National Vascular Registry

UPCARE: 1.00 Programme name - please do not change this field.*	National Vascular Registry
1.01 Abbreviation	NVR
1.1 Contract status	Ongoing
1.2 Audit or non-audit	Audit
1.3 HQIP commissioned*	Yes
1.40 Programme unique identifier*	HQIP113
1.41 HQIP AD	JT
1.42 HQIP PM	CG
1.5 Lead organisation*	Royal College of Surgeons of England
1.6 Programme homepage*	https://www.vsqip.org.uk/
1.7 Programme summary	https://www.vsqip.org.uk/faqs/
2.1 Organogram	https://www.vsqip.org.uk/wp-content/uploads/2025/01/NVR-Organogram_Dec-2024.pdf
2.2 Organisations involved in delivering the programme	Clinical Effectiveness Unit at the Royal College of Surgeons - https://www.rcseng.ac.uk/standards-and-research/research/clinical-effectiveness-unit/ Contracted by HQIP to manage and run the NVR. Also Provides the statistical methodology and the analysis presented in the annual report and associated short reports/ journal papers. Vascular Society of Great Britain and Ireland https://www.vascularsociety.org.uk/ The Vascular Society of Great Britain and Ireland is the pre-eminent organisation in the country promoting vascular health by supporting and furthering excellence in education, training and scientific research.

British Society of Interventional Radiology
https://www.bsir.org/

The BSIR is a charitable foundation founded to promote and develop the practice of Interventional Radiology.
What are the main objectives of the society?
• To support and develop access to high quality information on Interventional Radiology for patients and all healthcare professionals.
• To support audit and research in Interventional Radiology
• To support education and training in Interventional Radiology

Vascular Anaesthesia Society of Great Britain and Ireland
https://www.vasgbi.com/

VASGBI was formed in 1997 to provide a forum to promote communication and understanding among anaesthetists who care for patients undergoing vascular surgery. The society aims to support all those involved in vascular anaesthesia, from dedicated vascular anaesthetists to those with limited vascular responsibilities. The committee includes members from both district general and teaching/university hospitals to provide fair representation of all vascular anaesthetists.

2.3 Governance arrangements

The NVR is governed by a project board, which meets twice a year. The group is chaired by Prof Ian Loftus and includes representatives from the organisations listed in the organogram in section
3.1. The board is responsible for overseeing the audit and providing oversight and advice to the project. The board is the guarantor of the data from the audit and is responsible for signing off the annual report. The chair of the Programme Board is the accountable officer of the project.

The clinical reference group reports to the project board and is responsible for delivering the programme. It includes members from the Vascular Society's audit and quality improvement committee.

Decisions are only taken at meetings where meetings are quorate. There is a process for reviewing membership to ensure an active board, quorate meetings and which leads the direction of the programme.

2.4 Stakeholder engagement

Patients are involved by:
• Providing feedback on the infographics used within the 2017 annual report, so that they can be improved for future years,

Clinicians are involved by:
• Presenting key findings from the audit at the professional annual conference
• Collecting the data

2.5 Conflict of interest policy

All DOI are collected in advance of board meetings and decisions regarding whether a COI exists and appropriate actions are made by the Chair. Any new DOI are also requested at each board meeting as a standing agenda item.

3.1 Quality improvement goals	The process related quality improvement objectives of the NVR are to: 1. For AAA repair – (1) patients should have pre-operative CT/MR angiogram assessment; (2) All elective procedures should be reviewed preoperatively in an MDT that includes surgeon(s) and radiologist(s) as a minimum 2. For carotid endarterectomy – (1) the time between the onset of symptoms and treatment should be no more than 14 days; 3. For major lower-limb amputation – (1) Amputations should be undertaken on a planned operating list during normal working hours; (2) a consultant surgeon should operate, or be present in the theatre to supervise a senior trainee (ST4 or above) undertaking the amputation, (3) a patient should have routine antibiotic and DVT prophylaxis before surgery. The outcome related quality improvement objectives of the NVR are to reduce mortality and morbidity rates from all procedures. For patients underoing lower limb revasculisation for chronic limb threatening ischaemia (CLTI), they should have their procedure within 5 days of admission (inpatient pathway) or 14 days from referral (outpatient pathway)
3.2 Quality improvement driver diagram	https://www.vsqip.org.uk/wp-content/uploads/2024/06/NVR_Healthcare-Improvement-Strategy_Aug2023.pdf
3.3a Methods for stimulating quality improvement*	On-line Quality Improvement guides; Workshops
4a. Please add the most recent date that you have reviewed and updated an online version of UPCARE Programme section on your project's website (click into the response to see pop-up guidance).	29/01/2026
4b. Please add a hyperlink to UPCARE Programme section on your website (click into the response to see pop-up guidance).*	https://www.vsqip.org.uk/resources/guides/understanding-practice-in-clinical-audit-and-registries-tool-upcare-tool/