# PRESIDENT'S REPORT

**Professor Julian Scott**

First of all I would like to welcome you back to Manchester and I hope that you have an enjoyable time. The last few years have seen major changes in Vascular Surgery in Great Britain and Ireland, many of which have been led by the Vascular Society and its elected Council Members and Executive Officers. It has taken us ten years to get to the stage of a new independent surgical speciality and this year twenty trainees were appointed to the Vascular Surgery Programmes in England, Northern Ireland, Scotland and Wales. I was especially pleased to see that nearly half of the successful candidates were women. For the foreseeable future the vascular community will have to support both general surgery trainees and the new cohort of vascular surgery trainees.

During the first few months of my Presidency, I was faced with the real issue of a down turn in the economic environment with no evidence of recovery and it became clear that we had to critically evaluate our relationship between the Society and industry, and review the finances of the Society. We have established new rules concerning reimbursement for travel and dinners for Council. We have put together a new corporate package for industry which will be available at the end of the AGM, which will allow companies to make an informed choice about supporting the Society. Furthermore it will be incumbent upon the incoming Presidents and their Scientific Committee to plan the meeting well in advance so that information can be passed to Members and industry at the earliest opportunity.

This year we have moved away from the old style VS AGM to a new format, which I hope you will find interesting. Change is always a challenge, but I hope that this will provide greater educational opportunities for all, from trainees to established consultants, and greater involvement of the Rouleaux Club, SVN and SVT in the major sessions. We have retained the Sol Cohen, BJS and Richard Wood Prize sessions and have created a new oral poster presentation, which will be judged by our honoured guests and Members of Council. We have been fortunate to secure presentation from three major studies, IMPROVE, CLASS and VISION, all of which will have an impact upon our clinical practice. As always we welcome constructive feedback, which will be included in your CPD points for the AGM.

The second area which required development was the role of social media. A call was sent out to the membership for interested parties and thankfully Neeraj Bhasin, Consultant Vascular Surgeon in Huddersfield, and Hashem Barakat, Affiliate Member from Hull, responded to our request and have formulated our social media policy and established our twitter account which will engage with delegates at the AGM. Jeanette Oliver has been instrumental in developing the VS App, which is available to download from both Android and Apple devices. I hope you will get involved with social media, and feedback your thoughts to the team. I acknowledge that some of you will have different views, but I am convinced that this is one mode of communication for the future that will facilitate our exposure to a global vascular audience.

With the new speciality came additional roles and, this year, we have joined the Federation of Surgical Specialty Associations (FSSA), attended Council meetings at the Royal Colleges of Surgeons of England, and had joint meetings with the Glasgow, Edinburgh and Irish Colleges. Through the FSSA we now have regular meetings with Dan Poulter (Health Minister) where we discuss key issues in surgery and in particular the EWTD and Surgeon Outcome reporting. We have also taken on the role of reviewing all job descriptions for Consultant Vascular Surgeon posts for the RCS England. We have consistently used the POVS document as the standard by which we assess all posts.

The Society can now directly support its Members who wish to apply for a Clinical Excellence Award (Bronze, Silver and Gold) and can nominate individuals for the national honours system through the RCS England Honours Nomination Committee.

During the year we had an opportunity to look at our London accommodation, which was based within the ASGBI footprint. In the light of our new specialty status we took the decision to relocate to the main RCS accommodation and are now based on the 5th floor along with many of the other surgical specialty associations. We have been able to retain the use of the Moynihan room for our Council meetings and have access to a small meeting room within the office. This has been an important step for the Society and will provide a better working environment for Jeanette, Neelam and Rebecca.

During the year we have been in constant dialogue with our Irish colleagues as they try to move forward with their application for separate specialty status with the Irish Medical Council. I attended the Irish Association of Vascular Surgeons in May and gave a lecture on the history of our speciality status and how the VS could support them in their application. To further these discussions we arranged a VS Council visit to the Royal College of Surgeons of Ireland kindly organised by our Irish colleagues.

Surgeon level reporting of elective infra-renal AAA surgery and Carotid endarterectomy consumed a considerable amount of time and resource from you, the Members, and your Council. In particular the Audit and QI Committee and the Members of the Clinical Effectiveness Unit were heavily involved in the discussions with HQIP, the RCS Communications Department and VS Council.

At the outside of Offer 2 and Everyone Counts*, we went to great lengths to explain to HQIP and the DOH that we strongly believed that the reports should be unit level data rather than for individual surgeons, as vascular surgery frequently involves a multidisciplinary team approach. In addition we felt that the time frame was short, albeit that we had been working hard on our mortality data for the last few years to facilitate HES/NVD unit level reporting. Despite this advice and having expressed our concerns, HQIP and the DOH were insistent on requiring individual surgeon outcome data as there was a strong belief that consultant led data drives quality improvement and clinical outcomes as seen in cardiac surgery.

We were told that 7 of the 10 disciplines would release their reports on the same day, but, for reasons unknown to us, vascular and cardiac surgery were released first. Despite press pre-briefings and professional advice within the document, two press outlets failed to heed the dangers of misinterpretation of the data. This led to a flurry of media activity, which lasted for a few days. During this time the Society was contacted by several Members to whom we offered support, advice and also facilitated changes to their data entries. On the whole the press reporting of vascular surgery was positive and both HQIP and the DOH highlighted our level of openness and transparency.

The VS attended a debrief session with HQIP where the various stakeholders presented their views. We expect that the format will change next year and that the report will go out in early October 2014. It is expected that the option to refuse consent for surgeons in England will be removed on the basis of legal advice obtained by the NHS.

This year will see the new National Vascular Registry (NVR) which is designed to (i) improve the quality of data entry, (ii) risk adjust, (iii) document multiple consultant care (surgeon, dual consultant operating, interventional radiologist and anaesthesia), (iv) provide revalidation outputs and (v) assess process in particular timelines of care. This will be demonstrated at the AGM and I encourage all of you to take the time to familiarise yourself with the new programme.

I would strongly recommend that you look at your current dataset in the next few weeks to ensure a seamless change over from NVD to NVR. The overriding principle is that you have absolute control of the data you submit on your patients and in those where you have been involved in dual operating cases. It is critical that you engage with your coding departments to ensure that there is concordance between your NVD data and HES for your unit. I cannot stress enough the importance of accurate data and updated lines of communication between yourselves and the NVR based in the Clinical Effectiveness Unit (CEU) at the Royal College of Surgeons of England.

I would like to thank all Ordinary Members for their support and hard work during the last year, especially with the challenges of restructuring of services and mortality data.

My final thoughts go to those hard working and dedicated Council Members and Executive Officers who are leaving this year, and to the new team that will follow on. As always they will be supported by our CEO, Jeanette, and her team. I wish them well in the future and hope to see a vibrant and exciting Vascular Society as we more forwards with the new speciality.

(*)http://www.england.nhs.uk/everyonecounts/