National Women & Infants Health Programme

MODEL OF CARE AMBULATORY GYNAECOLOGY

IMPROVING ACCESS TO CARE

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When this Framework talks about "women" it is intended in the most inclusive sense of the word. It is used as shorthand to describe all those who identify as women as well as those that do not identify as women but who share women's biological realities and experiences. In using this term, we seek to include not exclude. Using gender to inform health service Frameworks and Models of Care is just one way of creating more targeted, personalised health services for all people in Ireland.

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ABBREVIATIONS

AN/MP	Advanced Nurse/Midwife Practitioner
BIU	Business Intelligence Unit
CSO	Central Statistics Office
DoH	Department of Health
GP	General Practitioner
HIPE	Hospital Inpatient Enquiry System
HSE	Health Service Executive
ICGP	Irish College of General Practitioners
IOG	Institute of Obstetricians and Gynaecologists
IP/DC	Inpatient/Day Case
NWIHP	National Women and Infants Health Programme
NCCP	National Cancer Control Programme
OP	Outpatient
OECD	Organisation for Economic Co-operation and Development
WTE	Whole Time Equivalent

CHAPTER 1 - OVERVIEW

1.1 INTRODUCTION

Gynaecology services are acknowledged and recognised by both the Department of Health (DoH) and the Health Service Executive (HSE) as being a service area that continues to be under significant and growing pressure. Demand for gynaecology services is now consistently outstripping supply on a year to year basis, with increased waiting lists at national level being experienced across all service delivery areas i.e. outpatient, inpatient and day case.

In response to the challenges being experienced in this area, gynaecology was one of six clinical specialised areas, identified and prioritised within the public healthcare system in 2019 as requiring the development of a tailored service improvement plan. The HSE's National Women and Infants Health Programme (NWIHP) were requested by the Department of Health to undertake this work in the context of an overarching Model of Care for gynaecology services.

The proposals and recommendations set out in this document in relation to the development of gynaecology services in Ireland have been guided by **Sláintecare** under the following principles:

- Management of women at an intervention level that meets their clinical needs;
- Embedding safe and appropriate clinical practices;
- Ensuring the cost-effective use of public resources; and
- Providing a sustainable and responsive service to the healthcare needs of women.

1.2 GYNAECOLOGY SERVICES

Gynaecology services in Ireland are delivered in 36 acute hospitals around the country, ranging from Level 2 to Level 4 hospital settings. Gynaecology services can be broken down into four main categories, namely:

- Oncology related gynaecology services;
- Urinary related gynaecology services;
- Infertility related gynaecology services; and
- General gynaecology services encompassing primarily benign services. It should be noted that these general services are a major access route for gynaecological malignancies presenting symptomatically.

In examining the extensive range of services and sub-specialty areas within gynaecology, specific aspects and components of gynaecology services have been prioritised by NWIHP in terms of the development of a tailored service improvement plan that if supported could yield positive results.

In developing and planning this approach, the NWIHP have been mindful of the following:

- The delivery and organisation of cancer services within the health service, including gynaecology-oncology services, are managed and developed under the auspices of the National Cancer Control Programme (NCCP). In line with the management of other cancers, acute services working within the resources available to them, prioritise the treatment of oncology related gynaecology services, with the treatment of such cancers now being centralised into a number of larger units around the country;

- Urology related gynaecology services are currently the subject of significant discussion and review between the HSE and the DoH on foot of and in response to the DoH's Chief Medical Officer's Report on the use of uro-gynaecology mesh. Women presenting with urology related symptoms are managed from a urodynamic, physiotherapy, counselling and surgical perspective within the acute sector; and

- Fertility related gynaecology services are currently the subject of a work programme between the DoH and the HSE's NWIHP, with a Model of Care for Fertility Service developed on a collaborative basis. It is envisaged that this Model of Care will be implemented in a phased basis, with phase one focusing on the provision of fertility services at secondary level within the acute sector.

In light of the above and to avoid duplication, it was determined to focus in the first instance on the group of gynaecology services referred to as general gynaecology.

1.3 SCOPE OF SERVICES

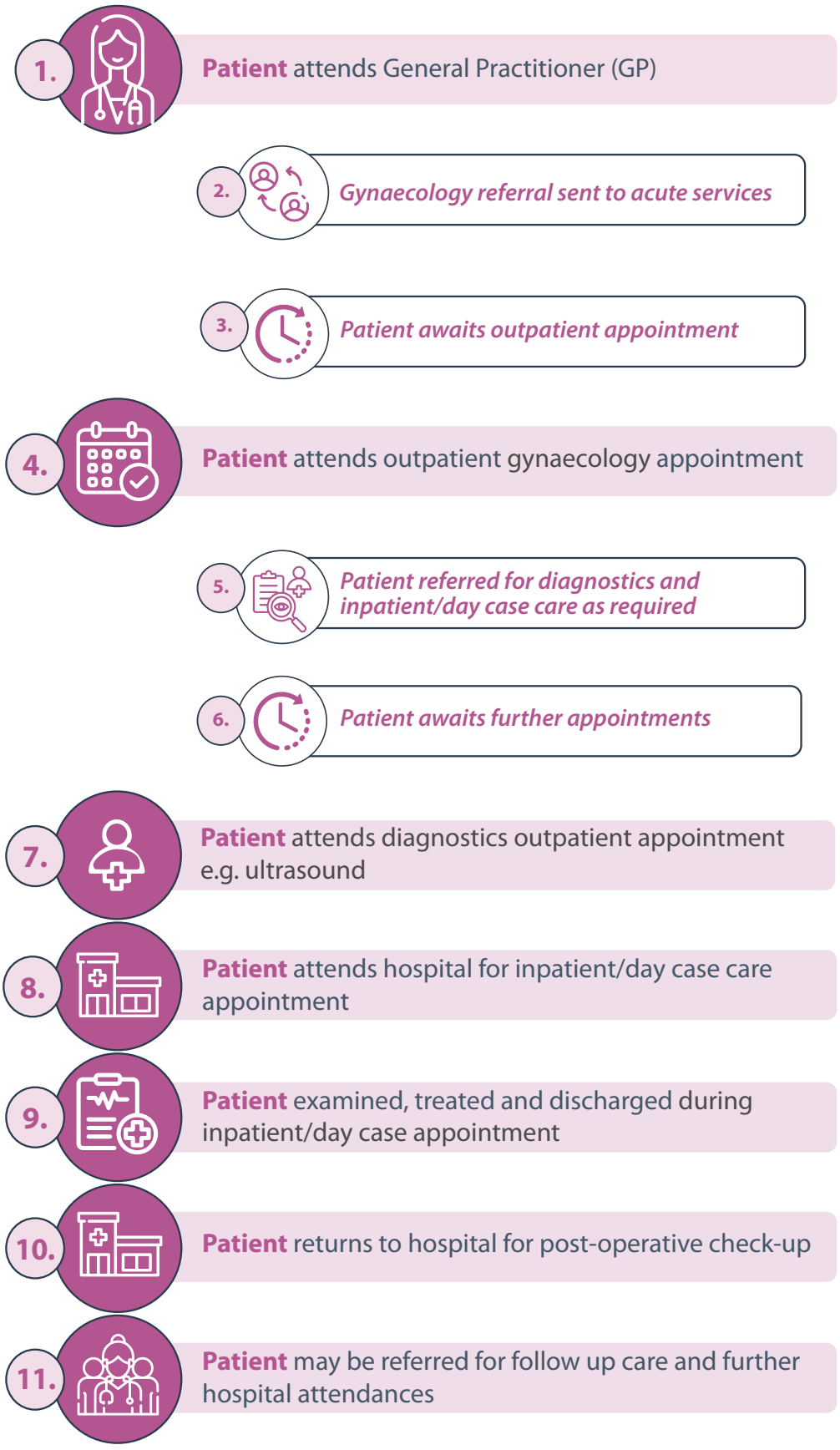
Irish gynaecology services are typically used by females from the age of 15 years onwards. The adult population within this age bracket has doubled between the period 1961 and 2016 from 942,191 to 1,915,464,with it being predicted that a further 11% growth will be experienced by 2031 (CSO, 2019).

In reviewing the types of symptoms and complaints that are referred to general gynaecology services from primary care, these can be broadly broken down into the following categories:

1.	Abnormal uterine bleeding;
2.	Pelvic pain;
3.	Endometriosis;
4.	Prolapse and Urinary incontinance;
5.	Amenorrhea;
6.	Urogynaecological issues;
7.	Psychosexual issues;
8.	Unusual or abnormal vaginal discharge;
9.	Hirsutism;
10.	Lost intrauterine devices;
11.	Vulval disorders.

The first four categories are estimated to comprise approximately 80% of referrals for general gynaecology services whist the latter seven categories comprise the remaining 20%.

Currently, with very few exceptions, the movement of women through the care pathway for these services around the country is very much the traditional model as set out below:



These high-level steps in a patient's journey do not reflect the duration that patients may have to wait to be seen, assessed and treated. In some individual patient cases, this can take several years as they move through the care pathways.

Chapter 2 discusses data on the demand for services across the country and the waiting times currently being experienced by women to access these services.

CHAPTER 2 - DEMAND FOR SERVICES

2.1 OUTPATIENT WAITING LISTS

Set out below in Table 1 is data related to the number of women on waiting lists for outpatient gynaecology care in the public sector in Ireland. This data is presented at national level from 2014 to August 2020. Table 2 then provides an overview of demand by Hospital Group as of August 2020. These figures demonstrate how there has been both a continual and consistent growth of women awaiting outpatient gynaecology care. The outpatient gynaecology waiting list is the 7th highest in the country when compared to all other medical and surgical specialties. This also needs to be considered in the context that this service is gender specific, representing only half the population, so the scale of the challenge is significant. This waiting list is expected to continue to grow in the absence of sustainable system improvements to manage this demand.

	Dec **2014**	Dec **2015**	Dec **2016**	*Dec **2017**	Dec **2018**	Dec **2019**	Aug **2020**
Total no. awaiting outpatient care	**20,288**	**21,791**	**23,841**	**27,473**	**27,889**	**27,239**	**30,202**

Table 1 *Total number of women awaiting outpatient care in the speciality of gynaecology at national level*

*CWIUH started reporting in 20172. NMH outpatient data not available via NTPF as of August 2020.
** Excludes OP waiting list figures associated with Children's Health Ireland in Crumlin, Temple Street, Tallaght & Connolly which were 143 as of August 2020.

Source: NTPF, August 2020

	OP Waiting Lists as of August **2020**	
National Trust	**30,345**	
***Ireland East**	**5,118**	**17%**
RCSI	**7,069**	**23%**
Dublin Midlands	**6,718**	**22%**
South/Southwest	**3,650**	**12%**
UL	**2,332**	**8%**
Saolta	**5,315**	**17%**
CHI	**143**	**<1%**

Table 2 *Total number of women awaiting outpatient care at Hospital Group level*

*NMH outpatient data not available via NTPF as of August 2020.
Source: NTPF, August 2020

Due to technical reasons, the National Maternity Hospital's (NMH) outpatient numbers were not provided to the National Treatment Purchase Fund (NTPF) as of August 2020 however, reporting of these figures is due to commence. Furthermore, it should be noted that the Coombe Women and Infants University Hospital (CWIUH) commenced reporting their outpatient waiting numbers to the NTPF in 2017, the inclusion of which contributed to the increase in numbers seen in 2017.

Not only are these waiting list figures growing consistently in global terms but in reviewing the associated wait time, a significant growth year-on-year in women waiting over 12 months has been observed. The NTPF reported 2,096 women waiting for an OP appointment greater than 12 months in 2015. As of August 2020 this figure has grown to 7,867 women, with more than half of these women waiting longer than 18 months.

2.2 INPATIENT/DAY CASE WAITING LISTS

Outlined in Table 3 is data related to the number of women on waiting lists for inpatient/day case gynaecology care in the public sector in Ireland. This data is presented at national level from 2014 to August 2020. Table 4 provides a further overview of demand by Hospital Group as of August 2020. These figures again demonstrate how there has been both a continual and consistent growth of women awaiting gynaecology care.

	Dec **2014**	Dec **2015**	Dec **2016**	Dec **2017**	Dec **2018**	Dec **2019**	Aug **2020**
Total no. awaiting IPD care	**3,030**	**3,368**	**3,851**	**4,316**	**4,414**	**4,480**	**4,765**

Table 3 *Total number of patients awaiting inpatient/day case care at national level*

* NMH, CWIUH & Rotunda inpatient/day case data not available to NTPF as of August 2020.
Source: NTPF, August 2020

	IP/DC Waiting Lists as of May **2020**	
National Trust	**4,765**	
Ireland East	**969**	**20%**
RCSI	**661**	**14%**
Dublin Midlands	**332**	**7%**
South/Southwest	**994**	**21%**
UL	**258**	**5%**
Saolta	**1,551**	**33%**
CHI	**0**	**<1%**

Table 4 *Total number of patients awaiting IP/DC treatment by Group*

Source: NTPF, August 2020

Due to technical reasons, the three Dublin Maternity Hospitals – The Rotunda Hospital, the NMH and the CWIUH Hospital – IP/DCs numbers are not provided to the National Treatment Purchase Fund (NTPF).

Not only are these waiting list figures growing consistently in global terms but in reviewing the associated wait time, a significant growth year-on-year in women waiting over 12 months has been observed. The NTPF reported 251 women waiting for IP/DC treatment greater than 12 months in 2014. As of August 2020 this figure has grown to 1,338, with 623 of these women waiting longer than 18 months.

As per NTPF data, a diagnostic hysteroscopy is the top inpatient/day case of women are awaiting nationally as of August 2020.

CHAPTER 3 - GYNAECOLOGY ACTIVITY

3.1 TOTAL OUTPATIENT ATTENDANCES

Table 6 displays outpatient gynaecology activity nationally. Activity recorded against Children's Health Ireland is excluded from the data presented.

Year	2016	2017	2018	2019
Referrals in	**50,833**	**49,257**	**51,766**	**57,386**
Total attendances	**115,187**	**114,430**	**120,079**	**127,083**
New attendances	**39,699**	**39,406**	**42,779**	**46,128**
Return attendances	**75,488**	**75,024**	**77,300**	**80,995**
Total DNA	**20,427**	**21,265**	**21,130**	**22,850**
New: Return ratio	**1.9**	**1.9**	**1.8**	**1.7**

Table 5 *Outpatient gynaecology activity, 2016 - 2019*

Source: HSE Business Intelligence Unit, 2020

As set out above, the number of referrals for gynaecology care between 2016 and 2018 remained relatively steady, displaying a 2% increase. However, as of 2019, the number of referrals being received within the acute sector has increased significantly. This jump in referral patterns is being attributed to the impact of the Cervical Screening Programme challenges, with gynaecology services in primary care being provided in an increasingly risk averse environment. This increased demand for acute based gynaecology services was also experienced within colposcopy screening units in 2019, which all experienced significant increases in the number and proportion of clinically indicated referrals received from primary care.

Whilst there has been a year-on-year increase in the number of new attendances managed by gynaecology services from 2017 to 2019, with the most significant increase being seen in 2019, demand continues to outstrip supply as measured by numbers seen and referral received. This gap extended to over 11,000 in 2019.

CHAPTER 4 - FUTURE DIRECTION OF TRAVEL

4.1 OVERVIEW

As set out previously, the management of general gynaecology services is currently delivered, with few exceptions, in a traditional manner involving resources across the outpatient and inpatient / day care setting. It is estimated that of the women presenting to outpatient clinics, upwards of 30% will be referred for further inpatient or day case management – often for relatively straightforward investigative procedures which may or may not result in further active treatment.

This not only results in significant delays for women accessing the care they require, it also results in resources involved in the provision of these services – both personnel and infrastructure – not being deployed with maximum effectiveness. This is particularly evident in the use of day beds and main gynaecology theatre resources being used to manage and provide relatively minor diagnostic procedures, with diagnostic hysteroscopy being a key example.

The direction of travel in the short to medium term must be on establishing safe alternative patient pathways that redirect women away from the traditional pathway and instead provides the care required in a more streamlined manner in less costly, more appropriate settings essentially shortening the care pathway for patients and enabling more effective and efficient use of resources. This will not only benefit the cohort of women that can be managed in this manner, it also enables a downstream positive impact regarding gynaecology service provision to other women awaiting care; by means of releasing valuable gynaecology inpatient and day care beds and scarce gynaecology theatre resources.

To commence these alternative pathways, the establishment of ambulatory gynaecology clinics within hospital groups has now been identified as a priority requirement.

4.2 AMBULATORY CLINICS

Ambulatory gynaecology services are designed and equipped to facilitate a consultation/review, any necessary diagnostics, as well as indicated treatment procedures in a single visit. This is in contrast to the traditional patient pathway that requires several patient attendances to the hospital.

Based on the experiences to date of the small number of such clinics present within the public health service, it can be estimated that up to 70% of general gynaecology referrals are suitable for management in an ambulatory setting. Management in this manner would alleviate pressures on acute inpatient and day care gynaecology services as a specific and significant cohort of women are treated in an alternative setting.

In 2005, approximately 60% of elective surgeries in the United States, Canada and Australia were carried out in the ambulatory setting, demonstrating that this approach to care has been widely and effectively adopted (Pasternak and Johns, 2005).

Acknowledging that rapid advances in health and medicine can often present challenges in developing and providing healthcare infrastructure, ambulatory gynaecology clinics are relatively simple clinics

to establish from an infrastructure perspective. In line with the key principles underpinning DoH, HSE and **Sláintecare** strategy, such clinics can with time be developed and delivered in Level 2 Hospital and community settings.

The ambulatory gynaecology clinic as a 'one-stop' approach provides the following stages of care to a woman within one visit in an outpatient type setting:

- Assessment;
- Treatment; and
- Discharge

Of all specialities, ambulatory care for gynaecology care has become increasingly common in Europe, Canada, the United States, Australia and Asia and is recommended by professional colleges and organisations associated with gynaecology care. Local and international studies have found that this model focuses on the needs of the patient, increasing patient satisfaction by streamlining the service and increasing the accessibility of care (Uzochukwu et al., 2016). The Institute of Obstetrics and Gynaecology/Royal College of Physicians in Ireland, The Royal College of Obstetricians and Gynaecologists and the British Society of Gynaecological Endoscopists all endorse the model of ambulatory gynaecology.

4.3 THE AMBULATORY MODEL

The following steps outline a patient's journey in accessing an ambulatory gynaecology service. Patients may be referred for follow up on an inpatient or day case basis as per their clinical need; an average conversion rates of 5 – 10 % have been reported.

1. **Patient** attends GP
2. *Gynaecology referral sent to acute services*
3. *Referral triaged by consultant and identified as appropriate for management in ambulatory clinic.*
4. *Patient awaits appointment in ambulatory gynaecology clinic*
5. **Patient** attends ambulatory gynaecology clinic, undergoes a medical consultation with any required diagnostics undertaken and ancillary treatment provided as appropriate during the same visit
6. *Up to 95% of patients may be discharged virtually with an estimated 5% referred for further specialist care*

This pathway has been designed to ensure that:

- Patients are fast tracked to a "see and treat" gynaecology service with same day diagnostics.
- Results may be delivered on the same day to the patient or provided virtually at a later date.
- Patients with abnormal results/findings can be identified and referred on to the appropriate specialist care pathway e.g. gynaecology oncology services.
- Patients are managed by the right person in the right location on their first visit.

4.4 BENEFITS & IMPACTS

- Increase patient safety as timely access to appropriate care is enabled thereby avoiding the delays associated with the traditional care pathway;
- Shortening the care pathway for patients offering faster access to diagnostics.
- Increase patient satisfaction by providing treatment in appropriate setting;
- Avoid the use of general anaesthetic (GA) by performing interventions in the outpatient setting as appropriate, thus avoiding the associated side-effects and risks of GA.
- Increase hospital bed capacity for management of complex gynaecology as day beds are freed up downstream;
- Increase theatre capacity for complex gynaecology procedures;
- Afford greater protection to gynaecology services from the pressures on emergency departments;
- Lead to more fruitful and effective deployment of health care resources in line with clinical need of patients; and
- Improved patient outcomes due to increased access to services.

While ambulatory gynaecology clinics are ultimately designed to provide a complete episode of care in a single visit, it is important that each case is comprehensively assessed and screened as regards suitability. There are many factors that affect a woman's experience of pain/discomfort during investigations and treatments of this nature. Everyone's experience of pain is different and an individualised approach to care should be adopted in relation to deploying ambulatory gynaecology.

4.5 RANGE OF SERVICES PROVIDED

Patients may present at the ambulatory clinic for the following reasons, in order of frequency:

- Abnormal uterine bleeding;
- Evaluation of adnexal mass – this mass may be benign or malignant;
- Management of precursors to cervical cancer – lesions caused by HPV;
- Vulval issues;
- Sexual dysfunction;

In providing a one-stop, see and treat service, ambulatory gynaecology clinics should be developed so as to provide the following suite of investigations:

Investigations	
Haematology	This is the study of blood.
Pelvic ultrasound	This is a diagnostic exam to assess organs and structures within the female pelvis. This is usually an internal ultrasound.
Diagnostic hysteroscopy	This is a technique used to examine the uterus and diagnose or treat a uterine problem. A thin, telescope-like device called a hysteroscope is used.
Endometrial biopsy	An endometrial biopsy obtains a small tissue sample from the endometrium. The sample is examined under a microscope to identify abnormal cells or any effects of hormones on the endometrium.

On foot of the clinical findings of the above suite of investigations, ambulatory clinics should also provide the following suite of treatments and minor procedures:

Procedures	
Cervical polypectomy	This is a procedure to remove small growths called polyps from the cervix.
Endometrial polypectomy	This is a procedure to remove small growths called polyps from the uterus.
Intrauterine device insertion, removal, replacement	Insertion, removal and replacement of copper-releasing or hormone-releasing intrauterine contraceptive devices.

4.6 CAPACITY OF AMBULATORY CLINICS

On average the appointment duration of a patient attending an ambulatory clinic is in the range of 30 to 60 minutes. Therefore in a two treatment room facility, with both rooms running simultaneously and allowing for the maximum one hour appointment, the capacity of a clinic over a four hour morning or afternoon session is approximately eight patients. It is recommended that care is provided by a consultant gynaecologist working alongside a team comprising of an advanced nurse practitioner (ANP), nurses, physiotherapists, HCAs and administrative personnel in fully equipped and multipurpose treatment rooms with adjoining private changing facilities and toilets.

Running at full capacity, it is estimated that a two roomed ambulatory clinic that has the appropriate ancillary facilities available to it, can manage and treat up to 3,000 patients per annum. The actual throughput of any given ambulatory clinic will be influenced by the number and type of staff available to resource it, the configuration of the clinic itself i.e. one room or two, range of ancillary facilities available and the setting of the clinic i.e. tertiary centre versus local centre.

Period	Morning session (8am-12pm)	Afternoon session (1pm-5pm)	Running clinics 3 days per week	Running clinics 4 days per week	Running clinics 5 days per week
Number of patients seen per day	8	8			
Number of patients seen per week			48	64	80
Number of patients seen per month			168	224	280
Number of patients seen per year			2,016	2,688	3,360

Table 6 *Estimating the maximum throughput of patients in a two roomed ambulatory gynaecology clinic supported by the appropriate ancillary facilities at 3 days; 4 days; 5 days per week over a 42 week year.*

CHAPTER 5 - IMPACT OF AMBULATORY MODEL

5.1 OVERVIEW

In developing and establishing this new diagnostic and treatment service within the acute sector, it is envisaged that each individual clinic will develop its ambulatory role on an incremental basis. This approach is required so as to enable gynaecology services, particularly new and existing resources, to expand and transition to incorporate this new pathway of care at the point of referral from primary care whilst also continuing the provision of traditional out-patient services. Even with the establishment of ambulatory clinics, a cohort of patients referred under the heading of general gynaecology will not be appropriate for management in these settings, so will continue to need management in the OP model.

In the context of the significant build-up of unmet demand and the significant waiting lists for gynaecology services, particularly from an outpatient perspective, there is a recognised requirement for the capacity generated by the proposed ambulatory clinics to be additional to existing outpatient capacity in the immediate to short term.

This position will evolve over time as individual services move towards a tipping point from a waiting list management perspective such that services can reduce down the number of traditional general gynaecology outpatient clinics they provide and rely on their ambulatory clinics to manage up to 70% of general referrals received. As part of the evolution of the service, it would be expected that additional capacity for specialised outpatient clinics would be developed whilst continuing to maintain a level of general outpatient clinics that meets the clinical need of the other 30% of referrals being received.

In the context of the demand for gynaecology outpatient services as measured by the NTPF waiting figures, it can be predicted that upwards of 20,000 women awaiting care in August 2020 would be suitable for management and care in the proposed one-stop, see and treat model.

5.2 SCALE OF AMBULATORY GYNAECOLOGY CLINICS

It is envisaged that the scale of ambulatory clinics will vary from site to site, with the demand being experienced by gynaecology service being a primary determinant of the scale at local level. Broadly, it is expected that two levels of provisions will be required, both of which will require additional investment albeit at different levels.

The first level will be developed in tertiary sites that provide large general gynaecology services and experience significant numbers of GP referrals. In these sites, it is recommended that an ambulatory gynaecology service is provided on a full time basis over five days per week. From an infrastructure perspective, in the tertiary centres the ambulatory clinics should ideally comprise of two adjacent clinical assessment rooms supported by the appropriate ancillary facilities e.g. changing rooms to support the maximum throughput of patients per year at full capacity.

In smaller services and sites, the second level of ambulatory gynaecology clinics will be developed, with the number of days per week of ambulatory service varying anywhere from two up to four days per week, with clinics on such site comprising of one to two clinical assessment rooms supported by the appropriate ancillary facilities.

5.3 DEPLOYMENT OF AMBULATORY GYNAECOLOGY CLINICS

Once embedded in the service it would be expected that ambulatory gynaecology clinics would focus solely on managing referrals received directly from GPs. However at their initial stage of deployment, these clinics would manage women sourced from both the OP waiting list and the IP/DC waiting list. The need for the latter arises from current practices in place around the country, whereby services in the absence of other options frequently manage women in main gynaecology theatres and day gynaecology theatres for procedures and diagnostics that are ideally suited to be provided in an ambulatory gynaecology care setting. A prime example of this is the extensive practice of hysteroscopy procedures being provided in theatres with or without an accompanying minor procedure.

Reviewing national activity data from 2018, focusing solely on the provision of hysteroscopies, it has been identified that a total of 14,931 such procedures were performed in IP and day care settings in 2018 alone. Whilst not all of these women would have been suitable for management within an ambulatory pathway and acknowledging that a relatively small proportion of these procedures may have been provided in the two existing ambulatory care settings established (Mayo and Connolly), the management of these women have traditionally involved the utilisation of scarce main or day theatre gynaecology resources and gynaecology day beds.

The additional capacity created upon the deployment of ambulatory clinics will have a direct impact on OP and IP/DC waiting lists at national level as women will be identified and triaged directly from both waiting lists. This approach not only supports the required transition process from a traditional service delivery model centred on point of access being outpatient clinics to a blended one involving ambulatory gynaecology, it also has a further direct positive impact downstream. The re-directing of appropriate cohorts of women for care in an ambulatory setting, frees up scarce gynaecology resources at theatre and day bed level which can be used to manage additional women from the inpatient/day case waiting list.

5.4 TARGET WAITING TIMES FOR AMBULATORY GYNAECOLOGY

As of the end of August 2020, there are 7,867 women waiting 12 months or more for a gynaecology OP appointment in the public health care service. In developing this model of care, it is acknowledged that significant work is required across the system to drive these wait times down. With the additional capacity which can be created with the implementation of ambulatory clinics as recommended, it is envisaged that an intensive work programme of up to two years duration will still be required on a number of sites to reach a point whereby waiting times for access to general gynaecology are 12 months or less.

In recommending this model of care, and proposing it as a core component of gynaecological care in Ireland, NWIHP would propose that the target waiting times for ambulatory gynaecology are even more ambitious than national OP waiting times target. As such it is recommended that as this model of ambulatory care embeds into the system, ambulatory gynaecology clinic wait times should be set at:

- Routine < 6 months
- Urgent < 4 weeks

The targeting of these waiting times allows ambulatory gynaecology clinics to effectively provide timely access to GPs for specialist assessment and review of patients they refer, with the urgent target commencing the formal implementation of rapid access clinics in gynaecology in Ireland for defined cohorts of presentations. This rapid access route for GPs can be established in the immediate to short term by the designation of specific sessions within ambulatory clinics specifically for this purpose. A primary example is women presenting with post-menopausal bleeding (PMB). HSE National Clinical Guidance on the appropriate timeframe for the investigation of PMB issued in August 2020 is now recommending a 4 week target timeframe from GP referral to a woman being seen in an OP/Ambulatory Clinic, and a further 4 week target for histology results to be available.

5.5 ROLL OUT OF AMBULATORY GYNAECOLOGY CLINICS

In developing an ambulatory care pathway for general gynaecology services it is recommended that this would be developed on a networked basis within individual hospital groups. Within this structure, the larger tertiary sites and services that deliver general gynaecology services would develop the first level of Ambulatory Gynaecology Clinics (i.e. Monday to Friday, two adjacent clinical rooms, full time), whilst the remainder of sites in the region that are appropriate for the development of general ambulatory gynaecology would develop the second level of Ambulatory Gynaecology Clinics.

The proposed distribution of networked ambulatory gynaecology clinics throughout the country and the recommended level of each is set out below in table 8. Given the current organisation and delivery of gynaecology services in specific areas in the country, it is expected that a number of sites identified in table 8 will work closely with their partner Level 2 acute hospitals and/or adjacent CHO primary care centres with a view to developing their ambulatory services off site.

Level of Clinic	**Hospital Group**					
	DMHG	***IEHG***	***RCSI***	***Saolta***	***ULHG***	***SSWHG***
First Level	Coombe	Holles St	Rotunda	Galway	Limerick	CUMH
	Tallaght					
Second Level	Portlaoise	Mullingar	Drogheda	Mayo*		Waterford
		Kilkenny	Cavan	Letterkenny		Kerry
		Wexford		Sligo		Clonmel
				Portiuncula		

Table 7 *Distribution of networked ambulatory gynaecology clinics and recommended level*

*Mayo already has in place a very successful ambulatory gynaecology clinic service and has been at the forefront of developing this type of care in Ireland. It would be intended that future investment in Mayo would be targeted at further developing and expanding this service.

The network of clinics overleaf results in Ireland having 20 ambulatory gynaecology clinics around the country. It is proposed that these clinics would be developed in a phased manner supported by a dedicated national investment programme as set out below in table 9

Phase One	Phase Two	Phase Three
Rotunda	Tallaght	Cavan
Galway	Drogheda	Sligo
CUMH	Letterkenny	Portlaoise
Limerick	Wexford	Kerry
Holles Street	Waterford	Mullingar
Coombe	Mayo	Kilkenny
		Clonmel
		Portiuncula

Table 8 *Proposed phased implementation of ambulatory gynaecology services*

CHAPTER 6 - STAFFING MODEL & COSTS

6.1 STAFFING MODEL

Two levels of ambulatory gynaecology clinics are envisaged in the Irish context, with the larger full time clinics being based in the tertiary centres and services which at full capacity are anticipated to manage up to 3,000 patients per annum, and the second level being developed in smaller services and sites. Second level clinics would manage anywhere between 500 to 1,500 patients per year depending on their configuration and number of sessions deployed per week.

Ambulatory clinics developed under this model of care, irrespective of size, are envisaged to be staffed by a blend of new and existing resources, with the buy-in and engagement of existing resources, particularly specialist resources at consultant level being a critical success factor for existing services to expand and transition to a blended model of provision i.e. traditional OP and ambulatory care.

To enable the successful delivery of safe, quality ambulatory gynaecology services in Ireland the input and expertise of the following professionals has been identified as required - consultant gynaecologists, advanced nurse practitioners, nurses, administrators and health care assistants. In particular, NWIHP are keen to highlight the role of the ANP in ambulatory gynaecology as being central to this model of care. The development of ANP's in gynaecology is at a relatively early stage in Ireland. Working closely with the lead consultant(s) for this service on sites, ANPs, further to appropriate training being provided, would be expected to manage the complete package of care for women attending the clinic. ANPs will facilitate better co-ordination of care, support standardisation of delivery and improved clinical outcome and will reduce the traditional over reliance on NCHDs for the provision of service.

The need for the ambulatory model of care to be further supported by physiotherapy expertise has been identified. From engagements with gynaecology services, access to physiotherapy services which are needed as part of the package of care required by many woman are associated with excessive wait times often in the region of 12 months plus. Therefore in order to ensure that ambulatory clinics and services are in a position to ensure that women have more timely access to this critical service, additional specialist physiotherapist resources specifically for women's health have been identified and recommended as a core component of the team recommended for ambulatory clinics and services.

6.2 REVENUE COSTS

Whilst the additional investment package required per site to support the deployment of ambulatory gynaecology services will inevitably be nuanced and informed by local needs and requirements, at a high level the following package of additional personnel has been proposed as required to enable the deployment of an ambulatory clinic on a tertiary site. These additional resources in tandem with existing gynaecology resources (specialist and otherwise) on site will support and enable the deployment of a tertiary ambulatory clinic:

Type of Clinician	No. WTE	Full Year Cost
Lead Consultant Gynaecologist	1	€234,276
Advanced Nurse Practitioner	1	€77,557
Clinical Specialist Physiotherapist	1	€64,127
Staff Nurse	1	€53,240
Healthcare Assistant	2	€88,534
Administrator (Grade IV)	1	€42,502
Non-Pay (20%)		€112,047
Total Revenue Costs		€672,283

In second level clinics, as set out previously, it is anticipated that the actual throughput of these clinics at full capacity will vary from site to site depending on the demands being experienced by general gynaecology services. Notwithstanding that, with a view to supporting services to embed this component of care in their service, reduce reliance on non-training NCHD posts for service provision and to support a transition from a traditional model of care to this new model of care so as to drive capacity in this service, the following package of additional personnel has been proposed as required. As set out above, exact requirements will be informed by local needs and structures.

Type of Clinician	No. WTE	Full Year Cost
Advanced Nurse Practitioner	1	€77,557
Clinical Specialist Physiotherapist	1	€64,127
Staff Nurse	1	€53,240
Healthcare Assistant	1	€44,267
Administrator (Grade IV)	1	€42,502
Non-Pay (20%)		€56,339
Total Revenue Costs		€338,031

As per normal practices for any new development, a 20% non-pay rate has also been built into the revenue costing models as set out above.

6.3 SET-UP COSTS

The development of any new ambulatory gynaecology clinic will require the financial support of once-off set-up costs. These costs support the renovations/retrofit/upgrading of existing spaces on sites and the purchase of required medical equipment, furniture, IT equipment etc. The exact figures required per clinic will be site specific, but can be estimated to be in the region of on average

€150 - €200k per clinic. These once of costs can be managed in the first year of establishment to a large degree utilising time related saving if full year revenue funding is provided in the year of approval. This approach has been adopted successful with the agreement of the Department of Health with other women related health initiatives overseen by NWIHP.

6.4 GENERAL PRACTITIONERS

As part of the development of this Model of Care, engagement was undertaken with the Irish College of General Practitioners regarding the potential role of GPs in the area of ambulatory gynaecology, based on the shared appreciated need for such services. NWIHP is aware of a small number of initiatives underway in some gynaecology services, whereby GPs are engaged by the hospital services to deliver general gynaecology OP type services under the governance of the hospital e.g. outreach clinic in Mallow supported by CUMH gynaecology services and local primary care and general practitioners, waiting list initiatives undertaken in Dublin based services utilising GP resources.

Ambulatory clinics are ideally placed to further support the expansion of GP's skill sets in this clinical service area, with real potential for a structured training programme to be developed between the Institute of Obstetricians and Gynaecologists (IOG) and the ICGP for formal accreditation and certification in this area.

In the short to medium term, it is envisaged that GPs could work under the governance of the hospital providing ambulatory gynaecology clinics and in the longer term the governance of this care could potentially be transferred to the community. This would reduce in the first instance the necessity of certain cohorts of patients being referred to acute gynaecology service by general practitioners as the requisite diagnostic and investigative skills would be available from their own designated GP colleagues within designated community provided and governed ambulatory gynaecology care services.

As Phase One and subsequent phases of this Model of Care are deployed, NWIHP will continue to actively explore with designated sites the potential of engaging with GPs regarding the development of ambulatory services in Ireland.

CHAPTER 7 - CONCLUDING SUMMARY

7.1 CONCLUDING SUMMARY

It is widely acknowledged that Gynaecology services are under significant and growing pressure with demand outstripping supply on a year-to-year basis. Waiting lists continue to grow apace and delays are being experienced across all service delivery areas. The area of women's health has been a prime focus for the DoH in recent years and the proposed development in ambulatory gynaecology clinics is an opportunity to strengthen the commitment to improving women's health by:

- Embedding safe and appropriate clinical practices;
- Providing a sustainable and responsive service to the healthcare needs of women ; and
- Ensuring the most effective and efficient use of resources available for the healthcare needs of women.

This model of care sees a departure from the traditional model of care, providing the care in a more streamlined and appropriate setting. The one-stop, see and treat clinics proposed through this model of care are internationally recognised to have improved patient safety and experience, minimised unnecessary hospital admissions and provided timely access to care.

This model of service delivery is endorsed by The Institute of Obstetrics and Gynaecology, Royal College of Physicians in Ireland, The Royal College of Obstetricians and Gynaecologists and the British Society of Gynaecological Endoscopists.

The introduction of two levels of ambulatory gynaecology clinics allows for a tailored approach to service demands in the Irish context. It is acknowledged that a bedding in period is required and that women will continue to be seen in the traditional OP clinics. However the introduction of ambulatory gynaecology clinics will allow for the redirection of valuable resources downstream in relation to inpatient and daycase gynaecology services.

NWIHP is committed to supporting the clinical sites to implement the successful roll out of high quality and effective ambulatory gynaecology clinics in a phased basis and is looking forward to continued collaboration with the DoH and relevant stakeholders to help best achieve this model of care.

REFERENCES

Central Statistics Office (2017) ***Persons on Live Register by Age Group, Sex, Social Welfare Office and Month*****. Dublin.** [Online] Available at:
https://www.cso.ie/px/pxeirestat/statire/SelectVarVal/Define.asp?Maintable=LRM07&PLanguage=0
[Accessed on 12 June 19]

Consultative Council on General Hospital Services (1968) ***Outline of the future hospital system report of the consultative council on general hospital services (Fitzgerald Report).*** [Online] Available at:
https://www.lenus.ie/handle/10147/46113
[Accessed on 13 May 19]

Department of Health (2018) Review of Health Demand and Capacity Requirements in Ireland to 2031. [Online] Available at:
https://health.gov.ie/wp-content/uploads/2018/02/71580-DoH-Dublin-Report-v6.pdf
[Accessed on 14 May 19]

Eurostat (2017) Hospital beds by type of care, 2015. [Online] Available at:
https://ec.europa.eu/eurostat/statistics-explained/index.php?title=File:Hospital_beds_by_type_of_care,_2015_HLTH17.png
[Accessed on 13 May 19]

NTPF (2017) National Inpatient, Day Case, Planned Procedure Waiting List Management Protocol. [Online] Available at:
https://www.ntpf.ie/home/pdf/National%20Waiting%20List%20Management%20Protocol.pdf
[Accessed on 21 August 2019]

NTPF (2019) National Waiting List Data. [Online] Available at:
https://www.ntpf.ie/home/nwld.htm
[Accessed on 30 August 2019]

OECD (2019) Hospital beds, Health at a Glance. [Online] Available at:
https://data.oecd.org/healtheqt/hospital-beds.htm
[Accessed on 13 May 19]

OECD (2019) Health at a Glance. [Online] Available at:
https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017/hospital-beds_health_glance-2017-62-en;jsessionid=YwQ_lN_zNvZE7IoJ25H-Mgwb.ip-10-240-5-41
[Accessed on 14 May 19]

Royal College of Obstetricians and Gynaecologists (2016) Providing Quality Care for Women Standards for Gynaecology Care. London, UK: RCOG

Royal College of Obstetricians and Gynaecologists (2011) Best Practice in Outpatient Hysteroscopy. London, UK: RCOG

Uzochukwu1, I., Burke, C., and Ní Bhuinneain, M. (2016) Patient Satisfaction and Acceptability: A Journey through an Ambulatory Gynaecology Clinic in the West of Ireland. Irish Medical Journal. [Online] Available at: http://imj.ie/2735-2/
[Accessed on 13 March 2019]

Wilson A, FitzGerald G, Mahon S (2010) Hospital beds: a primer for counting and comparing. ***Medical Journal of Australia:*** **193: 302-304.**

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