National Services Directorate (NSD)
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NHS National Services Scotland

minutes

Vascular Task and Finish Group

MS Teams Join the meeting now
Wednesday 12th March 2025, 15:30-17:00

Present: **Document Reference: VTF2025-12**

Andrew Murray (AM)	**CHAIR** and Medical Director	NHS Forth Valley
Andrew Tambyraja (AT)	Clinical Director for Vascular surgery	NHS Lothian
Bryce Renwick (BR)	Clinical Lead Vascular Surgery	NHS Grampian
Caroline Whitworth (CW)	Acute Medical Director	NHS Lothian
Christina Beecroft (CB)	Consultant Anesthetist	NHS Tayside
Claire MacArthur (CMac)	Director of Planning	NHS GGC
[redacted]	Programme Support Officer	NHS NSD
Elaine Henry (EH)	Operational Medical Director	NHS Highland
Ewan Murray (EMu)	Strategic Planning Manager	SAS
Graeme Guthrie (GG)	Consultant Vascular Surgeon	NHS Tayside
[redacted]	Programme Manager	National Services Directorate
[redacted]	Assistant Service Manager	NHS Fife
Karen Murphy (KM)	Consultant Vascular Surgeon, Clinical Lead	NHS Fife
Keith Hussey (KH)	Consultant Vascular Surgeon Surgery & Anaesthetics	NHS GGC
Kenneth Dagg (KD)	Acute Medical Director	NHS Lanarkshire
Kirstie Tinkler (KT)	Clinical Service Manager for Vascular and General Surgery	NHS Lothian
Lorraine Cowie (LC)	Professional Lead Health Planning and Sustainability	Scottish Government
Mark Allardice (MA)	Senior Programme Manager	National Services Directorate
[redacted]	General Manager	NHS Fife
Moira Straiton (MS)	Associate Director	National Services Directorate
Murray Flett (MF)	Consultant Vascular Surgeon	NHS Tayside
Paul Bachoo (PBa)	Acute Portfolio Lead, Acute Medical Director	NHS Grampian
Paul Blair (PB)	Independent Vascular Consultant	NHS Belfast Health Trust
Sally McCormack (SMcC)	Associate Medical Director	NHS Fife
Samuel DeBono (SDB)	Trainee Vascular Surgeon	NHS Lanarkshire
Tamim Siddiqui (TS)	Consultant Vascular and Endovascular Surgeon	NHS Lanarkshire
Wesley Stuart (WS)	Consultant Vascular Surgeon	NHS GGC

Apologies:

Abdul Qdair (AQ)	Consultant General Surgery	NHS Grampian
Ali Marshall (AMa)	Deputy Director of Planning	NHS GGC
Aris Tyrothoulakis (AT)	Site Director	NHS Lothian

Benjamin Cooper (BC)	Vascular Nurse Consultant	NHS Grampian
Cameron Matthew (CM)	Divisional General Manager Surgical Services	NHS Grampian
[redacted]	Clinical Care Group Manager	NHS Tayside
[redacted]	Service Manager	NHS Lanarkshire
Euan Munro (Emu)	Consultant Vascular Surgeon	NHS Grampian
[redacted]	Data Analyst	National Services Directorate
James Cotton (JC)	Interim Medical Director	NHS Tayside
John Keaney (JK)	Acute Medical Director	NHS Lanarkshire
Julie Christie (JCh)	Associate Medical Director for Surgery	NHS Tayside
Julie Greenlees (JG)	Assoc Director Vascular Services	NHS Tayside
[redacted]	Unit Operational Manager	NHS Grampian
[redacted]	Division General Manager	NHS Highland
Michelle Carr (MC)	Chief Officer Acute Services	NHS Lothian
Sanjay Pillai (SM)	Consultant Interventional Radiologist	NHS Tayside
Scott Davidson (SD)	Medical Director	NHS GGC
Sotiris Makris (SMa)	Consultant Vascular Surgeon	NHS Grampian
Stuart Suttie (SS)	Consultant Vascular Surgeon	NHS Tayside
William Edwards (WE)	Director of eHealth	NHS GGC

1 Welcome and Apologies

AM welcomed everyone to the final meeting of the Vascular Task and Finish Group and apologies were noted as listed above.

2 Declaration of Interest

AM requested any conflict of interest be declared; no conflicts of interest were highlighted.

3 Minutes from the previous meeting on 19/02/25 (paper VTF2025-09)

Minutes from the previous meeting were reviewed and approved.

4 Review of actions from the previous meeting (paper VTF2025-10)

All outstanding actions were reviewed and updated at the meeting.

ACTION VTF2024-18 Closed - AM advised that MDs were aware of the challenging situation/mutual aid position and encourage a move to the Sustainable Operating Model.

ACTION VTF2025-01 Closed – BR advised that Grampian and Tayside had been in contact and discussions between the two teams had been positive, both are willing to work together to implement the recommendations.

ACTION VTF2025-02 Closed – National Planning collated feedback around data accuracy and comments were reviewed/discussed at the meeting. An appendix will be added to the report detailing all comments received and actions taken.

ACTION VTF2025-03 Closed - NSD circulated a list of all outstanding questions with the meeting papers and responses were discussed at the meeting.

5 Feasibility Paper

- **Final agreement on actions outstanding/areas**
- **Final discussion and summary of comments**

- MS reaffirmed to the group that the current position was mutual aid which was unsustainable and not the proposed sustainable operating model to address feedback that had been received on timelines to move to the Target operating model. The group discussed that the **sustainable operating model** (SOM) (phased approach to TOM implementation) recommendation is that NHS Fife and NHS Highland would also form part of the NoS network as non-arterial (Spoke centres) with the network serving a population of 1.7M. This would provide 4 networks with 5 arterial centres supporting the

population of Scotland. The current resources and footprint are insufficient, necessitating interim network options and staged transfer of care to support capacity in Tayside, Grampian and Fife. The sustainable operating model proposes NHS Fife remain as part of the North of Scotland model whereby transition arrangements will require diverting work from Tayside to NHS Fife to alleviate capacity constraints, performing major and minor lower limb amputations in NHS Fife, and transferring NHS Fife's acute unselected take to Lothian with consultant triage. This approach will reduce the burden on Tayside, Grampian and Fife and support implementation of the TOM.

A gateway review is recommended to be implemented to monitor implementation of the SOM and reassess if the TOM is still the correct approach or if needs to be modified based on findings. Full delivery of the SOM will require realignment of existing funding and additional funding to support delivery including workforce increases and infrastructure changes.

The following comments were made:

AM referenced previous data discussions and requested the Group focus on what the data states in the first two bullet points. PB commented that there was limited capacity all over Scotland and stated that the initial Option 5 suggested Fife patients be divided between Tayside and Lothian as a patient balanced, pragmatic approach.

MS advised that implementation of the SOM would take place over the next 3-6 months as data was showing that the patient cohort from Highland was not as large as anticipated, however, it was noted that no sites had large amounts of capacity.

CW advised that a programme of work was under way in Lothian to reduce bed occupancy, however, stressed that there was currently no unused capacity at the Edinburgh Royal Infirmary (ERI) and bed space remained a significant challenge with regards to Fife patients in the proposed SOM.

MW added (in the chat function) that currently Fife patients do have a clear pathway. SMcC added that Fife currently works well as a spoke service, however, suggested that there was a danger of experiencing similar recruitment challenges as the Highland service in the proposed TOM. SMcC estimated that Fife patients occupy 39/40% of in-patient beds in Tayside, and it was anticipated that in-patient procedures would increase if Fife lost vascular surgeons in the TOM.

PB suggested that it may be worthwhile for Fife/Tayside/Lothian to get together to discuss where Fife patients would be best triaged to, for the benefit of patients.

MS commented (in the chat function) that the SOM was intended to spread the workload, not fragment services.

CB shared that there had been [redacted] patients from Highland treated in Tayside so far. The mutual aid model has highlighted the need for vascular services to be redesigned and that the problem exists for the whole of Scotland to contribute and manage. CB highlighted that Tayside cannot take Highland patients without support from elsewhere, CB suggested that Fife managing their own amputee patients could be helpful and agreed that the model could give more work to Fife in the future and share capacity.
It was acknowledged that the mutual aid position was not ideal for patients for anything more than a short term solution.

SMcC commented (in the chat function) that Fife does not have on-call overnight cover, and GG suggested the use of medical/ortho wards for stable amputation patients.

CW commented that realigning an established spoke service seemed counterproductive. MS reiterated that it was not possible to remain in a mutual aid situation for NHS Scotland patients. MS stressed the need to consider how to free up Tayside capacity and how to overcome the barriers for a sustainable future process. It was noted that subgroups may be developed to progress the implementation phase.
GG shared that Tayside had good discussions with Highland re rapid repatriation in cases where Fife patients want to be repatriated quickly and have care provided closer to home.
EH highlighted the importance of sharing learning. EH commented on the use of other disciplines to support repatriated patients to enable patients to access care close to home as soon as possible.
TS shared that the West of Scotland hub have mature pathways and an effective specialist workforce. This could be considered proof of success of the hub and spoke model similar to what is proposed for the SOM and TOM. However, TS added that careful consideration is required around population split and advised caution around a NoS network (including Fife) covering a 1.7M population alongside a SE network only covering 1M.

CB highlighted a view that the SOM/TOM gives a clear and sustainable way forward. CB acknowledged the challenges expressed within the room around implementing the SOM and TOM and highlighted that no alternative has been suggested.
AM reiterated that the Group had already considered and dismissed a number of model suggestions in previous meetings.
BR echoed CBs comments to focus on the strategy whilst acknowledging that the detail was still to be finalised.

PB suggested that based on discussions so far a pragmatic solution was the SOM and to support implementation i.e. Fife consultants to continue to work in Fife and support Tayside by (1) taking additional spoke services and also some selected inpatient work such as amputations and (2) assisting with covering 2 centre model for NOS Fife patients could be split on a geographic basis between Lothian and Tayside . This was the sensible option.

AM thanked everyone for their helpful comments, acknowledged concerns, however, confirmed that implementation of the SOM, addresses the mutual aid position which cannot continue, and gives the way forward.

MS confirmed that the next stage was for the SOM/TOM inclusive of the feasibility assessment paper to be concluded with the output from the T&F group and then put forward to the Planning and delivery board for consideration. A group would then be mobilised to take forward recommended actions and work towards implementation if endorsed. The papers would be shared with the T&F group once ready alongside going for endorsement due to the urgency of the situation. Further actions on the feasibility study/implementation would be owned by the implementation group and these actions would be clarified in the report.

JM presented the following Outstanding Questions:
How should emergencies be managed across the North and East? How could Fife/Lothian support Tayside and Grampian to mobilise the SOM?

- What considerations exist around repatriation requirements:
- What needs to be in place at spoke sites? E.g. transport and beds etc.
- What needs changed around current processes to improve repatriation?

- What pathways need to be established and what points of contact are required to make repatriation work smoothly?
- Should drop in consult services be embedded into the future model to improve flow and efficiency?
- What repatriation metrics should be used to monitor effectiveness?
- What care pathways and timelines are required?
- What transfer arrangements are required?

The following comments were made:
EH commented that emergency cases are easier to manage than chronic limb ischemia patients who are more complicated, difficult to define and repatriate.

GG commented that discharge co-ordination teams in Tayside manage repatriation well with links to the NoS, however, the geography would not change, and it will continue to be a challenge to manage patients from more remote locations.

BR expressed that teams are under pressure with the current mutual aid position and added that it was challenging to produce elegant solutions. CB supported the need to finalise the Task and Finish Group and move at pace to the SOM eliminating the ongoing need for rotating mutual aid.

CW commented that repatriation needs to be prompt with available bed/transport/support in place. EH commented that beds were less of a problem in Highland, transit risk was a live issue which requires development. EH added that future recruitment would be a struggle without a rotational hub model.

CW expressed the need for a a mechanism for specialist function at spoke sites.

SS highlighted that recruitment cannot happen with the current reliance on mutual aid and added that a network model will take time to establish so moving to SOM would be beneficial.
AM highlighted that there were good standard operating process examples available from GJNH around repatriation metrics.

Transfer arrangements

AM requested more clarity around SAS patient transport charges. EM clarified that legislation states that 999 calls must be taken to definitive care where patients will receive specialist care for serious illness/injury, this ties into major trauma centres and the moving of patients. EM highlighted that funding was not provided to transport patients all over Scotland. While SAS do not provide mutual aid it has been provided, when necessary, with mutual agreements for one-off arrangements or short periods of time.
EM added that SAS were looking at demand and capacity as part of the sustainability model, through their specific modelling system 'Ambsim.'

Vascular Trainees

AM reiterated that the Group had talked about the pipeline for trainees in previous meetings and it was agreed that source information would be required from NES around Workforce Planning and vascular trainees going forward.

Consultant Numbers

AM commented that consultant numbers would form part of the TOM.

Audit Facilitators

AM shared that a gap had been identified around audit facilitation, and it was noted that this needs to be properly resourced.

6 Governance Processes

AM shared an assumption that there would be a network MDT and oversight retained within Boards to monitor clinical governance risks during the transition arrangements. Consequences and implications had been discussed extensively in previous meetings.

7 Next steps

ACTION VTF2025-04 - NPT to review, collate and incorporate all feedback received, produce a 'you said we did' document and circulate the updated report to the Group.

ACTION VTF2025-05 – NPT to call for subgroups to complete any unfinished work /unanswered questions as required.

8 Any Other Business

CW questioned whether the feasibility study would be a separate paper and JM advised that feasibility was included within the report.
AM noted the anxieties expressed and acknowledged that work was just steps away from finalising the feasibility.

EH highlighted that 6 months of mutual aid was difficult to maintain and expressed keenness to follow up on the stepwise approach to stabilise the service. GG echoed EH comments as it was felt that patients were suffering.

MA confirmed that next steps were that MS would provide an update to the Planning and Delivery Board on 25th March. (**Post Meeting Note: PDB cancelled and rearranged to 14 April 2025)**

AM and PB thanked the Group for their hard work and PB shared that he hoped to continue in an advisory role until the summer.

MA passed on thanks from MS to AM for his leadership and chairing of the Group on behalf of National Planning.

9 Close of Group

AM thanked everyone for their input during the lifecycle of the Task and Finish Group and closed the meeting.