Comhairle na nOspidéal

Oral & Maxillofacial Surgery Services

June 2005

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FOREWORD

Arising from the Government's Health Service Reform Programme, the Health Service Executive (HSE) was established on 1st January 2005 pursuant to the Health Act 2004. The Act provided for the dissolution of the ERHA and its three area health boards, the health boards established under the Health Act 1970 and certain other bodies, one of which was Comhairle na nOspidéal. Under the terms of the Act the HSE is charged with managing, delivering or arranging the delivery of health and personal social services in Ireland in the context of policy developed by the Government and the Minister for Health & Children.

In line with section 57(2) of the Health Act 2004, the functions of Comhairle na nOspidéal, as specified in section 41(1)(b)(i) and (ii) of the Health Act 1970, were transferred to the HSE on its establishment date of 1st January 2005. Prior to the establishment date, the members of Comhairle were requested by the then Minister M. Martin, T.D. and Mr. K. Kelly, the then Chairman, HSE, to remain until the scheduled end of their term of office in December 2005 to complete ongoing specialty reviews and to provide advice to the HSE on the regulation of consultant and specialist / senior registrar appointments.

This report has been prepared by Comhairle na nOspidéal. It is intended that it will inform and guide the Minister for Health & Children, the Department of Health & Children and the HSE in relation to policy and consultant manpower requirements in oral & maxillofacial surgery in Ireland.

EXECUTIVE SUMMARY

The Comhairle na nOspidéal review of oral and maxillofacial services commenced in July 2001, following the establishment of the committee to review consultant manpower requirements for plastic surgery services. At the time, due to the areas of overlap between oral & maxillofacial surgery, plastic surgery and otolaryngology, it was decided that the one committee should examine the three specialties in parallel.

While this report focuses specifically on oral & maxillofacial surgery services, it may be read together with the Comhairle reports on otolaryngology services and plastic surgery services for a comprehensive understanding of all three specialties. This is the first report by Comhairle na nOspidéal on oral & maxillofacial surgery services.

At the time the committee was established, oral & maxillofacial services were acknowledged to be underdeveloped nationally, with a total of 5 permanent consultant posts serving the population of Ireland. Many regions were without consultant staffed oral & maxillofacial units. (OMFS units)

There are currently 6 posts of consultant oral & maxillofacial surgeon approved by Comhairle na nOspidéal, representing a ratio of one consultant oral & maxillofacial surgeon per 650,000 population.

Over the course of the committee's work, requests were made to each health board and relevant public voluntary hospital to make submissions pertaining to the specialty of OMF surgery. The committee subsequently sought professional expert advice, and carried out an extensive consultation process including, inter alia, site visits to health boards and relevant voluntary hospitals. The committee also reviewed literature relating to oral & maxillofacial service provision in the UK, mainland Europe and North America.

The main principles identified for the future development of oral and maxillofacial surgery services are:

- An equitable and patient-centred service
- No consultant oral & maxillofacial surgeon working in isolation
- A move towards regional self-sufficiency
- A collaborative approach between the three specialties of oral & maxillofacial surgery, plastic surgery and otolaryngology in respect of relevant patients.

The key recommendations are as follows,

- A ratio of one consultant oral & maxillofacial surgeon per 150,000 population in the context of a minimum of two consultants in each oral & maxillofacial unit serving a population of at least 300,000
- The designation of one OMFS centre in Dublin
- The designation of four regional OMFS units - Cork, Galway, Limerick and in the longer term at Waterford
- The priority appointment of 5 new posts, the re-designation of 2 other posts and the subsequent appointment of an additional 11 consultant posts
- Over time a fourfold increase in the number of consultant oral & maxillofacial surgeon posts, from 6 to 24
- The development of academic posts in oral & maxillofacial surgery
- The specialty to regain recognition for training in OMFS in Ireland as a priority
- A national high quality cleft lip and palate service to be developed in line with agreed best practice guidelines.

1 INTRODUCTION

1.1 BACKGROUND

1.1.1 At its meeting on 24th November 2000, the 8th Comhairle considered a request from the Irish Association of Plastic Surgeons that it establish a committee to review consultant manpower requirements for plastic surgery services. As its term of office was coming to an end, the matter was deferred to the incoming Comhairle. At its meeting on 28th February 2001, the 9th Comhairle decided to establish a committee, which held its first meeting on 23rd May 2001.

1.1.2 The issue of overlap between Plastic Surgery and the related specialties of Otolaryngology and Oral & Maxillofacial Surgery was considered by the committee and it was decided by Comhairle na nOspidéal, in May 2001, that the committee should also review the specialties of Otolaryngology and Oral & Maxillofacial Surgery. The membership of the committee was extended accordingly.

1.1.3 The committee took into consideration the principles of the government Health Strategy – *Quality and Fairness, A Health System for You* – of equity, people-centredness, quality and accountability in its deliberations and in the formulation of its recommendations. The recommendations are set out in section 5 of this report.

1.2 MEMBERSHIP OF THE COMMITTEE

1.2.1 The following members were appointed to serve on the Plastic Surgery, Otolaryngology and Oral & Maxillofacial Surgery Committee:
Dr S Ryan (Chairman) – CEO, Western Health Board
Ms A Cody – Clinical Nurse Manager II, Mater Hospital
Dr E Connolly – Deputy Chief Medical Officer, Department of Health & Children
Prof M Leader – Consultant Histopathologist, Beaumont Hospital and Professor of Pathology, RCSI
Mr P McLoughlin – CEO, South Eastern Health Board
Mr K Moran – Consultant General Surgeon, Letterkenny General Hospital
Prof D Moriarty – Consultant Anaesthetist, Mater Hospital and Professor of Anaesthesia, UCD
Mr T Nadaraja – Consultant Otolaryngologist, Sligo General Hospital
Mr T Martin - Chief Officer, Comhairle na nOspidéal.

Ms A Cunningham, A/Administrator was Secretary to the Oral and Maxillofacial Surgery Committee and she undertook the research and initial drafting of this report.

1.2.2 The first meeting of the committee for all three specialties took place on 19th July 2001. It was decided that each specialty would be reviewed individually, that areas of overlap between the specialties would be examined and that a separate report would be drafted and published in respect of each specialty. This report deals with Oral & Maxillofacial Surgery. It is the first time Comhairle na nOspidéal has reviewed this specialty which is relatively new in Ireland and reported on the matter. The terms of reference of the Oral & Maxillofacial Surgery committee were as follows:

"To examine the existing arrangements for the provision of consultant - level oral and maxillofacial surgery services nationally and following consultation with the interests concerned, to make recommendations to Comhairle na nOspidéal on the future organisation and development of oral and maxillofacial surgery services. The review will take into account recent advances in and increasing demand for oral and maxillofacial surgery services".

1.3 THE CONSULTATION PROCESS

1.3.1 Requests were made to each health board and relevant public voluntary hospital to make submissions pertaining to the three specialties to the committee. The committee subsequently carried out an extensive consultation process, meeting initially with representatives of the Irish Association of Plastic Surgeons; the Irish Institute of Otolaryngology; the Consultant Oral & Maxillofacial Surgeons Group; the Dublin Dental Hospital; the Cork Dental Hospital; the Department of Health & Children; the Chief Dental Officer; and Prof. S. Gelbier, (Consultant Oral & Maxillo-Facial Surgeon, King's College, London. The Committee then visited and met with representatives of every health board during the month of April 2002, carrying out site visits at relevant hospitals. The committee also met with representatives of the Eastern Regional Health Authority, the three area health boards and the voluntary hospitals, in Corrigan House, in April 2002. In November 2003, the committee met with the Consultant Oral & Maxillofacial Surgeons Group who presented a revised oral & maxillofacial surgery document which outlined future OMFS service configuration by location and speciality, as envisaged by their group.

1.3.2 The committee wishes to extend its sincere gratitude to all those involved in the consultation process and in the compilation of submissions.

1.4 OVERLAP BETWEEN THE THREE RELATED SPECIALTIES OF ORAL & MAXILLOFACIAL SURGERY, OTOLARYNGOLOGY AND PLASTIC SURGERY

1.4.1 Over the course of the consultation process, all three specialties were discussed and it became apparent that the nature and extent of overlap between the three was varied. The issue of the overlap and interface between the three specialties is dealt with in each report.

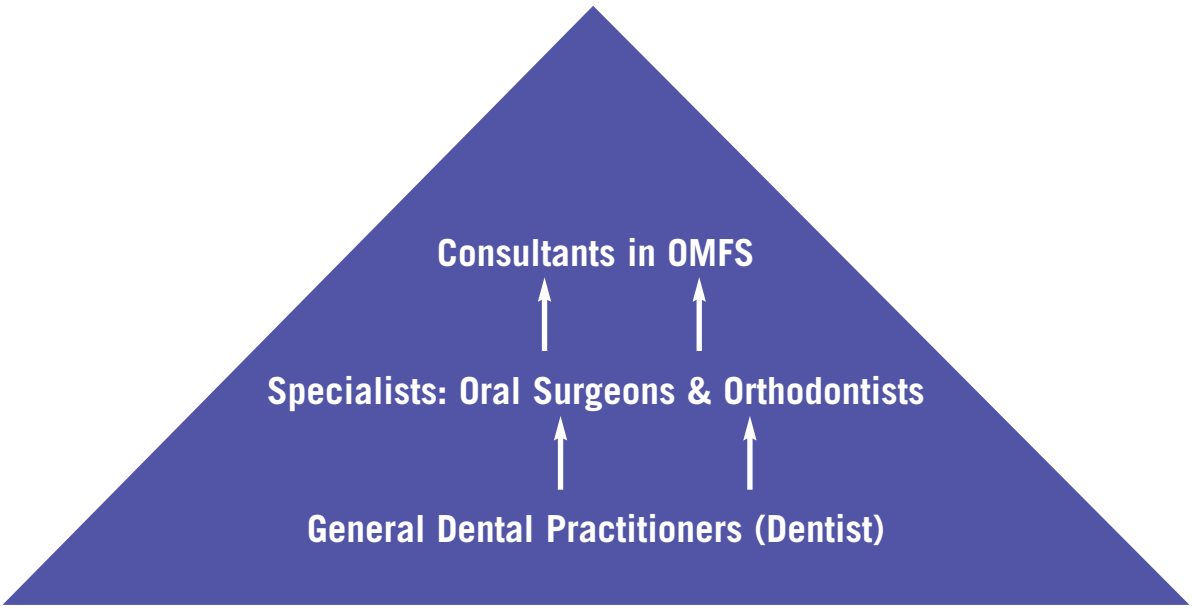
1.4.2 The overlap between otolaryngology and plastic surgery was clearer to the committee than that between oral & maxillofacial surgery and the other two subspecialties. However, the lack of clarity surrounding the overlap of OMF surgery with the other areas may be due, in part, to the fact that there are only a few consultant OMF surgeons in Ireland. Currently, the subspecialty of the surgeon performing surgeries which falls within the broad overlap between the three specialties is often determined by manpower, resources and the training undergone by the surgeon (e.g. the content of ENT training in Ireland or the UK might be slightly different to that in the US so that slightly different skills may be learnt and practised by surgeons depending on where they trained).

1.4.3 It would be expected that with the development of the three specialties as recommended by Comhairle na nOspidéal, clear guidelines would be drawn up regarding clinical pathways for patients, which would identify the lead clinician and the role of the multidisciplinary team, in line with agreed protocols. Comhairle na nOspidéal thinks that the RCSI and the professional bodies involved are best placed to devise guidelines regarding the overlap between the three related specialties of otolaryngology, plastic surgery and oral & maxillofacial surgery.

2 WHAT IS ORAL & MAXILLOFACIAL SURGERY?

2.1 ORAL & MAXILLOFACIAL SURGERY, ORAL SURGERY & GENERAL DENTAL PRACTICE

2.1.1 In order to comprehend fully the scope and practice of Oral & Maxillofacial Surgery (OMFS) it is pertinent to consider the components of and interface between primary and secondary care dental services. The work of the general dental practitioner, oral specialists, (including oral surgeons and orthodontists) and consultants in oral and maxillofacial surgery are inter-related and therefore need to be examined accordingly. The following diagram, provided to the committee, demonstrates the relationship between these disciplines:



General Dental Practitioners (Dentists)

2.1.2 The base of the triangle represents general dental practitioners (dentists). The field of activity of the general dental practitioner includes prevention, diagnosis and treatment of anomalies and diseases of the teeth, mouth and jaws and surrounding tissues.[1] The most complex and difficult of these procedures are largely undertaken by a specialist oral surgeon. These form the core of the activities of a specialist oral surgeon in addition to the other skills demanded of that specialist. General Dental Practitioners are trained in generic dental work and refer patients with complex problems to specialists for diagnosis and treatment.[1]

Oral Surgeons and Orthodontists

2.1.3 The second level of the triangle represents specialists in the field of dentistry e.g. oral surgeons and orthodontists. Oral and dentoalveolar surgery is more closely related to dentistry rather than to medicine.[1] Oral surgeons have additional training to general dental practitioners and treat patients presenting with more complicated symptoms than the more common dental problems.[1] Oral surgeons are trained to treat and manage surgical conditions of the mouth, jaws and associated structures.[1] Oral surgeons may work in conjunction with dentists in the primary care setting or in secondary care settings (usually the acute hospital). Patients are most frequently referred to the aforementioned specialists from general dental practitioners, i.e. dentists, at which point advice is given and/or treatment is provided. An Orthodontist examines, diagnoses and treats irregularities

and malocclusions of teeth and malrelations of jaws.[1] The Orthodontist examines patients and interprets and evaluates radiographs, models and clinical photographs to determine the nature and extent of deficiencies caused by irregularly positioned teeth and malrelations of the jaws, then evaluates the findings and determines the types of appliances to move and guide teeth and jaws into proper positions.[1]

Oral and Maxillofacial Surgeons

2.1.4 Oral & Maxillofacial Surgeons carry out surgery of greater complexity, for example, advanced trauma cases, requiring a multidisciplinary approach to patient management and treatment together with significant interface with other specialists.[1] Oral and Maxillofacial Surgeons work in the general hospital setting. Oral and Maxillofacial Surgery and Oral Surgery are defined and their scope is outlined hereunder.

2.2 DEFINITION AND SCOPE OF OMFS

2.2.1 Oral and Maxillofacial Surgery (OMFS) is defined as a branch of surgery that deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the human jaws and associated structures.[1] It is a relatively young speciality, which has been formally recognised as an independent specialty in some EU Member States, since the Medical Directives were first produced in 1975. In most English speaking nations, OMFS evolved from dental surgery and subsequently oral surgery. The specialty evolved because of the need for surgeons with training in dental surgery to be involved in many aspects of surgery of the head and neck. Historically, this commenced in the UK with the appointment of specialist dental surgeons to maxillofacial units dealing with wartime facial injury. The high level of training and skill gained in the management of such major trauma led subsequently to the establishment of the Faculty of Dental Surgery in the UK, the institution of the Fellowship in Dental Surgery and ultimately to the specialty being recognised as Oral and Maxillofacial Surgery. The Intercollegiate Board in Oral & Maxillofacial Surgery (established in 1996)[2], is the body that regulates the specialty in the United Kingdom and in Ireland.

2.2.2 The specialty of OMFS has grown to encompass the most complex treatment of pathological processes which affect the teeth, jaws, face, head and neck region[3]. The specialty is unique in requiring dual qualifications in medicine and dentistry. The British Association of Oral & Maxillofacial Surgeons, in a recent report[4], outlined that the **scope of the specialty** has been agreed internationally to include, but not to be specifically limited to:

- Management of cranio-maxillo-facial trauma (hard and soft tissues)
- Dentoalveolar surgery (surgery of the tooth-bearing components of the jaws)
- Pre-prosthetic surgery including implantology (surgery prior to rehabilitation of the dentition)
- Surgical and non-surgical management of diseases of the temporomandibular joint (between the lower jaw and skull-base)
- The management of head and neck cancer
- Reconstructive surgery of the head & neck to include hard and soft tissue grafts, mobilisation of regional composite flaps using, where appropriate, microsurgical techniques
- Surgical correction of acquired and congenital facial deformity (orthognathic surgery)
- Surgical treatment of other congenital anomalies including clefts of the lip and palate
- Craniofacial surgery including skull base surgery
- Cosmetic facial surgery
- Oral medicine (management of diseases of the jaws and soft tissues of the mouth and adjacent structures)

- Interdisciplinary co-operation with a broad spectrum of other specialties, in particular otolaryngology, ophthalmology, neurosurgery, plastic surgery, psychiatry, palliative care, radiation oncology, medical oncology, oral medicine, oral pathology, reconstructive dentistry, orthodontics and other specialised services
- Supportive care and the management of pain and anxiety.[4]

2.3 THE RELATIONSHIP OF ORAL & MAXILLOFACIAL SURGERY WITH OTHER SPECIALTIES

2.3.1 As a result of treating diseases located in the mouth, face, jaw and neck area OMF surgeons can provide advice on multi-system pathology where this affects the head and neck.[4] Advice is provided for specialties such as medical and radiation oncology to minimise and treat complications in the head and neck, following therapies provided by these other specialty groups. A large number of medical and dental specialties have a strong relationship with oral & maxillofacial surgery. The list hereunder gives an indication of the important role that the specialty has in the management of a vast range of clinical conditions.[4]

- Accident & Emergency - Oral & Maxillofacial surgeons provide major support to hospital A & E departments, for soft and hard tissue injuries to the face, scalp and neck.
- Neurosurgery & Neurosciences – OMF surgeons collaborate on surgery for trauma, deformity and oncology and are involved in the diagnosis of facial symptoms indicative of neural pathology. This is particularly important in the diagnosis and treatment of cervico-facial pain. OMF surgeons conduct facial disassembly procedures for intra-cranial and spinal access surgery and provide skull base reconstruction for neurosurgeons, fulfilling an important role in craniofacial surgical units.
- Opthalmology – OMF surgeons collaborate in the treatment of orbital trauma, oncology and deformity, and carry out orbital decompression in thyroid disease.
- Medical Oncology and Radiation Oncology – OMF surgeons have an important role in the management of head and neck neoplasia, working as part of multi-disciplinary teams with a special relationship with oncology and radiotherapy.
- Otolaryngology - as regards the interface between otolaryngologists and oral & maxillofacial surgeons, otolaryngologists mainly operate on the ears, nose, throat, thyroid, salivary glands, lymph nodes, upper respiratory tract and cancers of the head and neck while OMF surgeons deal mainly with fractures of the jawbone, mandible and orbit as well as carrying out dental work (realignment etc.)
- Plastic Surgery - plastic surgeons collaborate with oral & maxillofacial surgeons particularly in relation to cleft lip and palate surgery and craniofacial surgery.
- Paediatrics – OMF Surgeons collaborate with paediatricians in the diagnosis and treatment of cervical and orofacial infections and neoplasia in children, and provide treatment for neonates with craniofacial deformity, as part of the multi-disciplinary approach in cleft lip and palate and craniofacial units.
- Professions allied to medicine - OMF Surgeons have close relationships with speech therapy, dietetics, physiotherapy, occupational therapy, audiology and other specialities allied to medicine in the management of a large range of patients requiring support and rehabilitation during and after treatment of conditions affecting the mouth, face, jaws and neck.[4]

2.4 TRAINING IN ORAL & MAXILLOFACIAL SURGERY

2.4.1 The Role of the Medical Council and the Dental Council

To put into context current practice of OMFS training in Ireland, it is pertinent to describe the inter-related roles of the Medical Council, the Dental Council and the medical training bodies in respect

of training in Ireland. Under the Medical Practitioners Act, 1978, the Medical Council is the body charged with assuring the quality of postgraduate training of specialists in Ireland. To this end, the Council recognises 12 postgraduate training bodies responsible for the provision of a wide range of postgraduate training programmes. Under the Dentists Act 1985, the Dental Council is the regulatory body for the dental profession. It maintains a register of dentists and dental specialists and ensures that the standards of dental training are maintained.

2.4.2 Training in Oral & Maxillofacial Surgery in the UK and Ireland

2.4.2.1 It is important to note that the Higher Surgical Training Scheme in the specialty of oral & maxillofacial surgery, which has been established and developed in the United Kingdom, has largely been adopted in Ireland. The modus operandi of the scheme and the regulations are applicable to Ireland. The scheme of Higher Surgical Training is controlled and administered by the Joint Committee on Higher Surgical Training (JCHST)[5], representing the four surgical Royal Colleges in Great Britain and Ireland, the relevant Specialist Associations and the University Professor of Surgery. The JCHST is the advisory body to the surgical Royal Colleges (e.g. the RCSI), with regard to higher surgical training and it awards the Certificate of Completion of Specialist Training. The Higher Surgical Training Scheme in OMFS aims to provide comprehensive, structured and balanced higher surgical training, enabling trainees to complete the programme satisfactorily in order to undertake independent practice in the chosen specialty of oral and maxillofacial surgery and to be eligible for appointment as a consultant.[5]

2.4.2.2 Oral and maxillofacial surgery is one of nine surgical specialties recognised by the Senate of Surgery of Great Britain and Ireland.[5] It is unique in that although it is a surgical specialty, it is mandatory to possess registerable dental and medical qualifications, in addition to post graduate training equivalent to other surgical specialties. The dual qualification gives an understanding of the surgical anatomy and pathology of conditions affecting the face, mouth and jaws and associated structures. Basic qualifications must be registered with both the General Medical Council and General Dental Council in the UK and the Medical Council and Dental Council in Ireland in order to obtain a Certificate of Completion of Specialist Training (CCST)[5]. OMFS is one of the specialties listed in the General Medical Council's specialist register in the UK and the Medical Council in Ireland. The specialty is listed as a medical specialty in the European Union Medical Directives.

2.4.2.3 **OMFS Training - Current Practice in the United Kingdom**

Training in the UK and educational approval is overseen by the Specialist Advisory Committee (SAC) of the Joint Committee on Higher Surgical Training. OMFS is also represented on the Joint Committee for Specialist Training in Dentistry. The SAC has outlined a higher specialist training programme for OMFS[5], which is of five years duration, with an exit examination taken in the last year of specialist training. The SAC has advocated that the five year programme should comprise of four years in Clinical Oral and Maxillofacial Surgery and in the fifth year options could be undertaken for periods of time agreed by the SAC in (i) research, (ii), sub-specialisation and (iii) overseas experience. This together with successful completion of the Record of In-training Assessment (RITA), allows the specialist registrar to be awarded a CCST in OMFS and therefore be eligible for appointment as a Consultant in Oral & Maxillofacial Surgery in the UK. The majority of consultants in OMFS in the UK qualified in dentistry before qualifying in medicine. Currently, interface groups in relation to cleft lip and palate and head and neck surgery are developing CCST training requirements in these sub-specialty interests.

2.4.2.4 **OMFS Training - Current Practice in Ireland**

In Ireland, the specialty is recognised by the Royal College of Surgeons of Ireland (RCSI), with an exit specialist fellowship in OMFS being required before completion and receipt of a certificate of completion of specialist training (CCST). Similar to the UK, the responsibility for the organisation of higher training in OMFS is administered by the Specialist Advisory Committee of the JCHST. (OMFS is also represented on the Joint Committee for Specialist Training in Dentistry). An approved higher

training programme in OMFS had been in existence in Ireland, located at St. James's Hospital with rotations at Beaumont Hospital, linked to the Dublin Dental Hospital. However, a visit and inspection of the OMFS training programme in February 2001 and a subsequent report by the SAC[5], which outlined various deficiencies, resulted in the withdrawal of recognition, effective from 1st November 2002, of the SpR programme by the SAC. The programme ceased when the one specialist registrar went overseas to complete his training at the end of 2001. (Currently five registrars are employed in the St. James's Hospital OMFS unit). The principal reasons cited for the withdrawal of recognition of training by the SAC, included; limited case-mix - in particular lack of exposure to head & neck oncology, salivary gland disease, reconstruction, limited supervised training - in no small part due to very low number of consultants for the large volume of service workload, no formal systematic audit, no formal links with an academic unit and lack of formal rotation with other units. A number of recommendations have been made by the SAC in order for the units in Ireland to obtain accreditation again. The committee is aware of the implications of the withdrawal of the training recognition and expects that the appointment of additional consultant posts including the recent appointment of a Professor will assist in addressing this issue.

2.4.2.5 One of the statutory functions of Comhairle na nOspidéal is to regulate the number and type of senior registrar / specialist registrar posts in Ireland. In July 1998, Comhairle approved one SpR post in oral and maxillofacial surgery under St. James's & Beaumont hospitals linked to the Dublin Dental Hospital. There have been no subsequent SpR appointments in oral and maxillofacial surgery in the state as training recognition was withdrawn by the JCHST in 2002.

2.4.3 OMFS Training in U.S.A.

In the USA, OMFS is a specialty of dentistry. All OMF Surgeons are dentists, though some also hold medical degrees. The ADA (American Dental Association)[7] Commission on Dental Accreditation is responsible for the organisation and accreditation of OMFS training programmes. Following graduation after four years of dental school, OMF surgeons complete a hospital-based surgical residency of at least four years. All oral & maxillofacial surgical residents, whether they hold a dental degree or a medical degree, rotate through hospital medical, surgical and anaesthesia services, where they perform the same duties and procedures as residents in medical specialties. In addition to core surgical training, OMFS residency emphasizes diagnosis, treatment and management of the oral and maxillofacial region.[7]

2.5 QUALIFICATIONS SPECIFIED BY COMHAIRLE NA NOSPIDÉAL FOR POSTS OF CONSULTANT ORAL & MAXILLOFACIAL SURGEON

The following qualifications are specified by Comhairle na nOspidéal for consultant appointments in Oral & Maxillofacial Surgery:

2.5.1 Consultant Oral and Maxillofacial Surgeon

(a) Full registration in the General Register of Medical Practitioners maintained by the Medical Council in Ireland or entitlement to be so registered

and

(b) The possession of (i) a Dental Fellowship of the RCSI and (ii) the FRCSI or professional qualifications at least equivalent to these

and

(c) (i) Inclusion on the division of oral and maxillofacial surgery of the Register of Medical Specialists maintained by the Medical Council in Ireland

or

(ii) Eight years satisfactory postgraduate training and experience in the medical and dental professions including five years in oral and maxillofacial surgery.

2.5.2 To date Comhairle na nOspidéal has not approved any posts of consultant oral & maxillofacial surgeon with a designated special interest. The specialty of oral and maxillofacial surgery is in the early stages of development in Ireland. The position on formally approving special interests may need to be reviewed in the future, as areas of expertise develop.

2.6 DEFINITION AND SCOPE OF ORAL SURGERY

2.6.1 The definition of Oral Surgery, at it applies in Ireland is defined by the Irish Committee for Specialist Training in Dentistry (Oral Surgery Advisory Committee) as follows: *"Oral Surgery is considered to be the management of surgical conditions of the mouth, jaws and associated structures"*.[6] The specialty of Oral Surgery comes under the Dental Directives, as a specialty within dentistry, which deals with the diagnosis and surgical management of anomalies and pathological process of the dentoalveolar complex (teeth and the surrounding bone). The **Scope of Oral Surgery**, as outlined in the *"Report on Oral and Maxillofacial Surgery Services in the EHB"* (1999)[1], includes:

- surgical excision of roots and buried or impacted teeth
- exposure of unerupted teeth
- surgical management of oro-antral fistulae
- tissue integrated oral implant surgery
- mucosal, skin and bone grafts
- assessment and management of oral / facial pain and headache
- apical surgical treatment
- biopsies and excision of pathological oral and dental tissue, pre-prosthetic surgery.[1]

2.7 LINKS BETWEEN ORAL & MAXILLOFACIAL SURGERY, ORAL SURGERY AND GENERAL DENTAL PRACTICE

2.7.1 In the context of the foregoing paragraphs, it is evident that there are significant areas of overlap and interdependency between oral and maxillofacial surgery, oral surgery and general dental practice. The nomenclature and clinical activities of oral surgery and oral and maxillofacial surgery have evolved significantly over the past two decades. It should be noted that within the speciality of OMFS strong associations are formed with many other specialties, as outlined earlier in paragraph 2.3, in order to provide the comprehensive complete treatment of patients presenting with the most complex congenital and acquired anomalies of the jaws and facial skeleton. The interface been oral and oral & maxillofacial surgery is not clearly defined amongst practitioners. Therefore, due to the extensive areas of cross-over and co-dependency, this report covers elements of both oral surgery and OMFS. Notwithstanding that, the emphasis will be placed on OMFS in the context of hospital based services, in line with the statutory functions of Comhairle na nOspidéal. It should be noted that Comhairle na nOspidéal has no statutory role in the regulation of posts of oral surgeons or dentists.

3 THE OVERLAP/INTERFACE BETWEEN ORAL & MAXILLOFACIAL SURGERY AND THE RELATED SPECIALTIES OF PLASTIC SURGERY AND OTOLARYNGOLOGY

3.1 INTRODUCTION

3.1.1 Over the course of the committee's work, it became apparent that the nature and extent of the overlap between the three related specialties of otolaryngology, plastic surgery and oral & maxillofacial surgery was varied. While complementary for the most part; all share natural areas of overlap. While there is more overlap between otolaryngology and oral & maxillofacial surgery, the areas of overlap are less clear than those between otolaryngology and plastic surgery. As regards the interface between otolaryngologists and oral & maxillofacial (OMF) surgeons, otolaryngologists mainly operate on the ears, nose, throat, salivary glands, lymph nodes, upper respiratory tract and cancers of the head and neck while OMF surgeons deal mainly with fractures of the jawbone, mandible and orbit as well as carrying out dental work (realignment etc.).[30, 1, 3] Plastic surgeons are involved in the restoration of form and function of congenital, traumatic and acquired conditions.[17] An example of the crossover between the specialties occurs in the case of rhinoplasty (nose re-alignment). This procedure is typically classed as "cosmetic" surgery, leading to the perception that such work is done by plastic surgeons only whereas the input of otolaryngologists (e.g. in relation to the septum) and OMF surgeons may also be required. In some cases, training and manpower resources etc. will determine which surgeon (i.e. from which of the three specialties) does which surgery.[30] The committee suggests that there should be clear clinical guidelines and a consensus regarding protocols in this regard. Areas where significant overlap between OMFS and Plastic Surgery occurs, and where otolaryngology input may also be required, include cleft lip and palate surgery and craniofacial surgery. In these cases, multidisciplinary teamwork, including OMF and plastic surgeons is vital. These particular issues are dealt with in this section.

3.2 CLEFT LIP & PALATE

3.2.1 According to the British Association of Plastic Surgeons, cleft lip and palate is a common congenital anomaly occurring in 1 in 600 births and presents in a wide variety of forms and combinations.[17] Cleft lip ranges from notching of the lip to a complete cleft, involving the floor of the nose and may be associated with a cleft of the primary palate (alveolus / pre-maxilla) and with clefts of the secondary palates (hard and soft palate)[17]. The deformity has a potential effect on facial appearance, hearing, speech, feeding and social integration. Indicators of poor outcome, dysfunction and deformity include hearing loss, speech anomalies, problems with eating and swallowing and psycho-social difficulties. The aim of cleft surgery is the restoration of normal anatomy and the promotion of normal growth and development of all structures affected by the cleft. There are also other surgical procedures required as the child grows older. When growth is complete, orthognathic surgery to correct abnormal facial bone development in particular and under-developed maxilla may be needed. The treatment of patients with cleft lip and / or palate provides significant scope for cooperation between the plastic surgeon, OMF surgeon and the paediatrician from diagnosis and throughout the treatment of the patient.

3.2.2 What is meant by Cleft Lip & Palate Surgery?

3.2.2.1 In attempting to define cleft lip & palate surgery and the specialists who are involved in the provision of cleft lip and palate services in Ireland, the committee was provided with varying information from the specialists who are involved in cleft lip and palate surgery in Ireland, namely consultant plastic surgeons and consultant oral & maxillofacial surgeons. However, there was consensus advice from both groups that each may be trained to perform cleft lip & palate surgery. Each group also gave a commitment to close co-operation between the two specialties.

3.2.2.2 According to the Oral & Maxillofacial Surgeons Group in Ireland, cleft lip & palate surgery may be divided into what is termed "primary" cleft surgery and "secondary" cleft surgery. This terminology is consistent with the terminology used by the specialty in the UK. Advice received from Irish OMF surgeons indicated that *"Primary cleft surgery is surgery that is performed on cleft children when they are infants. It involves soft tissue repair of the cleft lip and palate. "Secondary" cleft surgery is further surgery performed after infancy. "Secondary" cleft surgery involves the following:*

- *Alveolar Bone Grafts*
- *Removal / Exposure of impacted teeth*
- *Secondary (revision) surgery of soft tissues*
- *Closure / Repair of fistulae*
- *Secondary lip / palate / nasal surgery*
- *Orthognathic surgery (facial bone osteotomies)."*

3.2.2.3 Advice received from consultant plastic surgeons in Ireland outlined the following:
"Primary cleft lip and palate surgery refers to the initial operation to repair a cleft lip or a cleft palate usually in infancy. Secondary surgery includes all surgery that is subsequently performed such as lip revisions, rhinoplasties, alveolar bone grafting, pharyngoplasties and fistula repairs….quite alot of secondary surgery is performed on children in a children's hospital. This includes fistula repairs, pharyngoplasties and sometimes early lip and nasal correction and revisions. It also includes alveolar bone grafting. The secondary surgery that is done after growth has finished includes facial osteotomies and late revisions of the lip and the nose".

3.2.2.4 The consultant plastic surgeons involved in the provision of cleft lip and palate services in Ireland also indicated that *"primary and secondary are terms correctly used in cleft conditions when referring to clefts of the primary lip and palate anterior to the incisive foramen and to cleft of the palate posterior to the incisive foramen (secondary). In Ireland where the first surgery to the lip and palate is carried out by plastic and reconstructive surgeons, it has been accepted by the majority of patients and service providers that the plastic surgeon should carry out any cleft revisions, rhinoplasties, pharyngoplasties and other so-called secondary operations".*

3.2.2.5 However, in attempting to define cleft lip and palate surgery into groups of paediatric and adolescent / adult, advice received from consultant plastic surgeons in Ireland indicated that *"it is incorrect to separate so-called secondary surgery into the artificial groups of paediatric and adolescent/ adult. Any revisionary surgery can be performed in either a paediatric or adult setting, depending on the age of the patient".*

3.2.3 Existing Cleft Lip & Palate Services in Ireland

3.2.3.1 The provision of cleft lip and palate services in Ireland has developed from individual consultant interest rather than strategic health policy planning. Owing to the small number of consultant oral & maxillofacial surgeons in Ireland, cleft lip and palate surgery has been predominantly undertaken by consultant plastic surgeons. According to information supplied to the committee by consultant plastic surgeons, all primary cleft lip and palate surgery is performed by plastic surgeons in Ireland. Currently all primary cleft lip and palate surgery is undertaken in either OLHSC, Crumlin, The Children's University Hospital, Temple St., Cork University Hospital or University College Hospital, Galway.

3.2.3.2 Secondary cleft lip and palate surgery is carried out in the four aforementioned hospitals. In Dublin secondary cleft lip and palate is also carried out in St. James's Hospital and the Mater Hospital. Approximately 80% of all children born with cleft lip and palate in Ireland are treated in the Dublin Cleft centre (i.e. OLHSC, Crumlin / St. James's Hospital and The Children's University Hospital, Temple St). Primary surgery is carried out by two consultant plastic surgeons. Secondary surgery is undertaken by the two plastic surgeons in conjunction with a consultant oral and maxillofacial surgeon. The OMF surgeon specifically carries out alveolar bone grafting and facial osteotomies. All other secondary cleft surgery is performed by the two consultant plastic surgeons.

3.2.3.3 Whilst plastic surgeons and oral & maxillofacial surgeons are both trained to perform primary cleft lip and palate surgery, the tradition in Australia, Ireland and the UK, for example, has been that primary cleft lip and palate surgery has been largely performed by plastic surgeons.

3.2.3.4 The Irish Association of Plastic Surgeons informed the committee that in the year 2000, the units in OLHSC, Crumlin/ St. James's Hospital and The Children's University Hospital, Temple St. combined to form the Dublin Cleft Centre. The IAPS indicated that *"this development had been supported and funded by the Eastern Regional Health Authority and the Department of Health & Children."* The IAPS informed the committee that *"the centre is a fully integrated service with agreed protocols, policies and audit structures in accordance with CSAG guidelines."* In addition, at a recent meeting of the IAPS, it was recommended that the Cork and Galway units integrate into a single cleft centre to be called the South Western Cleft Centre with agreed protocols as in Dublin.
(Cleft Lip & Palate workload data is provided in Appendix C)

3.3 BEST PROVISION OF CLEFT LIP AND PALATE SERVICES – LITERATURE REVIEW AND ADVICE RECEIVED

3.3.1 The committee reviewed literature and sought the advice of the professional bodies involved in the treatment of cleft lip and palate in Ireland, i.e. the Irish OMFS group and the Irish Association of Plastic Surgeons. A summary of the literature reviewed is outlined below:-

- **Clinical Standards Advisory Group Review**

  The Clinical Standards Advisory Group (CSAG) was established in April 1991, as an independent source of expert advice to the United Kingdom Health Ministers and to the NHS on standards on clinical care for, and access to and availability of services to, NHS patients. During the early 1990s concerns emerged about variations in the standards of treatment who have cleft lip and / or palate malformations, both within the NHS and between the UK and Europe. In July 1995 UK Health Ministers asked CSAG *"to advise on standards of clinical care for people with congenital cleft lip and/or palate… and to report on current levels of access to units that would be expected to achieve good outcomes and suggest any changes to existing clinical standards considered necessary in the light of findings"*. The findings were published in 1998 in their Report[16]. The Clinical Standards Advisory Group (CSAG),[16] in its 1998 report, recommended that a cleft centre should be staffed, inter alia, by two plastic surgeons undertaking at least 40-50 primary cases each annually, and by one OMF surgeon undertaking bone grafts and orthognathic surgery. The CSAG report also recommended that the number of cleft centres in the UK be reduced from the then 57 centres to 8-15 centres. The CSAG report noted that 15 centres would allow for one centre in each of Northern Ireland and Wales. This would equate to approximately one centre per 4 million population in the UK, which has a population of about 60 million.

- **British Association of Plastic Surgeons**

  The British Association of Plastic Surgeons[17] has recommended that "(cleft) *surgery (particularly the primary surgery) should not be carried out by the occasional operator and evidence indicates that primary surgery should not be carried out by those performing less than 20 primary operations per year"*

❖ Cleft Interest Group

The Cleft Interest Group stated in its *"Report of CSAG Implementation Sub-Committee"*[18] *(1998) that "while two man units performing 80 to 100 cases per annum may be practical in large conurbations such as London, Birmingham and Manchester, in other areas it would pose serious difficulties of access. We therefore advocate that a two man "unit" need not necessarily be in a single centre but could be in two centres, possibly geographically remote from each other, but working to the same protocol and with common audit…We recommend that very low volume operators should make immediate arrangements to transfer their new cases to an adjacent larger unit. Our initial discussions concerned single figure operators but, influenced by several surgeons with numbers in the mid teens stopping and several surgeons with numbers in the twenties considering it, we decided on the figure of 15 cases per annum.*

❖ UK Department of Health

The UK Department of Health in its *"National Reconfiguration of Cleft Services"* paper[19], written in light of the recommendations of the 1998 CSAG report and the advice of the Cleft Implementation Group, provided guidance on new surgical appointments to cleft centres, stating *"as a guide, a surgeon whose main responsibility is primary surgery should have undertaken primary surgery on at least 25 babies in the last year and a surgeon whose main responsibility is for secondary surgery should have carried out an appropriate number of alveolar bone grafts and/or maxillary osteotomies for cleft patients in the last year".*

❖ NHS Scotland

NHS Scotland has stated that *"The treatment of cleft lip and palate in Scotland has been organised by the Scottish Association for Cleft Lip and Palate (SCALP) since 1989. This has been a multidisciplinary effort involving a broad range of health professionals. A national Managed Clinical Network (CLEFTSiS) has now been developed, building on the foundations of SCALP, to provide a planned and coordinated system for delivering better quality patient care, through a single Scottish service delivered from many sites… (One of) the key aims of CLEFTSiS is to improve outcomes of care by concentrating the clinical caseload in the hands of a smaller number of surgeons treating primary clefts in Scotland, with the ultimate aim of reducing to a maximum of 3 surgeons undertaking this work. When the project started in early 2000, there were 6 surgeons performing primary cleft surgery in Scotland. Since the establishment of the network the number of surgeons treating primary cleft lip palate children in Scotland has reduced to 4".* The population of Scotland is approximately 5.1 million.

❖ Subsequent CSAG study (1999)

A subsequent CSAG study entitled **"Outcome, comparisons, training and conclusions" (December 1999),**[24] undertook a critical appraisal of cleft care in the United Kingdom and highlighted the poor outcomes for the fragmented cleft care in the UK compared with European centres. The study was a retrospective comparative study on all national health service cleft centres in the UK. The patients included children born with unilateral complete clefts of the lip and palate between April 1982 and March 1984 and April 1989 and March 1991. It involved newly appointed and senior cleft clinicians. The main outcome measures were skeletal pattern, dental arch relationship, success of alveolar bone grafting, dental health, facial appearance, oral health status and patient / parent satisfaction. It concluded that there is an urgent need for a review of structure, organisation and training in cleft care owing to the existing fragmented service situation.

- With regard to **proficiency** the study noted: *"Improved outcomes were associated with high volume for one third of the key variables assessed. One audit of a high-volume British centre has produced results after 12 years that are as good as the best European centres (Chate et al., 1997). The key point is that unless there is sufficient volume of patients being treated in a centre with appropriate records, quality of cleft care can never be verified over a reasonable time period."*
- In respect of **training**, the study highlighted the following: *"The size of a unit and the quality of its multidisciplinary activity are of great importance in training specialists for the future. Training is therefore possible only where there is high volume and a limited number of trainees should be geared to the number of vacancies of cleft specialists. If standards are to be improved it is essential that your*

specialists undergo a properly structured training program….There was strong support for training programs of all specialist cleft clinicians to be approved only in cleft centres at which high-volume and high-quality clinical experience are available. It was felt that the surgical specialties need to jointly develop a training pathway for the small number of surgical trainees required to specialise in cleft care."

- With regard to **infrastructure**, the study agreed with the recommendations of the CSAG 1998 report to the UK government, in that *"If the sample of centres visited was representative, it would suggest that only six – eight units in the UK could currently be regarded as providing truly multidisciplinary care of a good or excellent standard. A common weakness of fragmentation of services was inability to provide, and indeed afford, a comprehensive range of true specialists and resources".*
- With regard to **audit and research**, the study highlighted that *"comparative clinical audit and research require adequate samples of cases with similar prognosis…. ". It goes on to state that " well-organised treatment centres with large case-loads and standardized protocols hold the key to establishing reliable evidence for refining clinical protocols".*

❖ Development of Oral & Maxillofacial Surgery Services in the Eastern Health Board Region (1999)[1]

The Eastern Health Board's report entitled *"Development of Oral & Maxillofacial Surgery Services in the Eastern Health Board Region", (February 1999)[1] recommended that "the core cleft services in the Health Board's region should be organised into a highly integrated regional team (hub) based in a paediatric environment with two surgeons each undertaking approximately 45 cases".* According to the EHB Report the management of cleft patients should be organised as follows (based on the key conclusions of the CSAG Report):-

- *Care should be centralised in a "cleft hub" where highly skilled staff and resources can be concentrated.*
- *Some services available in spokes to increase accessibility.*
- *Cleft care should be provided by two surgeons, each undertaking approximately 40-50 cases annually.*
- *Support should be provided by a truly multidisciplinary team to provide continuity of care from birth to adulthood*
- *Cleft care should be provided in line with agreed best practice guidelines.*
- *The cleft hub should participate in ongoing quality review.*
- *The presence of a cleft co-ordinator in the team is an essential component in the provision of an integrated cleft service".*

❖ Irish Oral and Maxillofacial Surgery Group

The professional advice received from the Irish Oral and Maxillofacial Surgery Group in respect of the provision of cleft lip and palate surgery services for Ireland, is that *"cleft facilities would be ideally provided for a population of 4 million on a single site with Maxillofacial / plastic / ENT surgeons working on one site".* The Oral and Maxillofacial Surgery Group indicated that the above scenario would facilitate the practice of surgeons working in a multi-disciplinary environment, to undertake work on a sufficient number of cases to maintain & develop expertise and ultimately ensure better patient outcome.

❖ Irish Association of Plastic Surgeons

Recent advice received from the Irish Association of Plastic Surgeons outlined that *"there is still no clearly established evidence as to what constitutes best practice in the provision of Cleft Lip and Palate Services".* The IAPS further stated *"it is difficult to extrapolate figures from the UK to determine what may be required in Ireland... The original recommended figure of 40 cases per surgeon per year has since been modified to take account of geographical constraints. While it is difficult to extrapolate the CSAG recommendations into the Irish situation, there is as yet, no evidence to show any improvement in outcome from any particular caseload. Rather, outcome appears more related to the ability of each cleft*

centre to operate to set protocols and incorporation of audit structures. It is accepted that effective provision of cleft services should be based upon a multidisciplinary cleft team. It is important to recognise that the situation regarding accepted best practice is still evolving."

3.4 CONCLUSIONS FROM LITERATURE REVIEW AND ADVICE

- Significant weight of evidence refers to the benefits - for the patient - of a cleft lip and palate service being provided in a multi-disciplinary hospital setting where highly skilled staff and resources can be concentrated.
- The provision of future cleft lip and palate services should be provided in line with agreed best practice guidelines.
- Plastic and OMFS consultants together with their respective professional bodies, should agree to a methodology for integrating their combined expertise so as to provide a fully integrated quality cleft service.
- The existing fragmentation of cleft lip and palate services in Ireland is contrary to evidence and trends elsewhere.

3.5 RECOMMENDATIONS FOR CLEFT LIP AND PALATE SERVICES IN IRELAND

3.5.1 The committee recognises the existing dispersed cleft lip and palate service in Ireland spread over four sites – OLHSC, Crumlin, The Children's University Hospital, Temple Street, Cork University Hospital, University College Hospital, Galway **and proposes that these existing sites operate to set protocols and incorporation of audit structures, in accordance with CSAG guidelines.**

In the context of

- the advice received from the relevant professional bodies in Ireland
- international guidance / literature reviewed
- evidence presented in respect of improved outcomes associated with high volume cleft centres in relation to cleft lip and palate cases in the UK
- the move towards regaining training accreditation in Ireland
- the value of audit and research which is more easily undertaken at large centres to advance clinical knowledge for cleft lip and palate.

Comhairle na nOspidéal recommends a single national high quality cleft lip and palate service. As indicated earlier in the report, cleft lip and palate services are currently operating on several sites. In the meantime, the existing services should be co-ordinated and it is recommended that the HSE review the matter in the future.

3.5.2 Cleft lip and palate surgery should be undertaken in a multi-disciplinary hospital setting involving at least a cleft surgeon, (i.e. a plastic surgeon or an OMF surgeon with expertise in cleft lip and palate surgery), an otologist, a speech and language therapist, an orthodontist, paediatrician, a paediatric anaesthetist, specialist paediatric nurses and other support staff. The adherence to an agreed protocol working in a fully equipped and co-ordinated setting with a full complement of the necessary professionals and the facility for collection of data such that problems can be identified and corrected at the earliest possible opportunity, will assist the cleft lip and palate professional multidisciplinary team in ensuring the best outcomes for patients.

3.5.3 There should be a single set of agreed protocols operating at all four sites and a nationwide patient database should be established and shared by the four sites. Comhairle na nOspidéal considers that local evidence-based studies should be initiated immediately to form part of a national study, the results of which should form the basis of future policy development in the area.

Each unit and consultant performing cleft lip and palate procedures should review their caseload and their practice to ensure it is consistent with international practice and CSAG guidelines.

Comhairle na nOspidéal believes the active implementation of a national cleft service in Ireland, is the most appropriate way forward for best service provision and ultimately optimum patient care. It is suggested that the provision of cleft lip and palate services should be reviewed by the Health Service Executive (HSE) in the context of providing optimum standards of care in line with best international practice and evidence as outlined in 3.5.1 above.

3.6 CRANIOFACIAL SURGERY

3.6.1 According to the British Association of Plastic Surgery, craniofacial surgery is concerned with the management of patients presenting with congenital or acquired conditions, affecting the hard and soft tissues of the head and face. Craniofacial conditions include (i) craniosynostoses, (ii) craniofacial dysostes, (iii) orbital dysostosis (iv) encephalocoeles (v) craniofacial clefts. These conditions are evident early in life and most patients are children under the age of two. Patients referred to units are assessed and investigated by multi-disciplinary teams. Treatment combines the principles of maxillofacial reconstruction with neurosurgery. The surgical techniques employed in congenital conditions can also be applied to good effect in the treatment of skull base tumours and craniofacial trauma.

3.6.2 The craniofacial principles of wide surgical exposure, primary bone grafting and internal fixation are applied to the management of complex craniofacial trauma. Severely injured patients of all ages can be stabilised and offered early definitive treatment using these techniques. These surgical approaches can also be used to access intracranial and skull base lesions.

3.6.3 The management of craniofacial patients requires a collaborative and multi-disciplinary approach if optimal results are to be achieved. The core disciplines involved are usually maxillofacial surgery, plastic surgery and neurosurgery, supported by anaesthetic, ENT, ophthalmic and nursing expertise. By drawing on expertise gained in the management of trauma, tumour and congenital disease of the soft and hard tissues of the face, the maxillofacial surgeon plays a key role in craniofacial surgery.

3.6.4 The consultant plastic surgeons in Ireland have advised that *"craniofacial surgery strictly defined involves surgery for the correction of congenital abnormalities of the craniofacial skeleton specifically involving a combined extra cranial and trans cranial approach and usually involving movement of the orbits. A broader definition is often used to encompass other surgery related to the craniofacial skeleton including trauma and tumour surgery and surgery of subcranial skeletal abnormalities..... Craniofacial surgery necessarily involves a collaborative team approach including plastic surgeons, maxillofacial surgeons and neurosurgeons as well as other disciplines such as ophthalmology".*

Existing Craniofacial Surgery Services in Ireland

3.6.5 At present, the management of craniofacial patients in Ireland is fragmented owing to its evolution in an ad-hoc manner. Trauma and tumour are the main contributors to the adult workload. The service developed primarily due to the interest of a number of consultants, rather than strategic policy planning.

3.6.6 In respect of **adult** craniofacial surgery, the committee has been informed that adult craniofacial surgery is undertaken in Beaumont Hospital, the Mater Hospital and St. James's hospitals with occasional patients being treated in Cork. The team involved in adult craniofacial surgery includes plastic surgeons, neurosurgeons and maxillofacial surgeons.

3.6.7 Since 1989, **Paediatric** craniofacial surgery has been provided at The Children's University Hospital, Temple Street by a consultant plastic surgeon working with consultant neurosurgeons from Beaumont. When a consultant neurosurgeon with a s.i. in paediatric neurosurgery was appointed in

1992 to Beaumont Hospital (7 sessions) The Children's University Hospital, Temple St. (2 sessions) and OLHSC, Crumlin (2 sessions), it facilitated and enhanced this service. Currently paediatric craniofacial surgery is undertaken in The Children's University Hospital, Temple St. by a consultant plastic surgeon and the consultant neurosurgeon s.i. paediatric neurosurgery.

3.6.8 Paediatric craniofacial surgery for craniosynostosis is undertaken at The Children Hospital Temple. St. The IAPS informed the committee that *"Approximately 20 cases per year are operated upon and 200 patients per year are seen in the craniofacial clinic. Complex syndromal cases are treated in conjunction with Great Ormond St. Hospital in London. It is recommended by the IAPS "that all patients in this category should attend The Children's University Hospital Temple St, and to avoid other units treating fewer than ten cases per year"*.
Craniofacial Workload is provided in Appendix C.

3.7 LITERATURE REVIEWED AND ADVICE RECEIVED ON BEST PROVISION OF CRANIOFACIAL SURGERY SERVICES

3.7.1 The committee reviewed literature and sought the advice of the professional bodies involved in the treatment of craniofacial surgery in Ireland. A summary of the literature reviewed is outlined below:-

- **British Association of Oral and Maxillofacial Surgeons**

  The British Association of Oral and Maxillofacial Surgeons has recommended that *"The need to develop and maintain expertise has further strengthened the requirement that these operations be carried out primarily in a limited number of designated centres with a workload of at least 50 major craniofacial operations per year…. a craniofacial centre requires a catchment population sufficiently large to provide an adequate workload. For example, the Department of Health, within England and Wales, (population approaching 50 million) has designated and funded three supra- regional centres for the provision of craniofacial services, Great Ormond Street Hospital, London, Radcliffe Infirmary, Oxford, Queen Elizabeth and Children's Hospitals, Birmingham. In Scotland, where the health services are responsibility of the Scottish Office, for a population of 5.5 million craniofacial treatment is mainly provided in one craniofacial unit at: Canniesburn and Southern General Hospitals, Glasgow.*

- **Royal College of Surgeons Working Party for Craniofacial Surgery (UK)**

  The Royal College of Surgeons Working Party for Craniofacial Surgery (UK), recommended to the NSCAG in 2002 that: *"no further craniofacial centre or centres should be designated, any attempts (i) to resurrect a centre that has ceased providing a service or ceases to do so in the future or (ii) to create a new service where none previously existed should be strongly discouraged; 10 transcranial procedures per year is a level below which providing a service is not justified and there should be no separate consideration of adult patients in relation to NSCAG designation and service definitions"*.

- **British Association of Plastic Surgeons**

  The British Association of Plastic Surgeons recommended that *"where there are several consultants working in a large unit it is usual for all of them to practise some general plastic surgery while at the same time providing a specialised service for such conditions as burns, head and neck cancer, hand surgery and cleft lip and palate treatment. For the very rare conditions, e.g. cranio-facial deformities, supra-regional services with direct funding from the Department of Health have been developed…. Supra-regional facilities should be continued in a few specialised fields such as those recognised for cranio-facial surgery. These units are established for rare conditions requiring special technology and a multidisciplinary approach"*.

- **Irish Association of Plastic Surgeons**

  Recent advice received from the Irish Association of Plastic Surgeons outlined that *"an ideal unit for congenital craniofacial abnormalities would deal with patients of all ages in a multi-disciplinary team setting. This would require paediatric, adolescent and adult facilities at one location as well as the "core"*

specialties of plastic surgery, neurosurgery and maxillofacial surgery. Anaesthesia, radiology, otolaryngology and ophthalmic surgery are all related and essential specialties for a full craniofacial service".[24] *The IAPS also stated that: "there is no agreement on a minimum number of craniofacial procedures for any unit or individual to maintain expertise. Between 10 and 20 seems to be a compromise figure….. If both paediatric and adult craniofacial work was amalgamated, at least two plastic surgeons and two neurosurgeons would be required working closely with at least one maxillofacial and one ENT specialist". A green field site would be one where all specialties co-existed with both paediatric and adult facilities. At present there is only one site likely to fulfil this need within the next ten years (Mater and Temple St). However, the neurosurgical and maxillofacial and dental part of the team would need considerable expansion and formalisation. Major efforts to draw together the stakeholders are essential with more reliance on combined clinics and free movement of surgeons from one site to another".*

- **Irish OMFS Group**

  Advice received from the **Irish OMFS Group** outlined the following: *"Craniofacial surgery for adults involves a broad spectrum of work clarified into:*

  - *Craniofacial trauma*
  - *Craniofacial access surgery*
  - *Craniofacial vascular malformations*
  - *Skull base surgery*
  - *Post-traumatic deformity*
  - *Craniofacial developmental deformity*

  A consultant neurosurgeon with craniofacial experience and access to neurosurgery equipment and support is essential in any patient (paediatric / adult) where the dura / brain is likely to be exposed.[25]

  The team required for adult craniofacial deformity surgery:

  - *Multidisciplinary team co-ordinator*
  - *Surgeons – Neurosurgeon*
    Oral and Maxillofacial surgeon (cleft /craniofacial interest)
    Plastic Surgeon (Cleft / craniofacial interest)
    ENT with special interest in otology
    Ophthalmologist
  - *Neurologist*
  - *Radiologist with a special interest in craniofacial surgery*
  - *Orthodontist*
  - *Access to geneticist, speech and language therapists, constructive restorative dentist,*
  - *data manager, audit co-ordinator, hospital management support, secretarial support, ITU/HDU, maxillofacial technician, psychological services, social worker, self-help group."* [25]

3.8 RECOMMENDATIONS FOR CRANIOFACIAL SURGERY SERVICES IN IRELAND

3.8.1 Expert advice has recommended that all paediatric craniofacial work should be undertaken in one multidisciplinary centre. Comhairle na nOspidéal concurs with the advice received and recommends that craniofacial surgery services for children should be provided at The Children's University Hospital, Temple St, which is being relocated onto the Mater Hospital Campus.

3.8.2 Based on the advice received, Comhairle na nOspidéal recommends that adult craniofacial surgery should only be undertaken in hospitals with the presence of on-site consultant plastic surgeons, oral and maxillofacial surgeons, neurosurgeons as well as other disciplines such as otolaryngology and ophthalmology.

3.8.3 It is suggested that a detailed review of craniofacial surgery be undertaken by the Health Service Executive (HSE) in the context of providing optimum standards of care in line with best international practice and evidence.

3.9 HEAD AND NECK SURGERY

3.9.1 In Ireland, the majority of head and neck surgery is performed by otolaryngologists. This is also the case in North America. However, in the UK, head and neck surgery is usually carried out by oral & maxillofacial surgeons. OMF surgeons play a complementary role in head and neck cancers e.g. neck dissections for oral cancers. The primary centres for head and neck surgery are Dublin (St James's, Beaumont and Mater hospitals), Cork and Galway.

3.10 HEAD AND NECK CANCER

3.10.1 In Ireland, the vast majority of head and neck squamous cancers are treated by otolaryngologists, who also treat salivary gland cancers. Thyroid gland cancers are treated by both general surgeons and otolaryngologists while lip and skin cancers are treated by plastic surgeons and less commonly by otolarygologists[32].

The committee is aware that the treatment of head and neck cancer in Ireland is similar to that in North America and differs from that in the UK vis-à-vis which specialists treat head and neck cancer patients. In the UK, head and neck cancer surgery is primarily undertaken by plastic surgeons as distinct from otolaryngologists, whereas in Ireland, as in North America, otolaryngologists are usually more involved in the treatment of head and neck cancer. This may be due, in part, to the fact that many of the consultant otolaryngologists in Ireland have trained in North America. The committee feels that the question of a common training base is a matter for the training bodies. The issue of head and neck cancer surgery is further addressed in the Otolaryngology Report. (Section 6)

3.11 RECOMMENDATIONS FOR HEAD AND NECK CANCER SURGERY

3.11.1 Having taken into consideration the issues relating to head and neck cancer, as set out in section 6.4 of the Otolaryngology Report, Comhairle recommends that all advanced and complex head and neck cancer should be treated at supraregional cancer centres. Comhairle has been advised that this thinking is in line with the approach of the National Cancer Forum, which will most likely recommend the management of head and neck cancer at a supraregional level. The committee took into consideration guidelines issued by NICE[31] in the UK, which recommended that head and neck cancer services should be commissioned at a "Cancer Network" level. NICE also recommended that over the next few years assessment and treatment services should *"become increasingly concentrated in cancer centres serving populations of over a million patients."* It is acknowledged by NICE that multidisciplinary teams may be developed to cater for smaller numbers. Taking into consideration these guidelines as well as advice from the head and neck surgeons in Ireland and geographical considerations, Comhairle recommends that each supraregional centre should have a minimum throughput of 300 patients per year, which will generate approximately 50 major head and neck cases per year i.e. approximately one major head and neck case per week. Each such centre should be staffed by a multidisciplinary team, as detailed in paragraph 6.4.5. Four centres in Ireland currently meet many of these criteria – Beaumont Hospital, the Mater Hospital, St James's Hospital and the South Infirmary-Victoria Hospital. A service for advanced and complex head and neck cancer surgery should be developed at University College Hospital, Galway as Galway has been designated a supraregional centre for cancer services, including radiotherapy. Other hospitals may continue to provide an important contribution to head and neck cancer surgery services, in the context of clear protocols regarding referral to supra-regional centres with particular reference to diagnosis and follow up care. All major head and neck cancer cases diagnosed at regional centres should be referred to one of the five supraregional centres. Clear protocols should be devised by each major centre vis-à-vis other hospitals within its regional network. The five designated major head and neck cancer centres should collaborate where appropriate e.g. research and data collection.

4 EXISTING ORAL & MAXILLOFACIAL SERVICES

4.1 NATIONAL DISTRIBUTION OF OMFS SERVICES

4.1.1 Oral & Maxillofacial Surgery is one of the newest of the surgical specialties. To date, OMFS services have developed in Ireland in a piecemeal fashion, in the context of existing / traditional service provision and a pragmatic approach adopted by the relevant health authorities. The regulation of *"Maxillofacial Services"* (as entitled in Ireland in the 1970s), was under the remit of the Department of Health & Children until relatively recently. In 1997, the Department of Health & Children decided that the consultant staffing of the specialty of oral and maxillofacial surgery should come within the statutory ambit of Comhairle na nOspidéal. In Ireland, a maxillofacial service had been provided since 1979 by one consultant *"maxillofacial surgeon"* and support staff, under the direction and remit of the former EHB, at Dr. Steeven's Hospital. The service was subsequently transferred to St. James's Hospital, with the post holder providing two sessions in St. Vincent's Hospital and one session at Beaumont Hospital.

The current approved consultant staffing in oral and maxillofacial surgery is summarised in Table 2 and described in the following paragraphs.

Table 2: Current Consultant OMFS Staffing

Region		Consultant Establishment	Consultant/Population Ratio
East	1,401,441	3	1/467,000
Midlands	225,363	0	-
Mid-West	339,591	2	1/170,000
Northeast	344,965	0	-
Northwest	221,574	0	-
Southeast	423,616	0	-
Southern	580,356	0	-
West	380,297	1	1/380,000
Total	**3,917,203**	**6**	**1/653,000**

4.2 EAST§

Population: 1,401,441

4.2.1 There are three consultant posts in the East based in St. James's Hospital with sessions to Beaumont Hospital, St. Vincent's Hospital, the Dublin Dental Hospital and TCD. The sessional distribution of each of the three posts is outlined hereunder:

Table 3:**

	St. James's	Beaumont	St. Vincent's	TCD / DDS&H
Post 1	8 sessions	1 session	2 sessions	
Post 2	6 sessions	5 sessions	-	
Post 3 (full-time academic)	6 sessions	-	-	5
TOTAL	**20 sessions**	**6 sessions**	**2 sessions**	**5 sessions**

§ Notes:

Post 1 was subsumed by the DOH&C in the 1970s and was absorbed into Comhairle staffing statistics on the transfer of statutory responsibility for regulating consultant appointments in oral and Maxillofacial surgery in 1997.

Post 2 was approved by Comhairle na nOspidéal in June 1997, based at St. James's & Beaumont hospitals, given that an oral & maxillofacial surgery service had been established in St. James's Hospital and Beaumont Hospital provided a neurosurgery service.

Post 3, approved in May 2002, is classified as fulltime academic under St. James's Hospital and the Dublin Dental School & Hospital / Trinity College. This third post was approved to cement the development of academic and service links between St. James's and the Dublin Dental School & Hospital, together with aiming to provide additional consultant sub-specialty expertise. All three posts are joint appointments.

** In addition to the above total sessions, there is a full-time Senior Lecturer in Oral & Maxillofacial Surgery who holds an appointment with the Dublin Dental School & Hospital. The post holder undertakes oral surgery in the Dublin Dental Hospital and St. Mary's Hospital, Phoenix Park and provides a substantial oral and maxillofacial surgery service at the Mater Hospital via an inter-hospital arrangement.

4.2.2 **St. James's Hospital**

The Oral and Maxillofacial unit at St. James's Hospital provides both secondary and tertiary referral services for OMFS on both a national and regional level. The unit is staffed by the consultant complement (as outlined in the above table), in addition to NCHD staff, which varies over time, but at as of June 2004 consisted of five registrars and one intern, together with the associated allied health and nursing professionals. Approximately 60% of referrals to the unit are from within the eastern region. The remainder constitutes referrals from throughout the state. The activity of the unit includes, *inter alia*, orthognathic surgery, dentoalveolar surgery, facial deformity, cleft palate surgery, craniomaxillofacial implant surgery, skullbase surgery, facial trauma, the surgical and non-surgical management of the temperomandibular joint, reconstructive surgery and the management of head and neck cancer.

4.2.3 A Maxillofacial laboratory is located in St. James's Hospital, following its transfer from Dr. Steeven's Hospital. A wide variety of services are provided including the management of trauma, orofacial cancer and congenital malformations. There is a high degree of collaboration between these professionals and both OMF surgeons and oral specialists (e.g. orthodontists), particularly in the planning and treatment of oral cancer patients. The proximity of the maxillofacial laboratory to the OMF unit assists in the provision of a cohesive co-ordinated service for patients, many of whom will require treatment from the maxillofacial laboratory for life.

4.2.4 **The Dublin Dental School and Hospital (DDS&H)**

The Dublin Dental School & Hospital is a major provider of Oral and Maxillofacial services. In May 2002, a Consultant / Professor of Oral & Maxillofacial Surgery was approved by Comhairle na nOspidéal for St. James's Hospital (6 sessions per week) and the Dublin Dental School & Hospital / Trinity College (5 sessions per week), i.e. post 3 above. In addition to the latter, the DDS&H is staffed by a Senior Lecturer in Oral & Maxillofacial Surgery, an oral surgeon and two specialist oral surgeons (all DDS&H appointments), together with the appropriate support staff. Services are provided via out-patient clinics and day theatres. The DDS&H has two fully equipped operating theatres and a day bed facility. The DDS&H also has links with St. Mary's Hospital, Phoenix Park (within the day surgery dental unit) and the Mater Hospital. The Dental School, which is linked to St. James's Hospital, has a training programme for Specialists in Oral Surgery and currently there are two trainees. A training programme in OMFS involving the Dublin Dental School & Hospital and St. James's Hospital had been in existence for some years, (as described earlier in paragraph 2.4.2.4), until approval was withdrawn in 2002 by the SAC.

4.2.5 **OMFS links with the Neurosurgical Unit at Beaumont Hospital**

There are two posts of consultant oral and maxillofacial surgeon each with designated sessions, (1 session per week and 5 sessions per week, respectively) at Beaumont Hospital. The latter was appointed in 1997 to provide a service for patients with craniofacial trauma referred on a national basis. The service provided at Beaumont Hospital includes dentoalveolar surgery on a day care basis,

head and neck surgical oncology, the management of salivary gland disease, and the reconstructive surgery for major facial defects.

4.3 MIDLANDS

Population: 225,363

There is no post of Consultant Oral & Maxillofacial Surgeon in the Midlands. Patients requiring an OMFS service are referred to St. James's Hospital, Dublin with a small minority of complex neurosurgical OMFS cases referred to Beaumont Hospital. The committee understands that a private elective inpatient and day care service is provided in St. Josephs Private Hospital, Ballinderry, Mullingar by a Dublin based consultant.

4.4 MID-WEST

Population: 339,591

There are two posts of Consultant OMFS in the Mid-West based in the Mid-Western Regional Hospital Limerick, with a regional remit. The second post was approved by Comhairle in December 2003 and was filled in September 2004. The OMFS Department was initially located in the Dental Clinic in St Camillus Hospital, but was subsequently transferred to the MWRH, Limerick in 1997. The Department is now staffed by two Consultant Oral and Maxillofacial Surgeons, in addition to support staff in the form of a registrar, two SHOs and the appropriate nursing and allied health care professionals. The service is centred at the MWRH, Limerick, with out-patient clinics at Ennis, Nenagh and St. John's Hospitals. A peripheral clinic is held in Galway at the Western Regional Orthodontic Department, Merlin Park Hospital. A wide range of OMF Surgery is provided through the MWRH, Limerick including inter alia, dentoalveolar surgery, pre-prosthetic surgery, management of diseases of the temporomandibular joints, management of craniofacial trauma and deformities, surgical oncology, oral and maxillofacial malignancy and orthognathic surgery. Patient referrals are accepted from a broad base including health board area dental surgeons, general dental practitioners, hospital based consultants, the orthodontic service (MWHB and WHB) and the Accident and Emergency Departments in the Mid-West.

4.5 NORTHEAST

Population: 344,965

There is no post of Consultant Oral and Maxillofacial Surgeon in the North East. The majority of patients requiring an OMFS service are referred to St. James's Hospital, Dublin with the remainder referred to Beaumont Hospital.

4.6 NORTHWEST

Population: 221,574

There is no post of Consultant Oral and Maxillofacial Surgeon in the North West. However, a limited OMFS service is provided (for the patients from the Donegal environs), by a consultant from Altnagelvin Hospital in Derry who attends Letterkenny General Hospital on a monthly basis. Non-complex surgery and out-patients clinics are undertaken on site while more complex cases are sent to Altnagelvin. All patients from the Sligo / Leitrim area are referred directly to St. James's Hospital, Dublin. A visiting oral surgeon also provides some oral surgery treatment at Sligo General Hospital.

4.7 SOUTHEAST

Population: 423,616

There is no post of Consultant Oral & Maxillofacial Surgeon in the South East. The majority of patients requiring OMFS are referred to Cork (Cork University Hospital / University Dental School & Hospital) and the remainder to St. James's Hospital, Dublin.

4.8 SOUTH

Population: 580,356

A Consultant Oral and Maxillofacial Surgery service is provided in the South via the University Dental School & Hospital, Cork, with operating facilities and beds in Cork University Hospital (CUH). The oral & maxillofacial surgery service is staffed by a complement of two specialists, an oral surgeon and a professor of maxillofacial surgery, both of whom are employed by the University Dental School & Hospital, Cork. The professor of maxillofacial surgery post is not a Comhairle na nOspidéal approved consultant post.

The service provides for patients from the South and some from the South Eastern region. The main source of referral is from dental clinics in the South and South East, general medical and general dental practitioners and referrals from orthodontic services. CUH itself, is also a source of referrals, particularly from consultants providing care for patients undergoing cardiac and orthopaedic surgery.

The activity undertaken at the OMFS Department includes, orthognathic surgery, facial trauma, bone grafting, salivary gland surgery, and temporomandibular joint surgery. Out-patient clinics are provided in the Dental School and Hospital. The interface between the OMFS and the plastic surgeons at CUH is significant. Interdependencies have developed over time between the two specialties, particularly in the provision of a comprehensive head and neck surgery service at CUH.

4.9 WEST

Population: 380,297

There is one post of Consultant Oral & Maxillofacial Surgeon in the West based at University College Hospital, Galway. The post holder took up duty in April 2004 but resigned shortly afterwards. It had been envisaged that the work of the oral and maxillofacial surgeon would include all operations on the maxillo-facial skeleton, which would include both elective and trauma cases. Owing to the post being vacant for most of the past 3-4 years, consultants in other specialties, (e.g. one of the consultant plastic surgeons who is trained in mandibular and maxillary treatment) based at UCHG, carry out as much of the OMFS work as possible, with the remainder being transferred to St. James's Hospital, Dublin. Patients requiring dentoalveolar treatment are referred to a private oral surgeon.

4.10 SUMMARY OF EXISTING CONSULTANT ESTABLISHMENT

In summary, there are six Comhairle na nOspidéal approved posts of consultant oral and maxillofacial surgeon in Ireland. According to the census 2002 figures, the population of the Republic of Ireland has grown to 3,917,203. This equates to a ratio of 1 consultant per 653,000 population. Three of the six posts are located in the Dublin, with two in Limerick and one in Galway.

4.11 GUIDELINES FOR NUMBER OF CONSULTANT ORAL & MAXILLOFACIAL SURGEONS BASED ON POPULATION

The British Association of Oral and Maxillofacial Surgeons[5] currently recommends a ratio of one Consultant OMFS per 150,000 population. Their report (2002), states that *"a population in the region of one million would provide a critical mass for the service"*. However, it recognised that for the foreseeable future a district General Hospital in the UK serving a population of approximately 300,000 is likely to continue as the basic unit providing the majority of emergency and elective OMFS services. Similarly, the Senate of the Royal College of Surgeons of Great Britain & Ireland recommends 1 consultant per 150,000 population, in the context of OMFS units covering a minimum catchment population of 300,000.

The committee also noted that the American Association of Maxillofacial Surgeons recommend a ratio of 1 consultant OMF Surgeon per 150,000 population.

Table 4: International Consultant Oral and Maxillofacial Surgery Staffing

Country	Population	Total No. of Consultants	Consultant/Population Ratio
Ireland	**3,917,203**	**6**	**1 / 653,000**
UK	58,789,194	308 in total	1 / 190,874
England	49,138,831	253	1 / 194,224
Wales	2,903,085	18	1 / 161,282
Scotland	5,062,011	31	1 / 163,290
Nth. Ireland	1,685,267	6	1 / 280,877

Source – Ireland figures - Comhairle na nOspidéal, Consultant Staffing - 2005
Source – UK figures - British Association of Oral & Maxillofacial Surgery – List of Oral & Maxillofacial Hospital Units - (January 2005)[9]

Table 5: Regional Oral & Maxillofacial Centres - UK Comparisons

Country	Number of OMFS Units	Number of omfs consultants per unit	Ratio of unit, per population, per country
England pop. 49,138,831	129	2-3 majority of units 7-8 in 5 large centres	1/ 380,920
Wales pop. 2,903,085	6	2-4	1/ 483,848
Scotland pop. 5,062,011	11	2-3 majority of units 8 in glasgow centre	1/ 460,182
Northern ireland pop. 1,685,267	3	2	1/ 561,755
UK TOTAL pop. 58,789,194	**149**	**-**	**1/ 394,558**

Source – BAOMS – "List of Oral and Maxillofacial Hospital Units". January 2005[9]

4.12 ORAL AND MAXILLOFACIAL SERVICE PROVISION IN NORTHERN IRELAND

4.12.1 In Northern Ireland, oral and maxillofacial surgery is provided at three hospital sites; Altnagelvin Hospital, Derry, the Royal Victoria Hospital, Belfast and Ulster Hospital, Dundonald. The oral and maxillofacial department based at Altnagelvin Hospital provides a comprehensive service to a population of approximately 350,000 in the North and West of Northern Ireland. The department is staffed by two consultant OMF surgeons and four SHOs. The department is an integral part of a trauma centre service in Altnagelvin, complementing the treatment of the severely traumatised patient with other specialties on site.

4.12.2 The Oral & Maxillo-Facial unit in the Royal Victoria Hospital serves the greater Belfast region and the unit is staffed by four consultant oral & maxillofacial surgeons. Almost all the regional medical, surgical and dental services are provided at the Royal Group of Hospitals & Dental Hospital Health & Social Services Trust. The oral and maxillofacial unit in Ulster Hospital is staffed by three consultant OMF surgeons.

- The components of oral and maxillofacial surgery services at all three hospital units involves:
- Elective and emergency treatment
- Day case surgery
- Out patient sessions held at each of the three hospitals and at selected acute general hospitals in the neighbouring areas.

5 RECOMMENDATIONS FOR FUTURE DEVELOPMENT OF OMFS SERVICES IN IRELAND

5.1 FRAMEWORK FOR DECISION MAKING

5.1.1 During the course of the work of the committee, it became evident that there is a need for more consultant oral & maxillofacial surgeons in public hospitals in Ireland, linked to Dental Schools / Dental Hospitals. The specialty has developed internationally over the past 20 years and the roles of both the oral surgeon and oral and maxillofacial surgeon have evolved during this time. Before making recommendations on the future development of oral and maxillofacial surgery services in Ireland, the committee took into consideration a variety of factors which formed the framework for its recommendations. In formulating recommendations, the committee has taken into account the following:

- national and international surgical & dental advice,
- the principles espoused in the Health Strategy *"Quality & Fairness, A Health System for You"*[8] namely:
  (i) equity,
  (ii) people-centredness,
  (iii) quality and
  (iv) accountability
- the interface between OMF Surgeons and other relevant specialties,
- submissions from a range of bodies representing various surgical specialties
- the range of views expressed by consultant oral & maxillofacial surgeons to the committee
- the proposals of various health authorities and hospital authorities
- the existing network of hospitals
- the current distribution of consultant oral & maxillofacial surgeons
- variations in demographic and geographic patterns throughout the state.

5.1.2 The committee was advised by consultant oral & maxillofacial surgeons that OMF surgery is to a large extent consultant provided, as distinct from a consultant led service. There are 6 consultants and 10 NCHDs employed in the public sector. The professional advice received indicated that the aim of an oral and maxillofacial unit is to provide (with colleagues in other allied specialties) a comprehensive diagnostic and surgical service in the anatomical area of the face, jaws, oral cavity, neck and surrounding areas. It is necessary for services to be structured to facilitate OMF surgeons to be involved with other specialties in joint clinics and surgical work together with facilities for research. The professional advice received indicated that many of the routine OMFS procedures can be provided on a day-case basis in an OMFS unit.

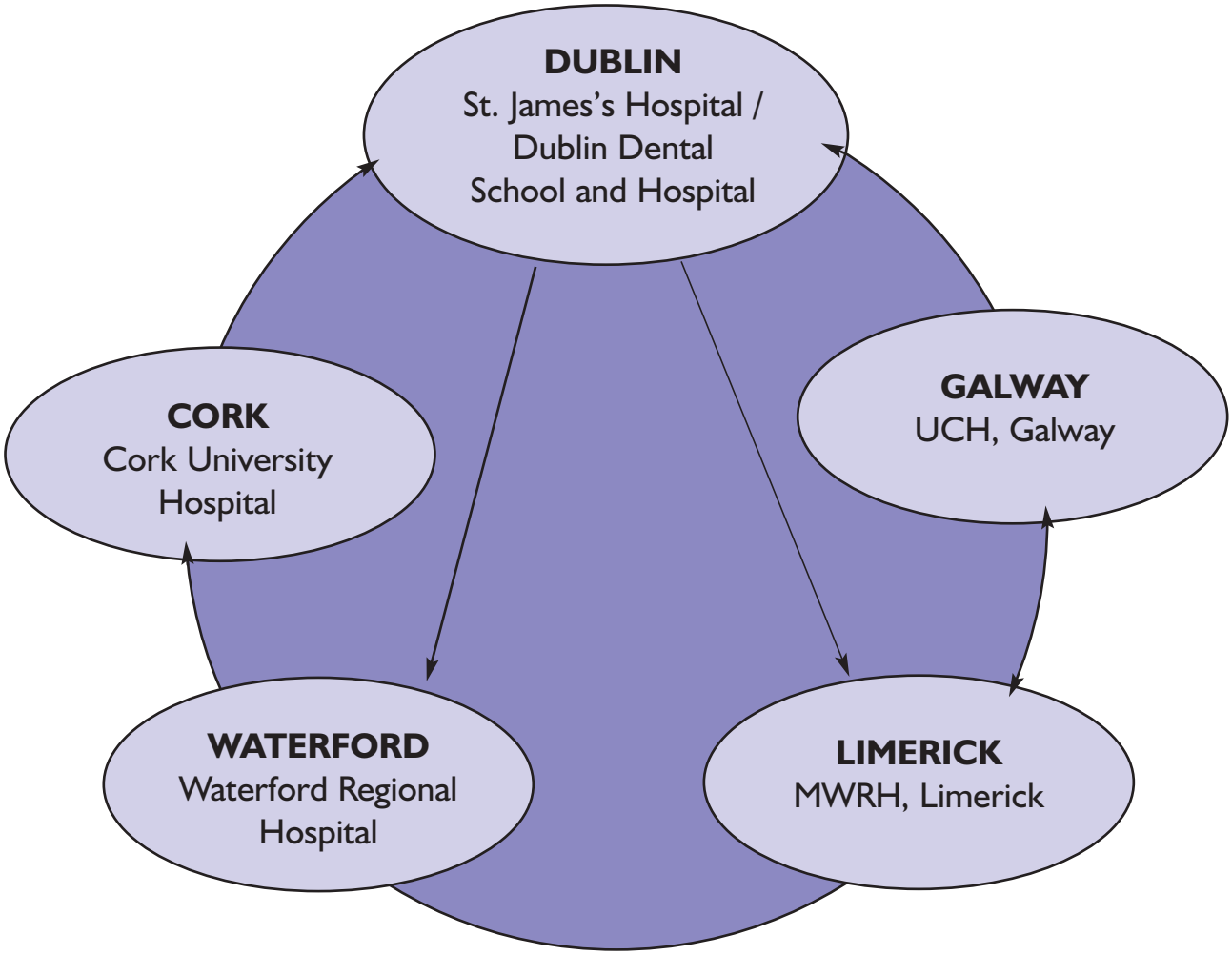
5.2 STRUCTURE OF SERVICES – OVERALL PICTURE

5.2.1 This report sets out a strategy for the planning and implementation of additional consultant staffing and services in Oral & Maxillofacial Surgery. The committee proposes to develop OMFS services at the existing major oral & maxillofacial surgery unit in Dublin, based at St. James's Hospital / Dublin Dental School and Hospital. In addition, the committee proposes the provision of a wider geographical distribution of OMFS services, consistent with good medical and dental practice and appropriate standards of care, through regional OMFS units around the country via (i) the continued development and expansion of existing OMFS services as a priority, and (ii) the establishment of a new regional OMFS unit as a longer term goal. Notwithstanding the competing priorities at national,

regional and individual hospital levels, the committee suggests the early implementation of its recommendations in order to address the unmet needs of patients identified by the hospital authorities and professional representatives. The achievement of these targets depends on a number of other important factors such as the availability of financial resources, provision of associated infrastructural requirements and the recruitment of skilled personnel.

5.2.2 It was evident to the committee that oral & maxillofacial surgery is a relatively young specialty and is evolving owing to (i) the emergence of new technologies and (ii) the range of personnel with various areas of expertise which are influenced by the location of their training and subsequent experience. Bearing these factors in mind, it was felt that capacity building, together with an increase in consultant staffing in existing hospitals providing an oral & maxillofacial surgery service, should be the initial priority area for development. As a priority, **Comhairle na nOspidéal recommends that the existing oral & maxillofacial service provided at St. James's Hospital / the Dublin Dental School & Hospital should continue to be the focal point for the organisation and development of Oral & Maxillofacial services in Ireland. It should provide services via shared consultant appointments with other major teaching hospitals in Dublin. This OMFS service should be augmented by regional oral and maxillofacial units throughout the country namely in Cork, Galway, Limerick and Waterford. It is also recommended that links be developed between the academic units in Dublin and Cork and later in Galway to support training.** The detailed recommendations in relation to service delivery and consultant staffing are set out in later paragraphs.

DIAGRAM OF PROPOSED STRUCTURE OF OMFS SERVICES, INCLUDING LINKAGES BETWEEN HOSPITALS



5.3 CONSULTANT STAFFING

5.3.1 The recommendations in the following paragraphs regarding consultant staffing are based on both the requirements of the immediate catchment area indicated and the relationship with, and the level of service to be provided to, other regions. The recommendations are broadly in line with the recommendations outlined by the Royal College of Surgeons in Ireland, in their document entitled "The Future of Surgical specialties in Ireland".(November 2003).[13]

5.3.2 According to the British Association of Oral & Maxillofacial Surgery, the minimum viable population for an oral and maxillofacial surgery service is approximately 300,000.[4] However, the Association also advised that no single-handed consultant appointments should be made in the future and where single-handed consultant appointments exist, an additional consultant post should be put in place as a priority. Based on advice received from the relevant professional bodies, Comhairle na nOspidéal advises that a ratio of one consultant oral & maxillofacial surgeon per 150,000 would be appropriate in Ireland, in the context of a minimum of two consultants per OMFS unit, serving a population of at least 300,000. The implementation of this target would mean that the existing number of consultant OMF surgeons would be increased fourfold, from 6 posts to 24. This is an ambitious target which will take some time to achieve. A more realistic interim target is to implement the priority posts identified in Table 6. The table sets out, in summary form, Comhairle na nOspidéal's priority recommendations and longer term proposals for the development of consultant oral & maxillofacial surgery services in Ireland.

5.4 FUTURE ORGANISATION OF OMFS SERVICES BY REGION

5.4.1 EAST (pop. 1.401,441)
OMFS Centre – Dublin (St. James's / DDS&H)

5.4.1.1 Comhairle na nOspidéal recommends the provision of oral & maxillofacial surgery services in the east via the existing St. James's / Dublin Dental School & Hospital service. There are currently 3 posts of consultant oral & maxillofacial surgeon based in St. James's Hospital. One post is shared with Beaumont and one post has sessions at St. Vincent's. The value and usefulness of these links was recognised by the committee. A similar model of shared appointments between the OMFS centre and the other major teaching hospitals in Dublin is proposed. The structure of posts is outlined in outlined Table 6.

5.4.1.2 Comhairle recommends that the St. James's / DDS&H OMFS centre should continue to be the focal point for the organisation and development of OMFS services in Ireland. It recommends that the centre should develop protocols and guidelines in line with best international medical practice which should be followed and implemented by all units providing an OMFS service.

5.4.1.3 It is recommended that each future consultant post based in St. James's Hospital / DDS&H would be a shared / joint appointment with a named teaching hospital in Dublin. It is envisaged that the consultant will provide OPD clinics and day case procedures in the named teaching hospital in accordance with local need and assessment. The on-call service should be at the major centre and patients requiring emergency OMF surgery should be transferred from other hospitals to the St. James's OMFS centre.

5.4.2 Service Delivery via the OMFS Centre in Dublin (to serve a pop. of 2.2 million)

5.4.2.1 The range of OMFS services to be provided via the **OMFS centre* - St. James's Hospital / DDS&H** - should include;

*The centre incorporates services provided at the other major teaching hospitals in Dublin via shared appointments.

- All major facial trauma
- in-patient care
- facial deformity

- paediatric maxillofacial surgery including cleft and craniofacial surgery
- craniofacial surgery[1] (adult) in conjunction with Beaumont which has consultant neurosurgeons on site
- paediatric craniofacial surgery in conjunction with Beaumont and Temple St. which has consultant neurosurgical expertise on site (2 sessions per week)
- cleft lip & palate surgery[2]
- facial access surgery
- head & neck work (collaboration between OMFS / ENT / Plastics)
- dedicated day case facilities
- collaborative research
- telemedicine facilites

[1] - See Section 3 for specific recommendations on where adult craniofacial surgery should be undertaken

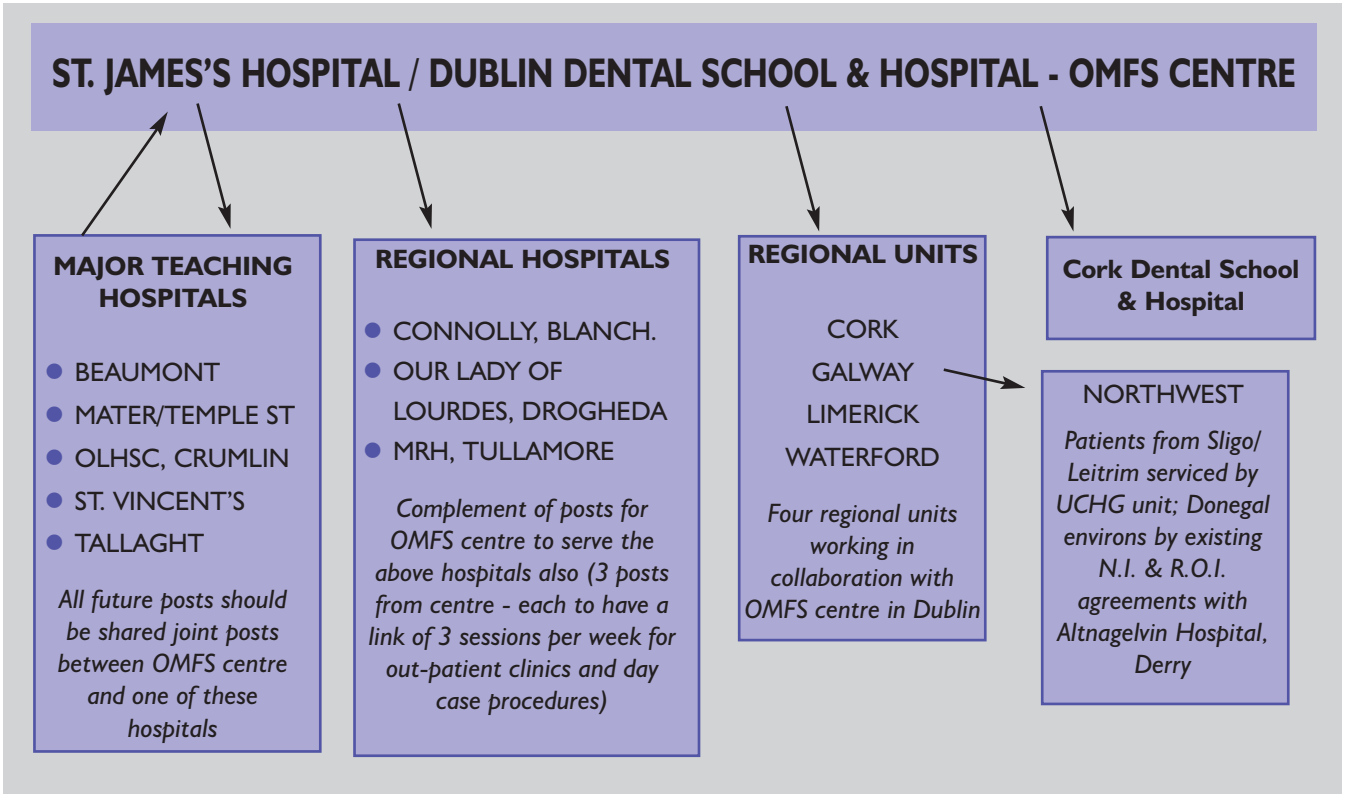
[2] - See Section 3 for specific recommendations on where cleft lip and palate surgery should be undertaken.

5.4.2.2 The committee recommends a concentration of specialist expertise in one centre. According to the advice received from the Irish OMFS group,[13]

"There are certain patients and procedures that should be treated in a single specialised centre with complete multidisciplinary teams. Cleft lip and palate / craniofacial surgery / advanced orbital and orofacial reconstructions are areas in maxillofacial surgery where it is believed better results are achieved in a specialised unit with the full multidisciplinary team. Surgeons / team members with specific skills often travel to the specialised unit to provide the best service for the patient."

The following diagram demonstrates the proposed linkages with the OMFS centre in St/ James's Hospital / Dublin Dental School & Hospital

Figure 1.2



5.4.3 MIDLANDS (POP. C. 225,000) & NORTHEAST (POP. 345,000)

Comhairle na nOspidéal recommends that the Dublin OMFS Centre based in St. James's Hospital / Dublin Dental School & Hospital provide an oral & maxillofacial service to the midlands and the north-east. Comhairle na nOspidéal recommends a complement of 13 posts in total for the east to serve a combined population of over 2 million, incorporating the east, the north-east and the midlands.

Comhairle na nOspidéal recommends that one post from the complement of 13 posts recommended for the major OMFS unit should be linked to Our Lady of Lourdes Hospital Drogheda, with three sessions per week, for out-patient clinics and day-case procedures. Similarly one post should be a linked to the Midlands Regional Hospital, Tullamore, with three sessions per week, for out-patient clinics and day-case procedures.

5.4.4 WEST (POP. C. 380,000)
OMFS UNIT – UCH, Galway

There is one approved vacant post of consultant Oral & Maxillofacial Surgeon in the West based at University College Hospital Galway. Comhairle na nOspidéal recommends that University College Hospital, Galway, be designated as a regional OMFS unit to provide a service for patients from Connaught.

Comhairle na nOspidéal recommends the filling of the replacement consultant post and the creation of a second post to be based at UCHG as a priority. Comhairle recommends an overall long term total of 3 posts of consultant oral & maxillofacial surgeon for the regional OMFS unit based at UCHG with one post having a formal link to NUIG. An ongoing collaborative approach with the OMFS centre in Dublin is recommended. It is also recommended that links be established / developed between the units in Galway and Limerick.

The range of OMFS services to be provided at **UCHG** should include;

- facial trauma
- in-patient care
- out-patient clinics
- facial deformity
- dedicated day-case facilities
- head & neck work (collaboration with OMFS / ENT / Plastics)
- collaborative research (with Dublin)
- telemedicine facilities

5.4.5 NORTHWEST (POP. C. 220,000)

Comhairle na nOspidéal recommends that patients from the Sligo / Leitrim area should be served by the OMFS unit at University College Hospital, Galway. In addition out-patient clinics and day services should be provided at Sligo General Hospital via consultant provision from the OMFS unit based at UCHG.

Comhairle na nOspidéal supports the proposal from the North West and the Department of Health & Children of the continuation and enhancement of OMFS services provided at Letterkenny General Hospital, for patients from the Donegal environs, by consultant OMF surgery input from Altnagelvin Hospital in Derry. It is recommended that formal discussions are entered into by the relevant authorities from Northern Ireland and the Republic of Ireland, and that mechanisms be put in place to formalise the continuation of the service.

5.4.6 SOUTH (POP. C. 570,000)
OMFS Unit – CUH / UCC Dental School

As outlined earlier, a consultant oral and maxillofacial surgery service is provided in Cork by a professor of maxillofacial surgery, employed by the Cork University Dental School & Hospital.

Comhairle recommends that Cork University Hospital in association with the UCC Dental School be designated as a regional OMFS unit to provide a service for the South and parts of the South East region. It is recommended that the existing professor / academic post be re-categorised into an approved HSE-Comhairle consultant OMF surgeon post as a priority, together with an additional consultant post for CUH / UCC Dental School.

Comhairle recommends an overall long term total of 4 posts of consultant oral and maxillofacial surgeon for the regional oral & maxillofacial surgery unit based at Cork University Hospital. It is recommended that links be established between the unit in Cork and the proposed recommended regional unit in Waterford Regional Hospital when established. An ongoing collaborative approach with the OMFS centre in Dublin is also recommended.

The range of OMFS services to be provided at **CUH/UCC dental school** should include;
- facial trauma
- in-patient care
- out-patient clinics
- facial deformity
- dedicated day-case facilities
- head & neck work (collaboration with OMFS / ENT / Plastics)
- collaborative research (with Dublin)
- telemedicine facilities

5.4.7 SOUTHEAST (POP. 425,000)
OMFS UNIT – WATERFORD REGIONAL HOSPITAL

Currently there is no post of consultant oral & maxillofacial surgeon in the south eastern region. As a long term goal, Comhairle recommends the establishment of an OMFS unit at Waterford Regional Hospital, with two posts of consultant oral & maxillofacial surgeon, to provide a service for people from the south east. In the interim it is recommended that links be established between Waterford Regional Hospital and the Cork OMFS unit. As an interim measure, it is recommended that out-patient clinics and day services could be provided at Waterford General Hospital via consultant provision from the OMFS unit based at CUH when additional posts are appointed to CUH. In the intervening period, it is recommended that patients travel to the unit in CUH. When the unit in Waterford is developed, it is envisaged that the services provided would be similar to those in Limerick.

5.4.8 MID-WEST (POP. C. 340,000)
OMFS UNIT – MWRH, LIMERICK

During the lifetime of this committee a second post of consultant OMF surgeon was approved in line with advice from the OMFS group that there was a need to complement the existing OMFS service at Limerick then staffed by one consultant.

Comhairle recommends the development of the OMFS unit at the Mid-Western Regional Hospital, Limerick.

Comhairle recommends an overall complement of 2 consultant oral & maxillofacial surgeons to serve the Mid-West, based at the Mid-Western Regional Hospital, Limerick. It is recommended that links be established between the OMFS unit in MWRH, Limerick and the Dublin OMFS centre. It is also recommended that links be established between Limerick and Galway.

The range of OMFS services to be provided at **MWRH, Limerick** should include;
- facial trauma
- in-patient care
- out-patient clinics
- facial deformity
- dedicated day-case facilities

- head & neck work (collaboration with OMFS / ENT / Plastics)
- collaborative research (with Dublin)
- telemedicine facilities

5.5 THE DEVELOPMENT OF ACADEMIC LINKS

5.5.1 One of the challenges for the future of oral and maxillofacial surgery in Ireland is to regain SAC approval for OMFS training. Comhairle believes that it is vitally important to regain recognition for training in OMFS in Ireland. Comhairle recommends the strengthening and development of academic links between the Dental and Medical Schools and hospitals. It is essential that current barriers to full accreditation be addressed as a matter of urgency to provide scope for the future development of the specialty. According to a report by the SAC[5] the principal reasons cited for the withdrawal of recognition of training effective from November 2002 included; limited case mix - in particular lack of exposure to head & neck oncology, salivary gland disease, reconstruction, limited supervised training – in no small part due to very low number of consultants for the large volume of service workload, no formal systematic training and lack of formal rotation with other units. In this context, and in an effort to address some of these barriers, Comhairle believes that it is essential to develop the existing OMFS services provided at St. James's Hospital / Dublin Dental School and Hospital. There is currently one full-time academic post of Professor of Oral & Maxillofacial Surgery / Consultant based at St. James's / DDS&H. As outlined earlier, it is recommended that the existing professor / academic post based at Cork University Dental School & Hospital / Cork University Hospital, be re-categorised into an approved HSE-Comhairle Professor of Oral & Maxillofacial Surgery / Consultant as a priority. It is also recommended that academic links be developed at Galway between UCHG and NUIG including a linked post as recommended in paragraphs 5.4.4.

5.6 PRIORITY AREAS FOR DEVELOPMENT

5.6.1 In the context of matters addressed in paragraphs 5.1 and 5.2 the order of priority development is recommended as follows:-

(1) **Dublin Centre** – St. James's Hospital / Dublin Dental School & Hospital / TCD / Crumlin (pop. c. 2.2million)

- Priority is 3 additional posts at the OMFS centre linked to the following major teaching hospitals, (i) OLHSC, Crumlin, (ii) The Children's Hospital Temple St. and (iii) Tallaght Hospital.
- The re-designation of a post of senior lecturer in OMF surgery who has a contract with the Dublin Dental School & Hospital and provides an OMFS service at the Mater Hospital, into a HSE-Comhairle consultant OMF surgeon. The reconfiguration of the post shared between St. James's and St. Vincent's hospitals to include more sessions provided at St. Vincent's Hospital.

(2) **Cork** – Cork University Hospital / UCC Dental School (pop. c. 600,000)

- Priority is to re-structure the post of prof. of maxillofacial surgery who holds an academic contract, into a HSE-Comhairle approved consultant OMF surgeon post
- Second priority is the creation of an additional post to complement service provided by UCC Dental School & Hospital and development of OMFS unit.

Galway - Galway University Hospital (pop. c. 500,000)

- Priority is approval of replacement vacant consultant post.
- Second priority is the creation of an additional post to the OMFS unit.

(3) **Limerick** - MWRH (pop. c. 350,000)

- Continuation of existing OMFS unit in MWRH Limerick, staffed by 2 posts of OMF surgeon.

(4) **Waterford – Waterford Regional Hospital** (pop. c. 450,000)

- Establishment of a new OMFS unit in WRH as a long term goal

Table 6: Recommendations re Consultant Oral & Maxillofacial Surgery Posts

← EXISTING SERVICE → ← FUTURE SERVICE CONFIGURATION →

BASE HOSPITAL	CURRENT CONSULTANT ESTABLISHMENT	PRIORITY RECOMMENDATIONS	INTERIM TOTAL	LONG TERM TOTAL
DUBLIN OMFS CENTRE (including service to Midlands and Northeast)				
ST. JAMES'S / DDS&H = Dublin OMFS CENTRE	2.5 wte	-	4 WTE DUBLIN OMFS CENTRE	4[A] (inc. sessions from two posts
CRUMLIN		+1 St. James's / Crumlin	0.5	to serve north east & midlands)
BEAUMONT	0.5 WTE	-	0.5	0.5
MATER / TEMPLE ST.	1*	*1 re-designated St. James's/ Mater	0.5	0.5
		+1 St. James's/Temple St	0.5	
TALLAGHT (inc. NAAS)	-	+1 St. James's / Tallaght	0.5	0.5
ST. VINCENT'S (inc. ST. MICHAEL'S & ST. COLUMCILLE'S	2 sessions	1 restructure as St. James's /Vincent's (6 sessions) / (5 sessions)	0.5	0.5
TOTAL (pop. c.2.2 million)	3	+3new & 1 re-designation = 4	7	13[A]
CORK OMFS UNIT				
CUH / UCC DENTAL SCHOOL (pop. c.600,000)	1*	*1 re-designated +1	2	4
GALWAY OMFS UNIT				
UCH, GALWAY (pop. c. 500,000)	1	+1	2	3 (inc. sessions from one post to serve Sligo Regional Hosp.)
LIMERICK OMFS UNIT				
MWRH, LIMERICK (pop. 350,000)	2	-	2	2
WATERFORD OMFS UNIT				
WATERFORD REGIONAL HOSPITAL (pop. c.400,000)	0	0	0	2
OVERALL TOTAL	**6**	**+5 new & 2 re-designated =7**	**13**	**24**

*These posts are filled by a (i) Senior Lecturer in Oral & Maxillofacial Surgery who has a contract with the Dublin Dental School & Hospital and (ii) a Professor of Maxillofacial Surgery with an academic contract with Cork University Dental School & Hospital. These posts are not Comhairle approved consultant OMFS posts. However they each provide a substantial OMFS service to patients via public hospitals / dental schools in their region & Comhairle recommends their formal restructuring into approved HSE posts as outlined above.

[A]- The organisation of OMFS services in the East should be reviewed when the present posts have been filled and in operation for some time. The allocation of further posts should be determined in light of this review.

6 SUMMARY & CONCLUDING REMARKS

6.1 In formulating its recommendations for the development of oral & maxillofacial surgery services, Comhairle na nOspidéal has endeavoured to be pragmatic in recognising the existing services and using them as the basis for future development, in accordance with the principles which it has identified. Comhairle na nOspidéal is of the view that a compelling case had been made for a significant enhancement of oral and maxillofacial services and a substantial expansion in related consultant staffing. This report details a plan for the development of oral & maxillofacial surgery services and consultant staffing in Ireland over the next decade or so. Comhairle believes that the recommendations set out in the previous section are in the best interest of patients who are entitled to see, in the planning of services, attempts to achieve the best service that modern hospital medicine has to offer, judged by international standards.

6.2 Comhairle na nOspidéal believes that the implementation of the its recommendations will go a long way towards eliminating the current low level of oral & maxillofacial surgery services which, to a large extent, is due to understaffing at consultant level. It hopes that the increased number of consultants and the recommended organisational framework - the development of a Dublin OMFS centre together with regional OMFS units - will facilitate the provision of an enhanced oral & maxillofacial surgery service.

6.3 Comhairle na nOspidéal recognises that implementation of the recommendations set out in the report will take time. Implementation of the recommendations as outlined will also require detailed planning by health authorities, hospitals and others involved in the planning and delivery of OMFS services, as well as commitment on the part of all staff and increased or redirected resources. Comhairle na nOspidéal strongly believes that the implementation of the recommendations of this review will have tangible benefits for patient care.

7 REFERENCES

1. Eastern Health Board. *Development of Oral & Maxillofacial Surgery Services in the Eastern Health Board Region.* February 1999. Dublin.
2.. Joint Committee for Specialist Training in Dentistry. *Joint Committee on Higher surgical training. A five Year Higher Surgical Training Programme*. 1996. London
3. The British Association of Oral & Maxillofacial Surgery. *Profile of the Association and Scope of the Specialty*.1993. London.
4. The British Association of Oral & Maxillofacial Surgery. *The Organisation of Oral and Maxillofacial Surgical Services in the United Kingdom, produced by the Council of the British Association of Oral and Maxillofacial Surgeons*. March 2002. London
5. Joint Committee on Higher Surgical Training, Surgical Specialties. www.jchst.org. July 2002.
6. Dublin Dental School & Hospital, University of Dublin, Trinity College, *"Submission on Oral & Maxillofacial Services"*, 2002.
7. American Dental Association – OMFS .
8. Department of Health and Children. *Quality and Fairness A Health System For You.* November 2001. Dublin.
9. The British Association of Oral and Maxillofacial Surgeons. List of Oral and Maxillofacial Hospital Units. May 2003. London
10. Royal College of Physicians and Surgeons of Canada. July 2002.
11. Central Statistics Office. *Census 2002 Principle Demographic Results*. June 2003. Dublin.
12. Comhairle na nOspidéal. *Consultant Staffing January 2003*. Dublin. 2003.
13. Royal College of Surgeons in Ireland. *The Future of Surgical Specialties in Ireland. Oral & Maxillofacial Surgery Submission*. November 2003.
14. Department of Health & Children. *The Health Service Reform Programme*. June 2003. Dublin
15. National Task Force on Medical Staffing. Mr David Hanly, Chairman. June 2003. Dublin.
16. The Clinical Standards Advisory Group (CSAG), *Cleft Lip and Palate,* Chair Prof. J. Murray, 1998. London.
17. The British Association of Plastic Surgeons, *"Clinical Areas in Plastic Surgery"*, www.baps.co.uk
18. Cleft Interest Group – *"Report of CSAG Implementation Sub-Committee,"* 1998. London.
19. Department of Health & Children, UK, *"National reconfiguration of Cleft Services"*. 2002. London.
20. British Association of Oral and Maxillofacial Surgeons. Consultation paper entitled *"The organisation or oral and maxillofacial surgical services in the UK"*. www.BAOMS.org.uk
21. Department of Health Social Services and Public Safety. *Regional Advisory Committee on Cancer.* Belfast. www.dhsspsni.gov.uk/publications/archived/racc.pdf. 1999.
22. Walsh, Prof MA., on behalf of the IIOHNS. Written communication. October 2004.
23. Joint Committee on Higher Surgical Training. SAC for Otolaryngology. www.jchst.org. July 2002.
24 The Clinical Standards Advisory Group (CSAG). Study. Part 4: *outcome comparisons, training and conclusions*. December 1999.
25 Lawlor, Mr D., President Irish Association of Plastic Surgeons, on behalf of the IAPS. Electronic communication. October 2004.
26. Prof L. Stassen on behalf of the Irish OMFS Group. Electronic communication. October 2004.
27. Mr. F. Brady. Consultant Oral & Maxillofacial Surgeon. Written communication. 2004.
28. Mr. M. Earley. Consultant Plastic Surgeon. Written communication. March 2005.
29. Mr. D. Orr. Consultant Plastic Surgeon. Written communication. April 2005.
30. Irish Institute of Otolaryngology Head & Neck Surgery. (IIOHNS). Policy Document, Otolaryngology Head and Neck Surgery. Dublin
31. Improving Outcomes in Head and Neck Cancers. National Institute for Clinical Excellence. London, November 2004. Available www.nice.org.uk (1st April 2005).
32. IIOHNS. Personal communication. February 2004.

8 APPENDICES

Appendix A – List of Questions posed to all Health Boards and relevant public Voluntary Hospitals

(a) list of oral and maxillofacial surgery procedures (number and type) performed during the past year. Please indicate whether in-patient or day surgery; identify type of anaesthetic administered i.e. general or local or regional block;

(b) total number of oral and maxillofacial surgery procedures performed in each of the last three years; the proportion of emergency V's elective and work done on a day basis;

(c) the number of in-patients by area of residence, in each of the last three years;

(d) the number of theatre sessions for oral and maxillofacial surgery;

(e) the location, number and frequency of out-patient clinics plus the number of attendances (new and return) in each of the last three years;

(f) details of the waiting list and waiting times, if any, for both in-patient and out-patient;

(g) access to beds and outpatient facilities;

(h) outreach services to other hospitals within the health board or other health boards;

(i) number and grades of NCHDs in oral and maxillofacial surgery and whether the posts are recognised for training;

(j) future plans in terms of staffing and resources;

(k) sub-specialty interests of current consultants and level of activity in each;

(l) your views on sub-specialisation in oral and maxillofacial surgery.

Appendix B – Meetings, Submissions and Site Visits

The committee met with representatives of and received presentations and/or written submissions from the following,

Eastern Regional Health Authority
East Coast Area Health Board
St Vincent's Hospital
Northern Area Health Board
Beaumont Hospital
Mater Hospital
James Connolly Memorial Hospital
The Children's University Hospital, Temple Street
South Western Area Health Board
Our Lady's Hospital for Sick Children, Crumlin
St James's Hospital
Tallaght Hospital
Midland Health Board
Mid Western Health Board
North Eastern Health Board
North Western Health Board
South Eastern Health Board
Southern Health Board
Cork University Hospital
Tralee General Hospital
South Infirmary-Victoria Hospital
Western Health Board

The committee also met with the following,

Representatives of the Irish Oral & Maxillofacial Surgical Group
Representatives of the Irish Association of Plastic Surgeons
Department of Health & Children officials and the Chief Dental Officer
Representatives of the Institute of Otolaryngology
Representatives of the Dublin and Cork Dental Hospitals
Professor S Gelbier Head of the Department of Dental Public Health and Community Dental Education, King's College

Further submissions were received from:

Prof. L. Stassen Irish Oral & Maxillofacial Surgical Group
Dr. G. Gavin, Chief Dental Officer DOH&C – Proposal for the Development of a Joint Oral and Maxillofacial Service for the North West of Ireland
Prof. D. Sleeman Department of Dental Surgery, University College Cork
Prof. J. Clarkson Dean of Dental School & Hospital, Trinity College, Dublin

Appendix C – Workload Data

CLEFT LIP & PALATE SURGERY

The following workload data relating to cleft lip and palate surgery has been provided by the ESRI for the year 2002.

TABLE 1 Health Board of residence by health Board of hospitalisation for discharges with ICD-9-CM procedure codes 27.54 and 27.6 Cleft Lip / or Palate Procedures. HIPE National Files.

Year: 2002

Health Board of Residence	Health Board of Hospitalisation ERHA	SEHB	SHB	MWHB	WHB	MHB	Total
Eastern Regional Health Authority	96						96
South Eastern Health Board	12	3					15
South Health Board	4		19				23
Mid Western Health Board	14		3	3			20
West Health Board	3			2	25		30
Midland Health Board	17					4	21
North Western Health Board	6				1		7
North Eastern Health Board	14						14
Total	**166**	**3**	**22**	**5**	**26**	**4**	**226**

Source – HIPE Unit ESRI, April 2004

CRANIOFACIAL SURGERY

Table of Procedures for discharges that had specified ICD-9-CM craniofacial procedure codes by hospital – Year 2002. (HIPE, National Files)

TABLE 2

Hospital	Total No. Craniofacial Procedures
St. James's Hospital	556
Cork University Hospital	215
MWRH, Limerick	91
Mater Hospital	61
The Children's Hospital, Temple St.	25
Beaumont hospital	21
Royal Victoria Eye & Ear	6
*Other hospitals	15

*A total of 15 craniofacial procedures were undertaken throughout the following hospitals:-OLHSC, Crumlin, St. Vincent's Hospital, Tallaght, South Infirmary-Victoria UCHG, Tullamore General, Mullingar General, Letterkenny General, Cavan General. The individual hospital numbers cannot be listed for data protection reasons.

Source – ESRI, HIPE National Files, April 2005.

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