Audit and Quality Improvement Committee Report

Chair: Mr David Mitchell

This last year has been one of significant challenge for the Audit and QI Committee. We began with the formalisation of our contract with HQIP for the new National Vascular Registry (NVR). This involved a number of important changes, not all of which will be immediately visible. Firstly, the NVR is being housed within the Clinical Effectiveness Unit (CEU) of the Royal College of Surgeons of England on behalf of the Vascular Society. The CEU provides a level of independent oversight and is run by dedicated staff under the leadership of Dr David Cromwell, CEU Director. The CEU team bring a new level of expertise in audit methodology and statistical analysis that has not been available to the VS previously. We continue to rely on Sam Waton who has moved from the RCP to the CEU as our NVR co-ordinator. Sam will be at the AGM and available to answer your queries - please come and meet him on the stand. While the CEU will house the NVR, I want to emphasise that the Registry is not an "English" audit tool, but one freely available to surgeons throughout the UK. We are actively looking at how we can provide access to our colleagues from the Republic of Ireland, something that has been absent in the NVD in the last few years.

The early part of 2013 saw detailed negotiations with potential IT suppliers and HQIP over the deliverables for our new contract and the timescales for these. I can confirm that Northgate IT solutions are developing the new NVR IT system and they will have a User Acceptance Testing version available for demonstration at the AGM. Please come along and test it out as it is scheduled to go live in December 2013. The new NVR datasets have reduced the number of fields required for collection and have more consistency across differing procedures. It will also allow us to develop links with the Vascular Anaesthesia Society, British Society for Interventional Radiology and Diabetes UK. As part of our development, there will be audit questions linked to pathways of care to allow us to report more completely on the facets of care that are important to our patients.

You will all be aware of the surgeon level report that was produced in the summer. The Department of Health (DH) demanded this in the spring, with a very short timetable for delivery. Your Society made strong representation that such reporting could be misunderstood and unhelpful in describing the quality of care provided by vascular surgeons. We were told to either deliver a report from our dataset, or that independent agencies would publish information from other data sources instead. There then followed a period of consultation with the membership and the report was published in late June.

The Executive was disappointed with the misleading reporting that followed, especially the inappropriate naming of surgeons, none of whom had been flagged as a statistical outlier. The good news that over 97% of patients coming to elective AAA surgery were surviving, and that our carotid outcomes were very good, was overlooked completely. The Society worked tirelessly to support inappropriately

named surgeons. The main lesson was that the majority of those named in the newspaper had failed to put in all their data (and subsequently were found to have better results once this was done). We have been actively communicating to the press, NHS Trusts and surgeons that no one was identified as having poor performance. For the vast majority of vascular surgeons, this has been a successful exercise providing clear evidence of the quality of service provided.

Some difficulties in producing the surgeon outcome figures were encountered. We are aware that teams of consultants undertake increasingly complex vascular procedures and have moved to recognise this in the new NVR. The IT system will allow up to four fields for GMC numbers and should allow us to describe this facet of our work more accurately in future. The DH has told us that it intends to require publication of surgeon level data on an annual basis and wishes to extend the scope of reporting. **It is very important that each one of us ensures that our entire audit dataset in the NVR is kept up to date at all times.**

By the time this report is available at the AGM, we will have published two unit level reports. The first is the round 5 carotid interventions audit report. This shows that vascular surgeons continue to improve access to carotid surgery for patients requiring vascular interventions. The second is our second unit level report into outcomes following elective repair of infra-renal AAA. Once again the Society is able to show evidence of improving outcomes and there is much for us to be proud of as a speciality. Please use these reports to provide supporting evidence of excellence and for revalidation. We hope that individual and unit level reports will be available to print for surgeons online in future, but this may take some years to deliver fully. At present, they are accessible through the Vascular Society website or the Vascular Surgical Quality Improvement website, www.vsqip.org.uk.

This is my final AGM as Audit Committee chair. I am very pleased to have worked with many very able people and to have had the privilege of travelling the UK as part of our quality improvement work. I am very grateful for both the support and feedback that has come to the committee over the last four years. It has helped shape our work and allowed us to report improvement in care delivery with confidence in a very open and transparent manner. I hand over to Professor Ian Loftus in November and the audit committee will be in very able hands. I wish him all success in building on the work of his predecessors. Ian is already at work having drafted and submitted a grant application for a quality improvement programme for lower limb amputation. This group of patients are the most vulnerable that we treat and have a high death rate that we believe can be improved. As a Society, we need not only to keep our focus on our AAA and carotid patients, but also extend it to amputees and subsequently those having revascularisation for PAD. I would encourage you all to look at your audit activity and ask how it can be improved. Re-configuration provides great challenges, but also great opportunity to change what we do and to demonstrate a continuing commitment to excellence.