Council, 11 December 2008

Application for the regulation of sonographers from the Society and College of Radiographers

Executive summary and recommendations

Introduction

This short paper updates to the Council about the progress of the application for the regulation of sonographers made by the Society and College of Radiographers.

At its meeting on 27 March 2008, the Council considered an application from the Society and College of Radiographers for the regulation of sonographers.

At its meeting on 4 July 2008, the Council considered a presentation from the Society on their application. The Council identified a number of areas where it believed that further consideration was necessary. These included the likely number of unregulated practitioners and the potential implications of any regulation upon other professional groups.

The Society and College of Radiographers has submitted further evidence for the consideration of the Council, and this is attached to this paper.

The Department of Health extending professional regulation working group is due to publish its final report in January 2009. The group meets to discuss developing a coherent approach to regulating new professions. The group is tasked with considering the possible different models of regulation; developing criteria for determining whether a group should be regulated; and providing guidance on how these groups should be prioritised. The group has also commissioned a piece of research looking at developing a risk-based model to decision making in this area.

The Council will wish to take account of developing government policy in this area in any decisions it makes about the regulation of new groups. A further paper will be brought back to the Council following the publication of the report (this is likely to be at the Council's meeting in March 2009) and the Council invited to make a final decision about the application for the regulation of the songraphers at that stage.

Decision

The Council is requested to note the document. No decision is required.

Background information

Information about the Department of Health extending professional regulation working group can be found here:

www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modernisingprofessionalregulation/ProfessionalRegulationandPatientSafetyProgramme/ExtendingProfessionalRegulation/index.htm

The HPC is represented on the group by the Chief Executive and Registrar.

Resource implications

None

Financial implications

None

Appendices

None

Date of paper

1 December 2008

THE SOCIETY OF RADIOGRAPHERS

Application to protect the title ‘sonographer’ as an additional protected title within the radiography family of titles

Further evidence from the Society of Radiographers

November 2008

Application to protect the title 'sonographer' as an additional protected title within the radiography family of titles

Further evidence from the Society of Radiographers, November 2008

1 Introduction

1.1 Early in 2008, the Society of Radiographers submitted an application to the Health Professions Council (HPC) under its procedures for applications for the regulation of a new profession. As was explained in the application, regulation was sought as a sub-section of the part of the register entitled radiography (see section 3 of the original application and reproduced in this document as appendix 1). The application was given preliminary consideration by the HPC at its meeting in March and further consideration at its July meeting. For the July meeting, the Society of Radiographers gave an oral presentation and responded to questions raised by Council Members. From the two meetings, it was evident that the application met the majority of criteria for aspirant groups with four of the criteria partly met. It was noted in the evaluation that "*The criteria for aspirant groups are tailored towards groups who are not substantially covered by existing regulation and therefore may not apply in the same way to this application.*"

1.2 As a result of the evaluation and the deliberations by the HPC, the Society of Radiographers agreed to provide a supplementary paper to address outstanding matters. Hence, this paper provides further evidence on:

- The partly met criteria:
  - Invasive procedures or clinical intervention with the potential for harm or exercise of judgment by unsupervised professionals which can substantially impact on patient health or welfare
  - Discrete area of activity displaying some homogeneity
  - Defined body of knowledge
  - Voluntary register(s)
- Matters raised by the HPC at its July 2008 meeting:
  - The need for further information regarding the number of unregulated practitioners, and about the possible numbers who would apply to be regulated under grandparenting.
  - The concern that unregulated practitioners of sonography might change their title if the title sonographer was protected.
  - The view of The Royal College of Midwives which had written to the Society of Radiographers stating that nurses who were practising sonography should be regulated by the Nursing and Midwifery Council, and clarification on the Society's stance on this matter.
  - Recent work on ultrasound competencies and the fact that this was not mentioned in the original application.
  - Concern about the extent of overlap with groups who were already regulated and the extent to which sonographers were a distinct group.

1.3 It also provides additional evidence from stakeholders on the application.

2.0 Invasive procedures or clinical intervention with the potential for harm or exercise of judgment by unsupervised professionals which can substantially impact on patient health or welfare

2.1 Evidence submitted previously demonstrated that ultrasound practitioners carry out invasive procedures and clinical interventions, for example ultrasound guided amniocentesis and chorion villus sampling in obstetrics both of which carry an increased risk of miscarriage; trans-rectal examination of the prostate gland including, at times, biopsy of tissue during the examination, and trans-vaginal ultrasound procedures in gynaecology spanning carrying out the examination with the ultrasound probe placed in the vagina through to the introduction of fluid and micro-bubble contrast agents to explore the uterine cavity and fallopian tubes. Various guidelines and papers on these and similar tests were included on the CD-ROM submitted as part of the original application to the HPC and show that, without doubt, those using ultrasound may be undertaking invasive procedures and making clinical interventions.

2.2 In terms of unsupervised individuals exercising judgement that can impact on patient health and welfare, it has long been recognised in the United Kingdom (UK) that ultrasound is a dynamic examination and judgements and reports should be made from the dynamic study as this provides the maximum information available to the ultrasound practitioner. Static images from ultrasound studies should be captured but for record keeping purposes and to illustrate particular findings, not for diagnosis. Hence, the person carrying out the scan is always making judgements that impact on patient health and welfare; for example, structural normality or abnormality of the fetus, whether or not the liver is normal or shows pathology, and the nature of that pathology, is there bleeding from an abdominal organ following trauma, is there evidence of deep vein thrombosis. Judgements such as these are being made on a daily basis by sonographers, a small proportion of which currently fall outside of any regulatory framework. It is the Society of Radiographers contention that this is unsatisfactory and represents risk to the public that it is possible to reduce. Support of this application would be a significant step forward in this regard.

2.3 A further issue is the ease of access to ultrasound technology, and the relatively low cost of some of that technology. This has led to the growth of private services in which the public are invited to purchase social and screening scans. So called ‘baby-bonding’ scans and opportunities to undergo vascular screening are the two largest areas of concern, and both are misleading the public. Women who undergo social scans during pregnancy may not understand that it is not a diagnostic or clinical scan and so may be shocked and distressed when a fetus is later found to be abnormal during a diagnostic scan, or when the baby is born with an unrecognised and unexpected condition. Some of the vascular screening scans on offer are without an evidence foundation and so cannot be justified; for example, offering women abdominal aorta screening tests has no proven clinical benefit. Indeed, so strong is the evidence against the efficacy of screening women for abdominal aortic aneurysm, that women are not included in the target population for this screening programme, currently at the beginning of being rolled out in England. Some of the advertising literature is also misleading, with claims being made that the service is offered by registered sonographers – there is no register of sonographers in the UK at present, other than the public voluntary register maintained by the Society of Radiographers in conjunction with the United Kingdom Association of Sonographers. Appendix 2 shows examples of the literature and unsolicited letters being sent to the public.

3.0 Discrete area of activity displaying some homogeneity

3.1 The Society of Radiographers acknowledges that ultrasound is used by a range of professionals and individuals within healthcare. Looking from the outside, it can be difficult to determine whether there is an occupational group whose core work is ultrasound, or whether it is a technology or tool that should be used by as many as possible. To evaluate this, the Society of Radiographers commissioned an independent piece of work to consider the question ‘ultrasound – profession or tool?’ This was undertaken by the University of Hertfordshire by Hazel Edwards, a Senior Lecturer.

3.2 As her report shows, ultrasound is, indeed, both a tool used by a number of health care professionals *and* also the primary tool of a discrete occupational group. Those using ultrasound as a tool, tend to be already regulated professions using ultrasound to enhance and extend their practice and to the benefit of their patients and clients. In terms of the discrete occupational group, these are individuals whose work is largely or wholly the carrying out of ultrasound examinations across a broad range of clinical applications (some of which may overlap to an extent with those using ultrasound as a tool).

3.3 The Society of Radiographers fully supports proper use of ultrasound, both by clinicians who use it as part of their practice at the point of care focusing on a highly circumscribed part of the spectrum of ultrasound investigations, and by the occupational group (sonographers) whose scope of ultrasound practice is extensive arising from referrals from a sizeable number of different sources/branches of medicine. However, for the latter, the Society of Radiographers is of the firm view that the occupational group whose primary role is the carrying out of diagnostic ultrasound examinations should all fall within a regulatory framework, without exception.

3.4 The report produced by the University of Hertfordshire is appendix 3 to this paper.

4.0 Defined Body of Knowledge

4.1 It is noted that the HPC feels that there is some overlap between the body of knowledge on which the practice of sonographers is based with other professions and occupational groups. This is not uncommon in healthcare practice and is part of the evolution of practice.

4.2 Ultrasound is a relatively new technology with it first being used as a diagnostic tool in the early 1950s, primarily by obstetricians and midwives. However, it was the diagnostic imaging community, particularly radiographers and radiologists, that exploited the technology during the late 1960s and through the 1970s, and developed the core body of knowledge. To date, radiographers remain the largest non-medical group practising sonography but the demand for ultrasound has grown to such an extent that non-radiographers and non-regulated individuals are being recruited into the workforce. These undergo various forms of education and training from ‘on the job’ to a CASE (consortium for the accreditation of sonographic education) approved programme. Case approved programmes are all underpinned by the body of knowledge set out in section 5 of the original application to the HPC.

4.3 The shortage of sonographers available to healthcare services in the UK has led to individuals being recruited from overseas. Some countries, notably Australia, the United States of America and Canada, regulate the practice of sonographers and did so many years ago. This causes considerable difficulties both for the individuals coming to practise in the UK as they have no equivalent regulatory home, and to employers who have little choice but to take on unregulated staff to deliver the service.

5.0 Voluntary Register of Sonographers

5.1 There is in existence a public voluntary register of sonographers. This came into being in the April 2007 and, by the time the application to the HPC to regulate sonographers was submitted in March 2008, 410 individuals were listed in the register.

5.2 In July 2008, further evidence was submitted to the HPC on the voluntary register and those sonographers currently outside any UK regulatory framework. This is included as appendix 4 to this submission of additional evidence.

5.3 Following the HPC’s deliberations in July 2008, the Society of Radiographers commissioned some work to explore in more detail the nature of the sonographic workforce in the UK. Given the limited time available to do this work, this concentrated on two English Strategic

Health Authorities and on the non-radiographic sonographic workforce; and on independent providers of ultrasound services in the UK. This work is reported in more detail in appendix 5 to this document. In summary, the report demonstrates that approximately 9% of the ultrasound workforce in the NHS is unregulated, and that the unregulated percentage in the independent sector is likely to be higher although this percentage is very difficult to quantify. Overall, it is perfectly possible that one in ten members of the public undergoing an ultrasound examination will have that examination conducted by an individual who is outside of any regulatory framework.

5.4 The attempt to further quantify those sonographers outside any UK regulatory framework took place during September and October and it is interesting to note that the public voluntary register of sonographers increased considerably during these two months to stand at 641 on 31st October 2008. This is an increase of more than 30% compared to the numbers on the register when the original application was submitted to the HPC.

6.0 Grandparenting

6.1 As noted in the preceding section, the numbers of sonographers outside the UK regulatory framework is very difficult indeed to quantify. In the original application, the figure was estimated conservatively at approximately 500. This is likely to be a sizeable underestimate, particularly as the ultrasound workforce must grow substantially to enable referral to treatment times to be minimised. To do this it is necessary to recruit sonographers from overseas and to develop direct entry programmes of education and training – at present, neither of these groups is eligible to apply for admittance to any UK statutory register.

7.0 Protected Title

7.1 The Society of Radiographers has given the concerns of the HPC some considerable thought and agree that it is possible for the title 'sonographer' to be protected and for the unscrupulous to adopt a different title if precluded from using the title sonographer. The most likely alternative title is 'ultrasonograher' and the Society of Radiographers suggests that consideration be given to also protecting that alongside the title 'sonographer'.

7.2 It is impossible to foretell how many individuals would seek to circumvent the law and it is not clear whether it is necessary or sensible to protect the two titles. Nevertheless, the public should be given the opportunity to consider this matter in due course. The Society's own evidence suggests that those known to be unregulated sonographers want to come within a regulatory framework and so would not flout new legislation but it needs to be recognised that the unscrupulous are unlikely to make themselves known to the professional body.

8.0 Midwife-Sonographers

8.1 The Society of Radiographers is concerned that the HPC may have misunderstood its intent in relation to midwife-sonographers, in particular, and to others who use ultrasound as part of their practice and already fall within a UK regulatory framework. To clarify, the application is not intended to change the regulatory 'home' of such individuals, nor to require or expect such individuals to become registered with two different regulatory councils. The Society takes the view that the right and proper regulatory body for midwives, including midwife-sonographers is the Nursing and Midwifery Council, and that their professional body is the Royal College of Midwives.

9.0 Recent Work on Ultrasound Competencies

9.1 As the HPC recognised, the original application was made prior to completion of work on ultrasound competencies that began during 2007. However, the Council may be interested to learn that this work, the draft standards of proficiency in the original application and the criteria for entry and retention on the public voluntary register are being brought together in a piece of work the Society of Radiographers will be undertaking early in 2009. In part, this is taking place in response to the difficulty the Commercial Directorate of the Department of Health (England) has experienced with the lack of a competence framework for those in the independent sector who deliver NHS ultrasound services; the Society will be liaising closely with the Commercial Directorate on this project.

10.0 Overlap with other Groups

10.1 The Society of Radiographers feels it has addressed this matter in this additional evidence under the sections entitled ‘defined body of knowledge’ (section 4.0) and ‘midwife-sonographers’ (section 8.0).

11.0 Additional Evidence of Support for the Application

11.1 Although not an outcome of the HPC’s deliberations in July 2008, the Society of Radiographers felt it was important to re-visit the matter of support for its application, particularly from those individuals and organisations that might be seen as ‘key stakeholders’. Accordingly, it commissioned some telephone interview work, the themes of which are summarised in appendix 6. This shows considerable support for, some confusion about, and a small degree of opposition to the application. A strong theme, however, is confusion and a belief that regulation would help resolve this. A related theme was the need to be seen to be protecting the public effectively, with the current situation being considered very much less than satisfactory.

11.2 Some key stake holders also followed up with letters and these are contained in appendix 7 of this additional evidence. The letters enclosed reflect the range of views garnered during the telephone interviews.

12.0 Summary and Conclusion

12.1 The Society of Radiographers is pleased to be able to submit this additional evidence in support of its application to the Health Professions Council to protect the title ‘sonographer’, doing so as a sub-section of the part of the register entitled radiography. As required, the application was made using the procedure for an application from a new profession/aspirant occupational group.

12.2 The Society believes it has addressed all of the concerns and questions raised by the HPC and has shown the importance of protecting the title ‘sonographer’. A substantial body of opinion supports this application and the number of sonographers on the public voluntary register is growing rapidly. The Society asks, therefore, the Health Professions Council to support the application.

APPENDIX 1: Extract (section 3) from original submission to HPC; this shows that the application is for regulation as a sub-section of the part of the register entitled radiography.

Section 3 Consideration of Alternative Routes to Regulation
Has the applicant occupation considered seeking explored regulation as a distinct subsection within a profession already being regulated and if so have you rejected this route?
If so, what were the reason(s) for rejection of alternative route?

The applicant occupation has explored regulation as a distinct sub section within an already regulated profession, those of radiography and clinical science. It has also explored regulation by the HPC independently. As noted, of the already regulated professions, the two considered were Radiographers and Clinical Scientists. Following much discussion, within the ultrasound community, it was agreed that protection of the public would be best served by seeking regulation as a sub-section of the Part of the Register entitled Radiography. This decision was made partly from advice given by an HPC advisor and partly because the majority of sonographers that practice within the UK are radiographers whose practice includes or is solely sonography. Some clinical scientists may undertake some ultrasound examinations in specific, limited fields and do this to a very high standard. However, in the main, their role in ultrasound, is scientific and technical rather than clinical. Additionally, it was recognized that the education standards for sonographers aligned more closely with radiography than with clinical science.

Protecting the title 'Sonographer' as a title within the family of titles covering the profession of radiography is also consistent with the fact that the Society of Radiographers is recognized as the primary professional body for ultrasound practice and is consulted on matters related to ultrasound practice by the four Governments in the UK, and by various other bodies, for example, the National Institute for Health and Clinical Excellence, The National Screening Programme.

The applicant occupation has members that are drawn from a variety of membership organizations and clinical backgrounds, although the majority are members of The Society of Radiographers (SoR). This application is made, therefore, by the SoR, supported fully by the United Kingdom of Sonographers (UKAS).

Has the applicant occupation considered joining other unregulated occupations in a similar field who are currently seeking HPC regulation or may do so?

Consideration was given in 2005 to linking with the British Society of Echocardiographers (BSE) and Society of Vascular Technology of Great Britain and Ireland (SVT) and the United Kingdom of Sonographers (UKAS) to seek regulation of sonographers and protection of the title "sonographer" by the HPC. This project was abandoned when the Chief Scientific Officer (Department of Health (DH), England) and the regulation branch of the DH (England) made it clear that echocardiographers and vascular scientists were already under consideration for regulation by the HPC. They advised that a joint application with BSE/SVT was inappropriate.

Appendix 2: Examples of letters and literature directed to members of the public

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LIFE LINE SCREENING
The Power of Prevention

Painless preventive health tests at

Silverdale & District Working Men's Club, Newcastle

On Tuesday 25th November

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To book call 0808 168 0028

Dear Miss

When I worked in a hospital, I saw the devastating effects of stroke including paralysis, loss of speech and memory, and nursing home admissions.

Did you know that 4 out of 5 people who suffered a stroke had no apparent warning signs?

As a Registered Diagnostic Medical Sonographer and a Registered Vascular Technologist in America, it was frustrating to know that many of the strokes could have been avoided with inexpensive and painless tests. As a result I have since devoted my career to the prevention of stroke and other life-threatening illnesses.

As the Director of Clinical Operations at Life Line Screening, it is my goal to provide preventive health screenings to people before they have symptoms, and identify underlying disease while the complications can still be prevented.

Life Line Screening has screened over 5 million people in the USA over the past ten years. We use advanced technology, operated by qualified sonographers to provide these potentially lifesaving tests to people throughout the country – and we are coming to your local area.

Where: **Silverdale & District Working Men's Club, Newcastle**
When: **Tuesday 25th November**

We use fast, painless, non-invasive ultrasound technology (the same technology used to see the foetus of a pregnant woman) to check for risk factors that could lead to life-threatening conditions.

If you are over age 50, early detection can allow your GP to advise on an appropriate course of action that could be lifesaving.

Test 1. Stroke/Carotid Artery Screening – for risk of stroke

Plaque build-up is the abnormal collection of calcium and cholesterol on the artery walls, as shown in the diagram here. This build-up can restrict blood flow to the brain or attract blood clots that can break off and become lodged in a blood vessel causing a stroke. Our painless ultrasound test visualises the inside of your carotid artery to see if there is plaque build-up.

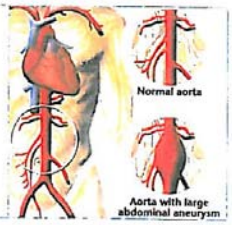
Test 2. Atrial Fibrillation – for risk of stroke and heart failure

Atrial fibrillation or AF is a condition that affects the heart, causing a rapid and irregular heart beat. This increases the risk of blood clots as the heart cannot pump blood efficiently. Having AF increases the risk of stroke up to six times. AF often occurs without symptoms and is considered a 'hidden disease'. Our painless 6-lead ECG (electrocardiogram) can quickly and painlessly identify if you have atrial fibrillation.

Source Code: MLHU-420

Test 3. Abdominal Aortic Aneurysm Screening – for risk of a ruptured aneurysm

An abdominal aortic aneurysm (AAA) is a 'stretching' of the wall in the abdominal artery (aorta). The majority of people with AAAs have no symptoms, but the mortality rate of a ruptured AAA is over 80%, with many not surviving long enough to reach hospital. If you have an AAA it can be identified in minutes using our painless ultrasound technology, which scans the abdomen for an enlargement in the aorta.



Test 4. Peripheral Arterial Disease Screening – for risk of heart disease

Peripheral arterial disease (PAD) is the build-up of plaque in the arteries of your legs. If you have PAD you are 2 to 6 times more likely to die from a stroke or have coronary artery disease that can lead to heart attack. Our painless ultrasound test looks for signs of PAD so you can make changes to your lifestyle or discuss treatment options with your GP to reduce the risk of heart attack.

Test 5. Osteoporosis Screening – for risk of brittle bones

Our ultrasound scan checks your bone-density to assess your risk for osteoporosis, which causes 200,000 fractures a year in the UK. If signs are caught early this is a preventable disease, so screening is invaluable.

All five tests can be performed in about an hour and you only have to take your shoes and socks off!

Results will be assessed by a fully accredited consultant and returned to you within 21 days. We always encourage you to discuss any findings with your GP.

I recommend that you take advantage of these fast, accurate and affordable tests when our screening unit visits. We are offering a special price of £139 for the four vascular screens. Stroke/Carotid Artery Screening, Atrial Fibrillation Screening, Abdominal Aortic Aneurysm Screening, Peripheral Arterial Disease Screening and you can add Osteoporosis Screening for only £10.

It's easy to make an appointment for you and your family. Call freephone 0808 168 0028 for more information and to book your place.

Yours sincerely

Karen R Law

Karen R Law – RDMS, RDCS, RVT
Director of Clinical Operations

PS. Your friends and family are welcome to have these tests even if they haven't received a letter. Please tell a friend or loved one – you may just save a life.

LET4528

LIFE LINE SCREENING
The Power of Prevention

48932017

Dear Ms

When I worked in a hospital, I saw the devastating effects of stroke including paralysis, loss of speech and memory, and nursing home admissions.

Did you know that 50% of all strokes occur in people who have no prior symptoms?

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When: **Saturday 16th August**

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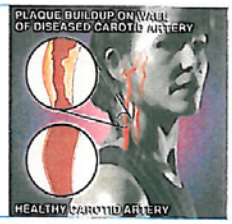

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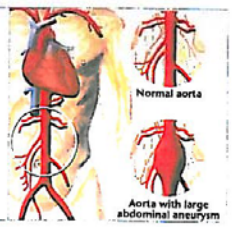

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Yours sincerely,

Karen R Law – RDMS, RDCS, RVT
Director of Clinical Operations
Life Line Screening

PS. Your friends and family are welcome to have these potentially lifesaving tests even if they haven't received a letter. Please tell a friend or loved one – you may just save a life.

Source code : MHHU-305

"Joseph had absolutely no symptoms and I'm sure he would have had a stroke very soon if it wasn't for Life Line Screening coming to town."
Cecille Flaherty-Arnone

Life Line Screening is coming to your local area.

"Thank you Life Line Screening for saving my life."
Linda Pruett

Call 0808 168 0028 to book your screen – it could save your life.

Life Line Screening is America's leading provider of community-based health screenings. We are now bringing our state-of-the-art technology to your local area, giving you access to fast, painless, and affordable health screens that could help to save your life.

All tests are carried out by highly skilled and experienced sonographers using advanced colourflow ultrasound and ECG technology. A fully qualified and accredited consultant will review and confirm all screening results within 21 days.

We are dedicated to providing the highest quality imaging technology at an affordable price. Our mission is to make people aware of undetected health problems and encourage them to seek follow-up care with their GP. By working in partnership with you and your doctor, Life Line Screening offers a convenient, affordable, confidential and accurate way to monitor your health. If a significant finding is noted, you should take the report to your GP who can decide whether further testing or treatment is required.

Appropriate modification of stroke risk factors (such as high blood pressure, smoking, heart disease, diabetes and poor diet) is necessary for stroke prevention. Our screenings cannot detect the risk of all forms of stroke and do not replace regular contact and follow-up with your GP.

Find out more

For more information on Life Line Screening or to book your screen, call 0808 168 0028 or visit:

www.lifelinescreening.co.uk

LIFE LINE SCREENING The Power of Prevention

Life Line Screening UK Ltd, 3rd Floor, Suite 8, 31 Chatsworth Road, Worthing, West Sussex BN11 1LY

We could help **you** avoid a stroke...

Five tests in about an hour

LIFE LINE SCREENING
The Power of Prevention

Tests to help you avoid a stroke and other complications of cardiovascular disease

Often people don't know they are at risk of having a stroke or heart attack until it is too late. 4 of 5 people who suffer a stroke have no apparent symptoms.

Life Line Screening offers fast, painless, accurate and affordable tests that could show if you are at risk.

"I had the Life Line Screening tests and I was advised to see my doctor for further testing. A carotid artery examination verified Life Line Screening's results."
Carlton Holmes

Reasons to get screened

1 Stroke is the biggest cause of severe disability in the UK, and it is the third most common cause of death according to The Stroke Association. Importantly, 80% of strokes can be prevented.

2 Having Atrial fibrillation (AF) increases the risk of stroke by 5 times.

3 Around 1 in 10 men over the age of 65 develop an abdominal aortic aneurysm, according to The Vascular Society. If the aneurysm bursts it can be fatal.

4 1 in 20 people over 55 have some degree of PAD[1] – a significant risk factor for heart disease.

Life Line Screening tests for signs of all these conditions to see if you are at risk. If signs are found, you can visit your GP who can help you determine the best next steps for you.

Source: [1]www.patient.co.uk

Vascular screening package – only £139

All five tests in about an hour

1. Stroke/Carotid Artery Screening
   – for risk of stroke

Painless non-invasive ultrasound scan of the carotid artery in the neck, to check for build-up of plaque, a major cause of stroke.

2. Atrial Fibrillation Screening (AF)
   – for risk of stroke and heart failure

We conduct a 6-lead ECG (electrocardiogram) which will identify AF. This condition is considered a 'hidden disease' and affects the heart. Having AF increases the risk of stroke 5 times.

3. Abdominal Aortic Aneurysm (AAA) Screening
   – for risk of a ruptured aneurysm

Painless non-invasive ultrasound scan of the abdomen to check for an enlargement (aneurysm) in the main artery (an AAA).

4. Peripheral Arterial Disease (PAD) Screening
   – for risk of heart disease

Screens for plaque build-up in the lower extremities. An abnormal result may indicate a risk for peripheral arterial disease and an increased risk of heart attack.

Add osteoporosis screening – for an extra £10

5. Osteoporosis Screening

One in two women and one in five men over the age of 50 in the UK will break a bone, mainly because of osteoporosis, according to the National Osteoporosis Society. But it could be treated. Life Line Screening offers a painless non-invasive ultrasound screen to check for the risk of osteoporosis.

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Appendix 3: Commissioned study to examine whether ultrasound is a discrete occupational group, or a tool for the use of existing groups.

Ultrasound: Profession or tool?

Hazel Edwards

Senior Lecturer, University of Hertfordshire

Introduction

This paper discusses whether ultrasound should be considered a specialist technique to be employed only by highly trained professionals or as a readily available tool to be used by many. In the UK, those who use ultrasound can be divided broadly into three groups; core imaging specialists including radiographers and radiologists, whose primary role is to produce and interpret images. The second group comprises clinical specialists who have adopted ultrasound for use in a limited capacity to enhance their diagnostic power. These specialists include midwives, physiotherapists, emergency physicians, anaesthetists, and rheumatologists (Andrews 2002; Kane et al 2004; Kendall et al 2007; Lumsden 2005; NICE 2002; Oxlade 2007; Taggart et al 2006). The third group uses ultrasound in a non-medical capacity by providing 'bonding' scans for pregnant women (Greene & Platt 2005; Coles 2007), and by inviting the 'worried well' of the public to pay for an ultrasound examination for reassurance.

The past

Thirty years ago diagnostic ultrasound was performed mainly by radiologists. As demand increased, particularly in the field of obstetrics, many radiographers, with the support of radiologists, extended their role to include sonography, therefore making ultrasound one of the earliest examples of role extension for radiographers (Hart & Dixon 2008). By the early 1980s they were performing the majority of obstetric scans (RCOG 1984). Nevertheless, ultrasound remained largely within the domain of the imaging department. A combination of events in the following years led to a change in this equilibrium.

Significant developments in computer technology during the late '80s and early '90s heralded ultrasound equipment which was easier to use, and images became easier to interpret (Kendall et al 2007; McNay & Fleming 1999). These advances directed many new applications of ultrasound, which attracted the interest of other clinicians keen to employ the technique within their own field (Wise 2008). Since ultrasound does not use ionising radiation, does not require potentially harmful contrast agents like MRI, and is not recognised as a specialty, there was little opposition.

The present

Today, in addition to core imaging specialists like radiologists and radiographers, there are burgeoning numbers of UK practitioners from non-imaging backgrounds using ultrasound to enhance and complement their practice (Aitken & Thompson 2006; Ellis 2005; Taggart et al 2006; Marhofer et al 2005; Hopkins 2007). Furthermore, a quick search on the internet will reveal many private companies willing to sell a variety of ultrasound examinations to self-referring members of the public (annex 1). Some of these businesses appear to be staffed by people with unspecified qualifications, and have misleading statements in their advertisements. Arguably, this latter group is using ultrasound for profit rather than patient well-being since there is growing evidence that many asymptomatic customers, having had an imaging test, leave with either a false sense of reassurance or a false sense of anxiety – neither of which are good (Pennachio 2002; Raloff 2003; Wald 2007).

There are many drivers for the acquisition of ultrasound skills by other practitioners and clinicians although all forms of role development among healthcare professionals should be aimed primarily at improving patient services (DH 2000; DH 2008a). The main influencing factors are the chronic

and continued shortage of radiographers and radiologists combined with escalating demand for ultrasound examinations (Aitken 2005; Bates 2003; DH 2008b). Full assessments by imaging experts are being replaced with focused scans by clinicians in order to answer specific questions, but in the absence of other clinical indicators, patient care is not being compromised. In fact, such practice champions new ways of working (DH 2000; DH 2008a). Examples may include a gastroenterologist who looks only for biliary duct dilatation, or an urologist excluding only hydronephrosis. Other examples of focused use of ultrasound include emergency physicians searching for abdominal haemorrhage, and anaesthetists locating veins for catheterisation (NICE 2002). By being independent of radiographers for scans, midwife sonographers are able to offer their clients a timely more holistic ultrasound service, and there are increasing numbers of general practitioners employing ultrasound in the surgery to negate the need for secondary referral. All these examples illustrate how focused ultrasound by a non-imaging professional can expedite identification and diagnosis which informs safe and effective patient management. Furthermore, radiographers are broadening their practice by moving out of imaging departments and into other clinics to provide effective combined services as 'one-stop shops' for a variety of conditions.

The range of clinical applications of ultrasound is now so diverse that it is unlikely one practitioner, the traditional sonographer, could achieve expertise in every field. This opinion was encountered repeatedly in a recent study investigating the use of ultrasound among midwives (Edwards 2008), and is illustrated best by this comment made by a midwife:

> *I believe health professionals should practise ultrasound in their own field, rather than radiographer-sonographers trying to master all aspects of ultrasound. It has become too broad and is advancing to quickly - so health professionals need to specialise in one area i.e. midwives specialising in obstetric ultrasound.*

Practitioners using focused ultrasound as a tool do so for one of three reasons; to diagnose and monitor; to screen; and to guide invasive procedures e.g. needle puncture for biopsy, aspiration, delivery of drugs or line insertions. Appropriate training, supervision and assessment are required for all three applications. However, it is a concern that some physiotherapists seem at pains to deny their use of ultrasound is for diagnostic purposes. In a recent article, the authors stress that it is employed 'to support a physiotherapist's clinical assessment' rather than to diagnose, and that 'imaging can confirm, or not, your clinical reasoning' (Oxlade 2007). Clearly, this is an exercise in semantics since there is no clear distinction between using ultrasound for diagnosis and for the purposes described by the physiotherapists. Their statements suggest a desire to avoid responsibility for their actions by denying they are using ultrasound for diagnostic reasons. Such practice may set a bad example to others who may be tempted to 'dabble' in ultrasound but under the 'protection' that they are not diagnosing. If ultrasound is not used for diagnosis, follow-up, screening, or guidance, then arguably it should not be used. It is regrettable, therefore, that the British Medical Ultrasound Society takes a weak stance on non-diagnostic imaging in obstetrics when it suggests that if women wish to pay for additional non-diagnostic scans they should at least try to make sure the staff are qualified and the clinic is reputable (BMUS 2007).

Training and education

Ultrasound may be described as both an art and a science (Meenagh et al 2007) and it is recognised universally as being highly operator dependent (Barnett 2004; Bodenham 2006; Finberg 2004; RCR 2005). Therefore, it is of some concern that ultrasound is being described frequently as the 'new stethoscope' in healthcare management (Barnett 2004; Leddy in Oxlade 2007; Siemens 2008; Wise 2008). Such claims infer a device which is inexpensive, portable, readily accessible, safe and easy to use. Not only does ultrasound contravene the last descriptor, but there is emerging evidence that some practitioners using currently available equipment are exceeding safety guidelines in terms of acoustic output (ter Haar 2008). The use of ultrasound, therefore, should be reserved only for those who have a full understanding of, and a healthy respect for, the modality.

A good sonographer makes ultrasound look supremely easy. This, combined with stethoscope analogies, can give some observers false confidence for beginning scanning themselves with little or no training, thus posing a significant threat to the public. Perhaps the place for the ultrasound and imaging specialist, therefore, lies in training and assessing competency in others in order to maintain standards (Bodenham 2006). This would be infinitely more achievable were sonography recognised as a profession. It is acknowledged that traditional education in ultrasound is not always necessary or practical for the diversity of practitioners currently using ultrasound (Bodenham 2006). This is suggested also by the development of recent guidelines for assistants using ultrasound (CoR 2008). Evolving equipment and applications mean that, for many using ultrasound as a tool, a short course ending in assessment would be adequate and appropriate.

Broadly, there are three routes to training that a non-medical person may access currently; a traditional postgraduate CASE - accredited course (Consortium for the Accreditation of Sonographic Education) which ends with an assessment of competency; a short course or study day which may not include assessment; or a newly developed assistant practitioner course aligned to recommendations from the College of Radiographers (2008). A fourth and most disturbing option, which is entirely within the law, is to seek no training at all.

Physicians new to ultrasound, and who wish to incorporate it into their professional practice often access a short course or study day (Bodenham 2006; Mandavia et al 2008). Some doctors may undergo a supervision period by a fellow physician who has experience already of the procedure (Hertzberg et al 2000). Others do not (Davis et al 2005). Frequently, competency may not be assessed and post-training audit may not be conducted. Rigorous guidelines devised by the Royal College of Radiologists (2005) emphasise the need for both supervision and assessment. The Royal College of Obstetricians and Gynaecologists' brand new ultrasound training guidelines focus now on competency and assessment rather than log books and hours (RCOG 2008). Indisputably, all users of ultrasound require training, supervision and assessment (Aitken 2005; Barnett 2004; CoR 2008; RCR 2005; Walton 2008). Equally, the importance of maintaining competency should not be over looked (Shaikh & Earnshaw 2008).

Education and training for both medical and non-medical UK ultrasound practitioners currently lack standardisation and will continue to do so until there is recognition of the specialty. Whilst it is almost certain that ultrasound will continue to be used increasingly (as a diagnostic stethoscope) by an ever-broadening range of practitioners, key ultrasound professionals are essential for advice, guidance and up-holding standards. They would find this task easier, more satisfying and rewarding were they recognised as a profession, as in Canada and Australia. Recognition would also likely facilitate and expedite the adoption of national guidelines, which would further help to control practice and maintain competency standards, thus affording the public greater protection (Skills for Health 2008). When undergoing a test or procedure, the patient is concerned less about the professional identity of staff and more about the quality of the service (Chapman 1997). Adequate training and recognising one's scope of practice, therefore, continues to lie at the heart of the debate on the use of ultrasound, not an individual's professional background.

Conclusion

Evidence indicates that ultrasound is both a tool to be used in a limited capacity by appropriately trained healthcare practitioners, and a profession practised by specialists whose scope includes a broad range of applications and settings. Prudent use of ultrasound undoubtedly enhances the patient experience through full diagnostic assessments by imaging specialists, to effective, focused, point-of-care management by discipline-specific clinicians. Training and competency standards remain key drivers of quality. Continued support and development for both groups is encouraged and advocated if ultrasound services are to remain sustainable and responsive. In view of public safety, further research into the potential benefit and harm of non-medical scans is required. In the meantime, high standards of training are as important for these providers as for all other users of ultrasound.

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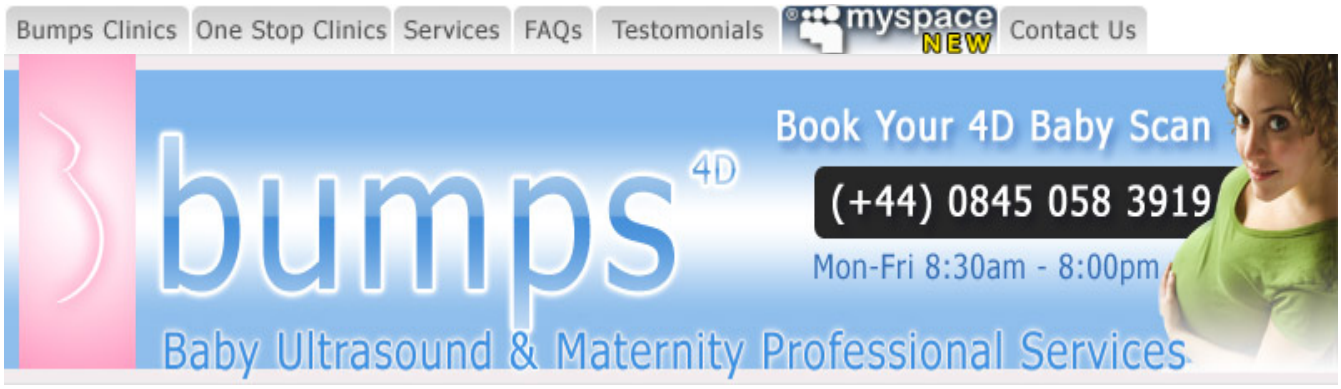
Annex 1 to Appendix 3
Six private companies offering ultrasound to asymptomatic self referrers.



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Appendix 4: Extract from supplementary statement provided for the HPC for its July 2008 meeting (Sonographers currently outside any UK regulatory framework)

Sonographers currently outside any UK regulatory framework

The number of sonographers outside of any UK regulatory framework is very difficult to establish. In the original application, the number was estimated conservatively at 500 and this still stands. The current workforce crisis in ultrasound in the UK is likely to drive this figure upwards if NHS organisations are to meet and sustain the various 'referral to treatment' targets set in each of the four countries of the UK. This is supported by the view of the National Imaging Board of the Department of Health (England) that ultrasound is the biggest of the problem areas in delivering the necessary imaging services (it is also worth noting that the Chair of the National Imaging Board, Dr Erika Denton, provided a letter of support for the application and this can be found on the CD-ROM submitted with the original application).

Anecdotal evidence of sonographers outside regulation and received since the application was submitted earlier this year includes:

- Two employing organisations raised questions with the Society regarding whether sonographers from overseas and ineligible for registration with one of the health care practitioner regulators in the UK may be employed in the NHS in the UK; one of these queries was from England, and the second from Scotland.
- Several employment and professional problems raised by non-radiographer sonographer members of the Society of Radiographer; the most extreme of these was a sonographer whose employer suddenly demanded she become HPC registered knowing that this was not possible and that they had not only employed her as a sonographer for in excess of four years but had previously trained her to become a sonographer.
- Receipt of a draft employment policy that shows the employer is looking to recruit overseas sonographers to address its current sonographer workforce shortage.
- Information from one employer indicating that it is employing overseas doctors as sonographers while they attempt to gain entry to the General Medical Council's Register.

These various matters that have arisen in the very short period (three months) since the application was submitted to the Health Professions Council show confusion about sonographer regulation and concern about the sufficiency of the sonographer workforce available currently. Both matters could be better addressed if the title of 'sonographer' was to be protected and sonographers were to come within a statutory regulatory framework.

In addition to the above, analysis of the voluntary register of sonographers established in May 2007 shows that in excess of 30% of those accepted onto the register are not radiographers. This is a high proportion and supports our view that the number of individuals that should be regulated as sonographers is sizeable.

Appendix 5: Survey work undertaken to further establish the numbers of sonographers in the UK currently outside of any UK regulatory framework

Introduction

A survey was undertaken in September/October 2008 to identify the background and qualifications of the ultrasound workforce operating outside of traditional NHS Imaging Departments. Those invited to participate included staff using ultrasound in non-imaging NHS-based departments and in private practice. In view of time constraints a convenience sample of two strategic health authorities was selected; London and South East Coast. An internet search using the terms 'baby scan', 'private scan', and 'private ultrasound' identified 35 independent providers of ultrasound across the UK.

Method

A short focused questionnaire requiring less than two minutes for completion was sent to 35 independent UK companies who provide ultrasound imaging. Six copies were sent to each organisation to allow members of staff to complete individually. A similar short focused questionnaire requiring less than two minutes for completion was sent to departments likely to perform diagnostic ultrasound located in the London and the South East Coast Strategic Health Authority regions. Departments for inclusion were physiotherapy, women's health, rheumatology, cardiology, stroke services, renal units, accident & emergency, critical care, anaesthetics, paediatrics and obstetrics. Radiology departments were excluded from the survey since they are most likely to be staffed only by radiologists and radiographers who are regulated by the GMC and the HPC respectively.

Independent sector returns: 21/210 (10%)
NHS based department returns: 73/565 (13%) and one returned incomplete

Both surveys had a disappointing response rate in spite of the questionnaire being very simple and quick to complete, and in spite of using up to date addresses and allowing over two weeks for completion. The low returns may have been due to some practitioners:

- being opposed to regulation
- having a lack of interest in the subject
- feeling suspicious of the reason for data collection
- preferring not to admit to offering non-medical 'for-profit' ultrasound
- having a FREEPOST address to respond to rather than a prepaid addressed return envelope
- a combination of the above

Independent Sector returns:

Perhaps predictably, with the exception of just one respondent, all those working in the independent sector were regulated by the GMC, or the HPC, or the NMC. The person who did not identify their regulatory council claimed to be a radiographer and had been practising ultrasound for two decades. Since the section on regulation was the only part of the questionnaire not completed, it is likely that this individual may have allowed his/her HPC (or formerly CPSM) registration to lapse. All held ultrasound specific qualifications for the areas in which they practised. All practised obstetric ultrasound, most practised also in other areas. Only one person performed musculoskeletal studies in the independent sector, and no-one was doing cardiac work. Some held qualifications for, but were not currently practising in, certain areas e.g. gynaecological and abdominal ultrasound.

This survey failed to identify unregulated practitioners. It is likely unregulated practitioners chose not to respond as they did not want to risk being identified or labelled in this way. It is also likely that a proportion of independent sector sonographers selling 'bonding' obstetric scans, and non-obstetric scans to the asymptomatic 'worried well' will be regulated but chose not to respond in

case their conduct in providing these scans might be considered to be unethical or unprofessional, or outside recommendations from organisations like the College of Radiographers and the British Medical Ultrasound Society. At present, they are working inside the law but the type of work they are doing may breach the first rule which doctors and healthcare professionals should adhere to; 'first do no harm'.

NHS returns

Of the 73 responses, eight were excluded since they stated or inferred that they were from a radiology department. In these cases the questionnaire had most likely been passed on to them from another department believing they had received it by mistake. Radiology departments were not the target of this investigation.

There were 35 responses from London, 28 from South East Coast, and two which failed to identify their location. In total there were 360 staff using ultrasound, but only 29% (104) held ultrasound-specific qualifications. Approximately 9% (31) were unregulated. This figure of 9% is lower than preliminary figures obtained from the public voluntary register held by the Society of Radiographers, although that may be because the voluntary register holds both NHS based and independent sector sonographers.

Whilst, in view of the sample size, it is unwise to generalise, the two sets of data above most likely underestimate the national trend. The very fact that sonographers are currently unregulated means that it will remain extremely difficult to quantify accurately this cohort in the absence of a central register. Of those unregulated, two did not identify which areas they practised in, five performed vascular studies, and 24 did echocardiography.

The numbers and their regulating councils are described in table 1.

Table 1

Council	**GMC**	**HPC**	**NMC**	**Unregulated**
Numbers (Total 360)	**277**	**43**	**9**	**31**

Conclusion

From this study at least 9% of the NHS ultrasound workforce appears to be unregulated and their areas of practice are not always stated. Although the majority are regulated, the number of practitioners holding ultrasound-specific qualifications is low. Whilst the NHS operates within strict governance frameworks, this is not mirrored universally in the independent sector where the standard of provision is more erratic. It is likely, therefore, that numbers of unregulated staff in this sector will be higher than within the NHS environment.

The findings from these surveys indicate that regulation is needed to protect the public from a significant minority. It may also help to raise standards of professional accountability in terms of training and education thus ensuring that those who use it will be required to obtain a minimum qualification.

Hazel Edwards, Senior Lecturer, University of Hertfordshire

Appendix 6: Further support for the application – a summary of Interviews with key stake-holders

Stakeholders from all four countries of the UK were contacted and invited to give their views on regulation of sonographers. No individual was contacted (either by email or telephone) more than twice. Approximately 50% chose to contribute. The remainder did not respond.

Common themes emerged from the discussions which were; protecting the public, maintaining and improving standards, training and education, and workforce numbers. The majority of respondents were in favour of the application but for different reasons, which were dependent on their position. Of those in favour, all believed that regulation would afford greater protection for the public. They felt it was essential that patients should have the opportunity to check the status of the sonographer performing their examination, but also suspected that very few patients would actually do this. The latter point is, however, irrelevant since the ability to do so is what is critical; an analogy is having the right to vote. Furthermore, it is recognised that patients are becoming more knowledgeable regarding matters relating to health, and have high expectations of the healthcare workforce.

Most respondents believed regulation was a key factor in standardisation of ultrasound practice, and that standardisation is inherently linked with education and training. The three issues are inseparable. Those involved in the delivery of obstetric services felt particularly strongly that regulation would promote good practice by requiring minimum qualifications and evidence of continuing professional development (CPD) in order to allow practitioners to remain registered. Regarding obstetric screening services, comments were made on inconsistencies and wide variations of ability between current staff, which in principle, may reduce the efficacy of any screening service. Again, an emphasis on measuring competency and fitness to practise, and its link with regulation, was noted in the comments.

Some thought that, through recognising sonography as a profession, regulation would expedite the development of new ways of educating the ultrasound workforce. The development of undergraduate degree programmes in ultrasound was mooted and was felt to be advantageous in allowing people to become qualified sooner without the need for a first degree in another health-related subject. It was anticipated that, in the long term, this may swell workforce numbers. Furthermore, it would help retention within radiography where traditionally new ultrasound students have been found.

Additional sonographers from abroad who are from a non-radiography background may also help to sustain and increase staffing numbers if regulation of sonographers is adopted in the UK. Currently, some find it difficult to gain employment in UK NHS trusts and independent healthcare settings if they are not registered with the HPC. Discussions with managers of recruitment agencies and private companies suggested there is a lot of confusion around employability which would be resolved in the event of regulation; although one agency happily recruits unregulated staff if they have appropriate skills and qualifications, they are difficult to place since many departments are reluctant to employ them for fear of increased vulnerability in the event of malpractice. The manager of a large private provider believed, wrongly, that sonographers had to be HPC registered and declines to employ any who were not. She said the situation is frustrating since her company is short of sonographers and would very much like to employ more.

There appears to be confusion and inconsistency within trusts as well as between trusts and companies; one interviewee recounted a situation within a hospital where one ultrasound department insists on HPC registration and the other department does not. The negative effect of this inconsistency is that when the ‘regulated’ department is short staffed, those who are unregulated in the other department cannot transfer to help their colleagues.

Ultrasound is the greatest barrier to meeting diagnostic targets. Certainly, situations like the one described above exacerbate this already difficult situation. Many of the interviewees were aware of this, and felt that there had been virtually no attention to succession planning either. Consequently, some felt that ultrasound services had reached crisis point and were likely to be unsustainable in their current form. One actually described the service as a ‘ticking time bomb’. They agreed that new ways of sustaining the service without compromising patient safety must be found and that regulation was likely to facilitate this through up-holding standards, as mentioned earlier.

Another theme which emerged from the discussions was interviewees’ misconceptions about sonographer practice and regulation. Some thought, wrongly, that all sonographers were

radiographers and therefore all were regulated already. One interviewee asked if every role extension taken on by radiographers was to have a protected title. Others thought the application was to introduce and encourage dual registration and to exclude other staff groups from performing ultrasound. Significantly, these misconceptions were echoed in a number of comments received from practising radiographer sonographers after publication of information on the Society of Radiographers' professional website. Clearly, if people had a better understanding of the reasons behind regulation it is likely there would be even more support for the application.

Of those interviewees with a good understanding of regulation a few had reservations about its introduction for sonographers. These reservations included issues around education at first degree level, whether such programmes were sustainable, and how they might impact on current staff with postgraduate ultrasound qualifications. There was also concern that regulation may restrict career development for other practitioners who may wish to use ultrasound in the future, and may narrow career options for those practising under the title 'sonographer'. It was postulated that an undergraduate degree course in ultrasound may be inappropriate if ultrasound is considered a tool to be used by many rather than a profession in its own right. Undoubtedly ultrasound machines are getting cheaper, are easier to use, and images are easier to interpret. It is for these very reasons, however, that regulation is overdue and this belief was echoed by a number of interviewees who had been advocating regulation for many years.

Interestingly, in the absence of any high profile cases of misconduct, other interviewees remained sceptical of both the numbers of unregulated practitioners and the extent of the danger posed to the public and therefore did not feel there was a strong need for regulation. However, one well informed interviewee noted that it was ironic that a radiographer may be struck off the HPC register for being an incompetent sonographer and may no longer practise under the title 'radiographer' yet there is nothing stopping them practising as a sonographer and carrying on just as before. Such loop holes in the law need closing urgently. Considering in excess of 80% of the UK sonographer population interpret and report on their own findings, the potential risks are clear. This was appreciated by many but particularly by those involved in obstetric services.

Hazel Edwards

Senior Lecturer, University of Hertfordshire

Appendix 6: Correspondence provided by a number of stakeholders (October 2008)

From: Crawley, Owen Dr. (DPHHP - Chief Scientific Adviser) [Owen.Crawley@Wales.GSI.Gov.UK]

Sent: 20 October 2008 15:27

To: Edwards, Hazel M

Cc: Gilbert, Mary (DHSS - NHSHR)

Subject: RE: Regulation of sonographers

Dear Hazel

Re: Regulation of sonographers

Further to our telephone conversation on 17th October 2008, whilst I clearly cannot make a formal statement on the application on behalf of the Welsh Assembly Government which anticipates the views of our Ministers I can forward some personal remarks and questions from a professional adviser perspective.

The majority of ultrasound practitioners operating within UK hospitals will be state registered already. Cardiac Clinical Physiologists practising echocardiography are likely to be the largest group practising ultrasound who are not currently formally regulated but would be covered by the forthcoming regulatory framework which will emerge from the programme of work on modernisation of healthcare science careers.

You described concern about a growing practice of private 'recreational' obstetric scans and body scans aimed at the healthy population and indicated that these scans can currently be undertaken by unregulated staff and that onward referral of "normal variants" could overburden NHS services. I agreed that one advantage of regulation might be to enhance the accountability of staff working in such services.

Increasing demand and shortages of appropriately trained practitioners present challenges to the reduction of waiting times for ultrasound investigations. A further challenge may be the need to structure posts to include a mix of activities to reduce risks from RSI (repetitive strain injury) reducing the percentage of time spent scanning. Any opportunity to increase the workforce without compromising patient safety would be welcome, therefore I was interested to hear your points on overseas sonographers and the introduction of undergraduate degree programmes in ultrasound. If there are significant numbers of qualified overseas sonographers from non-traditional backgrounds wanting to work in the UK it could be helpful to offer them, and others already in the UK, a regulatory home.

The plan for undergraduate programmes, however, raises some questions. If ultrasound becomes a 'direct entry' first degree profession, how would practitioners such as clinical physiologists, midwives and radiographers acquire skills in ultrasound should they wish? Is it envisaged that they would require mandatory regulatory recognition of ultrasound competence additional to their initial registration? Would they be able to access an accelerated programme or focused modules? What would be the effect of such programmes in relation to second degrees in ultrasound held by significant numbers of staff?

This leads me to another potential dilemma. Is ultrasound truly a profession and should it be recognised as such when arguably it is a diagnostic tool for an increasing variety of practitioners? I agree unreservedly that those using it must be appropriately trained, but another approach may be provision of focused modules for practitioners to acquire depending on their clinical environment. However, I accept your comment that core sonography specialists would still be required to provide focused training.

There are studies suggesting RSI (repetitive strain injury) is a risk for sonographers. Currently, the workforce still comprises mainly radiographers. Under their protected title of 'radiographer' and in view of their training background, if RSI prevents them from practising ultrasound they may transfer to another imaging modality, therefore remaining on the register and prolonging their career. What provisions would there be, though, for sonographers who are trained and registered only as sonographers? Would their options in the event of a debilitating musculoskeletal condition be extremely narrow?

I hope these comments are useful.

Yours sincerely

Owen Crawley
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From: McGeagh, Jackie [mailto:Jackie.McGeagh@DHSSPSNI.GOV.UK]
Sent: 06 November 2008 11:06
To: Edwards, Hazel M
Cc: HazelG@sor.org; Nigel Wethers; r.kelso@ulster.ac.uk; Rosaleen Malone
Subject: RE: Regulation of sonographers

I am supportive of regulation of sonographers, primarily for protection of the public.

Regulation will help to maintain standards within the very difficult and complex field of obstetric anomaly screening. Standards must be maintained not only in technique and interpretation of ultrasound, but also with regards to counselling and onward management of the obstetric patient.

Most sonographers in Northern Ireland are now responsible for conveying their findings to the patient rather than simply referring them onwards when a problem has been found. A high level of skill and knowledge are required to interpret appearances, understand variants, follow appropriate management pathways and explain the initial findings with the patient. Furthermore, gaining full consent before the ultrasound examination is also more complex , perhaps more so than other areas of ultrasound eg, liver/gallbladder studies, in view of the impact on the woman and her partner of any potential or definite abnormal findings. Therefore, high level education and training for staff is of paramount importance, and regulation can maintain standards and ensure the continued quality of such programmes. Especially considering that risk management and good governance are at the backbone of our services.

I believe the majority of staff undertaking obstetric ultrasound are regulated already by the HPC, NMC, or GMC, but there may well be some ultrasound practitioners in Northern Ireland who are not eligible for registration with one of these councils, therefore the public will not be protected from them. That said, I suspect actual numbers will be small. We are short of sonographers in this country but I believe the situation is worse on the mainland.

As far as I know additional private 'bonding' 2D/3D scans are performed in Northern Ireland, but to my knowledge these are usually performed under the supervision of an obstetrician who employs the sonographer. I do not have any involvement in this service.

In summary, I am in full support of the College of Radiographers' application for protecting the title of 'sonographer' for protecting the public and maintaining high standards within antenatal screening services in Northern Ireland.

Best wishes

Jackie

Jackie McGeagh
Regional Antenatal and Newborn Screening Coordinator

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Dear Hazel

I am very much in favour of regulation of sonographers. Having been a practising sonographer myself for many years, and a course leader for postgraduate ultrasound I believe that anyone using ultrasound, regardless of their professional background, must have reached a certain level of competency and should hold a minimum qualification. Regulation would mean that registrants would have to prove competency to practice in order to use the title, and competency could be measured using the new frameworks currently under development (some of which are completed) by Skills for Health. Such activity would raise standards in ultrasound and protect the public.

In Scotland the 20 week anomaly scan is not routinely offered at present in all Health Boards but is to be introduced, along with nuchal assessment, in the next couple of years (by end of 2011) therefore we need to find more sonographers to provide these services. The idea of direct entry ultrasound degree programmes makes sense and is our best bet for increasing workforce numbers in the long term. However, such programmes must have in-depth components/modules relating to counselling and communication in view of the nature of the work, particularly in Obstetrics. Regulation may expedite the development and commissioning of such programmes. With the existing structure I believe there is little scope for career development in ultrasound since most are at advanced level at the top of band 7 with nowhere to go with regards to career progression. The introduction of assistant and practitioner level staff would balance things out and sustain services. In addition to practitioner level courses I think, in view of the recent SCoR publication, assistant practice needs developing in ultrasound.

Private obstetric imaging is performed frequently in Scotland due to the absence of availability of anomaly and nuchal scans. However, to my knowledge these centres are staffed by fully qualified registered practitioners (eg. midwives and radiographers). We in the NHS get referrals from them in the event of a problem but these are usually always appropriate. I am not aware of any malpractice issues relating to competency in the independent sector. At the moment the two services; bonding scans and NHS scans seem to sit happily beside each other. However, the biggest implication for me is that many of my staff are part-time because they prefer to spend some of their time working for these private companies, and I would be able to run a more flexible service if I had more of their time! I wonder if the uptake of private scans may decline once nuchals and anomalies are offered routinely. I think this is possible.

In summary I support the application to regulate sonographers and feel primarily it will raise standards overall, and may improve recruitment in the long term, which is vital if current services are to continue to expand.

From: Murray, Carole (PRM) [Carole.Murray@ggc.scot.nhs.uk]
Sent: Monday, October 27, 2008 9:56 AM

10.10.08

Dear Ms Edwards,

I am delighted to write in support of State Registration of Sonographers with in the UK.

The current situation in which, in effect, any one can call themselves a Sonographer and undertake an ultrasound procedure, presents unparalleled danger to the patient and leaves the entire profession in a state of confusion.

As the largest provider of temporary Sonographers to the NHS and Private facilities in the UK, **Sonographers Medical** is forever coming across difficulties with the current situation.

In most hospitals, the Department Managers are aware that there is no State registration and will accept staff on the strength of their CV and References, with no concern about any registration. However, some hospitals have the mistaken belief that HPC registration provides some form of security that the Sonographer is competent to scan, and therefore will only take Sonographers with HPC registration; which in effect means only those with a Radiography background. I have even spoken to Superintendent believing that HPC registration provides insurance for such staff.

Furthermore, in some hospitals we have the farcical situation where the Ultrasound Service is split in to two or more separate Departments, and one Department insists on HPC registration and one does not. As a result, staff are unable to rotate between the Departments to cover staff shortages etc, which ultimately adds extra costs to the NHS and additional delay to the Patient and increased waiting lists.

As a recruitment company, we employ many State registered professions such as Physiotherapists and Radiographers. In recruiting from abroad, our first question is always whether the individual has State registration, since this is a priority even before we consider their recent experiences, references etc. With Sonographers, we do not have that luxury and have no way to assess their training in relation to that provided in the UK. As a result, we recruit staff based on a personal opinion of whether they ‘sound like’ they have been well trained and are competent to do the job.

As Sonographers ourselves, I suspect we have a significant edge in getting this assessment right, but that will not be the case with other Agencies; and I know of many people to whom we have refused employment that have gone on to work through other Agencies. I dare say some of these have been successful in such roles, but I know of many cases where that Sonographer has been rejected from the Department after a few hours, days or weeks on the grounds that they are not competent to scan.

Since there is no regulation of their conduct and performance, even if those individuals are removed from a job through incompetence, they can go on to work elsewhere with little or no difficulty – and if they do not put the ‘bad placement’ on their CV, no one will be any the wiser.

Equally, a HPC registered Sonographer (former Radiographer) can be ‘struck –off’ the HPC register. This means they will no longer be able to call themselves a Radiographer. But there is nothing what-so-ever preventing them from carrying on as a Sonographer and working with the same patients that the HPC considered they had put at risk.

On the other hand, there are many non-Radiographer Sonographers who are very very competent, especially some of those trained in Australia and New Zealand, and who are restricted in where they can work, because they do not have a Radiography background and therefore can not get HPC registration.

Explaining to the Department that HPC registration is 'not required nor possible' for some staff, generally falls on deaf ears.

In my opinion, the public are currently being put at serious risk, with unqualified and un-regulated staff undertaking medical examinations. Whilst registration will not prevent poor quality Sonographers from undertaking Ultrasound examinations; it will give a means to hold such staff accountable for their actions.

I hope this letter is of assistance in moving the push for State registration forward. If I can clarify any point, or add anything further, please have no hesitation in contacting me.

Kindest regards

Kevin

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Dear Hazel

Please find attached statement in support of HPC accreditation

Best wishes

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Statement for Hazel Edwards.

The West Midlands region equates to approx 10% of the population of England and Wales.

The West Midlands RUG was formed in the early 1990s and is a voluntary group of usually a sonographer and an obstetrician from 20 units across the region offering obstetric ultrasound (approx 40 members). They aim to meet 3 times per year. They share good practice, discuss topical issues, and work towards finding solutions for service delivery problems.

Currently there are huge pressures on delivering the ultrasound service due to workforce shortages, increased referrals, and new screening programmes. The RUG supports the application for regulation of sonographers in order to protect the public, facilitate, and expedite the development of direct entry degree courses, and to enable suitably qualified sonographers from overseas to register and practise in the UK. At present, a RUG Workforce Subgroup are working with the West Midlands SHA to recruit new radiography graduates onto existing HEI ultrasound training programmes with the options of 'passing' in some focused areas before others, e.g. dating scans. However, RUG feels that direct-entry training will be a significant step in facilitating the recruitment of sonographers.

As far as RUG are aware, all staff offering NHS-based obstetric ultrasound in the West Midlands region are regulated by the GMC, HPC or NMC. RUG has no knowledge of any member of staff who is not a doctor, radiographer, or midwife.

There are several private services within the region offering combined screening for Down's syndrome, viability scans, and 3D fetal imaging.

Discussion at previous RUG meetings has indicated that only a small proportion of those working in obstetric ultrasound within the region are registered.

Approved by RUG Workforce Subgroup

09 October 2008

Hazel Edwards
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3rd October, 2008

Dear Hazel,

Re: Sonographer regulation application to be submitted by the Society and College of Radiographers

Further to our telephone conversation today I wish to confirm that I am in full support of the application to the Health Professions Council (HPC), and have advocated the regulation of sonographers for many years.

I believe ultrasound is a unique specialty compared to other imaging modalities in that it is highly operator dependent. This results, potentially, in huge variations in practice and standards. I believe firmly that high quality ultrasound is, underpinned by high quality education. All practitioners, regardless of their professional background, should experience a period of supervision and assessment followed by continuous audit. Regulation would go some way to addressing these discrepancies and improving standards.

If the application to the HPC is successful, professionals who specialise in ultrasound should have the opportunity to obtain dual registration if they wish, rather than simply remain under their current title of, say, radiographer or midwife. This will be attractive to employers and may afford the public greater reassurance and protection. Those who use ultrasound as a tool to enhance their practice (and I feel ultrasound is both a tool and a profession), but are unregulated, will be able to obtain much needed registration once competency has been proven and accreditation has been awarded.

Furthermore, regulation will allow easier transference of the ultrasound workforce from overseas to practise in the UK. Currently, those not eligible for registration with the main UK councils find it very difficult to gain employment in spite of proven ability in ultrasound. In view of the chronic shortage of suitably qualified ultrasound practitioners, this is a potentially vital resource.

Finally, regulation is also an important factor for maintaining and improving standards among the growing number of independent providers of ultrasound services.

In summary, I support fully the imminent application for consideration by the HPC. I can anticipate no disadvantage of this legislation, and I hope it is successful.

Yours sincerely

Richard Dale MB.BS., FRCS
Medical Director & Caldicott Guardian
Commercial Directorate

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ED/nh

17th October 2008

Ms Hazel Edwards
Senior Lecturer
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Dear Hazel

Re: Regulation of sonographers in the UK

Further to our telephone conversation yesterday, I am delighted to add my support as National Clinical Lead for Diagnostic Imaging to the College of Radiographers' application seeking protection of the title 'sonographer'.

The primary reason for my support is that regulation will serve to protect the public. I believe the public has the right to expect that the person conducting their medical examination or diagnostic test has the appropriate credentials and qualifications. Regulation of sonographers will allow this to happen. There are growing numbers of practitioners offering non-medical scans, some of whom are likely to be unregulated by any of the three main UK councils. Regulation may go some way to controlling this practice and ensuring that all ultrasound scans are undertaken to the highest standards.

Regulation will raise standards overall within sonography as sonographers will need to obtain minimum qualifications and be proved competent to practise. Currently, in the absence of legislation or recognition of ultrasound as a specialty, this is not the case. I believe all practitioners using ultrasound should have specific ultrasound training and subsequent defined qualification.

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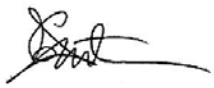
Many NHS ultrasound services are over-stretched and the demand for ultrasound examinations increases annually. New ways need to be identified to increase the workforce without compromising public safety.

Regulation will ensure that appropriately qualified overseas staff wishing to work in the UK and who are ineligible to register at present, will be able to register so making them more readily employable in the UK.

Direct entry ultrasound courses may also gain momentum once the profession is recognised. Careful development of such programmes, with specific recruitment policies, will reduce the current reliance on taking radiographers out of the imaging workforce to specialise in ultrasound and increase the ultrasound workforce. The long term effect of regulation is likely to be improved recruitment, thus ensuring that imaging targets continue to be met and that ultrasound services are sustainable.

Yours sincerely



Dr Erika Denton
Consultant Radiologist
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Received 13.10.08

NHS
Antenatal and Newborn Screening Programmes

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Hazel Edwards
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9th October 2008

Dear Hazel

Re: The State Registration of Sonographers

The national screening programme for fetal anomaly ultrasound is committed to improving patient care both from a quality of screening aspect as well as ensuring safety for the patient. The screening test is performed mainly by sonographers in the obstetric ultrasound department and clearly some of these come under a midwifery or radiography background. However as we attempt to deliver a high quality safe service for patients then from my point of view it is essential that we have a workforce that is not only competent to do that but also adheres to a set code of practice.

What is most pertinent is that the screening test could have major ramifications on the care of the pregnant woman and in many cases it is the sonographer who will present and give the information to parents when an abnormality is found. It is therefore understandable that the measurement they take and other interpretations of these measurements will provide a screening test result in its total form.

I am, and have been for some time, concerned that a number of sonographers are working outside of a code of practice particularly in such an important national screening programme which deals with unborn babies. As ever we are committed to ensure that the risk to the mother and the unborn baby is as less as possible and certainly in a screening test a misdiagnosis may open up the possibility of incorrect treatment and management of the pregnancy. I cannot emphasise enough the responsibility of the sonographer workforce in this area. We are presently trying to establish a supervisory framework for this workforce to raise standards. As you know I am a supporter of having a sonography workforce which goes under the umbrella of state registration and can adhere to a code of professional practice which will help us in ensuring a safe and effective screening test that sits within the National Programme. As promised I will also discuss this further with the policy team at the Department of Health to see if they can offer any further support.

I would be grateful if you could keep me updated on the progress of this through the professional pathway any Statutory process if it gets to that point.

In the meantime if there is anything further you would like me to support you on please let me know.

Yours sincerely

Pat Ward

Pat Ward

Copies to:
Anne Mackie
Jennie Carpenter
Audrey Paterson