National Services Directorate (NSD)
Gyle Square
1 South Gyle Crescent
Edinburgh EH12 9EB
www.nsd.scot.nhs.uk

NHS National Services Scotland

minutes

Vascular Task and Finish Group

MS Teams Join the meeting now
Wednesday 22 January 2025, 14:00- 16:00

Present: **Document Reference: VTF2024**

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
[redacted]	Service Manager	NHS Lanarkshire
Ewan Murray (EMu)	Strategic Planning Manager	SAS
Graeme Guthrie (GG)	Consultant Vascular Surgeon	NHS Tayside
[redacted]	Programme Manager	National Services Directorate
Karen Murphy (KM)	Consultant Vascular Surgeon, Clinical Lead	NHS Fife
Mark Allardice (MA)	Senior Programme Manager	National Services Directorate
[redacted]	General Manager	NHS Fife
Moira Straiton (MS)	Associate Director	National Services Directorate
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
Sanjay Pillai (SM)	Consultant Interventional Radiologist	NHS Tayside
[redacted]	Business Support Administrator	National Services Directorate
Stuart Suttie (SS)	Consultant Vascular Surgeon	NHS Tayside
Tamim Siddiqui (TS)	Consultant Vascular and Endovascular Surgeon	NHS Lanarkshire
Wesley Stuart (WS)	Consultant Vascular Surgeon	NHS GGC

Apologies:

Abdul Qdair	Consultant General Surgery	NHS Grampian
Ali Marshall	Deputy Director of Planning	NHS GGC
Aris Tyrothoulakis	Site Director	NHS Lothian
Benjamin Cooper	Vascular Nurse Consultant	NHS Grampian
[redacted]	Clinical Care Group Manager	NHS Tayside
Cameron Matthew	Divisional General Manager Surgical Services	NHS Grampian
Euan Munro	Consultant Vascular Surgeon	NHS Grampian
[redacted]	Data Analyst	National Services Directorate

James Cotton	Interim Medical Director	NHS Tayside
John Keaney	Acute Medical Director	NHS Lanarkshire
Julie Christie	Associate Medical Director for Surgery	NHS Tayside
Julie Greenlees	Assoc Director Vascular Services	NHS Tayside
[redacted]	Unit Operational Manager	NHS Grampian
Lorraine Cowie	Professional Lead Health Planning and Sustainability	Scottish Government
[redacted]	Division General Manager	NHS Highland
Kirstie Tinkler	Clinical Service Manager for Vascular and General Surgery	NHS Lothian
Michelle Carr	Chief Officer Acute Services	NHS Lothian
Scott Davidson	Medical Director	NHS GGC
Sotiris Makris	Consultant Vascular Surgeon	NHS Grampian
William Edwards	Director of eHealth	NHS GGC

1 Welcome and Apologies

AM welcomed everyone to the meeting and apologies were noted as listed above.

2 Minutes from previous meeting on 11/12/24 (paper VTF2024-16)

The minutes from the previous meeting were reviewed and agreed. CMcA advised that Ali Marshall's job title is Depute Director of Planning.

3 Review of actions from previous meeting (paper VTF2024-17)

The outstanding actions were reviewed and updated at the meeting.

ACTION VTF2024-16 - EH advised this paper is a work in progress, work plan agreed with the North of Scotland boards and is now closed.

ACTION VTF2024-17 - MS confirmed that NPT have collated and met with key stakeholders (Medical Directors, BCEs, Finance Leads, etc) and can close action.

ACTION VTF2024-18 – AM advised there has not been a SAMD meeting. This action is open.

4 National Planning Update

- **SOM Feasibility Paper for SPB**

MS/AM met with BCEs/MDs that will be affected by the change in the paper and had a positive discussion. Specific questions/concerns have been factored into the SOM. MS presented a summary of the SOM.

The following key comments were made:

PB advised the vascular service specifications 2021 are available online (jvsgbi.com/wp-content/uploads/2022/02/Vol1-Supp2-FINAL-PDF.pdf). This addresses all the concerns that have been raised and what timelines should be for vascular conditions. A spoke service is a non-arterial centre, but the definition of a spoke service is what CAN be done in a spoke not necessarily what MUST be done in a spoke centre. It is important spoke services are retained where possible with support from Hub consultants. As an example of expanded services in the community in Northern Ireland (NI) podiatrists have taken on foot problems where there has been a problem with high volume of cases.

MS shared the working assumptions with the group with the following comments:

AM asked if the assumptions meet the criteria of the task and finish group. MS confirmed they are, and the assumptions will underpin the SOM/TOM. This follows the case for change, the reason we are doing it and what the data is telling us about future planning. Once it is shared with the group, we will be looking for comment before it goes to the Planning and Delivery Board.

SP asked about leg amputations with CLI (critical limb ischemia) not being treated in spokes? PB advised that in Raigmore for example there is a vascular surgeon on site so would be ok there as a spoke, but these are better performed in high volume centres as there is concern about mortality with these procedures and potential delays in spokes. With diabetic patients there are systems in place, but CLI patients are still getting delays and tend to do worse when coming from a spoke centre.

CW raised a point about being able to describe and agree what will be delivered on spoke sites and how long a vascular surgeon should be on site. This remains a risk with potential delays with diabetic feet. AM described the Forth Valley experience as Hub services determining what needs to be available in spoke sites.

WS agrees with CW and advises once you have taken or reduced vascular surgeons' presence in a site there is a risk. Supporting podiatry in the community can replace spoke provision due to the rise of technology and advanced practice in that area.

MS confirmed that the feasibility report includes definitions of resource allocations within hubs/spokes and NSD have linked with NHS England commissioners – the report will be shared for feedback.

MS advised we do need to keep data updated with information as there is gaps in the data and what is filled out in the vascular registry. NSD have used multiple sources to validate the data we have.

BR raised a point about the assumption of 60 repair procedures in the two-centre network, NHS Grampian are currently doing 45-50 aneurisms per year. PB commented that conducting high risk procedures in bigger hubs would be preferrable but that utilising workforce within the model could be discussed within the network.

AM asked for clarity on the point of an arterial hub serving a population of 800K, this is the MINIMUM population.

MS advised one of the key issues is principles for repatriation. We have models we can look back on to detail high level principles and process time frames.

CM advised that metrics would be useful as sometimes patients do not meet the criteria for SAS transfer so need to consider taxi or other means of transport and who should pay for this.

CW advised repatriation is challenging and needs to be a top priority; the receiving hospital requires a bed and transport. If a spoke hospital no longer has a vascular ward where does patient get placed? WS advised what works well is contacts in general medicine/management - when beds are required, there is pressure all over. Basic principle is developing relationships and named contact(s).

EH advised that Highland have used phased flow, it is not unreasonable if patients have gone out from a board they need to come back. Agree with defined contacts.

TS advised NHS Dumfries and Galloway have a vascular nurse specialist to coordinate, lack of vascular beds require pathways. Under 65s do not fit neatly into a ward specialism so a Single Point of Contact (SPoC) is helpful.

SMcC advised that the group have a good opportunity to review national repatriation guidelines with locally agreed operational Standard Operating Procedures (SOPs).

MS thanked everyone for their comments which will be considered for the report.

5 Target Operating Model (TOM)

PB presented the key points for discussion. PB asked the group the following questions and key comments are recorded below:

Q1: Is the ultimate aim for 3 or 4 Hubs?

AM advised that we have enough of population base to sustain four hubs and a lot of reconfigurations that has already gone on in the west and this has worked well. TS is also in support of four hubs in terms of resources and accommodation.

WS made the point that Interventional Radiology is stretched and need to consider how these fit in with the model. TS advised that the south-west network is keen to develop a 24/7 IR Rota. MA advised we need to be mindful of the Directors Letter (DL) that came out in December 2024 detailing regional planning and which boards fit into which regions, and if we go for 4 hub model and we need to be clear why that is.

Q2: How will a two-centre network function? Resources required?

PB advised since we are going for 4 hubs this question will only apply to is the Grampian/Tayside network. BR advised that he has been tasked to discuss with Tayside how to manage the service and this is a work in progress but there is definite commitment from both sides. MS offered to support any write up of pathways etc. and to meet with BR.

ACTION VTF2025-01: NPT to arrange meeting with BR when appropriate.

Q4: Is there a role for Vascular Physicians (IP medical management)?

PB advised NI found foundation doctors managing complex vascular patients was exceedingly difficult and some units have looked at vascular physicians.
SS advised he thinks physicians embedded in the vascular team will be necessary with increasing amount of population and subsequent impact on theatre access. With the right governance and teaching this will be the workforce of the future and Boards are working towards developing these skills.

CW advised that the group should be wary of creating a model that needs a particular workforce for diabetes, general medicine, or Medicine of the Elderly (MOE) as this workforce currently does not exist. SMcC advised she can see the attraction however not CCT (Certificate of Completion of Training) certified and struggle to fill geriatric/medical posts currently, it is difficult to recruit. TS advised NHS Lanarkshire gave up a consultant's salary and initially had 11 consultants but now get 6 sessions per week of support from geriatricians who help patients journey and can deal with complex cases.

Q5: Approach to CLI and Diabetic foot workload?

PB advised there is an opportunity to work out where we want to be. NI have an issue with a shortage of consultants and how they got round this was they appointed podiatrists and local senior podiatrists who can directly refer to a consultant. With podiatry expansion urgent referrals from podiatry straight to a hub can be helpful. KM advised they currently

conduct fortnightly MDTs with highly skilled podiatrists which is an effective way to triage and avoids out-patient/emergency admissions to the hub.

Q6: Can we improve Audit with limited resources?
PB advised there is a chronic problem with audit and recording cases. The TOM needs a robust audit process which requires resources, and NHS Scotland owe it to the public to ensure data and outcomes are properly recorded. AT advised that audit and data information is challenging, and NHS Scotland need to resource audit facilitators to improve this. AM highlights the need for the right resources to be able to drive the audit. MA advised that Public Health Scotland currently run the Scottish National Audit Programme and the SCAP cardiac audit programme, however this needs a SG policy commitment and to be funded recurringly.

6 Summary, actions and next steps
MS advised the SOM was planned to go to the Strategic Planning Board in February but has now been stood down therefore the SOM will be submitted to the Planning and Delivery Board in March. The task and finish group has two more meetings in February and March, to focus on the TOM. NSD will now start mapping out and identifying outstanding questions, the TOM deadline is June 2025.

7 Any Other Business
WS advised that currently with 4 health boards supporting Highland the risk sits with clinicians and situation cannot go beyond spring. AM/MS gave assurance that senior NHS and Scottish Government management are aware of the situation and the plans are being developed. MS advised we are moving this quickly through governance to get completed. AM commented that there is commitment from colleagues across Scotland to get this right, and MS commented that it would be helpful to raise concerns within clinicians' own boards to get support for the proposed SOM. PB advised that delays in the SOM will come with risks, but we need to keep documenting this and needs to move quickly. EH commented that Highland massively appreciates support from local boards in North of Scotland. Rest assured they are working hard to implement changes and conscious of the impact. MS acknowledged that once the SOM is approved an implementation plan will need to be phased, once the SOM is unlocked clinicians should notice the changes. Even if we had funding now it would take time to implement change, it is important that we get buy in to the approach. SOM paper will be completed and circulated to the group for comment.

AM confirmed that there are 2 more meetings scheduled, and the plan is to present the SOM to Planning and Delivery Board in March 2025. AM thanked everyone for their input and closed the meeting.

8 Date and Time of Next Meeting
Wednesday 19 February 2025, 14:00-16:00pm

AM thanked everyone and closed the meeting.