National Services Directorate (NSD)
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NHS National Services Scotland

minutes

Vascular Task and Finish Group

MS Teams

Tuesday 29th October 2024, 14:00- 16:00

Document Reference: VTF2024-10

Present:

Andrew Murray (AM) - Chair	Medical Director	NHS Forth Valley
Ali Marshall (AMar)	Planning Policy Lead	Scottish Government
Andrew Tambyraja (AT)	Clinical Director for Vascular surgery	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
Craig Henderson (CH)	Clinical Lead	SAS
Elaine Henry (EH)	Operational Medical Director	NHS Highland
[redacted]	Data Analyst	National Services Directorate
Keith Hussey (KH)	Consultant Vascular Surgeon	NHS GGC/ NHS Forth Valley
[redacted]	Programme Manager	National Services Directorate
Julie Greenlees (JG)	Assoc Director Vascular Services	NHS Tayside
Karen Murphy (KM)	Consultant Vascular Surgeon and Clinical Lead	NHS Fife
[redacted]	Unit Operational Manager Surgical	NHS Grampian
Kirstie Tinkler (KT)	Clinical Service Manager for Vascular and General Surgery	NHS Lothian
Margaret Meek (MM)	Director of Hospital Services	NHS Lanarkshire
Moira Straiton (MS)	Associate Director Specialist Services & National Planning	National Services Directorate
Paul Blair (PB)	Independent Vascular Consultant	Belfast Health and Social
Scott Davidson (SD)	Medical Director	NHS GGC
Stuart Suttie (SS)	Consultant Vascular Surgeon	NHS Tayside
[redacted]	Business Support Administrator	National Services Directorate
Tamim Siddiqui (TS)	Consultant Vascular and Endovascular Surgeon	NHS Lanarkshire
Wesley Stuart (WS)	Consultant Vascular Surgeon	NHS GGC

Apologies:

Paul Bachoo (PBa)	Acute Portfolio Lead, Acute Medical Director	NHS Grampian
James Cotton (JC)	Interim Medical Director	NHS Tayside
John Keaney (JK)	Acute Medical Director	NHS Lanarkshire
Claire MacArthur (CMac)	Director of Planning	NHS GGC
[redacted]	Programme Support Officer	National Services Directorate

1 Welcome and Apologies

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

2 Minutes from previous meeting on 02/09/24

The minutes from the previous meeting were agreed to be a true and accurate reflection of the meeting.

3 Review of actions from previous meeting

All outstanding actions were reviewed, and updates provided.

4 Review of update data and dashboard

MS presented an overview of NHS Scotland's vascular services, focusing on creating a sustainable operating model to improve the delivery of patient care, in line with Phase 1 of this workstream. It was noted that links are already in existence among Centres in the East and West, but this is not yet established in the North. The presentation aimed to support the Group to collaboratively tackle service delivery challenges and develop a sustainable operating model based on accurate data. The updated dashboard featured funnel plots and consolidating information from different health boards for dynamic updates and clear data presentation, and showcasing the demand, capacity, workforce per 100,000 and average length of stay reported by each Centre. Data for the dashboard was obtained from the site visits to arterial centres as well as self-reported quantitative data.

The dashboard breaks down referral data by individual boards, distinguishing between inpatient and outpatient figures and overall demand. Notably, Glasgow and Highland are experiencing higher inpatient referrals. The workforce data reveals that Lothian has more specialist vascular nurses per 100,000 than other areas. Demand is assessed across various categories, day cases, elective admissions, emergency admissions and outpatient appointments, providing insight into workload versus workforce availability. Funnel plots illustrate variations in day cases, elective admissions, and emergency admissions, with Lothian notably having a high number of day cases and out-of-hours emergency admissions.

During the presentation it was agreed that the presented data lays a solid groundwork for evaluating future options. It highlights the necessity of leveraging this information to guide decisions and identify potential support areas among Centres. Observations from site visits indicate that Glasgow has reached capacity after accommodating patients from the Western Isles, while Lothian and Tayside have some available capacity, albeit not ideal. Grampian is facing capacity issues, and Lanarkshire is experiencing challenges with staffing, and would likely have to support Glasgow with some of the Western Isle patients.

Comments:
EH stressed the need for detailed staffing data, particularly for physiotherapists and occupational therapists in Highland, highlighting the operational challenges experienced. EH expressed concerns about the sustainability of services in Highland, noting a potential increase in the risk of losing surgeons and highlighted the need to move at pace for a sustainable operating model.

AT raised concerns about significant variations in activity data across health boards, questioning if the definitions interpreted by Centres is consistent. This will be noted in the final report as a caveat to the data report, however it was agreed that the data presented provides a good indication of the landscape in each Centre and is appropriate to guide decision making.

CW pointed out the absence of bed access information and emphasized the need for a clear strategic intent regarding the target operating model. AM highlighted that the Task and Finish Group's Phase 1 aim is to define a sustainable operating model while addressing immediate operational pressures. MS reinforced the need for a quick response to immediate risks in NHS Highland. It was noted that the Strategic Programme Board and Planning and Delivery Board have agreed this workstream to take a two-phase approach to first address the short-term risks before moving to develop a Target Operating Model.

TS noted completeness in Lanarkshire's data but mentioned gaps in Dumfries and Galloway and Ayrshire and Arran reported under the West of Scotland hub. This information will be added following the meeting.

KH highlighted high occupancy rates in Grampian and the need to accurately define demand for effective decision-making.

AM noted that any anomalies in the data are not sufficiently significant to affect the overall understanding of the situation. The validated data will inform further discussions on options for a sustainable operating model.

BR emphasised the importance of focusing on overall population numbers and the number of consultant vascular surgeons to understand the challenges faced.

5 Update on Sustainable Operating Model (SOM)

PB highlighted the context and time pressures to the group given the urgent need to address the short-term risks. PB presented key considerations for the SOM. These include capacity available within each Centre and how many KPIs are being met, as well as the impact change would have on the Centre and related teams/services such as IR. There was also an emphasis on maintaining Spoke Services. PB mentioned the importance of effective training and mentoring for staff, which are essential for properly triaging vascular patients within Spoke Services. Consideration was given to the role of specialty vascular nurses who could provide a key role in any future model. PB noted that there is a need for collaboration between larger vascular centers and smaller units that lack inpatient vascular beds as a way of improving capacity.
PB then went on to present several broad options for managing the workload associated within vascular care. It was acknowledged that these proposals are general in nature and further details will need to be refined as they progress.

Option 1- Division of Workload by Vascular Condition- PB discussed the initial proposal for managing vascular workload in Highland, which aimed to categorize vascular conditions by complexity and urgency, directing cases to appropriate centres. While the proposal has strengths which would alleviate the immediate pressure, the Group agreed that this option would be too difficult to implement.

Option 2- Share Highland Work on Rotational Basis Between MTC's- The next option considered a rotational sharing of responsibilities among the four arterial centres for managing vascular workload in Highland. This approach could allow for rapid implementation and create a clear division of responsibilities, leading to better patient management and resource allocation. However, several concerns were highlighted, including the risk of inadequate resourcing, as experienced in Belfast, which could lead to delays in addressing challenging cases and inequities in patient care. Additionally, issues related to clinical governance, variability in access to interventional radiology, potential over-triage by non-vascular staff, and ambiguous patient ownership could complicate the model and reduce feasibility. Seasonal pressures, such as winter bed shortages, might further exacerbate these challenges.

Option 3- Transfer Highland Patients to Grampian or Tayside- PB discussed the option of transferring patients from Highland to Grampian or Tayside as a strategy for managing vascular care. One of the main strengths of this approach is its potential to create a cohesive regional solution for northern Scotland, enhancing local care and improving patient experiences through established relationships and defined care pathways. However, weaknesses and challenges were also identified, such as capacity issues and recruitment difficulties in both Grampian and Tayside, particularly in interventional radiology. Transferring more patients could strain these resources which are already experiencing capacity issues.

Option 4- Permanent Division of Highland Case Load Based on MTC's- PB discussed the proposal for a permanent division of the Highland caseload based on geographic boundaries aligned with major trauma centres. A key strength of this approach is the establishment of clear responsibilities for patient management, which could reduce ambiguity and confusion in care

delivery. This division would lead to a more manageable workload for each centre, improving resource allocation and planning while providing patients with clear guidelines for seeking treatment. However, there could be challenges, such as capacity strains on centres like Glasgow, which are already managing substantial workloads since taking on the Western Isle patients. Recruitment may also be complicated by existing pressures, and patients close to boundary could face increased travel distances to reach their designated hospitals, affecting timely care.

Option 5- Merge and Division Option- PB presented the merge and division option to address vascular service challenges in northern Scotland. This would require the development of a collaborative network between Grampian and Tayside and transferring some of Fife's workload to Lothian. This approach aims to optimise resource allocation, enhancing patient transfers and care management. By establishing a novel network between a major arterial hub and a smaller arterial centre, the model could balance patient loads and improve continuity of care. Successful cooperation and coordination between Fife, Tayside and Lothian are essential, and logistical considerations must be addressed to ensure effective patient transfers. However, challenges such as existing pressures on Tayside and Lothian could reduce feasibility.

In conclusion, PB proposed 'Option 5- Merge and division' as a promising strategy for creating a more collaborative and resource-efficient vascular care system. It was acknowledged that this model would not be without challenge, but cooperation and creative thinking could yield improved patient outcomes.

Comments:
CW raised concerns about the sustainability of spoke services in the vascular care model, particularly for interventional radiology. The need to maintain these services during resource reallocation was acknowledged by the group.

SS stressed the urgency of addressing the vascular care crisis and advocated for collaboration among Tayside, Grampian, Highland, and Fife.

MS stated if Option 5 is chosen the next steps will be to focus on the feasibility of the proposed option and the need for practical planning.

TS identified option 5 as feasible despite challenges, emphasizing timely decision-making. TS also offered help to provide lessons learned from their experience in Lanarkshire.

AM highlighted the complexities of implementing option 5 and the importance of ongoing dialogue with boards.

MS updated on outreach efforts and funding considerations, assuring that infrastructure needs will be addressed.

The group agreed that Option 5- Merge and Division was the preferred option.

6 Target Operating Model

PB emphasized the importance of data and consultation in developing a target operating model for vascular services. There is a need to determine the optimal number of arterial hubs for Scotland. Some reports have suggested that 3 may be the optimal number. Based on experience, PB cautioned against overly large hubs that might neglect local needs, highlighting the merits of merging existing services to create a more cohesive network.

The Group discussed the need to address workforce challenges and flexible job plans when integrating smaller hospitals into the larger system. The Group highlighted the role of specialist nurses and support staff in improving efficiency and care.

Comments

CW considered the requirements involved in a three-centre model, referencing the need for a minimum population of around 800,000 to ensure adequate services.

PB clarified that the 800,000 figure was an early guideline for rationalising services based on minimum population size for AAA screening programmes and discussed the relationship between the number of centres and major trauma classifications, noting that vascular surgery presence was preferred but not a mandatory requirement for a trauma centre.

TS reflected on challenges from a previous centralisation effort when NHS Lanarkshire joined with NHS Dumfries and Galloway and NHS Ayrshire and Arran. Staffing and resource needs were key considerations as part of this process. TS expressed optimism about future staffing levels due to new consultants but acknowledged potential retirements.

AM concluded the discussion by recognising workforce complexities and the need for diversity to enhance service delivery, suggesting that learning from existing models could guide future approaches.

MS emphasised building on past work, focusing on gathering detailed information on service pathways and financial implications. There was recognition of the importance of stakeholder engagement and acknowledgement that compiled information would be ratified and presented to the Strategic Planning Board to refine the target operating model.

7 Summary, Actions and next steps

[redacted] updated the group on the consensus surrounding option 5, identifying it as the most viable path forward. Discussions with Medical Directors are ongoing to secure their support and that these conversations would continue to guide the project's direction.

Outlining the next steps, the focus will be on the feasibility of implementing option 5 and identifying the specific actions and resources required. It was noted that no new specific actions arose from this meeting for Group members.

8 Any Other Business

KM voiced concerns about representing Fife in the discussions, clarifying that agreement should not be seen as an endorsement from Fife's senior management, who were absent. KM stressed the need for broader representation from Fife to ensure their perspectives are fully considered.

AM acknowledged KM’s concerns and highlighted the importance of including Medical Directors in follow-up discussions to ensure that all relevant stakeholders can contribute.

MS encouraged KM to identify any additional representatives from Fife who should be included, emphasizing the importance of diverse input as they develop the target operating model.

9 Date and Time of Next Meeting

Monday 18th November 2024, 14:00-16:00

AM thanked everyone for their invaluable input and closes the meeting