National Women & Infants Health Programme

REVIEW OF AMBULATORY GYNAECOLOGY SERVICES 2024

Contact |
National Women and Infants Health Programme
Health Service Executive,
2nd Floor,
The Brunel Building,
Heuston South Quarter,
Dublin D08 X01F

Phone | 01 795 9983
Email | Nwihp.corporate@hse.ie
Visit | www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/

TABLE OF CONTENTS

LIST OF ACRONYMS

AG = Ambulatory Gynaecology
ANP = Advanced Nurse Practitioner
cANP = Candidate Advanced Nurse Practitioner
RANP = Registered Advanced Nurse Practitioner
AUB = Abnormal Uterine Bleeding
CRO = Centralised Referral Office
CSSD = Central Sterile Services Department
DNA = Did Not Attend
DoH = Department of Health
GP = General Practitioner
HCA = Healthcare Assistant
HSE = Health Service Executive
IUCD = Intrauterine Contraception Device
KPI = Key Performance Indicator
MoC = Model of Care
NMBI = Nursing and Midwifery Board of Ireland
NWIHP = National Women and Infants Health programme
OP = Outpatient
OTC = Over the Counter
PIL = Patient Information Leaflet
PMB = Postmenopausal Bleeding
RPOC = Retained Products of Conception
TVUS = Transvaginal Ultrasound
U/S = Ultrasound
WHTF = Women's Health Taskforce
WLAP = Waiting List Action Plan

FOREWORD

By Dr Cliona Murphy and Dr Venita Broderick

Dr Cliona Murphy

Dr Cliona Murphy
Clinical Director
NWIHP

The National Women and Infants Programme was established in response to the National Maternity Strategy. Since then, the scope has extended to encompass maternity, neonatology, and gynaecology. The development of new outpatient services for gynaecology commenced in 2018 led by my predecessor Dr Peter McKenna. A key driver for this change in the delivery of services was to improve waiting times and patient experience. A new Model of Care for Ambulatory Gynaecology published in 2020 confirmed this commitment to quality improvement. The clinical community responded very positively to the new Model of Care and NWIHP would like to thank all involved. This review of the services, led by Dr Broderick, was an opportunity to engage with frontline staff, to assess processes and to learn for future planning. We hope the findings will be useful and informative to those involved in the services and those planning similar initiatives. We wish to acknowledge the expertise, time and commitment of the medical, nursing and clerical staff who participated in this review.

Dr Venita Broderick

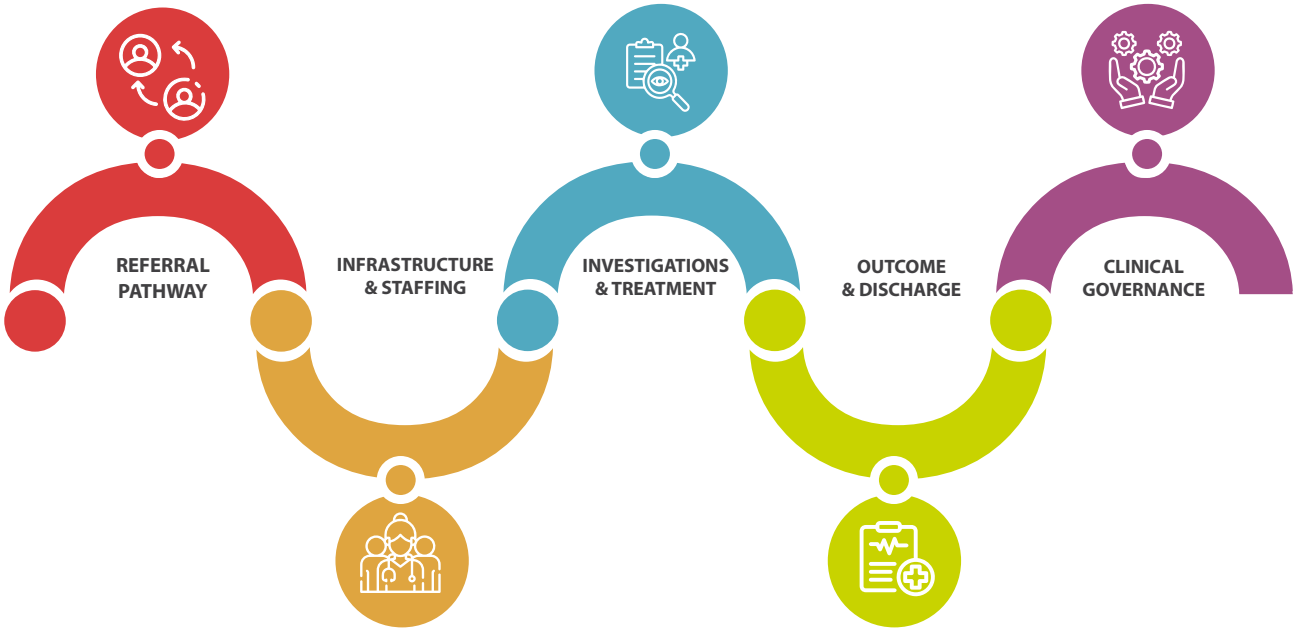
Dr Venita Broderick
Clinical Lead for Gynaecology
NWIHP

Between January and September of this year, we at NWHIP had the pleasure of travelling around the country to visit all 16 deployed ambulatory gynaecology units. It was an incredibly rewarding experience, from which we learned a lot. We are grateful to all the management teams as well as to the clinical teams for welcoming us and sharing your experience.

We were delighted to see for ourselves the success of the ambulatory gynaecology model of care. Central to the success of these clinics are the clinical teams who provide excellent patient-centred care.

In publishing this report, we would like to share the information we gathered from our visits so that we can learn from each other's experience and work together to provide the best possible care for our patients.

SUMMARY OF KEY RECOMMENDATIONS



REFERRAL PATHWAY

RECOMMENDATION 1:
Referrals for the following clinical conditions are suitable for management within the AG setting:

- PMB
- AUB
- IUCD Insertion or Retrieval
- Evacuation of retained products of conception
- Intrauterine Polyp/Fibroid

RECOMMENDATION 2:
Patients meeting the clinical criteria for assessment and management within AG be referred directly to this service following clinical triage.

RECOMMENDATION 3:
Services should apply the HSE National Outpatient Waiting List Management Protocol 2022 to their waiting list management processes.

RECOMMENDATION 4:
A PIL should be provided as a minimum to prospective AG service-users.

RECOMMENDATION 5:

- Appointment letters should be issued to patients six weeks before their appointment is due.
- For urgent patients, it is best practice to inform the patient of their appointment by both telephone and by issuing a letter.
- The DNA rate for each AG service should be reviewed on an ongoing basis, with a view to reducing.
- Appointment reminder processes should be implemented.

INFRASTRUCTURE & STAFFING

RECOMMENDATION 6:

- AG services/units should be clearly signposted from the main hospital entrance.
- A designated recovery bay is not essential provided services have identified an alternative location/solution for those patients who require additional time to recover from their AG visit.

RECOMMENDATION 7:

All consultants with a background in general gynaecology and the relevant skillset should participate in AG clinics.

RECOMMENDATION 8:

- All ANPs should undertake both hysteroscopy and AG ultrasound training with a view to autonomously providing ANP-delivered AG clinics.
- The candidate ANP is required to progress to registration as a Registered Advanced Nurse Practitioner (RANP) within 3 years of commencement of the cANP post.

RECOMMENDATION 9:

A consistent, well-trained HCA should be an integral member of the AG team.

RECOMMENDATION 10:

Provision should be made to ensure administrative capacity for the AG service.

INVESTIGATIONS & TREATMENT

RECOMMENDATION 11:

- A consent form specific to AG is recommended to obtain patient consent before investigations or treatment and should be provided along with PIL pre-appointment.
- Staff must regularly remind a woman that she is likely to experience period-like cramping and lower abdominal pain during and after the procedure, and that should she find the procedure too painful or distressing she should notify any member of her clinical team who will ensure the procedure is stopped immediately.

RECOMMENDATION 12:

Where appropriate and possible, AG services should provide a complete episode of gynaecological care in a single visit.

RECOMMENDATION 13:

- Ideally, all medical and senior nursing staff at a minimum should be competent to perform ambulatory gynaecology U/S scanning.
- All women who require a hysteroscopy should have an ultrasound done prior to, or during, the AG visit.
- The patient should be fully informed and it should be documented that the U/S scan performed in AG may be a limited scan. It may not evaluate the entire pelvis but rather investigate with respect to each woman's specific presenting symptoms. A limited scan does not screen for ovarian cancer.

INVESTIGATIONS & TREATMENT CONTINUED

RECOMMENDATION 14:
When selecting hysteroscopes, the smallest size scope should be selected in the context of procedures being performed in the outpatient setting and ideally performing procedures vaginoscopically.

RECOMMENDATION 15:
The following procedures constitute AG activity:

- TVUS
- Hysteroscopy
- Endometrial biopsy
- Hysteroscopic Polypectomy/myomectomy
- Hysteroscopic removal of RPOC
- Endometrial Ablation
- Hysteroscopic retrieval IUCD

RECOMMENDATION 16:

- All AG patients should be advised on appropriate over the counter medication prior to her appointment, unless contraindicated.
- A local anaesthetic should be administered if required.
- A procedure should be stopped at a woman's request and women should be reminded of this at several points during their visit.
- Where outpatient hysteroscopy will not be tolerated or is not desired, a theatre day case hysteroscopy should be booked.
- The use of Nitrous Oxide (Entonox®) or Methoxyflurane (Penthrox®) is not currently recommended and remains under review.
- The routine use of misoprostol is not recommended (RCOG).

RECOMMENDATION 17:
An electronic/digitalised record is the preferred method for documenting a patient's healthcare record.

OUTCOME & DISCHARGE

RECOMMENDATION 18:
Processes should be in place that seek to engage with patients regarding their experience and request suggestions to improve the service.

RECOMMENDATION 19:

- The referring GP must be informed of patient results.
- Patients with normal results should receive their results by letter. Results may also be communicated over the phone.
- A patient should be seen in person for communication of abnormal results.

CLINICAL GOVERNANCE

RECOMMENDATION 20:

- A centralised approach to referral management should be implemented.
- A pooled approach should be taken to triaging AG appropriate referrals.
- Patients should be allocated to the most appropriate clinician from the pooled waiting list on the basis of clinical suitability, sub-speciality or expediency, always keeping in mind the best interests of the patient.

RECOMMENDATION 21:

A pooled approach to theatre lists and capacity should be adopted amongst gynaecologists with the requisite skillset.

INTRODUCTION

The need to rethink the way in which gynaecology services were being delivered in Ireland led to the design and development of the Ambulatory Gynaecology Model of Care (MoC) by the National Women and Infants Health Programme (NWIHP). The MoC (2020) was developed in response to the significant and growing gynaecology waitlists being experienced across all gynaecology services and sites in the public health service. This MoC recommended the development of a network of 20 ambulatory gynaecology services dispersed across the country.

Much of the increase in demand in gynaecology services circa 2019 could potentially be attributed to heightened public and professional caution in the aftermath of challenges experienced within the Cervical Check Programme. The Irish health system has of course since experienced the impact of the Covid-19 pandemic that saw many services suspended or operating with reduced capacity for much of 2020 and some of 2021.

An initial and expected decrease in gynaecology referrals in 2020 was following by a sharp spike, with a 36% increase in general gynaecology referrals observed in 2021. While it is generally accepted that the system has now absorbed much of the impact of the pandemic, gynaecology referrals continue to rise at a rate not experienced by most other specialities. A further 13% increase was evident from the period 2021-22, whilst a further annual increase of 12% was observed from the period 2022-23. This trend in increased demand has continued into 2024, with an increase of over 17% evident between January and October 2024 as compared to same period last year.

NWIHP, with the support of the Department of Health (DoH) and the Women's Health Taskforce (WHTF), is overseeing the planning and development of 20 ambulatory gynaecology (AG) clinics to date. Additional investment provided by the WHTF in 2024 will fund the establishment of one more AG service, expanding the network to 21 services in total.

The AG model of care describes the establishment of two levels of AG service: A level one service, based in tertiary sites, is designed to operate full-time and at maximum capacity manage up to 3,000 patients per year. Level two services, based in regional gynaecology services are designed to operate between 2 – 4 days per week and have the capacity to manage between 1,000 – 1,500 appointments per year.

The initial three services deployed during the course of 2020. As of October 2024, 16 services are fully established and deployed across the country. Additionally, two other services are offering a level of service within their existing infrastructure and are expected to operate at full capacity once both have secured their dedicated footprint.

Appendix A provides an overview of the status of each of the 21 units identified in the MoC in relation to funding and deployment as of Quarter 3, 2024.

From a funding perspective, just under **€9.5 million recurring revenue funding** has been secured and allocated to enable services to recruit additional staff to open these services, whilst a further **€6.5 million has been allocated on a once-off basis** to support the required refurbishment and equipping of new ambulatory gynaecology clinical spaces.

METHODOLOGY

Commencing in January 2024, NWIHP undertook a series of site visits to all deployed AG services across the country (N=16). The purpose of these visits was to engage with both the clinical frontline and the hospital management teams leading out and managing these services.

With many services now well established, it was timely to undertake this review to attain an overview of the processes employed in the respective AG sites, the patient cohort managed within the AG services, and to review the infrastructure in terms of available equipment and clinical space.

NWIHP have collated the findings of this series of site visits and they are detailed in the following report. Key recommendations and areas of best practice, of which there are 21, are also presented.

NWIHP would like to express thanks to each AG team member who generously gave their time to facilitate these site visits and willingly engaged to provide NWIHP with the information contained in this report.

NWIHP suggest that the recommendations presented are reviewed by individual services with a view to adopting where possible and to support best practice in the delivery of AG care. The findings are underpinned by an ethos of patient-centred care, with the dignity, respect and empowerment of patients to the fore.

FINDINGS AND RECOMMENDATIONS

The findings and information obtained via these site visits is presented below, organised according to the patient journey as outlined in Figure 1 below.

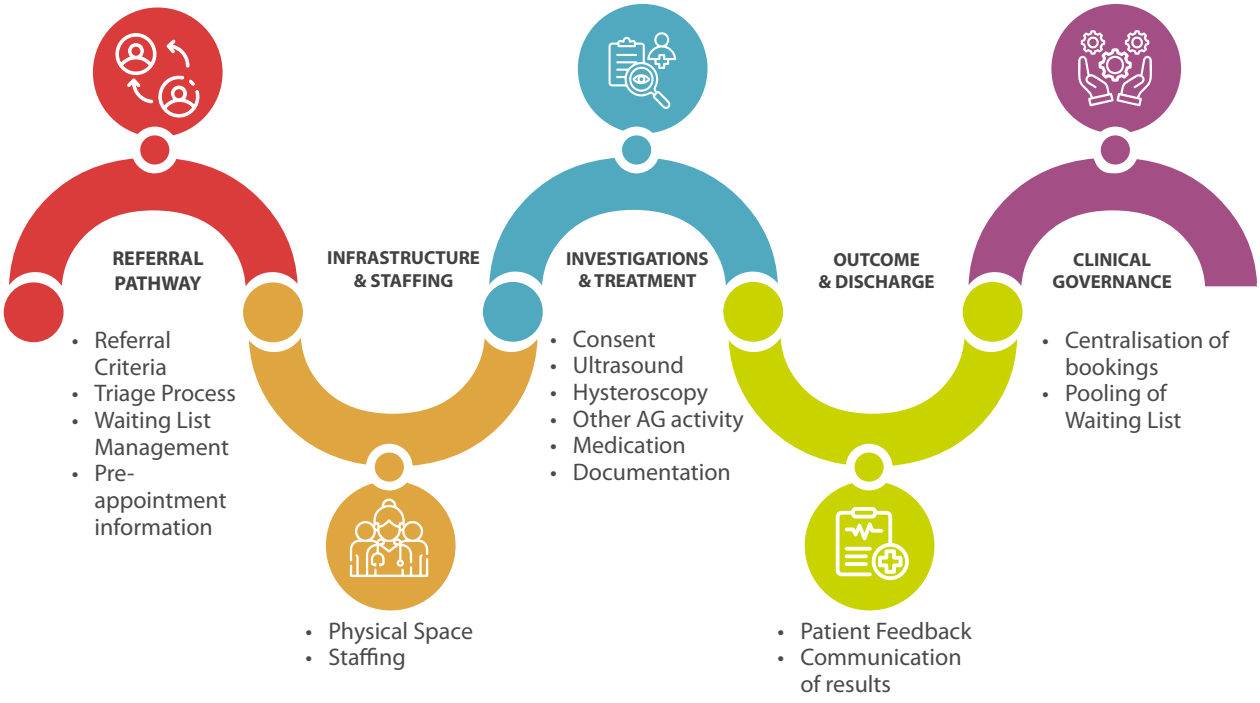


Figure 1. *Overview of the categorisation of findings and recommendations*

REFERRAL PATHWAY

REFERRAL CRITERIA

There is variance in referral criteria of the total patient cohort treated within AG services. The following indications are included and diverted to the AG setting across the various sites:

- Post-Menopausal Bleeding (PMB)
- Abnormal Uterine Bleeding (AUB)
  - (includes post-coital bleeding, intermenstrual bleeding, menorrhagia)
- Intrauterine polyps and small Fibroids
- Vulval Issues
- Intrauterine contraception device insertion/retrieval
- Evacuation of retained products of conception
- Uro-gynaecological issues e.g. Urinary Incontinence.

The variability in the indications deemed suitable for management within AG services can be somewhat attributed to both individual service capacity as well as service demand. Patient flow between general gynaecology outpatients and the AG service also varies across units, with this interface also impacting the cohort of women managed within the AG service. NWIHP note in particular that the patient cohort managed within AG differs most significantly between tertiary and regional services.

RECOMMENDATION 1:

Referrals for the following clinical conditions are suitable for management within the AG setting:

- **PMB**[1]
- AUB
- IUCD Insertion or Retrieval
- Evacuation of retained products of conception
- Intrauterine Polyp/Fibroids

Note, the recommendation above aims to clarify the referral criteria and therefore, the clinical activity that is considered true AG activity. This is not with the view to limiting gynaecology activity within the associated clinical spaces where capacity allows.

TRIAGE PROCESS

All services report that gynaecology referrals received for PMB are ultimately managed within the AG service (N=16), with most services directing PMB referrals directly to AG following clinical triage (N=14). One service is operating a centralised referrals process whereby all appropriate AG referrals are booked directly to AG slots following clinical triage. In two services, and for indications including PMB, some referrals are first directed to general outpatient clinics for initial assessment before being onward referred to AG (N=2).

Some services operate PMB only clinics, prioritising this cohort for access to slots, particularly where

demand outstrips current capacity. Services should adopt Clinical Prioritisation Processes as per the **HSE National Outpatient Waiting List Management Protocol 2022[2] (see Appendix B).**

RECOMMENDATION 2:

- Where the quality of the information provided on the original gynaecology referral supports the process, NWIHP recommends that patients meeting the clinical criteria for assessment and management within AG be referred **directly** to this service following clinical triage. *This is in keeping with the management philosophy of the MoC, which envisages a complete episode of care delivered in a reduced timeframe and with minimal patient visits.*
- The national gynaecology eReferral, developed in 2023, should be the primary source of referral information. This specific e-referral is designed to highlight potential red flags and enable efficient clinical prioritisation. Hospitals should ensure that their local processes support receipt of this e-referral.
- Clinical Prioritisation Processes as detailed in Appendix B should be applied as per the **HSE National Outpatient Waiting List Management Protocol 2022[2].**

WAITING LIST MANAGEMENT

There was some disparity observed in the management of referrals in the context of calculating time to treatment and time to discharge, particularly in relation to the definition of "Day 1". This is particularly relevant for accurately recording time to management and time to treatment for those attending with PMB and the subsequent reporting for the relevant national key performance indicators (KPIs).

The **HSE National Outpatient Waiting List Management Protocol 2022[2]** clearly defines waiting list management processes in this context. Accurate recording on the hospital PAS systems is integral to these processes.

Where a patient does not attend their appointment and the clinical decision is made to keep this woman on the outpatient gynaecology waiting list, the wait time clock should be re-started as illustrated below i.e. the clock starts again from the date the patient did not attend on their original appointment date.

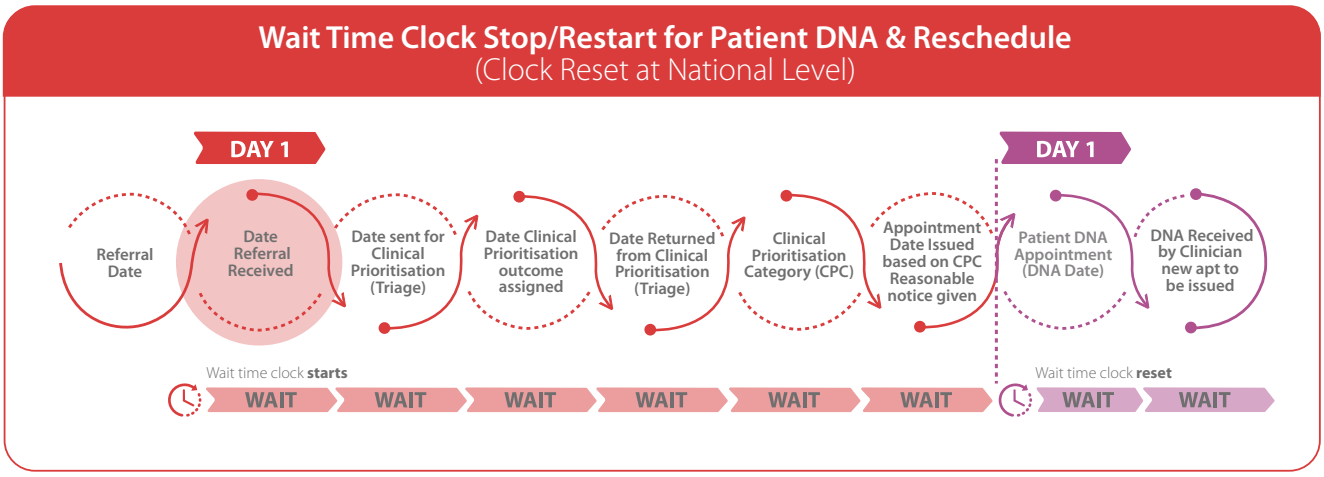


Figure 2. *Wait Time Clock Stop/Restart for DNA*

In instances where a patient cancels their appointment and reschedules their appointment to a later date, again the wait time from date referral received should be reset (see below).

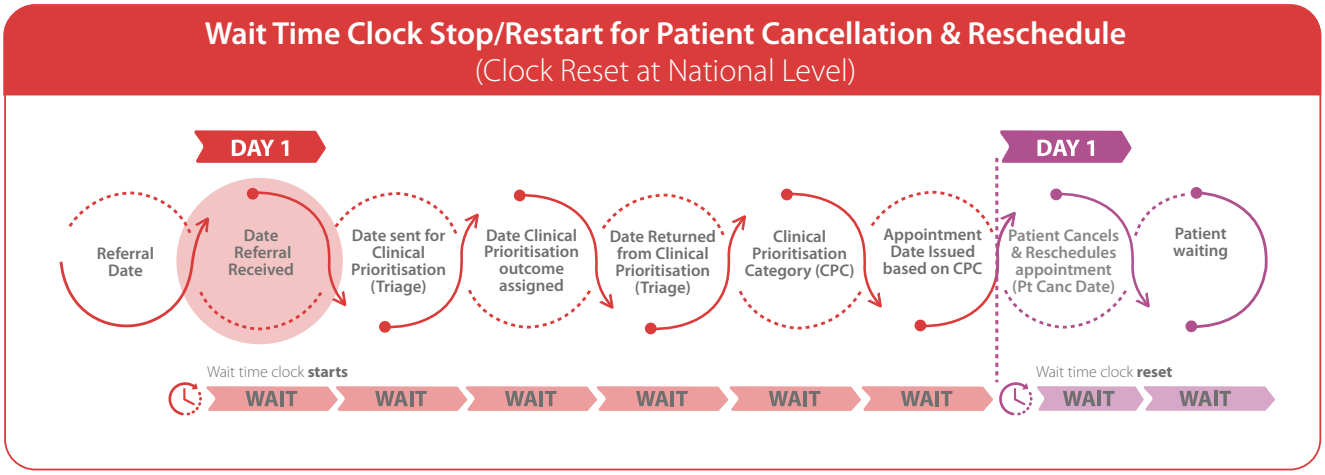


Figure 3. *Wait Time Clock Stop/Restart Rescheduled Appointment*

RECOMMENDATION 3:

- Services should apply the **HSE National Outpatient Waiting List Management Protocol 2022**[2] to their waiting list management processes.
  This is particularly relevant for accurately recording time to management and time to treatment for those attending with PMB and the subsequent reporting for the relevant national key performance indicators (KPIs). It is imperative that all services are reporting in a manner that is transparent and consistent.

PRE-APPOINTMENT PREPARATION

Patient Information

All services provide a patient information leaflet (PIL) in advance of a patient's attendance (N=16), while one service also has a patient information video available (N=1)[3].

RECOMMENDATION 4:

- A PIL should be provided as a minimum to prospective AG service-users[3].
- Patient information should be provided in an accessible format and if possible, in different formats. Written information should be available in print, which may include large print, digitalised (i.e. available via e-mail if required)[4].

  NWIHP are currently producing an animated patient-information video that will be available to all AG services. This will include audio description, subtitles and Irish Sign Language. NWIHP will also seek to make this video accessible for different language requirements.

Appointment Reminders

A key phase in the patient's healthcare journey is the point from receiving an appointment date for a procedure to the day of the scheduled procedure. Typically, appointment letters are issued 4 to 6 six weeks in advance of the appointment date. Urgent patients booked within 4 weeks are usually contacted firstly by phone with an appointment letter following.

There are several strategies in place across services to reduce Do Not Attends (DNAs) and late arrivals.

The following provides an overview of effective strategies employed across services:

- Some services phone patients in advance to remind them of their AG appointment details (N=3), while one service currently has a text-message reminder service in place (text sent 10 days pre-appointment).
- One AG service is operating a patient-initiated booking system whereby the patient receives a letter of offer and phones the AG clinic to book their appointment. This process has been extremely effective in almost eliminating DNAs for the AG service. NWIHP acknowledge that this process is administratively demanding, however, would encourage services to consider means by which it may be implemented. The HSE app, which was piloted in May 2024, will in future releases allow patients more autonomy in managing their own appointments.
- Another service (N=1) operates a virtual pre-assessment before the patient's AG appointment. This initiative is time consuming and many services may not have adequate resources to implement this. If adopted, the strategy should seek to optimise and reduce the time allocation for the patient's in-person visit.

The HSE's DNA National Guidance Document describes an end-to-end management system that aims to reduce non-attendance for scheduled appointments[5]. This document highlights the importance of effective communication, optimal timing of communication and the importance of adhering to the National Outpatients Waiting List Protocol timelines. In relation to text messaging reminders, a recent evaluation recommends a national rollout of SMS reminders to support reducing DNAs[6]. NWIHP are aware that not all services currently have the necessary infrastructure to enable text messaging reminding but a number are actively pursuing this at both service and hospital level.

RECOMMENDATION 5:

- Appointment letters should be issued to patients six weeks before their appointment is due.
- For urgent patients being allocated an appointment within the recommended 28 days, it is best practice to inform the patient of their appointment by both telephone and by issuing a letter.
- The DNA rate for each AG service is reported to NWIHP on a monthly basis.
- This rate should be reviewed on an ongoing basis at local service level, with a view to identifying any potential causes and exploring strategies that can be adopted to reduce this rate.
- Any AG service experiencing a DNA rate of 10% or higher should review their processes to actively put in place measures to reduce this.
- A process for reminding prospective AG patients of their upcoming appointment should be implemented. This should be done between 2 weeks before the scheduled appointment[5].
- Services should be familiar with the guidance as outlined in the HSE's DNA National Guidance

Document and implement recommendations as appropriate[5].

Notwithstanding the significant administrative element associated with phoning patients to remind them of their appointment, it is a demonstrable measure in reducing DNA rates.

This further demonstrates the importance of dedicated and ring-fenced administration support available for the AG service.

In time, a text-message reminder service will be enabled across all services in line with national developments[6].

AMBULATORY GYNAECOLOGY INFRASTRUCTURE

PHYSICAL ENVIRONMENT

Location and allocation of clinical space

Currently, all but two AG services are located on the associated hospital campus. In general, most services are easily accessible and well signposted from the main hospital entrance. Both offsite AG services are easy navigate to and parking is adequate.

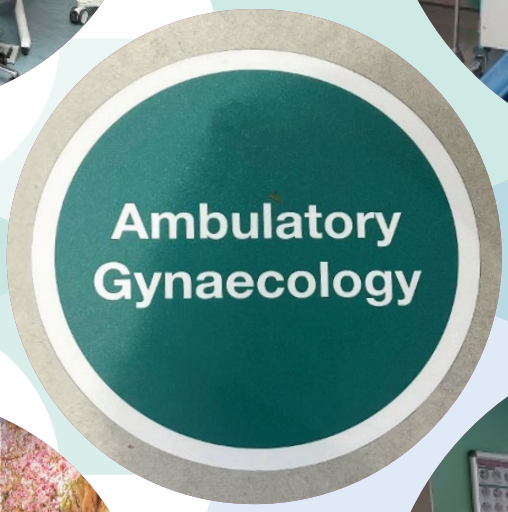
It is noteworthy that most AG services have been able to secure dedicated footprints (N=14). In fact, the agreement of this dedicated footprint was a key component of the MoC itself and a condition of the approved funding.

Working collaboratively with sites, NWIHP allocated significant once-off funding amounting to over **€6.5 million** to enable services to refurbish and design bespoke, ergonomic clinical spaces to support AG services.

While undertaking this series of site visits, NWIHP have been impressed with the standard to which refurbishments have been undertaken and the level of care and detail that has been applied to designing these clinical spaces in a patient-centred way. There is a growing body of literature on the meaningful role played by the physical environment in providing high-quality healthcare, while also being an important factor in increasing job satisfaction for health care workers[7].

Services have created spaces that respect and uphold privacy, dignity, and comfort for women, which is of the utmost importance, particularly when undertaking procedures of an intimate nature. The majority of AG suites are equipped with ensuite facilities and therefore, offer privacy for changing etc.

The majority of services do not have a recovery room within their AG service (N=10). Some services (N=5) address this with a recliner chair within their dedicated waiting area while for other services, this need is accommodated using the second AG clinic room (N=2) or accessing the theatre recovery bay/gynaecology ward when located in close proximity (N=3).


Ambulatory
Gynaecology

RECOMMENDATION 6:

- AG services/units should be clearly signposted from the main hospital entrance. Floor signage should also be considered.
- All Level One AG services should have *at least* one dedicated clinical room operational to optimise activity. Where available, a second AG clinic room should be deployed.
- Where a dedicated room cannot be provided and clinical space must be shared, consideration should be given to the service with which AG is co-locating such that there is minimal downtime and minimal removal/storage of equipment etc. between switch over of clinics.
- A designated recovery bay is not essential provided services have identified an alternative location/solution for those patients who require additional time to recover from their AG visit. An area offered for recovery should assure privacy.

STAFFING

Consultant Staffing

All services have a designated, named AG clinical lead. There is a wide range of participating consultants from service to service, reflecting the varying levels of consultant resources from site to site and between tertiary and regional services (range 2 to 11 consultants). This is also due to the areas of special interest adopted by consultant gynaecologists and the accompanying skillsets, equipment competencies etc.

RECOMMENDATION 7:

- Ideally, all consultants with a background in general gynaecology and the relevant skillset should participate in AG clinics such that the clinical workload and responsibilities are shared fairly across the relevant consultant resource.
    - This will most importantly ensure that all high-priority patients can access appropriate and timely management within these AG services (e.g. PMB).

Nurse Staffing

Each funded AG service received staff nurse resources as well as Advanced Nurse Practitioner (ANP) posts.

To date NWIHP, in conjunction with the Women's Health Taskforce, have funded 21 advanced nurse practitioners roles to support and ultimately take a lead role in providing AG services. All of these posts have been filled successfully and post holders are at varying degrees of their ANP education and training.

All cANPs are in the process of undertaking or plan to undertake hysteroscopy training, as well as ambulatory gynaecology ultrasound training.

Many services are already operating ANP led and delivered clinics. NWIHP also note that in some services, staff nurses are pursuing and undertaking the necessary training to perform both hysteroscopy and ultrasound scanning.

RECOMMENDATION 8:

- It is expected that all ANPs will undertake **both** hysteroscopy and AG ultrasound training to obtain the necessary qualifications, with a view to autonomously providing ANP-delivered AG clinics in line with the HSE MoC.
- As recommended by Bord Altranais and Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) (NMBI), the candidate ANP is required to progress to registration as a Registered Advanced Nurse Practitioner (RANP) within 3 years of commencement of the cANP post.
- With respect to acquiring the necessary case numbers for relevant training in a timely manner, it is recommended that cANPs link with larger sites within their hospital region.

Health Care Assistant Staffing

Most services have a dedicated healthcare assistant (HCA) working within the AG service (N=15). This funding allocation recognises the importance of these healthcare professionals by NWIHP. HCAs play an essential role in the patient journey, supporting both the physical and emotional aspects of patient care. The presence of this group of professionals at meetings during the NWIHP site visits underscores the significance of their role and the value of their contributions.

RECOMMENDATION 9:

- A consistent, well-trained HCA should be an integral member of the AG team, helping both clinical flow and optimal patient experience within the AG setting.
    - This healthcare professional and *'vocal local'* is increasingly valuable as a patient support, advocate, chaperone, and can help alleviate anxiety for women attending the AG clinic.

Administrative Staffing

There are discrepancies across sites in relation to the availability of administrative support present consistently to facilitate the operation of AG clinics.

While many sites report a dedicated administrative resource, some services indicate very limited ring-fenced administrative support. Likely factors contributing to this lack of availability include staff shortages across the hospital's wider administrative function, coupled with the recent recruitment moratorium that hindered the filling of vacant posts.

As per the suite of resources identified by NWIHP as being necessary to provide the AG services as intended, almost all services have been funded with 1.0 WTE administrative resource.

RECOMMENDATION 10:

- A ring-fenced AG administrative resource is a vital component of the AG team.
- Where funded, provision should be made to ensure administrative capacity for the AG service.
    - An administrative resource is crucial to the efficient flow of an AG service and can be instrumental in implementing processes to reduce DNAs, optimise capacity and collate data as per national data requirements.

INVESTIGATIONS & TREATMENT

CONSENT

The majority of AG services obtain written consent as part of their policy. A minority of services obtain verbal consent only but document within the patients chart when informed consent is obtained. Informed consent is crucial to ensure that patients have the right to make autonomous decisions about their medical care. It involves providing patients with clear, understandable information about their diagnosis, treatment options, potential risks, and benefits, as well as alternatives, so they can make an informed and voluntary choice.

RECOMMENDATION 11:

- The Clinical Team should be mindful of the fact that arrival of a woman to an AG clinic does not indicate that she has given consent for a procedure.
- Patients should be made aware of investigation/treatment options including inpatient procedures under general anaesthetic.
    - Appropriate pre-attendance and pre-procedure information sharing is recommended so that women are prepared for the often-intimate nature of gynaecology investigations and procedures. Previous traumatic events, including unwanted sexual contact, may influence a woman's choice or experience in relation to gynaecological care. All HCPs involved in a woman's care should be mindful of this and strive to create a safe and supportive physical and emotional space for patients
- A consent form specific to AG is recommended to obtain patient consent before investigations or treatment[3]. It is recommended that this consent form be provided along with a PIL pre-appointment[8].
- As per HSE consent policy[4], assigned consent form is only one means of documenting that a communication process has taken place.
  AG staff must document:
    - What has been explained, discussed and agreed with the person,
    - How consent was given.
- If different staff will be providing different aspects of care, they should each document their role in the consent discussion, as relevant.
- Importantly, staff must remind women that she is likely to feel period-like cramping and lower abdominal pain during and after the procedure, and that should she find the procedure too painful or distressing she should notify any member of her clinical team who will ensure that the procedure is stopped immediately[8].
- Most importantly, a shared-decision approach to care should be adopted, with the woman feeling empowered and supported to make the best decision for her care including treatment setting, pain control and type of anaesthesia.

'ONE-STOP' APPROACH TO CARE

Almost half of the AG services are primarily operating a one-stop, 'see and treat' approach to care, whereby an ultrasound, diagnostic hysteroscopy and concomitant treatment procedures can

be performed in a single visit, as / if clinically indicated (N=7). Most of the remainder complete a woman's episode of gynaecological care in two to three visits (N=9).

There are factors in relation to both structures and processes that influence a services capacity to provide complete care in one visit as envisaged in the MoC. An individual woman's acceptance of this approach is also a prime consideration. These factors are discussed in more detail below.

RECOMMENDATION 12:

- Where appropriate and possible, AG services should provide a complete episode of gynaecological care, to include consultation, investigations, diagnostics and treatment in a single visit.

ULTRASOUND

Access to ultrasound varies widely across the country, with access in tertiary services often significantly more challenging than in regional hospitals. All services are equipped with ultrasound scanning facilities as provided for via NWIHP funding.

A key observation with regard to ultrasound scanning is that consultants routinely undertake scanning in the AG setting in regional services. Overall, it is clear that access to ultrasound is a limiting factor for some services in providing an always-timely episode of care to women. For services that do not operate a 'one stop' approach to care, access to ultrasound is the primary cited limitation. NWIHP are aware of endeavours taken by individual services to combat this accessibility issue, which includes liaising with their local GP network to encourage uptake of the community access to diagnostics scheme to facilitate women availing of ultrasound in this way. Other services have negotiated outsourcing of scanning to private providers. There are options in relation to the GP Access to Community Diagnostic Scheme and the Acute Services Access to Community Diagnostics Scheme that can assist in enhancing ultrasound provision in the short term. NWIHP recently issued a circular to all AG services outlining the details of both schemes (See Appendix C).

RECOMMENDATION 13:

- All AG consultants and AG nursing staff should be positioned and supported to perform ambulatory gynaecology U/S scanning.
    - Consideration should be given to undertaking appropriate education in Ambulatory Gynaecology Ultrasound.
- As per the National Clinical Guidelines for the Management of PMB[1], an investigative ultrasound should be performed prior to hysteroscopy to assess endometrial thickness.
- Regardless of presenting symptoms, any woman who has not previously had an ultrasound scan in relation to the relevant episode of care and who requires a hysteroscopy, should have this scan done within the AG service during the woman's first visit.
- The patient should be **fully informed** and it should be clearly documented that the U/S scan performed in AG may be a **limited scan** focusing on uterine pathology. It may not evaluate the entire pelvis but rather investigate with respect to each woman's specific presenting symptoms. **A limited scan does not screen for ovarian cancer.**
- Structured pathways with the associated radiology departments should be implemented such that an incidental or significant finding on U/S imaging can be investigated thoroughly and in a timely manner.

While a scan performed in AG may not be a comprehensive, diagnostic evaluation of the entire pelvis, it is possible that some women will have an incidental finding observed on a limited AG scan. In such cases, a complete, diagnostic follow-up scan should be performed in the relevant radiology department. Access to radiology reportedly varies considerably across services, ranging from very good to poor with restricted and hindered access.

HYSTEROSCOPY

In terms of operative hysterosocopy, the majority of AG services use a combination of Myosure™ and Truclear™ hysteroscopy systems. NWIHP does not endorse the use of one brand name over another.

Overall, most services have sufficient diagnostic scope sets. Some services however share operative hysteroscopy equipment with theatre and some services expressed the need for additional scope sets. This shortage of equipment is the second cited limitation to operating a one-stop model of AG care. Further to significant and initial funding provided for equipment, NWIHP is now engaging with the relevant services to resolve any gap in equipment needs that may have emerged as a result of increased service activity, life-cycle of equipment etc.

In some cases, additional sets are required to combat central sterile services department (CSSD) turnaround times and ensure there is no unnecessary downtime or pause in AG clinic activity. It is notable that two services do not have a CSSD on site, which limits turnaround times and often affects the lifespan of equipment.

RECOMMENDATION 14:

- Each AG service should have an adequate number of scopes to facilitate efficiencies and the optimal use of appointment slots within the AG service, limiting clinical downtime.
- To minimise risk of damage, hysteroscopy equipment should not be moved between theatre and the OP AG clinic rooms.
- When selecting hysteroscopes, the smallest size scope should be selected in the context of procedures being performed in the outpatient setting and ideally performing procedures vaginoscopically[9].

OTHER AMBULATORY GYNAECOLOGY TREATMENTS

In relation to therapeutic procedures completed during outpatient hysteroscopy, findings varied as expected mirroring the variance reported in relation to the AG clinical access criteria across services. NWIHP have reviewed gynaecological activity that is currently completed within the AG clinics. Consideration has been given to what procedures constitute true ambulatory gynaecology versus activity that is better categorised as general gynaecology. This is summarised in the recommendation below.

It is important to note that this recommendation does not seek to impede additional activity occurring within the AG Setting.

Other gynaecology activity should continue in the AG setting where safe to do so and if capacity allows, provided all AG appropriate referrals have been triaged and managed appropriately.

RECOMMENDATION 15:

The following procedures constitute AG activity:

- TVUS
- Hysteroscopy
- Endometrial biopsy.
- Hysteroscopic Polypectomy/Myomectomy
- Hysteroscopic removal of retained products of conception
- Endometrial Ablation
- Hysteroscopic retrieval IUCD
- IUCD insertion

MEDICATION

All services advise over - the-counter (OTC) analgesia one hour prior to a woman's AG appointment (N=16). This can include paracetamol-based products and/or Non- Steroidal Anti-Inflammatory drugs (NSAIDs).
Two services prescribe Misoprostol to AG service users, one of which also prescribes *Diclofenac*.
Two services offer nitrous oxide (Entonox®) to patients prior to/during hysteroscopy procedure.

RECOMMENDATION 16:

- There should be clear protocols developed by AG services regarding the use of analgesia and anaesthesia.
- All AG patients should be advised on appropriate OTC medication prior to her appointment, unless contraindicated, with clear instruction of the best time to take the pain relief[8].
- In instances where a woman does not take the recommended pain relief medications, the recommended analgesia should be offered to her in the AG service and prior to any internal procedures.
- Everyone's experience of pain is different and factors such as parity for example can affect this. A local anaesthetic can be administered if required.
- A procedure should be stopped at a woman's request and women should be reassured and reminded of this at several points during their visit.
- The consistent use of pain assessment tools and/or patient satisfaction surveys can be useful in managing individual episodes of care[3,10]. Monitoring pain scores over time can also help services identify any emerging trends in reported scores.
- Where it is indicated that outpatient hysteroscopy will not be tolerated or is not desired, a theatre day case hysteroscopy should be arranged.
- Currently, there is little evidence to support the use of Nitrous Oxide (Entonox®) or Methoxyflurane (Penthrox®)[8]. We await results of further studies.
- **The routine use of misoprostol is not recommended as per the Royal College of Obstetricians and Gynaecologists Guideline for Best Practice in Outpatient Hysterosopy[10].**

DOCUMENTATION

Services use a range of electronic systems and devices to support thorough and consistent documentation of each woman's episode of care within AG.

MN-CNS is used in sites where this electronic healthcare record has been implemented (N=4).

Viewpoint™ has been integrated for documentation purposes in some sites (N=4), while Mediscan has been adapted in one service (N=1).

Almost a third of services are using a paper-based system and associated paper proformas (N=5), with two services using T-Pro, dictation and transcription software, to support letter documentation processes.

It is noted that for sites working with paper healthcare records, there are additional administrative requirements and logistical factors to be considered in the context of compiling all relevant documentation to enable a seamless flow from entry to exit for the patient.

RECOMMENDATION 17:

- An electronic/digitalised record is the preferred method for documenting a patient's healthcare record.
- Viewpoint™ or Mediscan™ or alternatives (e.g. Compuscope™) should be adopted where available and in the absence of an electronic healthcare record. Where possible, integration with IPMS and Healthlink is the preferred solution.

OUTCOME & DISCHARGE

PATIENT FEEDBACK

Most services have mechanisms in place via which to gather patient feedback. For example, patient experience questionnaires or suggestion/comment boxes in situ in waiting rooms. Gathering, actively reviewing and monitoring patient feedback is central to a continuously improving health service.

RECOMMENDATION 18:

- Effective processes should be in place that actively seek to engage with patients regarding their experience within the AG service and also requests suggestions from those accessing the service on ways to improve. Feedback should be reviewed by the AG team on a regular basis, with service improvement plans implemented if required.

COMMUNICATION OF RESULTS

Mostly, all services communicate normal histology results to patients via letter (N=12). A letter is also sent to the patient's referring GP. All services see patients in person to communicate abnormal results. Some services offer a virtual review, whereby the patient is contacted by phone with her normal results.

A minority of services report seeing patients in person in general gynaecology outpatients to communicate both normal and abnormal results (N=4).

RECOMMENDATION 19:

- The referring GP must be informed of patient result one available.
- All patients with normal results and not requiring any additional investigations, treatment or management should receive their results by letter. Results may also be communicated over the phone. GPs also need to be informed of results.
    - An in-person review is not considered necessary for this cohort of AG patients, although clinical discretion should supersede this recommendation on a patient-by-patient basis e.g. literacy challenges etc.

CLINICAL GOVERNANCE

CENTRALISED REFERRALS

A key initiative been driven by the HSE in recent years is the movement towards centralisation of referrals. The HSE's CEO is mandating centralisation in all hospitals and for all specialties as detailed in the Waiting List Action Plan (WLAP) 2024[11]. Centralised Referrals was implemented as part of a full end-to-end model in gynaecology in ULHG in November 2022.

Centralisation of referrals is achieved via the implementation of a Central Referral Office (CRO), underpinned by a system that improves outpatient referral management across four main areas: **Referral Receipt, Appointment booking and Scheduling, Patient Communication and Patient Outcome[12]**. There are numerous benefits achieved by implementing CROs for both the hospitals and the patients involved, with this approach most likely to benefit those who are long waiters, urgent patients (requiring an appointment within 28 days) and patients that require flexibility for appointments with the introduction of partial booking[12].

Based on NWIHP's observations during the course of site visits, a key enabler to providing efficiencies within AG care pathways and ensuring quality, timely care is adopting a centralised referral management system and a pooled waiting list approach.

POOLING OF WAITING LIST

Pooled approach to outpatient waiting list

In 2011, the Health Information and Quality Authority (HIQA) recommended that all referrals are made to a speciality or service as opposed to individual named clinicians[13]. In this way, all speciality referrals can be pooled for triage purposes. The specialist gynaecology e-referral implemented in 2023 supports a pooled process whereby the referral is directed via Healthlink to a service as opposed to an individual clinician, although the referrer can indicate *preferred* consultant but it is not a mandated field.

Generic referrals are considered good practice and promote equity of access, as waiting times for each clinical category will depend on next availability rather than specific consultant availability. To enable a pooled approach, it is essential from a clinical governance perspective that every patient on an outpatient waiting list is assigned to a specific consultant from the point of referral received. The named consultant must assume responsibility for the patient until the patient is triaged and allocated an appointment in clinic under a designated consultant. At this point, the designated consultant assumes responsibility. This approach has been taken in UMHL and has been a critical success factor in operating a pooled waiting list supported by a centralised management system. NWIHP are now aware that the National Maternity Hospital have also adopted a centralised gynaecology referral management system in recent times, further emphasising the achievability of this process change, irrespective of status (HSE, voluntary) or the size of the regional population. Figure 4 outlines the high-level steps required to a centralised system with a pooled waiting list.

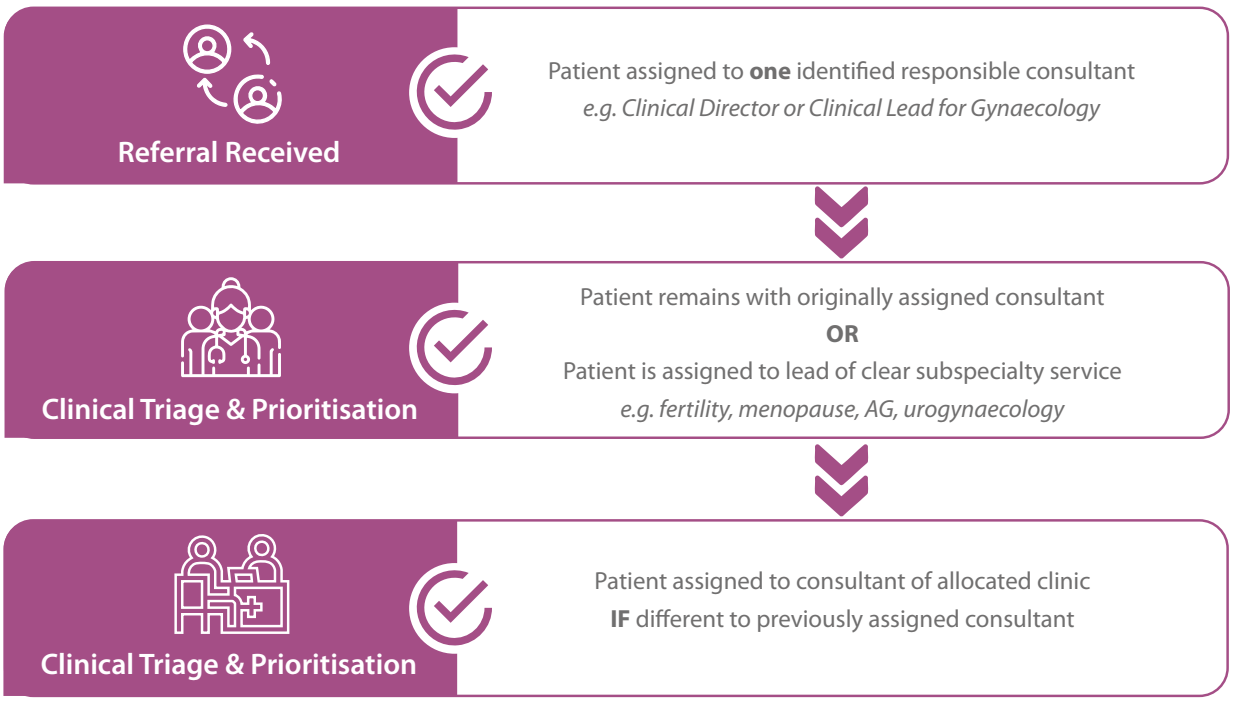


Figure 4. *Overview of Centralisation of Referrals*

RECOMMENDATION 20:

- Systems and processes should be put in place to implement a centralised approach to referral management.
- It is recommended that a pooled approach be taken to triaging AG appropriate referrals such that referrals received are placed on a centralised waiting list for all participating AG consultants. Patients should be booked to the next available appointment slot with reference to their clinical prioritisation.
- Once a referral is accepted, the referral must be placed under a named clinician (e.g. Clinical Director for the speciality or the Clinical Lead for the Speciality).
- Once an appointment has been allocated, the referral should be transferred to the relevant AG consultant.
- The patient should be allocated to the appropriate clinician from the pooled waiting lists on the basis of clinical suitability, sub-speciality or expediency, always keeping in mind the best interests of the patient[12].

Pooled approach to theatre

2023 data demonstrates that the range of patients attending AG services that are subsequently referred onwards for a day-case theatre hysteroscopy under general anaesthetic is approximately 6-22% across services. While this is a relatively small proportion of all attendances, it is important that structured pathways be in place to allow the transfer of patients in a reasonable timeframe and with respect to the indicated timeframe for the patients presenting symptom/condition.

There are varying levels of theatre access reported for AG consultants across the 16 AG services.

In the majority of services, all AG consultants have theatre access and a weekly list (full day or half day). Theatre access is reported as challenging and difficult for a quarter of services (N=4).

The process by which a woman who is unable to tolerate an outpatient hysteroscopy moves to a theatre list again differs. In some services, the patient is scheduled to the next theatre slot on the lists of the patient's named AG consultant. Alternatively, some services facilitate a woman who was unable to proceed with an outpatient hysteroscopy be placed on any AG consultant's theatre list for hysteroscopy, ensuring the best opportunity for timely management. This pooled approach to theatre list management provides the most efficiencies for both the service-user and the AG service itself. This is of particular relevance in the appropriate management of PMB cases requiring access to theatre within 10 days of their outpatient hysteroscopy appointment[1].

RECOMMENDATION 21:

- It is considered optimal to schedule a woman who requires a theatre slot to the next available theatre slot based on the recommended timeframes for appropriate and safe management[1]. That is, a pooled approach to theatre lists and capacity should be adopted amongst gynaecologists with the requisite skillset.

CONCLUSION

This report provides an overview of NWIHP's findings and observations drawn from a series of site visits that included invaluable discourse with executive management teams and importantly, the healthcare professionals at the fore of providing AG services to women nationwide.

Based on the findings and with reference to the evidence-base, NWIHP have surmised 21 key recommendations that reflect best practice in the delivery of AG services in the Irish context. Services are encouraged to review and reflect on these recommendations, and where indicated, implement process and/or system changes to align with these areas of best practice.

While optimisation of resources is an essential component to an efficient health service, it is imperative that a patient-centred approach is at the core of all healthcare activity. This includes open communication, fostering collaborative decision-making, enabling ongoing training of staff, and encouraging and enabling patient feedback to refine care delivery.

There are key recommendations in this report regarding informed consent that highlight the collective responsibility to ensure that patients are fully aware of any procedure that may be indicated during an AG appointment and what pain management options are available should they be required. This communication is a fundamental building block to successful patient and healthcare professional partnerships.

Finally, NWIHP would again like to acknowledge the ongoing work of the AG teams who over the last number of years have readily adopted and implemented a new approach to delivering gynaecological care. This model has demonstrated the ability to reduce significantly the number of patient visits required to complete a high-quality episode of care safely, while improving patient access to services.

REFERENCES

1. **Duffy A, Ní Bhuinneain M, Burke N, Murphy C. National Clinical Practice Guideline: Assessment and Management of Postmenopausal Bleeding. National Women and Infants Health Programme and The Institute of Obstetricians and Gynaecologists. December 2022.**
   Available at: https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/assessment-and-management-of-postmenopausal-bleeding.pdf

2. **Outpatient (OP) Waiting List Management Protocol. HSE. 2022.**
   Available at: https://www.hse.ie/eng/services/list/3/acutehospitals/patientcare/protocol-for-the-management-of-outpatient-services-and-guidance-documents/national-outpatient-waiting-list-management-protocol-2022.pdf

3. **Pain Relief and Informed Decision Making for Outpatient Hysteroscopy, Good Practice paper No. 16. Royal College of Obstetricians and Gynaecologists. February 2023.**
   Available at: https://www.rcog.org.uk/media/ymvha2n3/gpp16-final-publication-proof.pdf

4. **National Consent Policy, HSE. 2022.**
   Available at: https://assets.hse.ie/media/documents/ncr/20240524_HSE_Consent_Policy_2022_v1.2.pdf

5. **DNA National Guidance Document. HSE. July 2024.**
   Available at: https://www.hse.ie/eng/about/who/acute-hospitals-division/dna-national-guidance-document.pdf

6. **The Better Letter Initiative: An Evaluation of the Impact of Redesigned Appointment SMS Reminders on Outpatients DNAs. Research Services & Policy Unit, Department of Health April 2024.**
   Available at: https://www.gov.ie/pdf/?file=https://assets.gov.ie/290252/9080732f-796c-4726-8d13-1d7e225f04ae.pdf#page=null

7. **E.R.C.M. Huisman, E. Morales, J. van Hoof, H.S.M. Kort, Healing environment: A review of the impact of physical environmental factors on users, Building and Environment, Volume 58, 2012, Pages 70-80, ISSN 0360-1323.**
   Available at: https://doi.org/10.1016/j.buildenv.2012.06.016.

8. **De Silva PM, Smith PP, Cooper NAM, Clark TJ. Outpatient Hysteroscopy. BJOG. 2024; 00: 1–25.**
   Available at: https://doi.org/10.1111/1471-0528.17907

9. **Smith PP, Kolhe S, O'Connor S, Clark TJ. Vaginoscopy against standard treatment: a randomised controlled trial. BJOG 2019;126:891–9**

10. **Mahmud A, Smith P, Clark TJ. Benchmarking services in outpatient hysteroscopy (OPH): A quality improvement project. Eur J Obstet Gynecol Reprod Biol. 2021 Apr;259:211-221.**
    Available at: doi: 10.1016/j.ejogrb.2021.01.028. Epub 2021 Jan 26. PMID: 33573857.

11. **2024 Waiting List Action Plan. The Department Of Health.**
    Available at: www.gov.ie/2024WaitingListActionPlan

12. **Central Referral Office. National Guidance Document. Scheduled Care Reform Initiatives. Version: 2.0 April 2024.**
    Available at: https://www.hse.ie/eng/about/who/acute-hospitals-division/cro-national-guidance-document.pdf#page=64&zoom=100,92,97

13. **The Management of Outpatient Services. Version 2.1. February 2014. Office of the National Lead, Outpatient Services Performance Improvement Programme.**
    Available at: https://www.hse.ie/eng/services/list/3/acutehospitals/patientcare/protocol-for-the-management-of-outpatient-services-and-guidance-documents/out-patients-protocol.pdf

APPENDICES

APPENDIX A – OVERVIEW OF ROLL OUT OF THE AMBULATORY GYNAECOLOGY MODEL OF CARE

	Site	Level	Year Funded	Current Status
1	Galway	Level 1	Funded 2020	Deployed
2	Cork	Level 1	Funded 2020	Deployed
3	Rotunda	Level 1	Funded 2020	Deployed
4	Kerry	Level 2	Funded 2021	Community build in progress. Level of service being provided within current infrastructure
5	Waterford	Level 2	Funded 2021	Deployed
6	Nenagh Hospital (under the auspices of UMHL)	Level 1	Funded 2021 (in conjunction with Women's Taskforce)	Deployed
7	Tallaght	Level 1	Funded 2021 (in conjunction with Women's Taskforce)	Community based location in process of being secured. Level of service being provided within current infrastructure
8	OLOL	Level 2	Funded 2021	Deployed
9	Wexford	Level 2	Funded 2021	Deployed
10	Coombe	Level 1	Funded 2021	Deployed
11	NMH	Level 2	Funded 2021	Deployed
12	Letterkenny	Level 2	Funded 2021	Deployed
13	Portlaoise	Level 2	Partial funding 2021 Remaining funding 2022	Deployed
14	Sligo	Level 2	Funded 2021	Deployed
15	Mayo	Level 2	Funded 2021	Deployed
16	Kilkenny	Level 2	Funded 2022	Deployed
17	Mullingar	Level 2	Funded 2022	Deployed
18	Portiuncula	Level 2	Funded 2022	Anticipated service will deploy during Q4 2024
19	Cavan	Level 2	Funded 2022	Deployed
20	STGH	Level 2	Clinical Specialist Physiotherapist funded 2022	Possibility of community-based location for service being reviewed due to significant on-site infrastructural challenges.

Table 1. *Current status of Ambulatory Gynaecology Services*

APPENDIX B – CLINICAL PRIORITISATION CATEGORY DEFINITIONS & TIME-FRAMES

Outpatient Referral Clinical Prioritisation Category Definitions & Clinically Recommended Time-Frames (CRTs)			
Clinical Prioritisation Category	**Clinical characterisation/ outcomes of conditions within category**	**Clinically Recommended Time-Frame (CRT) to consultation to minimise risk and/or achieve best clinical outcomes**	**Notes/ discussion points**
Urgent	• Risk of permanent damage to organ system if treatment is delayed beyond CRT • Major functional impairment • Suspected malignant neoplastic disease • Rapidly progressing dysfunction (over a period of days or weeks) in established conditions	≤ 28 days	NCCP/Individual specialties and/or subspecialties may set urgent CRT at less than 28 days (e.g., as per breast disease)
Semi-urgent	• Risk of damage to organ system if treatment is delayed beyond CRT • Moderate functional impairment or progressive loss of function over a period of months or years • Benign neoplastic disease • Significant restriction of economic activity[1]	≤ 13 weeks	Individual specialities and/ or subspecialties and/or conditions may set semi-urgent CRT at less than 13 weeks for internal clinical management
Non-urgent	• Minimal risk of damage to organ system if treatment is delayed beyond 13 weeks • Moderate functional impairment • Significant restriction of societal activity[2] • Management issues in established conditions • Reassessment of stable/ chronic conditions that meet the criteria for review	≤ 13 weeks	
Excluded	• Conditions that have no impact on physical well-being, e.g., work assessments, cosmetic surgery • Sub-acute or minor conditions/complaints that will be safely diagnosed and/ or managed in primary care.		Specialties can decide on specific conditions/ complaints, based on literature and/or international best practice, taking account of Irish health system's structure.

Note 1: CRTs will be updated annually to reflect yearly Sláintecare target achievement
Note 2: Scheduled Care Pathways will set out nationally agreed same day, 'excluded' and high risk of malignancy conditions
Note 3: Clinical Prioritisation definitions and CRT's are relevant to the acute hospital sector only rather than community

[1] Significant restriction resulting in inability to work/support self and/or dependants
[2] Resulting in a deterioration of the person's overall well-being and/or mental health

Figure 1. *Outpatient Referral Clinical Prioritisation Category Definitions and Timeframes*

APPENDIX C – CIRCULAR REGARDING ULTRASOUND ACCESS

Clár Sláinte Náisiúnta do Mhná & do Naíonáin
Feidhmeannacht na Seirbhíse Sláinte, Aonad 7A, Áras Dargan,An Ceantar Theas, Baile Átha Cliath 8
T: 076 695 9991

National Women and Infants Health Programme
Health Service Executive, Unit 7A, The Dargan Building, Heuston South Quarter, Dublin 8
T: 076 695 9991

25th October 2024

RE: The provision of gynaecological ultrasound scanning

Introduction

The availability and timeliness of ultrasound scanning is central to the provision of a safe and quality gynaecology service. The National Women and Infants Health Programme (NWIHP) is aware that for many services, accessibility to ultrasound has become increasingly challenging and for some sites, is hindering services in completing a gynaecological episode of care in a desirable timeframe. NWIHP have engaged with sites individually as well as with colleagues in primary care in order to explore feasible solutions to accessing gynaecological ultrasound scanning in a timelier manner.

Ultimately, the long-term sustainable solution is that all relevant staff working within gynaecology services, in particular ambulatory gynaecology services, attain the necessary skills in order to perform ultrasound as clinically indicated at the point of care.

However, in the short term to alleviate the current build up in demand, NWIHP working with HSE Enhanced Community Care Programme & Primary Care Contracts recommend that gynaecology services consider the following two options to address demand in this area.

Option 1 - GP Access to Community Diagnostics

GP access to Community Diagnostics, inclusive of ultrasound, commenced in 2018 and is available to the following cohort of patients 16 years of age and over –

- Holders of a medical card,
- Holders of a GP visit card, and
- Holders of a Health Amendment Act (HAA) card.

These community-based diagnostics are provided by HSE approved private providers, with all ultrasound scans being undertaken by a CORU registered Radiographers and read by Radiologists.

There are several private providers approved by the HSE for this outsourced service and providers will vary depending on the regional health area. NWIHP now recommend that executive and clinical

management engage with your network of GPs with a view to requesting and encouraging GPs to avail of this scheme for the relevant patient cohort (Medical/GP/HAA card holders), with a referral for a community-based ultrasound being undertaken by the GP **prior** to submitting a gynaecology referral to your hospital-based gynaecology services.

Patients referred for ultrasounds by their GPs will be able to access diagnostics within the community thereby alleviating pressure on acute radiology services. Patients should receive their scan within one month for urgent or three months for routine referrals.

It would be advised by NWIHP, that gynaecology services would request / encourage their referring network of GPs to seek a community-based ultrasound for the following clinical symptoms / presentations in the first instance:

Presenting Symptoms	**Ultrasound Recommended**
Postmenopausal Bleeding (PMB)	TVUS
Abnormal Uterine Bleeding (AUB) + Hormone Replacement Therapy	TVUS
Abnormal Uterine Bleeding (AUB) in pre-menopausal women	TVUS
Suspected or palpable Enlarged Uterus / Pelvic Mass	US Abdomen Pelvis + TVUS
Suspected benign cause (including endometriosis and PID)	TVUS

Table 2. *Recommended Ultrasound Diagnostics*

The preferred timing of the GP referral to your acute service will vary. Some services may be happy for a GP referral to precede the report of the ultrasound (i.e. ultrasound report does not accompany the referral but is forwarded by the GP when received). Other services may prefer that a referral is only sent once the GP is in receipt of the ultrasound report (i.e. the ultrasound report accompanies the hospital referral). The desired sequence should be determined by each individual service. Healthlink enables a GP to attach a report to the referral, however this functionality must be 'turned on'. It is advisable to ensure that this is the case in your hospital to enable GPs to easily share US reports.

However, where access times to community based ultrasounds services are short in your region / area, it may be preferable to adopt the second option.

Further information on GP access to Community Diagnostics and FAQs can be found at the following links:

- https://www.hse.ie/eng/services/list/2/primarycare/community-healthcare-networks/gp-diagnostics/
- https://www.hse.ie/eng/services/list/2/primarycare/community-healthcare-networks/gp-diagnostics/gp-access-to-diagnostics-faqs11.pdf

Option 2 - Acute Services Access to Community Diagnostics

In addition to the above pathway that allows GPs to refer patients directly for diagnostics within

the community and in anticipation of completing a gynaecology referral, there is some additional capacity available via awaiting list/ back log scheme that acute services can avail of.

This scheme is open to any GP referred patient awaiting ultrasound in your service and allows acute services to request the required scan be completed with one of the HSE approved private ultrasound providers in the community at no cost to your hospital or the service user. Unlike the GP diagnostic referral scheme, there is no additional criteria associated with this pathway other than the referred patient must be 16+ years old. Of note, there is no time-waiting related criteria to access this scheme i.e. there is no minimum time a patient must be waiting for diagnostics. This scheme is overseen, managed and paid for by GP Access to Community Diagnostics Programme.

NWIHP recommends that services explore the feasibility of establishing the necessary processes to enable usage of this outsourcing scheme. As indicated, utilising this scheme would again help to address demand in this area.

A brief summary of the process is detailed below:

- Services not already participating in this option, must contact community diagnostics (community.diagnostics@hse.ie) to confirm that your hospital / service is an approved user of this outsourcing option and what capacity is available. Details will be provided to your hospital as to available HSE approved providers in your locality. Your hospital will need to contact the relevant approved provider(s) directly in your jurisdiction.
- Each provider will advise if they have the capacity to accept referrals from your service and provide an indication of volume of workload they can receive.
- If capacity is available, the hospital will need to validate its ultrasound waiting list by contacting each patient.
- The validation will involve the following steps:
    - Ask the patient if they still require an ultrasound scan; if they do not require an ultrasound scan, the patient will be removed from the waiting list.
    - If the patient still requires an ultrasound scan, the hospital will go through a list of appointed service providers with the patient and will ask the patient to select their preferred service provider (this is an authorisation scheme).
    - Ask the patient to consent to share their information with their preferred service provider.
- The hospital will then provide a list to the service provider of patients who have consented for them to provide their scans. The processes implemented will comply with GDPR and data protection guidelines.
- The service provider will use this list to contact the patients to book them for scans.
- This list will be shared regularly as new patients are validated and as a means for the hospital to monitor the service provider's progress.
- The provider scans patients.
- Images and reports are sent back to the site (BEAM®).
- Provider will invoice GP Access to Community Diagnostics directly.

Staff training and education

NWIHP have this year engaged in a series of site visits to ambulatory gynaecology services across the country. While access to timely ultrasound is relevant to many services, it is NWIHP's experience that this issue of scanning capacity is not experienced uniformly across sites.

While demand as expected influences this, sites in which more staff have obtained the necessary skills and competence to complete gynaecological ultrasound scanning in the ambulatory clinics, report fewer issues in terms of obtaining ultrasounds. This includes members of the nursing team who have completed specific ambulatory gynaecology scanning education.

UCD have developed a Professional Certificate in Ambulatory Gynaecology Ultrasound Scanning that is six-months in duration and covers clinical skills in the performance of gynaecological ultrasound including, but not limited to, the assessment of the endometrium in postmenopausal women and the assessment of intrauterine contraceptive devices.

NWIHP would advocate that sites should support their relevant staff to undertake the necessary training to enable services to expand the number of healthcare professionals available to undertake these scans and to enhance their current level of ultrasound provision.

ENDS

Murphy Print & Design 064 6634650