

GOVERNANCE FRAMEWORK FOR VASCULAR SURGEONS AND THE NATIONAL VASCULAR DATABASE.

Proposed action for “outliers” in the National Vascular Database (NVD) and extent of VSGBI remit for standards throughout vascular surgery.

1. Background.

1.1 The NVD was established in 1999 as a voluntary register for risk adjusted outcomes of selected “index” arterial operations (carotid endarterectomy, aortic aneurysm repair and infrainguinal bypass, recently enlarged to include limb amputation). Its aims were to allow vascular surgeons to compare their results with national figures and to demonstrate a form of governance for vascular surgery.

1.2 Contributors to the NVD have increased year by year and over half of the members of VSGBI now contribute. Nevertheless, a significant number of VSGBI members do not contribute and there are surgeons undertaking index arterial operations who are not Vascular Society members.

1.3 The GMC document “Good Medical Practice” states that:

1. 43. You must protect patients from risk of harm posed by another colleague's conduct, performance or health. The safety of patients must come first at all times. If you have concerns that a colleague may not be fit to practise, you must take appropriate steps without delay, so that the concerns are investigated and patients protected where necessary. This means you must give an honest explanation of your concerns to an appropriate person from your employing or contracting body, and follow their procedures.
2. 44. If there are no appropriate local systems, or local systems do not resolve the problem, and you are still concerned about the safety of patients, you should inform the relevant regulatory body. If you are not sure what to do, discuss your concerns with an impartial colleague or contact your defence body, a professional organisation, or the GMC for advice.

This document makes clear that the VSGBI has a duty to act if it identifies poor performance that suggests that patients might be at risk as a result of operation by a particular surgeon. It also makes clear that the Vascular Society has a duty to inform the surgeon's employer.

1.4 The Chairman of the Professional Standards Committee of the Royal College of Surgeons of England (RCS Eng) has advised against dealing with concerns “internally”, specifically in view of indemnity issues. He has suggested that the VSGBI should involve the RCS Eng, employers and other external agencies early in the process.

1.5 The advent of local and regional networks with devolved governance structures and the introduction of the National Abdominal Aortic Aneurysm Screening Programme (NAAASP) have created alternative avenues through which

performance concerns may be raised. This document updates the previous governance framework from 2005.

2. Current mechanism when results of a contributor to the NVD transgress an agreed threshold.

2.1 The thresholds for concern and action as a result of NVD figures should be agreed by Council in discussion with representatives of the Audit and Research Committee and with other advisors selected by Council. They should not be determined by the Professional Standards Committee.

2.2 Scrutiny of the results of the NVD is undertaken by the Chairman of the Audit and Research Committee on a regular basis, using the reporting tool within the database. The society receives uploads from surgeons using in house databases periodically and the reporting tool is checked prior to each council meeting (four times a year). If the figures of any surgeon transgress agreed thresholds, the Chairman and database manager check that the identity of the surgeon and the figures are correct. If it is confirmed that the outcomes exceed VSGBI thresholds, the President of the VSGBI and the Chairman of the PSC are notified. The identity of the surgeon is kept confidential to these three officers and to the Chief Executive of the Society who deals personally with any correspondence.

2.3 The President will inform the surgeon and the Medical Director of the employing Trust simultaneously by confidential letter. He/she contacts the surgeon personally by telephone *before* dispatching the letters. He/she tells the surgeon about his/her figures and the imminent letter to his/her Medical Director. The surgeon is advised that he/she should not undertake the particular procedure in question until the matter has been resolved. The letter to the Medical Director will be copied to the surgeon and includes:

- Background about the NVD and its governance.
- Explicit information about the cause for concern, with detailed figures.
- A suggestion that the Trust might wish to explore the figures as a governance matter, but emphatic advice that the figures should be verified locally.
- Emphasis that this is a sensitive matter which would best be handled in a confidential manner initially.
- A suggestion that the figures should be interpreted in the context of casemix and local circumstances.
- Advice that the surgeon should not perform the particular procedure in question until the Trust has investigated the matter to its satisfaction: but that there is no reason the surgeon should not continue to undertake other work and procedures in the normal way.
- A request that the President be informed of the findings and conclusion of the Trust's investigation.
- A specific request to be informed about the findings of the local data verification process – in particular whether local audit correlated with the NVD figures, or not.
- Figures from the NVD giving the results of the surgeon's other index operations.

- A list of the names of the other vascular surgeons in the Trust who contribute to the NVD.
- An offer of assistance from the Society in the form of
 - Personal support for the surgeon from a senior member of the VSGBI.
 - Advice on interpretation of figures; setting them in context; and explanation of any matters relating to vascular practice.
 - Advice on making changes in the local vascular service.

2.4 The Medical Director may choose to inform the Professional Standards Chairman of the appropriate Royal College. That is a local decision and not a matter for the VSGBI.

3. Proposed new procedure

3.1 The society may receive notification of possible poor performance of individual surgeons from analysis of the NVD reports, from local governance committees or from the NAAASP who will identify poorly performing units and request individual surgeon performance be reviewed.

3.2 Notification of poor performance will trigger immediate review of the surgeon's NVD contribution and outcomes. Individual poor performance (outlying beyond VSGBI thresholds) identified by whichever route, will trigger the mechanism described above. If an individual within a poorly performing programme is identified as having acceptable performance, then the VSGBI governance framework will not apply.

3.3 Management of poorly performing aneurysm screening units is the responsibility of the NAAASP and not the VSGBI. The VSGBI will provide professional input and support to the NAAASP process as described in 3.1.

4. Non-contributors to the NVD and non-Members doing index operations.

4.1 The VSGBI should write to the Medical Directors of all Trusts in the UK and Ireland to inform them which surgeons in their hospitals are contributing to the NVD. The letter will point out that other surgeons performing elective index operations may be practising without any form of external audit or governance (although they may be contributing to another database). The letter will ask for the names of these surgeons as a matter of information.

4.2 The letter to Medical Directors will point out the resource issues required for contribution to the Database (i.e. adequate help with data extraction and entry).

4.3 Medical Directors will be sent information about the NVD annually, with an update of contributing surgeons in their Trusts and a request to inform the Society about any other surgeons undertaking elective index operations.

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