VSGBI NEWS

July 2011

President's Message

Peter Lamont

I am delighted to confirm, in this mid-term report, that the Society's Council and sub-committees have been hard at work on a number of current issues. Perhaps first and foremost, and the one I get questioned most about, is the progress of our separate specialty application to the Department of Health. Clearly the Department have other things on their mind at the moment, in light of their need to revise the NHS reforms.

As a result the progress of our application has been slower than expected and a final recommendation to the Minister of State is not likely to be decided now until the end of July. One downside of this delay is that it risks us missing the deadlines for ST3 recruitment in August 2013, because it would still take another 3 months from the decision by the Secretary of State to sign off the application before it would be legally entered as a statute in law. We may thus be held back until 2014 before we can start training in the new specialty. The delay has been useful to us though, in that it has allowed us to address concerns raised by the Royal College of Radiologists and by the British Society of Interventional Radiology regarding the proposed syllabus. An amended syllabus has now been jointly agreed and both RCR and BSIR have written to the DH to unreservedly withdraw their objections and express their full support for our new specialty application. One major hurdle remains though, in that I have been advised that there are elements within the 4 Health Administrations (England, Wales, Scotland and Northern Ireland) who are opposed to new specialty applications on principle as being costly and unnecessary in the current climate, even though the principle of a separate specialty had already been signed off by the Secretary of State last September. The RCSEng is taking a lead on this application on behalf of the Surgical Royal Colleges and John Black has agreed to lobby for our cause in the corridors of power. We could not have got anywhere near as far as we have without John Black's positive support and the specialty will owe him a great debt of gratitude should our bid finally succeed.

In the meantime, Jonathan Beard has led the Education & Training Committee to develop a newly updated version of the Society's document setting out our recommended standards for training, which he has summarised for you in this Newsletter. I personally believe this to be an excellent document and am delighted to report that it was approved unreservedly by Council in May. Should we get

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Spring meeting 2012 - Belfast

The 'Vascular Society's Spring Meeting' will be in Belfast next year and will run from Thursday 22nd March to lunchtime on Friday 23rd March 2012.

We are delighted that the Northern Ireland Vascular Group and the Association of Irish Vascular Surgery have agreed to jointly host this meeting, which will be held at the famous Europa Hotel and Conference Centre in the city centre. The theme will be vascular trauma and the programme will cover topics on a wide range of vascular emergencies, drawing on local expertise in vascular trauma. It will also include talks on the endovascular management of ruptured aortic aneurysms, the complications of EVAR, and venous thromboembolism in pregnancy. In addition, there will be a vascular trauma workshop for trainees on the Thursday morning. A gala dinner will be held on Thursday evening in aid of the Circulation Foundation.

We hope that Members will wish to sample the excellent hospitality which Belfast has to offer, and we would like to thank Paul Blair for agreeing to co-ordinate the meeting on behalf of the Society.

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specialty approval, this document will be used to inform the Schools of Surgery and Deaneries of the standards we will expect for vascular surgical training in the future.

David Mitchell has also been hard at work with the Audit and Quality Improvement Committee, dealing not only with the complexities of IT for the NVD but also putting in an immense amount of effort to develop the AAA Quality Improvement Programme, which already appears to be showing results with a reduction in elective AAA mortality recorded on the NVD over the past year. Council have approved a bid to HQIP from David and his Committee for a grant to provide the full running costs of the NVD. Although there are some downsides to this, in that the Society and its Members would no longer be the exclusive owners of the data entered, such an investment would be a great help in developing the systems which all of us will need in the future, as submission of outcome data to a national database is very likely to be a mainstay requirement for GMC revalidation.

To this end, **I would also like to initiate a discussion with Society Members at our Annual Meeting in November on the controversial issue of the publication of individual surgeons' results.** The cardiac surgeons have noted a significant improvement in outcomes since they started doing this and we should at least have a think about it ourselves. Such emphasis on outcome data is clearly high on Bruce Keogh's agenda, as he advised us last year in Brighton and it is also interesting that a number of SHAs/PCTs are now stipulating contribution of data to the NVD as a condition of vascular surgical commissioning. Should National Commissioning be adopted for vascular surgery (and the current advice from those advising the DH on the NHS reforms is that it should be), **I believe it highly likely that NVD submission will be required for any unit commissioned to provide vascular surgical services, so if you are not submitting data now I suggest you consider it for the future.** The Society is happy to share advice on how to set up a submission process and I am sure David Mitchell or Sara Baker would be willing to help if you are having problems.

Ian Franklin has already injected new pace and energy into the Circulation Foundation Committee after only a few months in the Chair and we are expecting significant new income streams for our charitable arm as a result, much of which Shervanthi Homer-Vanniasinkam's new Research Committee has already earmarked to spend on developing vascular research programmes in a structured and organised way. Ian and Shervanthi's work offers much potential for the future and both the initiatives started by Shervanthi last year, the Surgeon Scientist Award (£50,000) and the President's Early Career Award (£100,000) are being repeated this year. These awards are also thanks in no small part to the organised and efficient way our Treasurer, Simon Parvin, has managed the accounts and created a stable financial platform on which to base their continuation.

The Secretariat continues its sterling work, led so effectively by Jeanette Robey and ably assisted by Neelam Seeboruth. Mike Wyatt has brought his immense energy and past experiences on SARS and ASGBI Councils to bear on the office of Honorary Secretary. In addition to the heavy workload involved in supervising the administration of the Society, Mike has taken on a revision of the Provision of Services for Patients with Vascular Disease 2009, as reported in the February Newsletter. **If you have any comments to make on this subject, particularly if your SHA has been conducting a review of vascular service provision, then please do get in touch with Mike, who is really keen for your input into the revision.**

> *An amended syllabus has now been jointly agreed and both RCR and BSIR have written to the DH to unreservedly withdraw their objections and express their full support for our new specialty application.*

Finally, I look forward to seeing as many of you as possible at the **Annual Meeting in Edinburgh from 23rd to 25th November.** Full details are now available on the VS website, but highlights will include symposia on the impact of volume/outcome on vascular service provision, the use of hybrid theatres and the publication of surgeon outcomes. The endovascular training workshop has now been moved to the Wednesday morning and will focus on EVAR planning, targeted particularly at existing consultants who need to get more involved in sizing and ordering stents in the future if we are to retain our traditional role in AAA repair. I am delighted also to welcome BSET, the ESVS and the UEMS Section of Vascular Surgery to deliver sessions to the meeting for the first time. Bruce Campbell has agreed to deliver the RCSEng Kinmonth Lecture on "The Evolution of Evidence" and Julie Brittenden has agreed to give a lecture on behalf of the RCSEd in memory of Ali Bakran, who will have been known to many of you. Along with participation of the Venous Forum, SARS, SVT and SVN and with the usual excellent social activities, the event promises to deliver its usual high standard and I hope to see you there.

Report from the Audit and QI Committee

Quality improvement

Our quality improvement programme for aortic aneurysm is now in the active implementation phase. Most regions of the country have organised a planning day for the QI programme and we aim to involve all parts of the UK by the end of the year: you will have received an interim report on the programme with this Newsletter. The message is that **improving consistency in what we do to patients is the key to improving the quality of our service.** The QI programme for amputation is about to start, but we are currently unable to access timely HES data feeds. This means that we will not be in a position to provide data feedback to vascular units until such access is granted.

Mortality data for QI programme

The QI team have recently mailed out comparison data for HES and NVD mortality for elective infra-renal AAA. This has been sent to every UK unit undertaking AAA interventions. Some of this data is clearly contaminated, with widely varying mortality rates. We plan to publish mortality rates in the final QI report in Spring 2012, and to avoid units being misrepresented, **we do need you to validate your own data with some urgency (Deadline 15 July 2011).** The questionnaire is available on the QIP website through this link:
www.aaaqip.com/aaaqip/datavalidation.html#tp
Please complete it as soon as you can so that we can publicise accurate data about national AAA mortality. This validation has to be carried out within individual units as we do not have access to patient identifiable data and cannot do this exercise for you. If you are experiencing any difficulty with the analysis, please contact us via email or telephone.

Multi-disciplinary team meetings

The last national membership survey of vascular practice produced confusing responses around multi-disciplinary teams. The Society is of the opinion that standardising the process of decision making is in the best interests of our patients and this view is supported by our patient focus group. There is a strong desire to see all team members involved in optimising patient fitness for intervention and helping to guide the choice of most-appropriate intervention. While the current focus of attention is on AAA care, this also applies to carotid surgery, lower limb bypass and amputation.

A multi-disciplinary team exists when a minimum of a vascular surgeon, a vascular interventional radiologist and a vascular anaesthetist jointly assess and discuss the care for patients needing complex vascular interventions (AAA, carotid, bypass and limb amputation, plus rare diseases). **An x-ray meeting is not a MDT.** We recognise that not all units can convene a meeting with all three parties in attendance and present alternative models in the QIP report. It is critical that all three specialty groups have formal input prior to admission for intervention. The output from the MDT should be formally documented in the patient notes and shared with the patient. There should be joint decision making involving the team and the patient in the choice of care provided.

It is not however possible to gather a complete picture of AAA practice without capturing the cases "turned down" for intervention. To this end, in September we are hoping to undertake a short (4 - 6 weeks) snapshot audit throughout the UK. Details will be distributed shortly and we would encourage you to get involved and help us to gain a more complete picture of our service. Finally I would like to thank all the members of the Society and our sister organisations, the BSIR, VASGBI, SVN and SVT, who have contributed to our work this year. You are too many to mention, but none of our work would take place without your enthusiasm and commitment.

Mr David Mitchell, Chair

VSGBI Training and Education Committee Report

Professor Jonathan Beard, Chair

The work of the Committee over the last six months has focused on refinements to the Vascular Surgery Syllabus and the writing of a new Training Standards Document.

The Syllabus will be required by the GMC once our application for specialty status has been approved. Although a draft syllabus has already been submitted, there will be an opportunity for revision, and it is obviously important that the syllabus accurately reflects the competencies required by a future Vascular Specialist. This task has been made more difficult in that we do not know whether vascular surgery will be delivered through a regional outreach/in-reach service, or by a local network. Both models have pros and cons, but it is difficult to design a training programme that can cater for both. A local network model will require 'hybrid' specialists who are trained in vascular

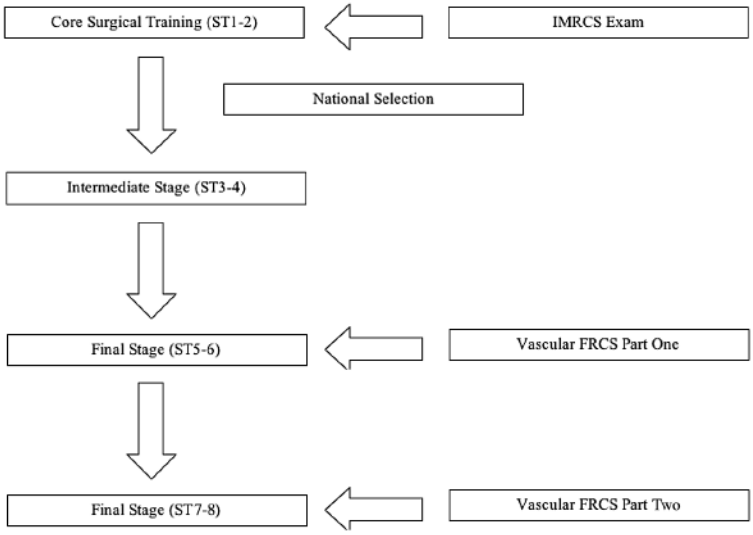

Figure1. Outline of selection and assessment system for vascular specialty training. A successful ARCP will also be required at the end of each level of training (ST1-8).

medicine, duplex imaging, axial image interpretation, open intervention, endovascular intervention and vascular access. I have my doubts whether such a specialist can maintain sufficient competence in all the areas required. A regional model could be linked to trauma and cardiothoracic services and has the advantage of larger volumes, which have been shown to improve outcomes. If this model prevails, trainees will probably need to sub-specialise into one or two areas in the last few years of training. We await with interest the Department of Health's decision on Specialty Commissioning.

The new *'Training in Vascular Surgery & Standards for Vascular Surgery'* document has been approved by Council. The document explains the outline of vascular training and the standards required for a hospital that wishes to provide training. Entry into specialty training will require successful completion of core surgical training and the IMRCS exam followed by a competitive national selection process. Specialty training will consist of a minimum of 6 indicative years, with a minimum of 4 years requiring exposure to emergency vascular surgery. Intermediate training will consist of the first two years (ST3-4) and will include a year of GI surgery. The final stage of training will be delivered over four years, ST5-8. The first part of the Vascular FRCS (test of knowledge) will be taken during ST5-6 and the second part (test of clinical and procedural skills) during ST7-8. Training rotations will be regional, with trainees working for different consultants and in several hospitals to allow a breadth of experience in all subspecialty areas. An outline of the selection and assessment system is shown in Figure 1.

Vascular training will be on specialist units with surgeons who are in dedicated vascular practice and members of the Vascular Society. Vascular surgery units who wish to provide training must demonstrate

(1) a high volume of work

(2) outcomes in line with national defined standards and

(3) a consultant rota which provides a sustainable 24/7 emergency surgical and interventional radiology service.

Most vascular training units will have insufficient specialty trainees to provide middle-grade cover, especially at night. There will be only approximately 120 vascular trainees in the UK, with a trainee:consultant ratio of 1:3 required to conform to national workforce planning requirements. The timetable for vascular trainees from ST5 upwards should maximise their supervised elective and emergency vascular experience and is incompatible with shift-working. Alternative arrangements, such as on-call from home, or long-day rather than night working will be required. If there are more approved training places than trainees, placements may be allocated on the basis of the quality of training and outcomes.

The ***'Training in Vascular Surgery & Standards for Vascular Surgery'*** document can be found at www.vascularsociety.org.uk and I would welcome comments from members. The Committee's next tasks are to develop a national selection system and a new Vascular FRCS examination.

VASCULAR COURSES AT THE RCS(ENG)

Vascular Access for Dialysis, 20 - 21 September 2011

www.rcseng.ac.uk/education/courses/vascular-access-for-dialysis

Modern Management of Varicose Veins, 18 October 2011

www.rcseng.ac.uk/education/courses/modern-management-of-varicose-veins

The Management of Venous Ulcer Disease

You may recall a recent request to complete an online survey regarding current practices in the management of Venous Ulcer Disease. I would like to take this opportunity to thank those of you who have already completed the survey: to date we have a 40% response rate, with some very useful data emerging. If you have not yet completed the survey, we would be most grateful if you could spare a few moments to visit www.surveymonkey.com/s/PPCGC8P

We are most grateful for your support of this important project and your views will be of great use in the development of both the Vascular Curriculum and to continued work on the management of venous disease.

Thank you.

Professor Ian C Chetter

Vascular Tutor Royal College of Surgeons of England

RCS Improving Outcomes Meeting

The Royal College of Surgeons of England held a seminar entitled "Improving Performance through Outcomes" on Wednesday 13th April 2011, at which the Vascular Society was invited to participate.

Bruce Keogh, NHS Medical Director began with an overview of the NHS Outcomes Framework. He reminded the audience that the 3 areas of health improvement, proposed by Lord Darzi, are effectiveness, patient experience and safety. The 5 outcome goals which fit into these are:

- to prevent premature death
- to enhance quality of life for long term illness
- to help people recover from ill health/injury
- to ensure a positive experience of care and
- to provide care in a safe environment and protect from avoidable harm.

NICE is planning to build a library of statements regarding quality standards not only to inform the commissioning board but also to shift payment away from pure volume and more towards the quality of care along the goals outlined above. These will enable a clinically focused commissioning outcomes framework, provider payment mechanisms incorporating tariff, a standard contract, CQUINs and QOFs, and commissioning guidance.

A presentation from the Society for Cardio-thoracic Surgery stressed the value of national audit. Whilst it costs about £1.5m a year to run, the Society has identified about £5m savings in improved outcomes and bed savings based on intensive outcome data collection and analysis. Dr Penny Wood from the Picker Institute stressed the importance of improving performance through the assessment of the patient experience in detail and the specific use of patient reported outcome measures. Other speakers used national studies to stress the importance of clinical organisation and coding. David Cromwell from the RCS Clinical Effectiveness Unit highlighted difficulties in drawing conclusions about clinical performance. He concluded that drawing conclusions about performance demands:

- well defined outcome measures
- adequate data quality
- appropriate risk adjustment
- an indication of the effect of random variation

NICE are also drawing up quality statements to drive quality improvement in clinical care. We can expect these to involve significant aspects of the care that we provide to patients. Our current QI frameworks map closely to national strategy, but it is clear from these presentations that there are significant challenges that face us professionally. **We all need to focus on improving the quality of our audit data and our national audits need to focus, not just on mortality, but also on the pathways of care so that we can demonstrate the quality of the service that we provide.** The Carotid Audit leads the way for the Vascular Society and we have recently lodged a formal application to HQIP for financial support to re-develop the National Vascular Database as a Vascular Registry to meet the needs of both vascular surgeons and patients in the future.

Ian Loftus & David Mitchell

Quality Assurance

for the NHS Abdominal Aortic Aneurysm Screening Programme

The NHS Abdominal Aortic Aneurysm Screening Programme (NAAASP) aims to reduce AAA related mortality by providing a systematic population-based screening programme for men during their 65th year and for men over 65 on request. The programme commenced in March 2009 and is currently being rolled out to all areas of England. It is expected to cover the whole of England by March 2013.

As part of the programme, a quality assurance (QA) framework has been developed in order to ensure that NAAASP delivers care of the highest possible standard and to provide information to the public and professionals about quality.

The programme has already developed quality standards which have been applied to the pre-implementation phase of new local screening programmes in order to ensure that these local programmes work to a high standard. These standards are based on those set out by the Vascular Society of Great Britain and Ireland (VSGBI), defined in the ***'Framework for improving the results of elective AAA repair'.*** The QA assessment to date has included a desk based assessment, and a QA visit, followed by a report highlighting any corrective or preventative action required.

Once local programmes are up and running, further QA assessment will be required at defined time intervals in order to ensure that screening is proceeding effectively and efficiently and to a high standard. Whilst the screening programme is still new in many areas, some of the early implementation centres have already been running for over a year. The NAAASP team is therefore working to put in place the QA process for ongoing regular assessment of the programme. This QA process will include a self-assessment component along with site visits and will sit within the framework for QA of the UK National Screening Committee. The process will measure against the defined quality standards and key performance indicators will be produced. The QA assessment will examine both the screening process itself and the outcomes in patients who are identified as having an AAA. Examples of QA data would be; the number of patients invited for screening and the number attending; variation in ultrasound measurements of AAA size; the speed of referral and treatment of patients with an aneurysm of ≥ 5.5cm; the provision of patient information; the percentage of patients referred for treatment who undergo surgery; and mortality rates of patients identified as having an AAA, including those who do not have treatment. Some of the information required will be obtained from existing IT within the screening programme and reports from the National Vascular Database of the VSGBI. Therefore assessment of these systems will also be required, in particular assessment of missing data and data accuracy.

These processes will identify any outliers and the NAAASP will seek to work with local programmes to assist them in implementing change.

Tim Lees

Regional Adviser to NAAASP

Edinburgh 2011

Annual Scientific Meeting

ABSTRACT SUBMISSION

Abstract submission is now available on the Society's website. The deadline is 4pm on Monday 1st August. Full details are available on the Society's website and via the link http://agm.vascularsociety.org.uk/

A summary of the guidelines:

- The abstract must consist of four paragraphs, entitled: Objective, Methods, Results, Conclusions
- The abstracts are to be submitted as text only
- The text should be no longer than 250 words and fit comfortably on a single page of A4 using 12 font
- Since the abstract will be judged anonymously, the text may not reveal the institutional affiliation
- The category which best describes the subject of your work should be indicated
- If the paper is to be considered for a prize or a poster, the relevant box should be marked
- The material should not have been published or presented at any major national meeting before

The Vascular Society takes a serious view of Research Governance. Please ensure that the abstract has been seen and agreed by all of the named authors before submission. All of the authors have a responsibility to ensure that the data submitted is accurate, is not extrapolated and fairly represents the presentation to be given at the Scientific Meeting.

Once selected, the abstracts will be available on the Society's website for Members' information prior to the meeting. They will also be published in the Society's Yearbook, which will be available at the AGM, and later by post to those Members who do not attend the AGM. The abstracts from the meeting will be published electronically via the BJS website.

POSTERS

Abstracts not selected for presentation at the meeting will be considered for poster display, and these will be displayed throughout the meeting at the conference centre.

PROGRAMME HIGHLIGHTS

Symposia on

- The impact of volume vs outcome on vascular service reconfiguration
- Should the National Vascular Database publish individual surgeon's results
- The role of the UEMS section and board of vascular surgery
- Hybrid theatres

Key note lectures from Professor Eric Verhoeven and Professor Hans-Henning Eckstein

Kinmonth lecture by Professor Bruce Campbell on The Evolution of Evidence

Educational Masterclass on Rare Vascular Diagnosis

Endovascular Workshop on EVAR Planning for consultants

Dedicated sessions for:

Venous Forum	Society of Vascular Nurses
SARS	Society for Vascular Technology
BSET	Circulation Foundation

SOCIETY OF VASCULAR NURSES AND SOCIETY FOR VASCULAR TECHNOLOGY

We are delighted that the SVN and SVT are holding their annual meetings alongside the Vascular Society AGM. Members are asked to encourage their vascular nurses and vascular scientists to attend both their own Society meetings and the VS meetings, and to join in the Society's Annual Dinner on Thursday 24th November.

REGISTRATION

On-line registration is now available at http://agm.vascularsociety.org.uk

This year, the Society has introduced a discounted registration fee for Medical Students attending the conference. In addition, trainees, who are not currently Affiliate Members of the Society, will receive their first year's membership at a subsidised rate if they join the Society at the same time as registering for the AGM. Abstract presenters will receive a 10% discount if attending all three days of the AGM (Wednesday to Friday inclusive). Members are encouraged to take advantage of the early-bird discount and register now. This rate will apply until the 16th October.

The Vascular Society of Great Britain & Ireland

Report from the Spring Meeting of the Vascular Society

King's Fund London, 10th March 2011

Michael Wyatt, Honorary Secretary

A big thank you to all who supported the recent Vascular Society Spring Meeting in London. This was timed to support the Vascular Disease Awareness Week entitled 'Are Your Legs Killing You?' which ran between the 7th - 13th March 2011. The meeting attracted a multi disciplinary professional team, including vascular surgeons, radiologists and nurses, podiatrists, physiotherapists, diabetologists, rehabilitation physicians and representatives from the Vascular Society Quality Improvement Framework.

A big thank you to Rob Hinchliffe for organising this important event, which succeeding in highlighting the plight of patients with peripheral arterial disease and threatened limbs due to diabetes, renal failure and vasculitis.

We discussed at length topics such as the diabetic foot, reducing the burden of amputation, optimising peri-operative care, limb salvage, the theories behind arteriogenesis and angiogenesis, and considered the many important adjuncts available to wound healing. Lessons learned from the BASIL trials were debated along with the prevention of re-ulceration, reducing amputation morbidity and mortality and rehabilitation. Many important talks were delivered during the two day meeting and the Vascular Society will be producing a short report on the meeting later this year.

The next Spring meeting is in Belfast from Thursday 22nd - Friday 23rd March 2012 and the theme is 'Trauma'. Do come and support your Society at this meeting. Please bring your colleagues, nurses and radiologists and we guarantee you will have a great few days. A Circulation Foundation Dinner will be organised for the Thursday night. Come and enjoy the 'Craic' and at the same time support your charity, The Circulation Foundation.

ACCEA

As you will know, ACCEA is currently under review by the DDRB, which is expected to report to Ministers in July 2011.

ACCEA is currently working on the basis that the 2012 round will be proceeding as normal and it therefore expects the timeframe to be similar to that of previous years (i.e. the round will open in September/October 2011 and close in December). The most likely date for the closing deadline would be Friday 9 December. In addition to any direct submission to the ACCEA, you may also wish to consider enlisting the support of The Vascular Society. As a professional organisation, we are allowed to support candidates in proportion to the size of our membership. Although individual online applications do not have to be submitted to the ACCEA until December, the supporting Societies have to submit their ranking list to the ASGBI and RCS by early September. The deadline is so that the Society's Awards Committee can consider your application citation in time to send it on to the ASGBI and RCS Awards Committee, who consider nominations from all of the associated Specialty Associations. The ASGBI in turn has a deadline to send their recommendations to the Royal College, who consider nominations from all the surgical specialties. While we can, and do, send citations on any late submissions directly to the ACCEA, such submissions will miss the above process for influencing a College citation.

The Society's Awards Committee therefore needs to receive your ACCEA application by Friday 5th August 2011. We are hopeful that the results of the 2011 awards allocation will be available from the beginning of August. You will need to submit your application to the VS on the forms provided by ACCEA, which are available on the Society website. You should also submit a copy of your form separately to the ASGBI and to the RCS(Eng) (Deadline date 15th August) for consideration by their Awards Committees.

The Circulation Foundation

www.circulationfoundation.org.uk

RESEARCH PROGRAMME

Surgeon-Scientist Award 2011

We would like to offer our congratulations to Alan Karthikesalingam of St George's Vascular Institute who beat off stiff competition to be awarded £55,000 for his research into ***Stratification of the Risk of Re-intervention after Endovascular Aneurysm Repair, and Rationalisation of Postoperative Surveillance.***

This is a very exciting piece of work and one that the Foundation is delighted to be supporting with their new Surgeon-Scientist Award. We would also like to offer our congratulations to the other shortlisted candidates, all of whom had excellent projects and presentations.

1/4 million pounds a year

The Foundation has committed to spend at least £250,000 a year for the next 4 years on research. We are really looking forward to an exciting future, focusing the majority of our funding on research and, by exploring new income streams, we very much hope to be able to increase these amounts in the near future.

As the only UK charity which focuses entirely on vascular disease and with our heritage as the fundraising arm of The Vascular Society, funding a vibrant research programme is our most important objective. We want to support and encourage vascular research in the UK to ensure that advances can be made in the prevention and treatment of vascular disease.

We will be announcing our new research awards programme in the autumn.

CIRCULATION FOUNDATION COMMITTEE

We are currently developing our fundraising tools and are looking to increase awareness, as well as our funds! If you would like to be involved with the Foundation, we are currently looking for volunteers who would like to help us at this exciting time. We are looking for members of the Vascular Society to take on well defined roles on the Committee and to help mould the future of the Foundation. If you are interested, please email Chairman Ian Franklin at i.franklin@imperial.ac.uk

FUNDRAISING EVENTS

Vascular Disease Awareness Week

Thank you to all who took part in Vascular Disease Awareness Week which ran between the 7th – 13th March 2011. 23 events took place around the country, ranging from promotional displays to drop in information sessions, sponsored walks, fun runs and cake or fruit sales. We also had some fantastic coverage online in lifestyle and medical magazines which increased our website traffic by over 400% during the week.

The week aimed to increase awareness of the dangers of vascular disease in particular peripheral arterial disease (PAD). Across the UK events were held at public venues and health centres. Vascular nurse specialists were on hand to offer advice and information on vascular disease to members of the general public, especially to those with diabetes. The emphasis was on the need for early diagnosis and referral. We also designed and launched a vascular risk checker on our website. This simple tool uses series of multiple choice questions which assesses the participant's vascular risk and has had over 2000 hits to date.

NHS Regatta Report 2011

Yet again the intrepid band of vascular surgeons set off with the twin targets of raising money for the Circulation Foundation and winning the B. Braun sponsored NHS Regatta. The weather was kind – there was a reasonable breeze on the practice day, but only just enough on the Saturday for one race. In the first race we had an excellent start and played the tide and wind right to be in the top three at the first mark. The good news was that we had won the B Braun Challenge Cup for the winner of the first day - this was presented at the event dinner in Cowes that evening.

The next morning dawned glassily calm; probably lucky as there were some rather jaded crews from the night before! Eventually we moved to a start line and set off with a good start and again 3rd at the windward mark. We then crept up to 2nd on the downwind leg but lost

The Circulation Foundation - Fundraising

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out to 4th on the last beat. We snatched a place back just before the finish so were counting 1st and 3rd and thought we had won overall. Unfortunately the boat (from landlocked Birmingham!) that had been 'gifted' the 2nd place in the first race won the second, and so were one point better than us.

Second overall is one better than we have ever done before –we will just have to keep trying. We were very sorry not to have our usual mainsheet man, Ray Dawson from Edinburgh. He is recovering from major surgery but we were able to exchange good wishes and report on the event and hope to have him back next year. We must thank Ian Brown and Rostra for their very generous sponsorship. I hope we will raise £3000 for the Circulation Foundation – also better than ever before. The Challenge Cup now proudly resides on the Circulation Foundation office mantelpiece.

The crew was as follows:

Andrew McIrvine (Kings College Hospital)

James Brown (Southend)

John Wolfe (St Mary's)

Jonathan Beard (Sheffield)

Mike Wyatt (Newcastle)

John Thompson (Exeter)

Peter Lamont (Bristol)

Matt Waltham (St Thomas')

London Marathon

A huge well done to our three dedicated runners for completing what some people only dream of achieving in a life time - the London Marathon. On a warm Sunday in mid-April, Olly Pickard, Nigel Roberts and Guy Salter took to the streets of London for the gruelling 26.2 mile route around the city. Together they have raised over £8,000 for the Circulation Foundation and donations are still coming in.

Places for the 2012 London Marathon are filling up fast so if you would like to be considered for one of our marathon places for 2012 and raise funds for the UK's only vascular disease charity, please get in touch with Rebecca Wilkinson in the CF office on 0207 304 4779.

An easier way to give

You can now donate to the Circulation Foundation by text! The great news is that as there are no set-up or admin charges, we receive 100% of the donation and it's free for you to send the text.

All you need to do is text CIRC01 and the amount you would like to give (up to £10) to 70070 and they do the rest. You'll then receive a text with a link to a Gift Aid form, which if you are a UK taxpayer, allows us to claim the tax back making your gift 20% more valuable to us!

The Shackleton Route

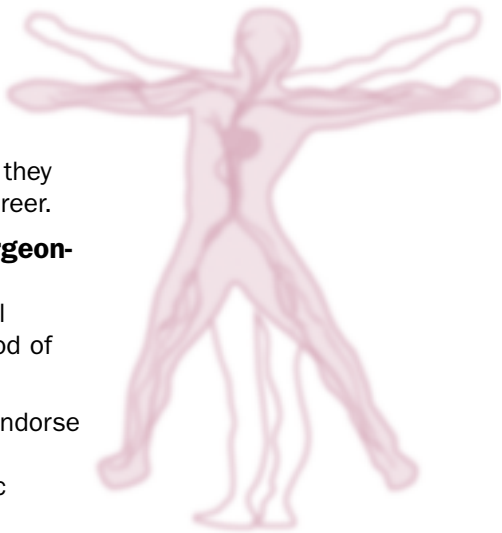
Our next fund raising event is being organised by a previous President of the Society, John Wolfe. He, along with a group of 7 friends, including two other members of the Vascular Society (Tom Carrell, and Martin Thomas), will be sailing across the Southern Ocean from The Falklands to South Georgia and will then be dragging sledges and skiing across South Georgia (the Shackleton Route).

South Georgia remains relatively unexplored with many unclimbed peaks. Its remoteness and harsh weather conditions are not for the faint-hearted or ill prepared. Unlike Shackleton, they will not be in an open boat but will be well supplied with modern equipment but they will, nevertheless, hope to retrace the steps of that epic journey. The training should help them stave off peripheral arterial disease and, if all goes well, they may attempt an unclimbed peak. The group is seeking your sponsorship for this event and all proceeds will be donated to the Circulation Foundation.

This is an excellent opportunity to show your support for the Circulation Foundation. Their target is £25,000 and if Members of the Society would like to contribute, you can do so by visiting Just Giving online at www.justgiving.com/John-Wolfe-Circulation-Foundation. Further details of this journey can be found by visiting the Circulation Foundation Website at www.circulationfoundation.org.uk/

Research Committee

Professor Shervanthi Homer-Vanniasinkam



The Society's Research Committee is now firmly established, and over the past year has developed a close working relationship with the Circulation Foundation. Professor Alison Halliday, a new member of Council, has now joined the Committee.

Following the successful launch last year of the **President's Early Career Award** (PECA), we are pleased to announce that the award continues this year. Consultants within 5 years of their substantive appointment are supported by generous funding (£100,000 over 2 years) as they develop an independent research career.

A second new grant, termed the **Surgeon-Scientist Award** (SSA), has been established to fund vascular surgical trainees while they engage in a period of formal research.

These two awards, PECA and SSA, endorse the Society's view that research is fundamental to a career in academic vascular surgery.

The Research Committee looks forward to continuing its partnership with the Circulation Foundation in the future.

Venous Forum

The Venous Forum (VF) continues to prosper in its role as the main specialist organisation representing those who treat venous disorders in the UK.

We see our role as promoting clinical best practice in venous disease, promoting and providing education, sponsorship of research into venous disorders and more recently lobbying for improved resources for venous disorders within the NHS. We are jointly linked with the Royal Society of Medicine (RSM) and the Vascular Society (VS). We have also recently formed a private practice sub-committee to represent the views and interests of those who work in the independent sector. Additionally, our international links continue to expand and we collaborate closely with the American College of Phlebology, the American Venous Forum, the European Venous Forum and other organisations.

We hold two main meeting a year, one at the RSM in the Spring and one at the VS annual meeting. The highly successful 2011 Spring meeting was organised by our current President, Professor Andrew Bradbury. It was a joint meeting with the Society of Vascular Nurses and the Association of Sclerotherapists, involving several eminent overseas speakers and a highly entertaining interactive voting session on difficult clinical scenarios. During the meeting, Mr Peter Holt gave his report on his 2010 pump priming grant ***"Acute DVT. Management uncertainties and research priorities".***

You do not have to be a member of the VF to attend either meeting, although we would encourage VS members with an interest in venous disorders to join us. Others functions of the VF are to award travel and research grants and we have an arrangement for members to receive a subscription of our closely linked journal, Phlebology, edited by Professor Alun Davies: this is cited on Medline and is the premier journal specialising in venous disorders.

We believe that there is a real threat to NHS varicose vein surgery. Our recent document "Recommendations for the referral and treatment of patients with lower limb chronic venous insufficiency (including Varicose Veins)" represents our view that varicose vein and other venous treatments should continue to be provided by the NHS. It has been circulated to all Chief Executives and Primary Care Trusts, as well as to other key organisations and individuals. The document is available for download on our web site: www.rsm.ac.uk/academ/forvenou.php
We have also published 2 special documents - the VEIN projects - the first on varicose veins and the second on leg ulcers. VEIN 3 on venous thrombosis is in preparation for launch at next year's Spring meeting. Again these are all freely available through our web site.

The Venous Forum is extremely keen to continue its successful links with the Vascular Society and hope that you will join us for our meeting on Wednesday 23rd November in Edinburgh for what I am sure will be a most stimulating morning of education and debate.

Gerard Stansby, Honorary Secretary

Andrew Bradbury, President

Isaac Nyamekye, Treasurer

Vascular Reports from CORESS

Frank CT Smith, CORESS Programme Director

The following reports have recently been submitted by consultants. Both draw attention to the need for scrupulous checks when administering intravascular fluids.

Local anaesthetic line flush (Ref: 110)

I undertook open insertion of a double lumen Hickman line in a paediatric patient undergoing chemotherapy for osteosarcoma. The case proceeded normally. The line was tunnelled from chest wall to cervical region, using the blunt tunnelling device in the kit, and inserted into the internal jugular vein. Line tip position in the right atrium was confirmed by image intensifier. The venotomy was closed with 6.0 prolene and both lumens of the Hickman line were flushed with heparinised saline.

Just prior to closing I realised that I had inadvertently tunnelled the line through the pectoralis major muscle, rather than superficial to it. Concerned that this might cause pain or early occlusion, I removed the line and re-sited it superficial to the muscle. The radiographer was called back to theatre to re-confirm line tip position. After checking luminal back-bleeds again, I asked the scrub nurse for the heparinised saline and flushed both Luer locks and line lumens. At this point the scrub nurse realised that she had given me a syringe containing Bupivicaine instead of hepsal flush. Both syringes had been contained in the same kidney dish, appropriately labelled with circumferential grey and white stickers around the syringes respectively.

The anaesthetist was immediately informed and both lines were back-bled again. Fortunately the instillate was a small volume and no adverse sequelae or cardiac arrhythmias were noted. The patient made an uneventful recovery from the procedure.

Reporter's Comments:

I was distracted by the procedural revision and failed to check the flush prior to administration. In this case, both the heparinised saline flush and Bupivicaine were in similar syringes with pale-coloured labels. Syringes containing separate drugs should be clearly labelled and kept separate. After giving local anaesthetic ensure that any surplus has been thrown away before flushing the lines. Always re-check a solution before re-administering it, even if it has already been checked before and has already been given.

CORESS Comments:

This case illustrates a recurrent theme of inadvertent administration of the wrong drug due to procedural and systems failures, previously highlighted in recent CORESS reports.

When there are several solutions available, they must be clearly labelled. It is always the responsibility of the person giving the drug to check that it is the appropriate solution. This must be done even during a surgical procedure.

Wrong Dose Heparin (Ref: 126)

There are times when the vascular surgeon becomes worried about systemic coagulopathy. On this occasion, I was performing a straightforward carotid endarterectomy, having stopped clopidogrel seven days before surgery, but having continued the patient on aspirin 75mg daily. Before cross clamping the carotid artery I requested the usual 5000 units of heparin to be given intravenously.

The endarterectomy was uneventful, but in recovery it became apparent that the skin edges were bruising, the Redivac drain filled with blood and the tissues became inspissated with haematoma. This appeared to be due to a coagulopathy, and we immediately ordered blood tests to check INR, APPT, platelet count and haemoglobin. The APPT was greater than 2.5 and this was therefore reversed judiciously with small incremental doses of Protamine. This is a drug I dislike because of its hypotensive properties and indeed the systolic pressure fell to 40mmHg for a short period.

The situation resolved without further adverse sequelae but clearly both hypotension and use of Protamine could have resulted adverse thrombotic consequences for the freshly endarterectomised site.

The cause of this problem was inadvertent intravenous injection of 25,000 units of Heparin, rather than the 5,000 units requested. We usually use 1000 units per 1ml ampoules, but on this occasion the concentration inadvertently used was 5000 units in 1ml.

CORESS & Reporter Comments

Clearly this problem was due to human error, but the question of whether hospital operating theatres should stock only one concentration of heparin rather than both, or whether they should be stored separately is raised.

The problem has already been brought to the attention of Sir Liam Donaldson by Professor Brian Toft. The article "The Dangers of Heparin Flushes" (Qual Safe Healthcare, April 2009, Vol 18; 2) was sent to the CMO who responded: "the NPSA guidance on anticoagulants recommends the use of 1000 units per ml Heparin products in clinical areas and the subsequent removal of higher strength products such as those involved in the incident you are investigating"

Clearly this message needs to be disseminated more widely.

OBITUARY Martin Birnstingl

Martin Birnstingl, President of The Vascular Society in 1986, passed away in January, aged 86. He was a leading vascular surgeon and a passionate campaigner for human rights, who employed his medical expertise on many occasions to challenge the official line. After leaving school, he studied at St Bartholomew's Hospital Medical College. Beginning in the hospital's surgical unit, under Sir James Patterson Ross, Birnstingl soon developed an interest in the new discipline of vascular surgery, which had been pioneered in America in 1948. In 1952 he and a visiting American fellow, Jack Connolly, toured the pioneering vascular surgery centres of Europe. After a year at Stanford University, California, he returned to Barts', becoming assistant director of the surgical unit where he became one of the country's most respected vascular surgeons.

Nominations for Membership of Council

There will be three vacancies on Council in November this year, due to the completion of the terms of office of Mr Paul Blair, Professor Shervanthi Homer Vanniasinkam (who will continue as Chair of the Research Committee), and Mr Shane MacSweeney.

A nomination form can be downloaded from the Vascular Society website, which should be returned to the Secretariat by 31st August 2011.

Members elected to Council become Trustees of the Charity, and have a responsibility to act in accordance with Charity Commission regulations in achieving the Society's objectives:

- To take part in formulating and regularly reviewing the strategic aims of the organisation
- To ensure that the policy and practices of the organisation are in keeping with its aims
- To ensure that the organisation functions within the legal and financial requirements of a charitable organisation and strives to achieve best practice.

The Vascular Society is legally responsible for the operation of the fundraising activities of the Circulation Foundation and Council members are therefore encouraged to take an active interest in supporting the aims and objectives of the Circulation Foundation.

The Council meet four times a year - February, May, September and November, and Council Members are generally asked to serve on one of the Society's working committees - Audit and Quality Improvement, Training and Education, or Research. Council also meet with the Vascular Advisory Committee twice a year.

Welcome to the following new members of the Vascular Society

Ordinary

Chris Davies	Morriston Hospital
Adib Khanafer	Christchurch Hospital
Christopher Parry	Derriford Hospital
Jonathan Smout	Aintree University Hospital Trust

Affiliate

Muzaffar A Anwar	Imperial College London
Rovan D'Souza	Royal Free Hospital
Matthew J Fincher	Royal Free Hospital
Hayley Moore	Charing Cross Hospital
Alex Vesey	Royal Alexandra Hospital
Ruwan Weerakkody	St Mary's Hospital

The Vascular Society of Great Britain and Ireland

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Mr Michael Wyatt

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Mr Simon Parvin

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Professor Jonathan Beard

Chairman, Audit and Quality Improvement:
Mr David Mitchell

Chairman, Research Committee:
Professor Shervanthi Homer-Vanniasinkam

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