Women's Health Paper
For
HSE Board
By
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Introduction

The National Women and Infants Health Programme (NWIHP) was established in January 2017, at the request of the Minister, to "lead the management, organisation and delivery of maternity, gynaecological and neonatal services within the HSE."

The establishment of NWIHP was in direct response to a range of significant adverse clinical events that had arisen in previous years including; HIQA review into Midlands Regional Hospital Portlaoise relating to obstetric and neonatal care; the tragic death of Savita Halappanavar; and the Flory review into obstetric care in Clonmel and Cavan. These and other related events severely dented public and political confidence in our maternity services.

NWIHP was established using the template for the National Cancer Control Programme, which was set up a decade earlier, in response to challenges in poor cancer outcomes. The purpose was to adopt a programmatic approach to ensuring consistent, high quality care, across the 19 maternity hospitals/units.

The NWIHP team started small, but now has a team of over 30 people (20 whole-time equivalents) comprised of a number of clinical leads working with the clinical director; a team of midwives and nurses working with the lead midwife; and management and administrative support.

NWIHP has a broad remit covering the following main areas:

- Maternity services*
- Gynaecology services*
- Neonatal services
- Fertility*
- Abortion Care*
- Sexual Assault Treatment Units (SATU)
- Women's Health Taskforce
- Perinatal Pathology
- Perinatal Genetics

*For this paper we will only cover the four * areas.

There are a number of legislative, strategic or policy documents that underpin these services. In maternity care it is the 2016 National Maternity Strategy (NMS) "Creating a Better Future Together". In fertility it is the Ministerial announcement in Budget 2023 for the introduction of publicly funded, privately provided Assisted Human Reproduction services, for example IVF. In abortion care it is the 2018 Health (Regulation of the Termination of Pregnancy) Act. For SATU it is a policy review

conducted by the Department of Health and for Women Health it is the Women Health Action Plan 2022-2023.

Women's health is obviously much broader than NWIHP's remit, and women specific programmes such as cervical and breast screening; and women cancer care are not covered in this paper.

Maternity Care

The implementation of the National Maternity Strategy (NMS) remains the primary focus for NWIHP in relation to maternity care. NWIHP developed a detailed implementation plan in 2017, addressing the 77 recommendations in the NMS. This implementation plan was updated in 2021, following a recommendation from HIQA that the HSE produce a revised "time-bound and fully costed" implementation plan. The revised implementation plan is on the HSE website (https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/national-maternity-strategy-revised-implentation-plan.pdf), and 94% of the recommendations are now either completed on ongoing.

The NMS has four pillars:

- Health and well-being of mother and baby
- Choice
- Safety and quality; and
- Leadership and governance

Our maternity services are provided through 19 hospitals. Four of these hospitals are standalone – Rotunda, National Maternity Hospital, Coombe Women and Infants University Hospital and University Maternity Hospital Limerick. One hospital is collocated with an adult teaching hospital Cork University Maternity Hospital. The remaining 14 are maternity units within regional hospitals:

1. Cavan General Hospital
2. Our Lady of Lourdes Hospital
3. Wexford General Hospital
4. St Luke's General Hospital, Kilkenny
5. Midlands Regional Hospital Mullingar
6. Midlands Regional Hospital Portlaoise
7. University Hospital Waterford
8. University Hospital Kerry
9. South Tipperary University Hospital
10. Portiuncula University Hospital
11. University Hospital Galway
12. Sligo University Hospital
13. Mayo University Hospital
14. Letterkenny University Hospital

The maternity services differ greatly in size and complexity. The hospital with the highest number of births is the Rotunda, with over 8,000 births per annum. South Tipperary University Hospital has less than 800 births per annum.

The NMS recommended the establishment of maternity networks, where the larger tertiary maternity units would work collaboratively with the smaller units. This model is now well established, and there are clinical leads in place in each network, who take responsibility for maternity services within that network. The models are not entirely consistent, as the three largest

hospitals are in Dublin and are all voluntary hospitals. The governance models vary between the statutory and voluntary sector, but the network is working well and ensuring smaller units are not operating in isolation.

The NMS recommends that every woman should be able to expect the same quality and safety of service, regardless of location. NWIHP has a safety and quality framework that is rolled out across the maternity networks. Every maternity network holds a monthly maternity specific incident management forum (SIMF), where all adverse maternity events are discussed. This facilitates network level learning, and that the smaller units are supported by the larger ones. Every maternity network has been funded for a safety and quality manager, who supports the SIMF and learning throughout the network. NWIHP host an annual safety and quality conference, to facilitate national level learning, and we also funded each maternity network to host their own annual learning event, thereby creating a learning community.

NWIHP also prioritised the recruitment of additional obstetricians in the regional hospitals with maternity units. Each hospital needs to have a minimum of six consultants so an appropriate roster can be developed, and reduce dependency on locum support. That process is almost complete, with only three hospitals not funded for six consultant posts.

While we know Irish maternity outcome data is very good by international comparison, adverse maternity events account for almost 70% of the State Claims Agency accrued liability. This is mainly due to babies who are deprived of oxygen during labour, a condition known as hypoxic ischemic encephalopathy (HIE). Many babies who get HIE will go on to develop cerebral palsy, requiring lifelong care. The financial cost is a proxy for the human suffering for those families.

NWIHP established the National Neonatal Encephalopathy Action Group (NNEAG) in 2019. NNEAG is a tripartite approach of the Department of Health, State Claims Agency and HSE, working together to try and reduce the incidence of HIE. NNEAG has engaged with colleagues in the UK, to examine their approach to address this issue. NWIHP developed the Obstetric Event Support Team (OEST) as an initiative to try and reduce the incidence of HIE. The OEST involves a team of three people – senior obstetrician, midwife and safety and quality manager – visiting a hospital after a serious adverse event has occurred. The OEST review the circumstances of the event with the local team, and bring "fresh eyes" to the discussion, allowing for additional perspectives to be considered. The OEST then harvest any learning from these events and share them with the other hospitals. The process commenced on a phased basis in August 2021, and the early indications are that there has been a reduction in the number of HIE events in that period.

Gynaecology Services

Gynaecology has been something of a "Cinderella service" within the HSE. It wasn't prioritised, and because the women were not suspected of having cancer, outpatient clinics and theatre lists were regularly cancelled. The situation was exacerbated in 2018 following the cervical check audit, as concerned women starting being referred to colposcopy clinics, because there was very poor access to general gynaecology clinics, and waiting lists of over two years.

When NWIHP examined the issue, we decide to stratify gynaecology into different conditions, and develop models of care for each condition. The first four conditions were:

- Ambulatory gynaecology
- Fertility
- Endometriosis

- Menopause

Prior to the development of these models of care, women were referred into generalist clinics, and as well as long wait times, may not have been seen by the right subspecialised gynaecologist on their first visit, resulting in a further appointment. In addition significant inpatient bed days were lost with patients admitted for hysteroscopy, a condition that is usually well tolerated in an outpatient setting. NWIHP worked with colleagues in the Department of Health and specifically the women's health taskforce, and secured funding for each of these pathways.

As of October 2023, there are now 14 ambulatory gynaecology clinics operational, with two more clinics scheduled to start before year end. There are six regional fertility hubs operational; six regional complex menopause clinics; five regional endometriosis clinics and two supra-regional centres for complex endometriosis surgery. This approach of stratifying gynaecology conditions, and creating separate pathways has yielded significant benefits for patients. These include:

- Outpatient waiting lists have reduced 9% between 2021 and 2023, while referral rates increased by 30% in the same period.
- In 2021, 55% of women were waiting between 0 – 6 months, with **14%** of women waiting greater than 18 months, as of September 2023, this has changed to **76%** of women waiting between 0 – 6 months, with **3%** waiting greater than 18 months.
- Examples – Cork 95% waiting < 6 months, Rotunda 93% waiting < 6 months, Letterkenny 99% waiting < 6 months, Galway 80% < 6 months, Kerry 77% <6 months, Limerick 97% < 6 months

In 2023 we estimate that an **additional 15,000** women will be seen through the ambulatory gynaecology clinics. When all the models of care are fully implemented outpatient gynaecology capacity will exceed the current level of demand.

The fifth stream of gynaecology is general gynaecology, conditions often requiring surgery and inpatient admission. To address this concern requires a detailed analysis of current protected bed base and theatre access; an analysis of current referral rates, and an analysis of the demographic factors that are going to grow demand over the next five years. Once the analysis is complete, we will know what it will take to meet current and future general gynaecology in terms of theatre access and inpatient beds.

Fertility

In 2019 the Department of Health discussed with NWIHP the introduction of Assisted Human Reproduction services, with a budget of €1m. NWIHP developed a model of care for fertility, and as with all models it starts with the lowest level of clinical intervention – General Practice. If, following a consultation(s) with a GP and appropriate tests, the fertility issues have not been addressed, the patient/couple can be referred to one of six regional fertility hubs. The hubs are staffed by clinicians with subspecialised training in reproductive medicine. At the clinics patients will have a series of tests relating to their fertility, including ovarian reserves and semen analysis. The patient may require medical or surgical invention, and in approximately 50% of cases, the regional fertility hub can resolve the fertility issue.

In Budget 2023 the Minister announced that publicly funded Assisted Human Reproduction (AHR) services would be available in the private sector from September 2023. NWIHP worked with colleagues in the Department of Health to work out the details of the service, and the Minister announced the access criteria for the service in July 2023. HSE Procurement ran a tender process for

NWIHP, and there is a now a list of eight authorised private providers of AHR services. The AHR services that are available are intrauterine insemination (IUI), in-vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI).

With effect from the 25th of September 2023, all patients seen by a regional fertility hub, who are deemed to require AHR services, can now pick a provider of their choice from the list of authorised providers, and a referral will be made by the hub to that private provider. The HSE will pay the invoices associated with that treatment, in line with the provisions of the contract for service.

The service commenced successfully on the 25th of September, and the hubs are seeing a good level of referrals from general practice. To date over 30 patients have been referred to the private providers for AHR services.

Abortion Care

Abortion care was legalised in Ireland in 1 January 2019. The model of care developed by the HSE and the Department of Health, sees the vast majority of the patients requiring an abortion under Section 12 of the Act (abortion less than 12 weeks gestation) being made in primary care, either general practice or family planning clinics. Abortions between 10 and 12 weeks gestation need to be managed in the hospital setting.

The Department of Health mandated that all 19 maternity hospitals/units would provide the service. This has proved challenging as the legislation provides for clinicians not to provide the service, if they have a conscientious objection. The rollout of the service in the hospital sector started slowly, with only eight of the 19 hospitals providing the service on the 1st of January 2019. This increased to ten at the start of February 2019. In April 2022 Sligo University commenced service provision, and in June 2023 University Hospital Kerry started the service.

NWIHP is working with Acute Operations and hospital groups to get a further five hospitals to commence the service in December 2023, and with last two hospitals commencing in Q2 2024. GP coverage is also less comprehensive that originally expected, with some 400 out of over 3,000 GPs providing the service. The increase in hospital provision will provide confidence to general practice, and is expected to have a positive impact on GP service provision.

In addition to access to the service, there is a very considerable body of work ongoing regarding abortion services. In April 2023 a review of the implementation of the abortion legislation was published by the Minister. A review into the operation of Section 11 (termination for fatal fetal anomaly) which was commissioned by the Chief Clinical Officer was also published. NWIHP is now progressing an implementation plan with ten separate work streams for these two reviews.

Opportunities

Under the current Minister, women's health has been prioritised for the first time. This has provided recurring funding in both 2021 and 2022 to advance issues like menopause and endometriosis that have a significant impact on women's lives. It has also had the effect of making women's health a mainstream agenda item, and an area for both research and investment.

Pregnancy can often provide an insight into areas of future morbidity for women. For example, women who develop gestational diabetes have a 50 to 60% chance of developing type 2 diabetes in later life. The same is true for conditions such as high blood pressure, and cardiovascular disease. These predictors in pregnancy provide an opportunity for targeted interventions that could have a significant positive impact on women's morbidity in later life. In 2024, NWIHP intends to collaborate

with colleagues in academia to develop an evidence base, and model of care for what is often described as the “life-course”.

Challenges

As with many areas of the health system, funding for women’s health is an ongoing challenge. When the maternity strategy was launched, NWIHP was advised that ring-fenced funding of €9m per annum would be provided for the first three years, and then taper off to a lower level of annual investment. The NWIHP implementation plan (2017) costed the strategy at approximately €86m, up until 2027. However, to date investment in maternity care is a total of €29.5m. There has been other investment such as €12m for abortion services; €10m for gynaecology services; and €18m for fertility. In total approximately **€69.5m** have been invested with NWIHP since 2018. All this funding has gone into the 19 maternity hospitals/units, with the exception of investment in Tallaght for endometriosis.

NWIHP still have an overhang of unfilled posts, so recognise that continued investment has to be seen in that context. The real challenge is the lack of reliable funding, and unavailability of a fund to address issues relating to safety as they emerge. For example, a review of an adverse event might highlight that there is no supernumerary Clinical Midwife Manager on the labour ward. NWIHP cannot fund that post (circa €60k) and will need to submit that application as part of the next estimate cycle. This effects our ability to respond in real time to the challenges maternity services face.

The other challenge facing women’s health is its position in the new health structure. Maternity is about 4% of the acute hospital budget, and we have to work hard to have our voice heard. In the context of the new health regions maternity will be less than 2% of a regional budget, and our ability to influence direction and investment may be negatively impacted.

Summary

Women’s health has moved centre stage over the past three years, and there has been considerable investment and prioritisation within both the Department of Health and HSE.

In maternity care we have seen significant changes with the implementation of the National Maternity Strategy. Maternity networks have improved governance arrangements and enhanced the quality and consistency of care provided to women and their babies. While there will always be tragic adverse events in maternity services, the developments have helped to stabilise the service, and commenced the process of rebuilding public confidence.

The investment in gynaecology services has resulted in improved wait times for outpatient appointments, and there is a real opportunity to continue that investment to move gynaecology service provision up to the level it needs to be at.

The commencement of public AHR services is a welcomed development, and provision in the private sector is the first step to public provision in future years.

A high quality, safe abortion service is operational in Ireland, and the work programme that is now underway will further enhance the service in years to come.

Women’s health faces both opportunities and challenges in the years ahead, but with the support of the HSE EMT and Board, there is every reason to believe that the positive progress can be built upon.