National Services Directorate (NSD)
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NHS National Services Scotland

minutes

Vascular Task and Finish Group

MS Teams Join the meeting now
Thursday 29th May 2025, 14:00 – 16:00

Present: **Document Reference: VTF2025-xx**

Paul Blair (PB)	**CHAIR** and Independent Vascular Consultant	NHS Belfast Health Trust
Ali Marshall (AMa)	Deputy Director of Planning	NHS GGC
Andrew Walker (AW)	Consultant Radiologist	NHS Lothian
Bryce Renwick (BR)	Clinical Lead Vascular Surgery	NHS Grampian
Cameron Matthew (CM)	Divisional General Manager Surgical Services	NHS Grampian
Caroline Whitworth (CW)	Acute Medical Director	NHS Lothian
Christina Beecroft (CB)	Consultant Anesthetist	NHS Tayside
Christopher Cartlidge (CC)	Associate Medical Director	NHS Fife
[redacted]	Programme Support Officer	NHS NSD
Elaine Henry (EH)	Operational Medical Director	NHS Highland
Ewan Murray (EMu)	Strategic Planning Manager	SAS
Fiona Schofield (FS)	General Manager Surgical Services	NHS Lothian
Graeme Guthrie (GG)	Consultant Vascular Surgeon	NHS Tayside
[redacted]	Programme Manager	National Services Directorate
John Stevenson (JS)	Assistant Service Manager	NHS Fife
Karen Murphy (KM)	Consultant Vascular Surgeon, Clinical Lead	NHS Fife
Karin MacLeod (KMcL)	Unit Operational Manager	NHS Grampian
Kevin Sim (KS)	Consultant in Critical Care	NHS Grampian
Lorraine Cowie (LC)	Professional Lead Health Planning and Sustainability	Scottish Government
Louise Noble (LN)	Service Manager	NHS Fife
Mark Allardice (MA)	Senior Programme Manager	National Services Directorate
Margaret Meek (MM)	Director of Hospital Services	NHS Lanarkshire
Miriam Watts (MW)	General Manager	NHS Fife
Moira Straiton (MS)	Associate Director	National Services Directorate
Neil Masson (NMa)	Consultant Radiologist	NHS Lothian
Paul Bachoo (PBa)	Acute Portfolio Lead, Acute Medical Director	NHS Grampian
[redacted]	[redacted]	NHS Lanarkshire
Sanjay Pillai (SPi)	Medical Director Acute Services	NHS Tayside
Sharon Hilton Christie (SHC)	Executive Medical Director	NHS NSS
Shilpi Pal (SPa)	Interventional Radiologist	Tayside

Tamim Siddiqui (TS)	Consultant Vascular and Endovascular Surgeon	NHS Lanarkshire
Wesley Stuart (WS)	Consultant Vascular Surgeon	NHS GGC
Zahid Raza	Consultant Vascular Surgeon	NHS Lothian
Apologies:		
Abdul Qdair (AQ)	Consultant General Surgery	NHS Grampian
Andrew Murray (AM)	CHAIR and Medical Director	NHS Forth Valley
Andrew Tambyraja (AT)	Clinical Director for Vascular surgery	NHS Lothian
Aris Tyrothoulakis (AT)	Site Director	NHS Lothian
Benjamin Cooper (BC)	Vascular Nurse Consultant	NHS Grampian
Christina Navin (CN)	Clinical Care Group Manager	NHS Tayside
Claire MacArthur (CMac)	Director of Planning	NHS GGC
Erin McEwan (EMcE)	Service Manager	NHS Lanarkshire
Euan Munro (Emu)	Consultant Vascular Surgeon	NHS Grampian
[redacted]	Data Analyst	National Services Directorate
James Cotton (JC)	Executive 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
Katherine Sutton (KSu)	Division General Manager	NHS Highland
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
Michelle Carr (MC)	Chief Officer Acute Services	NHS Lothian
Murray Flett (MF)	Consultant Vascular Surgeon	NHS Tayside
Rahul Velineni (RV)	Consultant Vascular Surgeon	NHS Lothian
Scott Davidson (SD)	Medical Director	NHS GGC
Sotiris Makris (SMa)	Consultant Vascular Surgeon	NHS Grampian
Stuart Suttie (SS)	Consultant Vascular Surgeon	NHS Tayside
Wendy Croll (WC)	Associate Director of Surgery	NHS Tayside
William Edwards (WE)	Director of eHealth	NHS GGC

1 Welcome, Apologies and Introduction

PB welcomed everyone to the exceptional meeting of the Vascular Task and Finish Group and apologies were noted as listed above. PB explained the need for the extra meeting and gave a brief update of the current position and communications which had led to a recent request to consider a revised North of Scotland (NoS) option. PB shared appreciation of the group effort, robust population based planning process, data submissions and difficult discussions that had helped look for the best solution to make changes to a vascular service facing the urgent and critical issues. While he agreed that additional resources would ultimately be required, to ensure the safety of Scottish vascular patients it was important to make the best possible use of resources throughout Scotland. PB highlighted the time constraint and clarified that a delayed decision would create increased risk to patients.

The ask of the group by Scottish Government is to consider if the recommended SOM could effectively become the TOM. i.e. NHS Fife remain in the NOS model with the NOS networks supporting a population of 1.7M.

2 Declaration of Interest

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

3 Minutes from the previous meeting on 12/03/25 (paper VTF2025-13)
Minutes from the previous meeting were approved.

4 Summary of original recommendations and discussion around revised option
MS highlighted the outcome of the final Task and Finish Group meeting where there was consensus for the proposed original Standard Operating Model (SOM) with an agreed future phased approach towards the Target Operating Model (TOM), with option 5 which was the preferred option of the T&F Group and subsequently reported to the Strategic Planning Board (SPB) and Planning Delivery Board (PDB).
MS explained that a NoS Group has mobilised to specifically look for solutions for enhanced mutual aid for NoS patients. It was noted that this was a separate piece of work which ran in parallel to the work of the T&F Group.

MS presented a reminder of the principals and requirements for implementation:

Principles of SOM

- **NHS Highland** ceases to be an arterial centre with immediate effect
- **NHS Grampian, NHS Tayside & NHS Fife** form a North of Scotland (NOS) network with two arterial centres with Grampian undertaking selected arterial cases with a focus on endovascular interventions.
- **NHS Fife** to confirm capacity they have to free inpatient capacity for **NHS Tayside** to support the NOS model. The task and finish group recommends that **NHS Fife** major and minor limb amputations should be performed in **NHS Fife -** this will reduce the burden on theatre access and bed space in **NHS Tayside**. An amputation rehab service must be in place to support this.
- **Proportion of NHS Fife** acute unselected take transferred to **NHS Lothian** with **NHS Fife** triaging these patients to effectively manage demand. This would free capacity for **NHS Tayside** to support the NOS patient demand (NHS Lothian to confirm what they could support in the short term while we work through the SOM)
- **NHS Highland** patients transfer to **NHS Tayside** as part of the longer-term transition to the demand being met by the NOS network.
- **Southwest Scotland network** remains unchanged apart from work to resolve the OOH IR issues.
- **West of Scotland (WOS)** network remains unchanged apart from OOH IR work mentioned above.
- **Southeast network** remains largely unchanged apart from potentially some additional patients from **NHS Fife** and continues as the National centre for TAAA and complex aortic conditions.
- **NHS Highland** to operate as a non-arterial centre To be taken forward by the **service oversight group** who will be responsible for implementation.
- **NHS Highland** funding for resources to be released to support recruitment to the new model of delivery.

Proposed original TOM

- NHS Fife to form part of the SE network

Requirements for implementation (presented at the meeting)

- The Sustainable Operating Model is designed to support a phased transition that moves NHS Scotland towards a more stable position before advancing to a fully resourced and financially sustainable Target Operating Model.
- Maintaining the current mutual aid arrangement indefinitely is not a viable solution.
- A fully resourced plan will take time to implement, and immediate financial investment alone will not resolve the issue. Despite existing funding allocated for positions, roles remain unfilled.
- One of the immediate priorities should be the enactment of a training, recruitment, and retention strategy, building upon the successful initiatives in the West that have increased vascular consultant numbers.
- While it is acknowledged that addressing these challenges will take time, delaying all action until a fully resourced plan is in place risks patient safety and may contribute to geographical disparities in access to treatment across NHS Scotland
- Full implementation of this model will require investment in workforce, infrastructure, and equipment, necessitating a phased approach to allow sufficient time to identify, seek endorsement and implement.
- Prior to the submission of business cases the direction of travel requires to be agreed. Without clarity and agreement on the direction of travel there is a risk of investing significant time, expertise, and resources into an approach that may not be widely supported.
- To facilitate this process and provide the detail, a service implementation group would be mobilised to oversee a phased transition, incorporating key checkpoints to confirm readiness at each stage.
- This is not an immediate shift, but rather a structured, incremental approach to delivering vascular services, ensuring that the evolving model effectively meets the needs of the population

MS shared the original recommendations to the PDB:

1. Accelerate the implementation of the proposed North of Scotland model, to align with the model in the rest of Scotland. This will result in the first step to a sustainable operating model of four networks and enable closer delivery of best practice model of care. The Board implications were set out in the detailed report and summarised on p8. The move to this networked model of care across Scotland will result in changes that will initiate nationally instigated service change.

2. Planning and Delivery Board were asked to note that work to standardise referral pathways into the centres and agreement of repatriation protocols needed final agreement. This requires to be agreed at executive level due to the implications it has on the wider functioning of all hospitals concerned.

3. To enable robust data on quality, a commitment to mandatory input to the Vascular Registry is essential going forward. Disparity in completion was evident particularly in outcomes. The ability to assess effectiveness of the new model and for future resource planning, this is essential. It is therefore recommended that all centres

monitor reporting compliance with the Vascular Registry to allow reporting improvement and sustainability of this model of care.

MS reiterated the ask to the Group.

Based on the information available to date:

Is there still a broad consensus to proceed with the previously recommended phased implementation to the TOM via the SOM (Option 5)?

OR

Does the group recommendation change following consideration of the SOM becoming the TOM and if barriers/constraints to this could be addressed.

MS opened the floor for discussion.

Comments were:

CW shared concerns around the delivery of unscheduled emergency/OOH care as moving patients from Fife to Lothian would double the current Lothian emergency workload, and how can we ensure a vascular presence remains in Fife in the future if triage is necessary?

PB suggested a more detailed discussion was needed between Fife and Lothian to clarify exact emergency/OOH numbers and to negotiate options around how best to manage those patients rather than dismiss the possibility entirely.

CC thanked MS for an extremely useful summary and agreed that the solution needs to be workable rather than aiming for perfection. The issues were that Lothian would have to double their capacity in order to manage the large number of Fife vascular emergencies. There is currently no inpatient vascular beds and no rehabilitation for amputee patients in Fife and the three vascular surgeons who currently support Tayside (on call rota) are not willing to relocate should patients go to Lothian. PB queried the actual number of vascular emergencies from Fife and also the change in practice and suggested the need for further exploration and work.

EH shared an update on the Highland service. The final vascular surgeon leaves on 30th June 2025, Highland currently have no access to MDT and the single locum is present to review repatriated patients 4 days a week. EH highlighted that, with no clear pathways, there was further significant risk as waiting patient cases deteriorate and become emergencies.

TS commented that increasing the Tayside population responsibility would potentially destabilise the largest stable unit in Scotland which would be less attractive to trainees. MS clarified that the need for the TOM became apparent following site visits as it was clear that there was no immediate space in Tayside to accommodate a 1.7m population hence the need for the NoS to look at a more enhanced mutual aid interim model. MS added that changes could be made to improve services going forward with phased implementation, as future mutual aid is separated out and a consensus strategic direction of travel is agreed.

CB commented that Tayside felt well informed and have confidence in the process. The NoS currently include a Grampian and Highland network, and CB stressed that the focus must be what is best for the patients going forward. CB expressed that a Tayside

population of 1.7m was not sustainable and supported option 5 as the best patient centered option.

BR reminded the Group of the volume of work carried out by PB and the National Planning Team to review the service (in terms of sustainability, ability to recruit and retain workforce). BR shared, that with a focus on logistical boundaries and funding, Grampian were supportive of option 5.

WS reiterated PBs consistent question over past meetings of "is there a point when we get too big or fragmented?" WS shared Greater Glasgow experience, due to their increase in catchment population, that in reality beds are full, IR support has reached the limit, elective and emergency services are affected, patients spend time in other wards/beds and ward round time is greatly extended meaning that the current model is close to being completely broken.

GG agreed that a service of 1.7m population was not sustainable and had potential for being unsafe. GG felt that there was a need to distribute the population equitably in order to make the best of a bad situation and fully agreed with the process thus far.

CW agreed that the current model was close to breaking and commented that the strategic direction needs to be deliverable and patient centered. With the Highland mutual aid, it was noted that bed occupancy was increasing and IR access waits were lengthy.
PB commented that Grampian were not far being Highland in terms of capacity and resourcing challenges.

CB thanked EH for the Tayside repatriation support and agreed that geography was always a challenge and assumed that patients located north of Cupar would go to Tayside with Grampian/Tayside (as per current pathways) offering a supportive network going forward. CB highlighted the current significant impact on the workforce, due to patient travel and surgeon access, and agreed that option 5 was the best option.

SJ also agreed that the model for a 1.7m population was not a viable option.

SHC shared understanding around the Tayside/Grampian and Fife/Lothian model concerns and ZR agreed that a Fife/Lothian model would be more equitable.
KM commented that although a Fife/Lothian model would be the most equitable solution, Fife surgeons would not relocate therefore there would be 2 immediate surgical vacancies.
PB noted that in similar UK service reconfigurations some surgeons in Spoke hospitals had to re-evaluate their job plans if not prepared to move to an alternative arterial centre.

MS highlighted that the original TOM proposal recommendation was for Fife to move to Lothian, and that this was not an immediate implementation rather a phased approach over a number of years.

CB reiterated that the NoS model requires workforce to travel to Highland and for surgeons to think about new surgical workplans. CC added that this would require organisational change.

SP commented, from a Tayside Interventional Radiologist perspective, that currently IRs were so stretched that a 1.7m population model was not a sustainable solution and shared that, with the current IR recruitment issues, the workforce already works well beyond their agreed job plans.

5 Summary and Actions

PB summarised the focused discussion and outcomes:

- Acknowledgement of the Fife/Lothian original proposal concerns.
- Consensus agreement that the NoS proposal for a 1.7m population model was not sustainable.
- Original option 5 was still the consensus recommendation and this is the proposal that will be put to the Planning and Delivery Board/NHS EG.
- With the following caveat - Fife, Lothian and Tayside to participate in detailed discussions around how patients/surgeries can be moved equitably plus what funding is required.

ACTION – NHS Fife, Lothian, Tayside to have detailed discussion re Fife split.

Final comments were:

PB formally supported the decision to endorse option 5 as a desired and critical next step of the process.

KM clarified that currently there was nothing in Fife's gift to give as there are no inpatient beds or infrastructure to provide patient care.

PB clarified that the reference to 480 patients was for the whole of Fife and highlighted the need for more work to be carried out around demarcation of Fife patients between Lothian and Tayside. He advised that option 5 would allow the necessary step change towards a more equitable and fair use of resources .

CB formally supported option 5 as the fairest and most equitable solution.

MW commented that this was the first time that a Fife patient split had been discussed and highlighted that this added a layer of complexity but gave assurance that this had been successfully managed for other services. MW suggested that the Fife 'spoke' status be revised as there would be requirement for more in-patient beds going forward.
MW gave support for Fife, Lothian and Tayside (North-East Network) to engage in detailed discussions around how to move forward.

SHC agreed with option 5 as the consensus decision with further in-depth discussion around the practicalities of making the detail work.

EH shared that historically North-East Fife patients went to Tayside and suggested that there was a potential opportunity for Highland to become a 'spoke network' not just a 'spoke donor'. EH highlighted that Highland have IR beds and the opportunity to upskill would be greatly improved by linking up with another centre.

EH asked for clarification around next steps and any potential delays.

MS clarified that the finalised report and recommendation would be submitted to the PDB (Medical Directors and Board Chief Executives included on the membership) and the NHSEG.
ACTION – NPT to submit final report and recommendation to PDB.

MS confirmed that not obtaining buy in from the Governance Groups could cause delay and possible de-railment.

CB confirmed that good working boundaries already exist in Fife and Tayside and added that redrawing boundaries may raise concerns.

CW raised a concern that the need for investment was acknowledged, however, there had been no discussions around where, how, or who that would come from. MS clarified that the first step was to agree the strategic direction of travel which puts us in an informed position and will allow a Service Oversight Group (to be created) to have oversight of the Business Plans and any funding agreement would be decided by the PDB/NHSEG. The direction of travel needs endorsed to allow these next steps to then take place.

KM shared concerns for individual surgeon governance and ZR added, that as the only Lothian surgeon at the meeting, it was crucial that surgeons make themselves available to be involved in discussions going forward.

6 Any Other Business

PB gave thanks for the clinical goodwill, frank discussions and hard work of the Group

PB formally closed the Group.