

COMHAIRLE NA NOSPIDÉAL

**PLASTIC SURGERY
SERVICES**

June 2005

Comhairle na nOspidéal

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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 plastic surgery in Ireland.

EXECUTIVE SUMMARY

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

While this report focuses specifically on plastic surgery services, it may be read together with the Comhairle reports on otolaryngology services and oral and maxillofacial surgery services for a comprehensive understanding of all three specialties. This report builds on the recommendations of a previous Comhairle report on plastic surgery services (1991).

There are currently 19 permanent posts of consultant plastic surgeon approved by Comhairle na nOspidéal in the public sector in Ireland, representing a consultant / population ratio of 1:206,000.

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 plastic 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 plastic surgery service provision in Europe and North America.

The main principles identified for the future development of plastic surgery services are:

- ❖ An equitable and patient-centred service, ensuring accessibility for all, regardless of geographic location.
- ❖ Regional self-sufficiency. Plastic surgery services should be developed at selected regional multi-disciplinary hospitals with appropriate facilities and other related specialist services such as consultant provided A&E services, major trauma services, cancer services and orthopaedic surgery services
- ❖ Each regional centre should provide local outreach services including appropriate outpatient and day surgery services, in line with quality and safety considerations
- ❖ A minimum of three consultant plastic surgeons at each plastic surgery centre
- ❖ Collaboration between the three specialties of plastic surgery, oral & maxillofacial surgery and otolaryngology.

The key recommendations are as follows,

- ❖ A ratio of one consultant plastic surgeon per 90,000 people
- ❖ The designation of 12 regional plastic surgery centres
- ❖ The establishment of plastic surgery units in Waterford, Limerick and Tallaght should be prioritised with subsequent developments at Sligo, Drogheda and Tullamore
- ❖ 25 new posts of consultant plastic surgeon, to give a total of 44 posts
- ❖ The priority appointment of 15 new posts of consultant plastic surgeon and the subsequent appointment of an additional 10 consultant posts
- ❖ The development of academic posts in plastic surgery
- ❖ To regain full accreditation in a number of hospitals
- ❖ A national high quality cleft lip and palate service to be developed in line with agreed best practice guidelines.

1

INTRODUCTION

I.1 BACKGROUND

- I.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.
- I.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.
- I.1.3 The committee took into consideration the principles of the government Health Strategy¹ – *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 6 of this report.

I.2 MEMBERSHIP OF THE COMMITTEE

- I.2.1 The following members were appointed to serve on the Plastic Surgery, Otolaryngology and Oral & Maxillofacial Surgery Committee:

Dr. S. Ryan (Chairman), Chief Executive Officer, 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, Chief Executive Officer, 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 S Downing was secretary to the plastic surgery committee. Ms. A. Cunningham, and Ms. S. Downing undertook the research for and the drafting of this report.

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 plastic surgery. The terms of reference of the plastic surgery committee were as follows:

“To examine the existing arrangements for the provision of consultant – level plastic surgery services nationally and following consultation with the interests concerned, to make recommendations to Comhairle na nOspidéal on the future organisation and development of plastic surgery services. The review will focus on updating the 1991 Comhairle report taking into account recent advances in and increasing demand for plastic surgery services”.

I.3 THE CONSULTATION PROCESS

- I.3.1 Requests were made to each health board and relevant public voluntary hospitals to make submissions to it pertaining to the three specialties. 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 and the Dublin Dental Hospital and the Cork Dental Hospital; the Department of Health & Children and the Chief Dental Officer. 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 associated Dublin voluntary hospitals in Corrigan House, in April 2002. In November 2003, the committee met with the Consultant Oral and Maxillofacial Surgeons Group who presented a revised oral and maxillofacial surgery document which outlined future OMFS service configuration by location and specialty, as envisaged by their group.
- I.3.2 The Committee wishes to extend its gratitude to all those involved in the consultation process and in the compilation of submissions.

I.4 OVERLAP BETWEEN THE THREE RELATED SPECIALTIES OF PLASTIC SURGERY, ORAL & MAXILLOFACIAL SURGERY AND OTOLARYNGOLOGY

- I.4.1 Over the course of the consultation process, all three specialties were discussed and it became apparent that the overlap between the three was varied. The issue of the overlap and interface between the three specialties is dealt with in each report.
- I.4.2 The overlap between plastic surgery and otolaryngology 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 fewer consultant OMF surgeons. Currently, the subspecialty of the surgeon performing surgery 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 their training).
- I.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 clearly 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 PLASTIC, RECONSTRUCTIVE AND AESTHETIC SURGERY?**2.1 DEFINITION AND SCOPE OF PLASTIC SURGERY**

- 2.1.1 The official title of the specialty is Plastic Surgery. The word plastic is derived from the Greek “plastikos” and Latin “plasticus” meaning to mould or shape. Plastic surgery can be defined as the branch of surgery concerned with restoration of form and function by reconstruction of congenital, traumatic and acquired conditions. The role of the plastic surgeon is to enhance the quality of life of the patient by improving bodily function and appearance which is abnormal due to birth defects, trauma, infection or by correcting body features displeasing to the patients.²
- 2.1.2 The work of plastic surgeons originates from a number of different sources including acute referrals from A&E and elective referrals from GPs.³ Apart from direct GP referrals for management of a whole range of conditions, variable amounts of reconstructive surgery are carried out in collaboration with other surgical specialties e.g. orthopaedic, otolaryngology, neurosurgery, oral and maxillo-facial surgery and general surgery, thus resulting in increased referral workload. This has led to a growth of inter-specialty cross-referral, e.g. orthopaedic surgery (hand surgery) and formal joint working arrangements within the general hospital framework. The committee was informed that the need for reconstructive surgery following breast cancer and the growth of inter-specialty cross-referrals within the general hospital framework are two areas where demand exceeds supply.

2.2 RECENT ADVANCES IN AND INCREASING DEMAND FOR PLASTIC SURGERY SERVICES

- 2.2.1 There has been an increasing appreciation among the public of the scope and ability of plastic surgeons to satisfy reconstructive demands. Higher patient expectations have been accompanied by increased potential to realise these demands by new developments in techniques. A desire for consultant based services has also been identified as a factor in the rising demand for plastic surgery services. This demand for a consultant-based treatment is both consumer-driven and driven by increased surgical accountability from a medico-legal viewpoint.⁴ The increase in trauma workload has followed a reluctance of surgeons to treat patients outside their own specialty. It is well recognised that soft tissue injuries, facial injuries and hand injuries are now often referred to plastic surgeons in the first instance.⁴ The imbalance between the levels of elective and emergency workload was a key concern highlighted by the IAPS. In Ireland, acute trauma surgery accounts for approximately 50% of referrals to the plastic surgery services. While in the United Kingdom, approximately 30% is acute surgery referred from A&E departments.³ The IAPS has stated that the volume of the emergency workload is clearly restricting the extent and scope of elective work which the plastic surgery service can offer.³ This imbalance has had a serious impact on already lengthy waiting lists, particularly for elective surgical procedures.
- 2.2.2 The Irish Association of Plastic Surgeons has asserted that it has been conclusively shown that involvement of consultant plastic surgeons at the initial stages of treatment was far more beneficial to the progress of patients and decreased the need for secondary treatment.³ The British Association of Plastic Surgeon (BAPS) has stated that where plastic surgery is easily accessible to the population the referral rate is high since general practitioners and other doctors recognise the benefits of a specialist surgical service². They argue that many patients would benefit from greater provision of plastic surgical services in local units as well as in major plastic surgery centres².

2.3 SUB-SPECIALTIES OF PLASTIC SURGERY

- 2.3.1 In the last two decades, plastic surgery has significantly expanded its scope and has evolved to treat any condition that changes the outward appearance or function of a body part. The need for sub-specialisation is very real in plastic surgery, as this specialty covers a broad field, encompassing all ages, all regions of the body and many pathological conditions in both sexes.⁴ The development of sub-specialisation within plastic surgery is being influenced by patient expectations, demands for consultant-delivered service and the growing complexity of treatment. There is now increasing sub-specialisation amongst plastic surgeons in areas such as craniofacial surgery, head and neck cancer surgery, breast surgery, reconstruction and trauma such as burns, facial, hand and leg injuries and birth defects including cleft lip and palate. In 2004, Comhairle na nOspidéal approved a post of Consultant Plastic Surgeon with a special interest in cleft lip and palate following advice from the Irish Association of Plastic Surgeons. It is acknowledged by the British Association of Plastic Surgeons that these conditions are generally best treated where plastic surgeons work together with medical and other professional staff in areas where there are particular benefits for patients from shared expertise: “where there are a number of plastic surgeons working in a large unit, it is usual for each consultant to practise some general plastic surgery and also to provide one of a range of specialised services for conditions such as burns, head and neck cancer, hand surgery and cleft lip and palate treatment”.
- 2.3.2 Due to the small number of consultants in Ireland, there has been limited development of sub-specialty interests. Sub-specialties have arisen as a result of individual expertise rather than being designated in the structuring of the consultant post. A key issue raised during the committee’s consultation process was the inadequacy of existing numbers of consultant plastic surgeons. The committee was informed that while sub-specialty interests were required to further enhance existing services, this could only be achieved with an increase in the current number of consultant plastic surgeon posts.

2.4 SCOPE OF PLASTIC SURGERY

- 2.4.1 Plastic surgery covers a very large field and can be considered under the following clinical areas:-³

1. Congenital Abnormalities

- Cleft lip and palate and other facial deformities
- Cranio- facial defects
- Congenital hand deformities e.g. syndactyly
- Genital abnormalities e.g. hypospadias
- Congenital skin conditions

2. Trauma

- Facial trauma - including maxillo-facial trauma
- Hand trauma e.g. bone, tendon and nerve injuries
- Replantation / revascularisation of digits / limbs
- Lower limb trauma
- Skin loss problems e.g. extensive degloving injury of a limb.
- Birth trauma e.g. brachial plexus injury.

3. Burns

- The early treatment of burns cases is considered essential in the minimisation of morbidity and mortality. Early treatment requires dedicated Burns Units with a dedicated theatre and medical and nursing staff. Rehabilitation services are required to return patients to optimum function.

4. Hand Surgery

- Most hand trauma in Ireland has been traditionally referred to plastic surgeons, particularly the major hand mutilations.
- Congenital hand deformities e.g. syndactyly, tend to follow the same referral pattern.
- Degenerative hand conditions e.g. rheumatoid arthritis, are shared between the plastic surgeons and orthopaedic surgeons who have an interest in hand surgery.

5. Benign skin lesions

- Malignant skin tumours e.g. basal cell carcinoma (BCC), squamous cell carcinoma (SCC) and melanoma, which includes the management of not only the reconstruction of the post-excisional defect but also the management of the related lymph nodes.

6. Head and Neck Cancer Surgery

- Advances in microsurgery in particular have dramatically improved the quality of reconstruction possible for patients who have undergone major excisional / ablative surgery for cancer of the head and neck. This has brought about a dramatic reduction in the morbidity resulting from major head and neck cancer surgery.
- Treatment of head and neck cancer often involves close co-operation between a number of surgical disciplines, particularly otolaryngology, oral & maxillo-facial surgery and radiation oncology.

7. Breast Reconstruction

- Congenital aplasia (failure of development)
- Congenital asymmetry
- Virginal and mature breast hypertrophy
- Post mastectomy breast reconstruction: there is growing demand for restoration of body form and body image after breast surgery.

8. Facial and other areas of reconstruction

- Residual congenital deformities
- Post traumatic
- Post tumour resection
- Facial palsy
- Aesthetic (cosmetic)

A blend of cranio-facial and micro-surgical techniques, together with the advent of tissue expansion, has facilitated advances in these areas.

9. Microsurgery

- This is now an integral part of modern training in plastic and reconstructive surgery. It is relevant to nerve repair, revascularisation, replantation and microvascular free tissue transfer in major limb and facial reconstruction. It requires technical expertise, microsurgical accessories and increased theatre time.

10. Other Conditions requiring Reconstruction

- Reconstruction of large defects including skin, bone, nerve and tendon.
- Pressure sores and other chronic wounds

11. Aesthetic (Cosmetic) Surgery

- Rhinoplasty
- Blepharoplasty
- Facelift
- Endoscopic rejuvenative surgery
- Breast surgery (augmentation and reduction)
- Liposuction

12. Collaborative Surgery

- As reconstruction surgeons, plastic surgeons often work with other specialists offering combined treatment. Out-patient clinics are held with oncologists, dermatologists, rheumatologists and other medical disciplines. Complex surgery is frequently carried out with orthopaedic surgeons, otolaryngologists, oral and maxillofacial surgeons, neurosurgeons and general surgeons. Although this collaborative work is performed on relatively small numbers of patients, it can be extremely time consuming when compared to most routine plastic surgery procedures.
- Trauma management has benefited enormously from advances in plastic and reconstructive surgery, particularly facial and limb soft tissue injury. Plastic Surgeons are an essential part of acute major trauma teams.

2.5 TRAINING IN PLASTIC SURGERY**2.5.1 Training in Ireland and the UK**

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. Plastic surgery training in Ireland and the UK is similar and educational approval is granted by the same body i.e. the Specialist Advisory Committee (SAC) of the Joint Committee on Higher Surgical Training (JCHST).

- 2.5.2 In Ireland, the Irish Surgical Postgraduate Training Committee (ISPTC) of the Royal College of Surgeons in Ireland is responsible for the organisation of higher training in plastic surgery.⁵ The training programme is progressive and is divided into Years 1&2, Years 3&4 and Years 5&6. The entry requirements for the programme include the satisfactory completion of basic surgical training (or equivalent) and possession of MRCS / FRCS (or equivalent), such equivalence being jointly agreed by the four Surgical Royal Colleges of Ireland and Great Britain. The first four years of the programme cover the basic sciences and surgical procedures and an Intercollegiate Specialty Examination is taken at the end of the fourth year. In the fifth and sixth years, the trainee can continue general specialty training at a more advanced level or has the opportunity to enter advanced sub-specialty training for all or part of the time.⁶ In the UK, trainees who have successfully completed the six year SpR training programme with satisfactory annual assessment and completed the specialty FRCS are eligible to apply to the Specialist Training Authority (STA) for award of the Certificate of Satisfactory Completion of Specialist Training (CCST) in plastic surgery. In Ireland, the entry qualification is the FRCSI and the CCST is awarded by the ISPTC which allows recipients to apply to the Medical Council to have their name entered on the division of plastic surgery of the Register of Medical Specialists maintained by the Medical Council in Ireland. Such qualified plastic surgeons are also eligible to apply for posts of consultant plastic surgeon.

- 2.5.3 At present, an approved higher training programme in plastic surgery rotates through Dublin and Cork and has recently been extended to Galway. Another SAC inspection is due in 2005. There are 11 posts recognised by the Specialist Advisory Committee as suitable for SpR training in plastic surgery based in the following hospitals – St. James’s / OLHSC, Crumlin, Mater / Temple St, Cork University Hospital and University College Hospital, Galway. Eleven SpR posts are approved for years 1-4. Two of these posts based in the Dublin hospitals are approved for years 1-6. 7 Comhairle na nOspidéal has approved 10 SpR posts in plastic surgery, following requests for approval from the ISPTC.

Table 1: The following posts are recognised by the SAC of the Royal College of Surgeons for Higher Specialist Training in Plastic Surgery⁵:

Hospital	SAC Approved Posts	Years Approved
St. James’s Hospital / Crumlin	3	Yrs 1 - 4
St. James’s Hospital / Crumlin	1	Yrs 1 - 6
Mater / Temple St.	1	Yrs 1 - 4
Mater / Temple St.	1	Yrs 1 - 6
Cork University Hospital	3	Yrs 1 - 4
University College Hospital, Galway	2	Yrs 1 - 4
	9	Years 1 - 4
	2	Years 1 - 6
Total	11	

2.6 PLASTIC SURGERY TRAINING OUTSIDE OF IRELAND

It is recognised that many Irish consultants spend all or a significant part of their time training in the UK, Australia, Canada and the USA. The following paragraphs outline the plastic surgery training schemes in these countries. Following the successful completion of an accredited plastic surgery training programme, candidates can apply for inclusion on the division of plastic surgery of the Register of Medical Specialists maintained by the Medical Council in Ireland.

2.6.1 Training in the USA

In the USA, the Accreditation Council for Graduate Medical Education (ACGME) has the responsibility for establishing national standards for graduate medical education. The ACGME has authority over and provides guidelines for several committees, including the Residency Review Committee (RRC) for plastic surgery which monitors graduate medical education, sets the educational requirements and accredits training programmes in plastic surgery.⁸ The American Board of Plastic Surgery, Inc. (ABPS), also sets the educational requirements and examines and certifies the graduates of those programmes.

Residency education in plastic surgery is designed to educate and train doctors broadly in plastic and reconstructive surgery. The RRC recognises two training models; the Independent or Combined model and the Integrated model for post graduate training in plastic surgery.⁹ The former is based on prerequisite training in general surgical disciplines being completed outside of the plastic surgery residency programme, followed by 2 or 3 years of concentrated plastic surgery training after having completed the prerequisite training. In comparison, residents on the integrated model complete 5 or 6 years of ACGME accredited plastic surgery training following graduation from medical school. Following successful completion of the ‘integrated’ programme or the ‘independent’ plastic surgery programme, candidates are admissible to be accepted for certification by the American Board of Plastic Surgery (ABPS).

2.6.2.1 Sub Specialty Training in the USA

Following the successful completion of an accredited residency in plastic surgery, graduates have the opportunity to pursue a postgraduate fellowship in sub specialty areas of plastic surgery. Postgraduate fellowship programmes are a minimum of one year's education in direct association with an accredited residency programme in plastic surgery. There are sub speciality fellowship programmes in cranio-facial and hand surgery.

2.6.3 Training in Canada

The Royal College of Physicians and Surgeons of Canada is the national body responsible for setting and maintaining the standards for postgraduate medical education and for certifying specialist physicians and surgeons in Canada. The plastic surgery training programme is five years in duration. The first two years of plastic surgery training include core training in surgery to gain experience and proficiency in the care of surgical emergencies, trauma and the management of pre and post operative care and surgical intensive care. In the subsequent three years, training is expanded to include specialities relevant to plastic surgery such as orthopaedics, neurosurgery, otolaryngology, vascular surgery and urology. Surgeons who complete the requirements of postgraduate residency education prescribed by the College and those who pass the examinations conducted by the College are granted a Specialist Certificate. Certificated specialists in plastic surgery are entitled to use the FRCSC designation.¹⁰

2.6.4 Training in Australia

In Australia, a Specialist Plastic Surgeon must first complete a 5-6 year bachelor of medicine and surgery degree (MBBS). They must then be accepted into advanced surgical training specialising in plastic and reconstructive surgery. There is a rigorous training and examination process culminating in admittance to the Fellowship of the Royal Australasian College of Surgeons in Plastic and Reconstructive Surgery (FRACS). This takes a further 8-10 years.¹¹

2.7 QUALIFICATIONS SPECIFIED FOR POSTS OF CONSULTANT PLASTIC SURGEON BY COMHAIRLE NA NOSPIDÉAL

Under the Health Act, 1970, it is a function of Comhairle na nOspidéal to regulate the number and type of appointments of consultant medical staffs in publicly funded hospitals in Ireland and to specify the qualifications for such appointments. The following are the qualifications currently specified by Comhairle na nOspidéal for consultant appointments in plastic surgery:

2.7.1 Consultant Plastic 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 the FRCSI or a qualification equivalent thereto
- and**
- (c)** (i) Inclusion on the division of plastic 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 profession including six years in plastic surgery.

2.7.2 Consultant Plastic Surgeon

(with a special interest in cleft lip and palate)

(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 the FRCSI or a qualification equivalent thereto

and

(c) (i) Inclusion on the division of plastic 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 profession including six years in plastic surgery.

and

(d) including one year in primary and secondary surgery for cleft lip and palate.

3

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

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).^{12, 13 14} Plastic surgeons are involved in the restoration of form and function of congenital, traumatic and acquired conditions.² An example of the crossover between the specialties occurs in the case of rhinoplasty (nose realignment). This procedure is typically classed as "cosmetic" surgery, leading to the perception that such work is done by plastic surgeons only whereas such surgery may also be undertaken by otolaryngologists (e.g. in relation to the septum) and OMF surgeons. In some cases, training and manpower resources etc. will determine which surgeon (i.e. from which of the three specialties) does which surgery.¹² 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 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.² 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)². 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. 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. Primary cleft lip and palate surgery has been predominantly undertaken by consultant plastic surgeons. This specialised surgery is limited to no more than four plastic surgeons of whom two are based in Dublin, one in Cork and one in Galway. Primary cleft lip and palate surgery is currently undertaken in OLHSC, Crumlin, The Children’s University Hospital, Temple St., Cork University Hospital and 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 Report⁵. The CSAG 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 Surgeons² 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"*⁶ (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” paper¹⁷, 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 Scotland¹⁸ has stated that “The treatment of cleft lip and palate in Scotland has been organised by the Scottish Association for 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”.¹⁸ 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),¹⁹ 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 & 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)**

The Eastern Health Board’s report, entitled *“Development of Oral & Maxillofacial Surgery Services in the Eastern Health Board Region”*¹³ (February 1999) 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 OMFS 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 Comhairle na nOspidéal 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 :

- (i) the advice received from the relevant professional bodies in Ireland
- (ii) international guidance / literature reviewed
- (iii) evidence presented in respect of improved outcomes associated with high volume cleft centres in relation to cleft lip and palate cases in the UK
- (iv) the move towards regaining training accreditation in Ireland
- (v) 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 dysostoses, (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”.* 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 with 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".²⁰

❖ 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.²¹

The team required for adult craniofacial deformity surgery:

- ❖ Multidisciplinary Team Coordinator
- ❖ 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."²¹

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 also 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 otolaryngologists²².
- 3.10.2 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 NICE²³ 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 in the Otolaryngology Report. Four centres in Ireland currently meet many of these criteria – Beaumont Hospital, the Mater Hospital, St James's Hospital and the South Infirmiry-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

PREVIOUS COMHAIRLE NA nOSPIDÉAL REPORT ON PLASTIC SURGERY SERVICES (SEPTEMBER 1991)

4.1 OVERVIEW OF 1991 REPORT

4.1.1 The 1991 Comhairle na nOspidéal report, entitled “Plastic Surgery Services” recommended a ratio of one consultant plastic surgeon per 250,000 population in the short term. The report envisaged the development of plastic surgery services in two phases; phase one would focus on the development of plastic surgery services in Dublin, Cork and Galway, while phase two would involve the establishment of plastic surgery units in hospitals in Limerick and Waterford. Units at Sligo, Tullamore and Drogheda were also envisaged as being a later part of phase two. The position in 1991, the recommendations of the report in terms of consultant staffing and the current situation are outlined in Table 2.

Table 2: Summarises consultant staffing in 1991, the recommendations of the 1991 report and the current situation in relation to consultant posts

HEALTH BOARD AREA & POPULATION (1991)	CONSULTANT POSTS (1991)	CONS. / POPULATION RATIO	TOTAL CONSULTANT COMPLEMENT RECOMMENDED (1991)	CURRENT CONSULTANT ESTABLISHMENT JUNE 2005	IMPLEMENTATION (CURRENT CONSULTANT ESTABLISHMENT AS % OF RECOMMENDATIONS OF REPORT)	CURRENT CONS. / POPULATION RATIO ⁴
DUBLIN (Leinster & Ulster) c. 2,500,000	5	1 / 400, 000	9	12	100+%	1 / / 200,000 c. 2,352,000
CORK (Munster) c. 1,000,000	2	1/500,000	3	4	100+%	1 / 275,000 c. 1, 101, 000
GALWAY (Connaught) c. 500,000	1	1/500,000	2	3	100+%	1 / 160,000 c. 464,000
TOTAL¹ c.3,500,000	8	1/450,000	14	19	100+%	1/ 206,000 P. 3, 917,000

¹ The population of the Republic of Ireland was 3,917,206 (Census 2002)

4.2 DEVELOPMENT OF SERVICES SINCE 1991

4.2.1 There has been substantial improvement in the number of consultant posts in plastic surgery since the publication of the previous national review of services by Comhairle na nOspidéal in 1991. In terms of consultant staffing, the 1991 short term targets have been exceeded in all health board areas. There has been an increase in consultant staffing from 8 posts in 1991 to 19 posts in 2005. These new posts have been designated to the existing centres (Dublin, Cork and Galway) to enhance current service provision. The initial phase aimed at strengthening the three existing plastic surgery

centres in Dublin, Cork and Galway has been achieved. The recommendations with regard to phase two of the plan to establish plastic surgery units at hospitals in Limerick and Waterford and later at Sligo, Tullamore and Drogheda have not been realised yet. In relation to the provision of outpatient clinics, currently, one outpatient clinic per week is provided at Connolly Hospital, Blanchardstown and one outpatient clinic per month is held at OLOLH, Drogheda, in line with the 1991 Report. The recommendation that out-patient services be provided at Limerick, Sligo and Waterford have not been implemented to date.

4.3 CONSULTANT STAFFING IN 1991

- 4.3.1 In 1991, there was a complement of 8 posts; five in Dublin; two in Cork and one in Galway. The 1991 Comhairle Report noted that plastic surgery services in the Dublin region were fragmented. A total of ten hospitals provided plastic surgery services in Dublin. The report commented on the number of shared and joint appointments between adult and paediatric units in Dublin.
- 4.3.2 The 1991 committee envisaged one major plastic surgery/ burns/ maxillofacial unit in Dublin to be based at St. James's / OLHSC, Crumlin hospitals. It was proposed that it should function as an integrated unit spanning the two hospitals. A total of 9 consultant posts in the Dublin catchment area were recommended. Five posts were recommended for South Dublin, one to be based whole-time at St. James's/OLHSC, Crumlin while two posts would be shared between St. James's and St. Vincent's hospitals and two would be shared with Tallaght Hospital. It was also recommended that one of the posts based at St. James's / OLHSC, Crumlin hospitals would include a commitment to provide a regular outpatient service at Tullamore General Hospital. This has not happened. In North Dublin, four posts were recommended, two posts each would be based at Mater / Temple St. Hospitals and Beaumont Hospital. The 1991 report envisaged that each plastic surgeon based in a Dublin hospital should be linked by way of a sessional commitment – minimum of one session- to the unit at St. James's / OLHSC, Crumlin hospitals. It was envisaged that the proposed grouping of nine plastic surgeons in Dublin, all attached to the National Centre at St. James's / OLHSC, Crumlin, presented a unique opportunity for the development of a team approach to the provision of plastic surgery services. This has not become a reality.

4.4 BURNS UNIT

- 4.4.1. In relation to burns, the 1991 report recommended that there should be one major burns unit in Dublin, based in St. James's Hospital / OLHSC, Crumlin. Smaller units should be established in Cork and Galway.

4.5 NCHD STAFFING AND TRAINING

- 4.5.1 In the absence of recognised training posts in Dublin at the time, the 1991 Report recommended that improvements should be made to the unit at St. James's Hospital and also improvements to the Cork unit, particularly in relation to microsurgery, which would facilitate obtaining formal recognition from the Joint Committee on Higher Surgical Training for higher specialist training leading to accreditation in plastic surgery.

5

EXISTING PLASTIC SURGERY SERVICES**5.1 NATIONAL DISTRIBUTION OF PLASTIC SURGERY SERVICES**

5.1.1 Consultant plastic surgery services are located in Cork, Dublin and Galway. There are nineteen permanent posts of consultant plastic surgeon. Of the nineteen consultant plastic surgery posts; twelve are based in Dublin, including three posts with majority commitments to one of the children's hospitals in Dublin; four are located in Cork and three are based in Galway. According to the census 2002 figures²⁸ the population of the Republic of Ireland has increased to 3,917,203. This equates to a ratio of 1 consultant plastic surgeon per 206,000 population. Eight new consultant plastic surgery posts (five new and three replacements) have been approved during the lifetime of this committee. The committee stressed to health boards and hospital authorities during the consultation process, that the processing by Comhairle na nOspidéal of permanent applications for consultant posts in plastic surgery, which were consistent with the thinking of the committee, would not be inhibited by the work of the committee.

5.2 DISTRIBUTION OF CONSULTANT PLASTIC SURGERY POSTS

5.2.1 Table 3 compares the distribution of the population of the state with that of the consultant plastic surgery posts in Ireland. The population of the eastern region represents 35.7% of the total population of Ireland and has 12 (65%) consultant plastic surgeons²⁸. However, this number includes three consultant plastic surgeons that are based at the children's hospitals, who treat patients from all over the country. The population of the midlands, mid-west, northeast, northwest and southeast comprises of 40% of the state's population but currently they have no locally based approved consultant plastic surgeon posts.

Table 3: Distribution of population and consultant plastic surgeon posts by region.

Region	Population	% Population	No. of Posts	% Posts
East	1,401,441	35.70%	12	63%
Midlands	225,363	5.70%	0	0%
Midwest	339,591	8.60%	0	0%
Northeast	344,956	8.80%	0	0%
Northwest	221,574	5.60%	0	0%
Southeast	423,616	10.80%	0	0%
South	580,356	14.80%	4	21%
West	380,297	9.70%	3	16%

EAST

Population: 1.4 million

Provision of Plastic Surgery Services in Eastern Region

5.2.2 Plastic surgery services, both in-patient and out-patient, in the Eastern region are provided at four acute general adult hospitals: St. James's, St. Vincent's, Beaumont and the Mater hospitals, by nine consultant plastic surgeons, while three consultants plastic surgeons attend the two children's hospitals, OLHSC, Crumlin and The Children's University Hospital, Temple St. Out-patient facilities

are also available at Connolly Hospital, Blanchardstown. Outreach services are also provided by the Dublin based consultants at three other hospitals: the Coombe Women's Hospital, the National Maternity Hospital, Holles St., and Our Lady of Lourdes Hospital, Drogheda. An outreach service is provided also every six months at Sligo General Hospital for cleft lip and palate related problems. The consultants in Dublin have a variety of sub-specialty interests, covering the spectrum of plastic surgery. Plastic surgery services are not provided in Tallaght Hospital. The posts and their sessional commitments are set out hereunder in Table 4.

Table 4: Current sessional commitment of the twelve permanent Comhairle approved consultant plastic surgeon posts in the East.

EAST	ST. JAMES'S	CRUMLIN	MATER	TEMPLE ST.	BEAUMONT	CONNOLLY	ST. VINCENT'S HOSPITAL	ST. LUKE'S
Post 1	4	-	-	-	-	-	7	-
Post 2	-	4	-	-	-	-	7	-
Post 3	-	-	-	-	-	-	11	-
Post 4	-	-	-	-	7	4	-	-
Post 5	4	-	7	-	-	-	-	-
Post 6	-	-	5	6	-	-	-	-
Post 7	-	-	5	6	-	-	-	-
Post 8	6	4	-	-	-	-	-	1
Post 9	8	3	-	-	-	-	-	-
Post 10	4	6	-	-	-	-	-	1
Post 11	11	-	-	-	-	-	-	-
Post 12					11			
2005 Total	37	17	17	12	18	4	25	2
1991 Total	12	9	3	4	2	4	5	-

MIDLANDS

Population: 225,363

- 5.2.3 There is no Comhairle approved post of consultant plastic surgeon based in the midlands. Patients requiring plastic surgery services are referred to Dublin for treatment.

MID-WEST

Population: 339,591

- 5.2.4 There is no Comhairle approved post of consultant plastic surgeon based in the mid-west. However, a limited service is provided by a consultant plastic surgeon from Cork University Hospital who attends MWRH, Limerick on a monthly basis. Complex cases requiring a plastic surgery service are referred to either Galway or Cork.

NORTHEAST

Population: 344,965

- 5.2.5 There is no Comhairle approved post of consultant plastic surgeon based in the north east. A satellite service is provided by a consultant based at St. James's Hospital on a monthly basis to Our Lady of Lourdes Hospital, Drogheda, comprising of an outpatient clinic and a laser clinic. The majority of patients requiring a plastic surgery service are referred to St. James's Hospital and to a lesser extent

to the Mater Hospital. Paediatric cases are referred to OLHSC, Crumlin and The Children's University Hospital, Temple St.

NORTHWEST

Population: 221,574

- 5.2.6 There is no Comhairle approved post of consultant plastic surgeon based in the north-west. A limited outreach service is provided every six months at Sligo General Hospital for cleft lip and palate related problems by a consultant based at the Mater / The Children's University Hospital, Temple St. Patients from the northwest requiring a plastic surgery service are referred to Galway, Dublin or Belfast.

SOUTHEAST

Population: 423,616

- 5.2.7 There is no Comhairle approved post of consultant plastic surgeon based in the south east. Patients requiring a plastic surgery service are referred to either Dublin or Cork for treatment. In relation to orthopaedic trauma, patients with open fractures, are initially stabilised at Waterford Regional Hospital before being transferred to Cork University Hospital.

SOUTH

Population: 580,356

- 5.2.8 The plastic surgery unit is based in CUH / St. Mary's Orthopaedic Hospital and is staffed by four consultant plastic surgeon posts, including one approved vacant post with a designated special interest in cleft lip and palate and one approved vacant post with responsibility for the development of breast reconstruction surgery services in the southern region. Two posts are based at CUH and two posts are joint appointments between CUH and the South Infirmary-Victoria Hospital. At Tralee General Hospital two review clinics are provided on a monthly basis by the CUH based consultants.

Table 5: Current sessional commitment of the three permanent Comhairle approved consultant plastic surgeon posts in Cork.

Hospital	Cork University Hospital	South Infirmary
Post 1	11 sessions	-
Post 2	11 sessions	-
Post 3	7 sessions	4 sessions
Post 4	6 sessions	5 sessions
Total	35 sessions	9 sessions

WEST

Population: 380,297

- 5.2.9 There are three permanent Comhairle approved consultant plastic surgeon posts based at the University College Hospital, Galway, including one approved vacant post. Currently, complex burns cases are referred to St. James's Hospital, Dublin.

5.3 TRAUMA VERSUS ELECTIVE PLASTIC SURGERY WORKLOAD

- 5.3.1 According to the IAPS, the current ratio between trauma and elective work in Ireland is 2:1. The IAPS has stated that at present there are not enough consultant plastic surgeons and facilities to perform elective surgery to any degree. The IAPS policy document stated that the volume of the

emergency workload is also restricting the extent and scope of elective work which can be undertaken and is limiting the amount of sub-specialised work undertaken due to the high volume of trauma.² The high level of emergency workload in plastic surgery was also a factor taken into consideration when the SAC previously withdrew recognition for higher surgical training in years 5 and 6. An increased number of consultant plastic surgeons would redress the current workload imbalance, allow for the development of sub-specialisation and allow for proper supervision and structured teaching.

5.4 IMPACT ON TRAUMA AND OTHER SERVICES IN HOSPITALS WITHOUT A PLASTIC SURGERY SERVICE

5.4.1 Over the course of the committee's visits and following a review of the submissions received, it became evident that the lack of a plastic surgery service in large teaching hospitals had implications on trauma services and other associated services. For example, it was pointed out to the committee that Waterford Regional Hospital was the centre for orthopaedic trauma in the south east and in terms of open fractures the lack of plastic surgery services on site constituted a serious deficit. In any given year, approximately 30 – 40 open fractures per year required the input of a plastic surgeon. Without an on-site plastic surgery service in Waterford Regional Hospital, these patients, following stabilisation have to be transferred to CUH for treatment. The lack of a plastic surgery service in Waterford Regional Hospital also has an impact on the development of patient care. Breast surgery patients requiring the services of a plastic surgeon are currently referred to Cork and Dublin for treatment.

5.4.2 In respect of trauma services where major trauma can be defined as having involved the presence of at least the following:

“Admission to an intensive care unit for more than 24 hours, requiring mechanical ventilation

Serious injury to two or more of the body's internal systems

Urgent surgery for intra-cranial, intra-thoracic or intra-abdominal injury or for fixation of pelvic or spinal fractures”²⁴ the committee believes that the presence of an on-site plastic surgery service will alleviate some of the pressures placed on trauma services in the major hospitals. A national trauma plan would identify major trauma centres and the range of services required.

5.5 WAITING LISTS

5.5.1 Waiting lists for consultant plastic surgery services remain high, despite a reduction in the period of September 2002 – December 2003 from 1,402 to 839 patients. The Government Health Strategy aimed to significantly reduce hospital waiting lists.²⁵ The root cause of the problem according to the IAPS, is that the number of patients being referred for specialist surgery exceeds the present capacity that can be delivered and, as a result, waiting lists continue to grow.³ In this context, a considerable increase in the number of consultant posts in plastic surgery and the necessary support staff will be required to reduce the public waiting lists for plastic surgery procedures. The National Treatment Purchase Fund (NTPF) is now responsible for waiting lists. Comhairle welcomes the recently announced pilot project²⁶ to provide outpatient appointments in private hospitals for public patients that have been waiting for long periods. Plastic surgery is one of the specialties included in the pilot project.

5.6 BURNS FACILITIES

5.6.1 At present, the National Burns Centre is based at St. James's Hospital, while paediatric patients are treated at both Our Lady's Hospital for Sick Children, Crumlin and The Children's University Hospital, Temple St. It is noted that the IAPS supports the concept of a single paediatric burns centre in Dublin and has proposed that a custom-made paediatric burns centre should be placed in Our

Lady's Hospital for Sick Children, Crumlin. Less extensive burns injuries are treated at plastic surgery units in Cork University Hospital and University College Hospital, Galway. The recent National Burn Care Review Audit in the UK states "all burn injuries requiring hospitalisation should only be admitted under the care of specially trained specialist staff".²⁷

5.7 PLASTIC SURGEONS IN FULL-TIME PRIVATE PRACTICE

5.7.1 There are ten specialists in plastic surgery in private practice in Ireland. Four are based in the east, two each in the mid-west and the midlands and one each in the south and west. It is noted that this is in addition to a number of private cosmetic clinics.

5.8 GUIDELINES FOR THE NUMBER OF CONSULTANT PLASTIC SURGEONS BASED ON POPULATION

5.8.1 The Irish Association of Plastic Surgeons, has recommended that a minimum ratio of one consultant plastic surgeon per 125,000 would be an appropriate target for Ireland based on recommendations from the UK. However, it was accepted that not all UK recommendations can be applied directly to the Irish hospital system, given the differences in the configuration of the two hospital systems and geographic factors. The Royal College of Surgeons in Ireland in their document entitled 'The Future of Surgical Specialties in Ireland' suggested that "if one is to accept the figure of one consultant plastic surgeon per 100,000 population (Senate of the 4 colleges) then a round figure of 40 consultants should be considered"⁴ In addition, the Royal College of Surgeons of England recommended ratio is 1 per 125,000.²

Table 6: International Consultant Plastic Surgeon Staffing

Country	Population	Total No. of Consultants	Consultant / Population ratio
Ireland	3,917,203	19 ¹	1 / 206,000
England	49,138,831	236 ²	1 / 208,000
Wales	2,903,085	7 ³	1 / 415,000
Scotland	5,062,011	26 ⁴	1 / 195,000

¹ Comhairle na nOspidéal, Consultant Staffing 2005.

² Consultants by Specialty / head count in England at 30th June 2004, Department of Health England.

³ Correspondence from Welsh Assembly, 30th Sept. 2003,

⁴ Scottish Health Statistics. 30th September 2004

It should be noted that different hospital and medical staffing systems and hierarchies exist in different countries as regards grades of doctors, so direct comparison with countries other than the UK may not be meaningful.

5.9 NCHD STAFFING AND TRAINING IN PLASTIC SURGERY

5.9.1 In Ireland, there are 11 posts recognised by the Specialist Advisory Committee (SAC) as suitable for SpR training. The committee noted that the SAC had previously revoked the 5th and 6th year of the plastic surgery training programme. The decision had been made on the grounds that not one of the units had sufficient junior or senior staff or were of sufficient standard to maintain training. The IAPS believed that it was a combination of the two issues. The high proportion of trauma to elective work and the limited amount of sub-specialised work undertaken due to high volume of trauma were also noted as contributory factors. However, since a preliminary SAC visit in 2003, two posts based in Dublin hospitals have had training recognition re-instated for years 5-6 based at St. James's Hospital / Crumlin and Mater / Temple St. hospitals respectively. A full SAC visit is expected to take place during 2005. It is noted that a minimum complement of three consultant plastic surgeons per plastic

surgery centre is required by the SAC for SpR training recognition. An increase in the number of consultant plastic surgeons would improve the disparity between the proportion of emergency and elective workload, which would improve training opportunities for NCHDs as a better balance of workload would ensure exposure to the full spectrum of plastic surgery workload.

5.10 DISTRIBUTION OF NCHD POSTS IN PLASTIC SURGERY

5.10.1 In addition to consultant posts, there are a significant number of non-consultant hospital doctor posts in plastic surgery. In total there are 36 NCHDs in plastic surgery in the public sector in Ireland. The distribution of NCHDs by hospital and grade is set out in table 7.

Table 7: Distribution of NCHDs in Plastic Surgery

HOSPITAL	HOUSE OFFICERS	REGISTRARS	SPRS-	TOTAL NCHD STAFFING	CONSULTANT POSTS SESSIONAL COMMITMENT (WTE)	CONSULTANTS (WTE): NCHDs
St. James's	4	1	3	8	39 sessions/wk (3.5)	1:2.2
Crumlin	1	-	1	2	17 sessions/wk (1.5)	1:1.3
Mater	-	1	1	2	17 sessions/wk (1.5)	1:1.6
Temple St.	.5	-	1	1.5	12 sessions/wk (1.1)	1:1.4
Beaumont	.5	1	-	1.5	18 sessions/wk (1.6)	1:1.0
Connolly hosp	1	1	-	2	4 sessions/wk (0.4)	1:1.5
St. Vincent's	1	2	-	3	25 sessions/wk (2.3)	1:1.3
CUH	4	2	2	8	35 sessions/wk (3.2)	1:2.5
UCHG	3	3	2	8	33 sessions/wk (3.0)	1:2.7
Total	15	11	10	36	189 sessions/wk (19)	1:9

Source: Postgraduate Medical and Dental Board: 'NCHD Staffing Complements at 1st October 2004'.²⁹ and Comhairle na nOspidéal 'Consultant Staffing January 2005'.³⁰

6

RECOMMENDATIONS FOR FUTURE DEVELOPMENT OF PLASTIC SURGERY SERVICES IN IRELAND

6.1 INTRODUCTION

6.1.1 Before making recommendations for the future development of plastic surgery services in the Republic of Ireland, the committee believes that the considerations which should underlie the organisation of the services should be clarified, as follows:-

- The interests of patients are of greatest importance and should always come first. Our committee's objective is to recommend the best possible service at reasonable cost. At the same time, it is necessary to develop minimum standards of care and provision of services.
- It is envisaged that the recommendations set out in this report will address the current inequity in the provision of plastic surgery services in Ireland, by bringing services closer to the patient irrespective of geographic location, in line with the Government Health strategies of 1994 and 2001. Regional self-sufficiency is an achievable goal for plastic surgery, with the exceptions of cleft lip and palate surgery and craniofacial surgery (which are dealt with in section 3). This issue is of particular note in the South-East, the Mid-West, the North East, the North West and the Midlands, where there has previously been no locally based plastic surgery services.
- There should be a reasonable spread of plastic surgery services throughout the state and patients requiring plastic surgery should have reasonable access to consultant plastic surgeons. The desirable infrastructure to enable plastic surgeons to work effectively and safely must also be taken into account e.g. the proposed system must avoid professional isolation of plastic surgeons, provide sufficient workload to maintain expertise and facilitate opportunities for research and teaching.
- There should be no consultant plastic surgeon working in isolation. Each plastic surgery centre should be staffed by a minimum of three consultant plastic surgeons.
- Plastic surgery centres should have local outreach services, including appropriate outpatient and day surgery services, in line with best practice guidelines.
- All plastic surgery centres should be located in a multi-disciplinary hospital setting. Some plastic surgery treatment is provided exclusively by plastic surgeons (as outlined in section 2). However, a major part of the work of a plastic surgeon involves participation in a multi-disciplinary team which generates cross-referrals between colleagues in disciplines such as A/E, orthopaedics, dermatology, otolaryngology, oral & maxillofacial surgery, general medicine and general surgery.
- Existing plastic surgery services at units in Dublin, Cork and Galway should be enhanced and plastic surgery centres should be established at a further 6 centres namely; Waterford, Limerick, Tallaght, Sligo, Drogheda and Tullamore. The establishment of plastic surgery centres at Waterford and Limerick should be prioritised, given the distance of each from the nearest plastic surgery units in Dublin, Cork and Galway and the large population base of each region. The establishment of a plastic surgery centre at Tallaght Hospital should also be given priority due to the large trauma and A&E workload at the hospital.
- Comhairle na nOspidéal recommends that a national review of trauma services in Ireland should be carried out by the Health Service Executive.

6.2 DEFINITION OF A REGIONAL PLASTIC SURGERY CENTRE

- 6.2.1 The committee is recommending a significant expansion in the number of plastic surgery centres on a national basis. Therefore, it is necessary to determine the criteria necessary for the establishment of a regional plastic surgery centre. As a general principle, a regional plastic surgery centre should serve a catchment population of approximately 300,000 population. In some areas, the catchment population may be less due to demographic patterns and geographical considerations. A regional plastic surgery centre should be based only in large multi-disciplinary general hospitals, with appropriate facilities and related specialist services such as consultant provided A&E services, major trauma services, cancer services and orthopaedic surgery services. Each plastic surgery centre should be staffed by a minimum complement of three consultant plastic surgeons to provide the full range of plastic surgery services and in order to ensure training recognition. As 50% of plastic surgery work is related to trauma, the regional plastic surgery centre should be located close to an accident and emergency department. The IAPS state that for a quality service to be delivered an appropriate number of consultant plastic surgeons must be in place, with appropriate resourcing.³

6.3 STRUCTURE OF SERVICES – OVERALL PICTURE

- 6.3.1 While the continuation and enhancement of plastic surgery services at existing units in Dublin, Cork and Galway is recommended, the overall framework through which services are currently provided should be re-configured. A re-organisation and extension of the existing provision of plastic surgery services from the three cities (Dublin, Cork and Galway), as outlined in the 1991 report, to 12 regional plastic surgery centres is recommended. It is recommended that plastic surgeons be grouped into the designated centres and, where appropriate, provide services to the other hospitals in the catchment areas served by these centres. The twelve hospitals identified as suitable for designation as regional plastic surgery centres are presented in table 8.
- 6.3.2 The model of the provision of plastic surgery services via regional centres is supported by the British Association of Plastic Surgery. According to the BAPS² “*The country {UK} should be best served from major plastic surgical centres planned and located to best serve chosen territories of the country. Because of the nature of plastic surgery, these units should be on a hospital site with a major accident and emergency service together with as many of the other surgical services with which plastic surgeons collaborate, e.g. orthopaedic, maxillo-facial, ENT, neurosurgery and oncology.*”

Table 8: The 12 hospitals suitable for designation as regional plastic surgery centres

REGION	HOSPITALS INVOLVED
Dublin	St. James’s Hospital/ OLHSC, Crumlin St. Vincent’s University Hospital Tallaght Hospital Beaumont Hospital Mater / The Children’s University Hospital, Temple St.
South	CUH/ St. Mary’s Orthopaedic Hospital
West	University College Hospital, Galway
Southeast	Waterford Regional Hospital
Midwest	MWRH, Limerick
Northwest	Sligo General Hospital
Northeast	OLOLH, Drogheda
Midland	MRH, Tullamore

6.4 FUTURE CONSULTANT STAFFING

- 6.4.1 Taking Ireland's geographical and demographic considerations into account, the location of existing services and in the context of a minimum of three consultants per plastic surgery centre serving a population of at least 300,000, Comhairle na nOspidéal recommends a consultant / population ratio of 1 consultant plastic surgeon per 90,000 population. A total of 44 consultant posts in plastic surgery is recommended, including 25 new posts. This is in line with advice received from the IAPS and the Royal College of Surgeons in Ireland.
- 6.4.2 The implementation of these recommendations would mean that the existing number of consultant plastic surgeon posts would be more than doubled from 19 to 44. This is an ambitious target which will take some time to achieve. Therefore, a more realistic short to medium term target of increasing the number of consultant plastic surgeons by 15, to an interim total of 34, is proposed. This number is consistent with the IAPS recommendation of 1 consultant plastic surgeon per 125,000. In the implementation of this report, Comhairle na nOspidéal envisages that its priority recommendations will take precedence over its longer term proposals and advises the Health Service Executive accordingly.

6.5 RECOMMENDATIONS FOR THE FUTURE ORGANISATION AND STAFFING OF PLASTIC SURGERY SERVICES

6.5.1 Priority Recommendations

In the context of matters addressed in previous paragraphs, the order of priority areas for development are recommended as follows:-

- (1) **Waterford** – Waterford Regional Hospital (pop. c. 420,000)
Comhairle na nOspidéal recommends the establishment of a new regional plastic surgery centre at Waterford Regional Hospital staffed by three consultant plastic surgeons. The appointments should also have formal sessional commitments at other hospitals within the catchment area to provide regular outpatient clinics and in-patient consultations. Comhairle na nOspidéal envisages a complement of four consultant plastic surgeons based at Waterford Regional Hospital in the longer term.
- (2) **Limerick** – MWRH, Limerick (pop. c. 340,000)
Comhairle na nOspidéal recommends the establishment of a new regional plastic surgery centre at the Mid-Western Regional Hospital, Limerick with a complement of three consultant plastic surgeons. The appointments should have formal sessional commitments at other hospitals within the catchment area to provide regular outpatient clinics and in-patient consultations.
- (3) **Tallaght** - Tallaght Hospital
Comhairle na nOspidéal recommends the establishment of a plastic surgery centre at Tallaght Hospital and the appointment of three consultant plastic surgeons to be based at Tallaght Hospital. One of the new posts should provide out-patient clinics and in-patient consultations to Naas General Hospital.

6.5.2 Intermediate Recommendations

EAST

Comhairle na nOspidéal recommends the provision of plastic surgery centres at 5 regional centres in the East, staffed by a total of 18 consultant plastic surgeons, as follows:-

- **St. James's Hospital / Our Lady's Hospital for Sick Children, Crumlin**
St. James's Hospital/OLHSC, Crumlin should be designated as a regional plastic surgery centre. Comhairle na nOspidéal recommends the appointment of one additional consultant plastic surgeon

to be based at St. James's Hospital with a sessional commitment to Our Lady's Hospital for Sick Children, Crumlin, to provide a complement of five consultant plastic surgeons based at St. James's / Crumlin hospitals. Comhairle na nOspidéal envisages that one of the five consultant plastic surgeon posts would have expertise in burns management and a commitment to the burns unit.

- **St. Vincent's University Hospital**

St. Vincent's University Hospital should be designated as a regional plastic surgery centre. St. Vincent's University Hospital incorporating St. Michael's Hospital should continue to provide a plastic surgery service to patients from its catchment area based on its current complement of 3 consultant plastic surgeons.

- **Beaumont Hospital**

Beaumont Hospital should be designated as a regional plastic surgery centre. In addition to its local catchment area, Beaumont Hospital should continue to provide a plastic surgery service to Connolly Hospital, Blanchardstown. Comhairle na nOspidéal recommends the appointment of an additional consultant plastic surgeon to be based at Beaumont Hospital, to provide a total complement of three consultant plastic surgeon posts. In addition to the existing posts, out-patient clinics and in-patient consultations to James Connolly Memorial Hospital should be provided by the additional consultant post.

- **Mater / The Children's University Hospital, Temple St.**

The Mater/ Children's University Hospital should be designated as a regional plastic surgery centre. The proposed amalgamation of the two hospitals on the Mater campus is noted. Comhairle na nOspidéal recommends the appointment of one additional consultant plastic surgeon to be based at the Mater Hospital with a sessional commitment to The Children's University Hospital, Temple St, to provide a complement of four consultant plastic surgeons to be based at Mater / Temple St. The current position and recommendations regarding (i) cleft lip and palate surgery and (ii) craniofacial surgery are set out in section 3.

SOUTH

- **Cork University Hospital Group**

It is noted that currently plastic surgery services are provided by four consultant plastic surgeons over three hospital sites (i.e. CUH, St. Mary's Orthopaedic Hospital and South Infirmar-y-Victoria). Cork University Hospital should be designated as a regional plastic surgery centre. Comhairle na nOspidéal recommends the appointment of two additional consultant plastic surgeons to be based at Cork University Hospital, providing a complement of six posts in total. It is envisaged that the two posts would be structured between Cork University Hospital and St. Mary's Orthopaedic Hospital, one of which would also have a formal sessional commitment to Tralee General Hospital for regular outpatient clinics. Comhairle na nOspidéal envisages that one of the six consultant plastic surgeon posts would have expertise in burns management and a commitment to the burns unit in CUH. At least one appointee should have expertise in paediatric plastic surgery. The current position and recommendations regarding (i) cleft lip and palate surgery and (ii) craniofacial surgery are set out in section 3.

WEST

- **University College Hospital, Galway**

University College Hospital Galway should be designated as a regional plastic surgery centre. Comhairle na nOspidéal recommends the appointment of a fourth consultant plastic surgeon to be based at University College Hospital, Galway. It is envisaged that the complement of four consultant plastic surgeons to serve the West will have sessions designated for the provision of outpatient clinics and inpatient consultations at other hospitals in the region. Comhairle na nOspidéal envisages that

one of the four consultant plastic surgeon posts would have expertise in burns management and a commitment to the burns unit in UCHG. The current position and recommendations regarding (i) cleft lip and palate surgery and (ii) craniofacial surgery are set out in section 3.

6.5.3 Long Term Objectives

NORTHWEST

- **Sligo General Hospital**

As a longer term objective Comhairle na nOspidéal recommends the establishment of a new plastic surgery centre at Sligo General Hospital to be staffed by three consultant plastic surgeons. At least one of the appointments should have formal sessional commitments to Letterkenny General Hospital to provide regular outpatient clinics and in-patient consultations.

NORTHEAST

- **Our Lady of Lourdes Hospital, Drogheda**

As a longer term objective Comhairle na nOspidéal recommends the establishment of a new plastic surgery centre at OLOLH, Drogheda with a complement of three consultant plastic surgeons. The appointments should have formal sessional commitments at other hospitals within the catchment area to provide regular outpatient clinics and in-patient consultations.

MIDLANDS

- **Midland Regional Hospital at Tullamore**

As a longer term objective Comhairle na nOspidéal recommends the establishment of a new plastic surgery centre at Tullamore General Hospital with a complement of three consultant plastic surgeons. The appointments should have formal sessional commitments at other hospitals within the catchment area to provide regular outpatient clinics and in-patient consultations.

6.5.4 The priority recommendations and overall longer term proposals are set out below in table 9. It should be noted that the population figures provided are the most recent available official population figures (i.e. Census 2002).

Table 9: Recommendations re. Consultant Plastic Surgeon Posts

BASE HOSPITALS	CURRENT WTE CONSULTANT ESTABLISHMENT	PRIORITY RECOMMENDATIONS*	INTERIM TOTAL	OVERALL LONG TERM NO. OF POSTS ENVISAGED	PROPOSED CONSULTANT/ POPULATION RATIO
EAST					
St. James's / OLHSC, Crumlin	4	+1	5	5	
St. Vincent's	3	+0	3	3	
Tallaght	0	+3	3	3	
Beaumont	2	+1	3	3	
Mater / Temple St.	3	+1	4	4	
Total Dublin (pop. c. 1.4. million)	12	+6	18	18	1 / 78,000
SOUTH					
CUH (pop. c. 580,000)	4	+2	6	6	1 / 97,000
WEST					
UCH, Galway (pop. c. 380,000)	3	+1	4	4	1 / 95,000
SOUTHEAST					
Waterford Regional Hospital (pop. c. 420,000)	0	+3	3	4	1 / 106,000
MIDWEST					
MWRH, Limerick (pop. c. 340,000)	0	+3	3	3	1 / 113,000
NORTHWEST					
Sligo General Hospital (pop. c. 220,000)	0		0	3	1 / 73,000
NORTHEAST					
OLOLH, Drogheda (pop. c. 345,000)	0		0	3	1 / 115,000
MIDLAND					
MRH, Tullamore (pop. c. 225,000)	0		0	3	1 / 75,000
OVERALL TOTAL (pop. c. 3,917,000)	19	+15	34	44	1 / 90,000

* Includes Intermediate Recommendations

6.6 OTHER RECOMMENDATIONS

6.6.1 Burns

In relation to burns, the committee noted the IAPS view that there should be one major burns centre in St. James's Hospital / Our Lady's Hospital for Sick Children, Crumlin with smaller burns unit at Cork university Hospital and University College Hospital, Galway. Comhairle na nOspidéal recommends the continuation and further development of the burns unit in St. James's Hospital / OLHSC, Crumlin. An additional consultant post has been identified to complement the current service. In relation to Cork and Galway, Comhairle na nOspidéal notes that the treatment of minor cases in such units is advantageous as a first point of treatment. However, it recommends the establishment of structured referral arrangements to the burns unit in St. James's / Crumlin hospitals for complex cases. It is recommended that one appointee at each of the Cork and Galway centres have expertise in burns.

6.6.2 Facilities

While Comhairle na nOspidéal does not generally make specific recommendations on hospital facilities, it was a statutory function of Comhairle to advise on the organisation and operation of hospital services. To this end, Comhairle na nOspidéal has considered documentation from the IAPS and BAPS relating to the facilities deemed to be appropriate and necessary for the provision of a high quality plastic surgery service. Comhairle na nOspidéal has noted these and suggests that they be considered by the relevant parties when developing existing plastic surgery centres and establishing new centres.

6.6.3 The Development of Academic Centres and Training

Comhairle na nOspidéal recommends that the plastic surgery centres in Dublin, Cork and Galway should be supported by academic appointments and the fostering of academic links between the medical schools and relevant hospitals in the above named cities.

As regards training, Comhairle na nOspidéal believes that it is important that the training scheme in Ireland be sufficient to accommodate capacity building in the future in light of the committee's recommendations for 25 new consultant posts. It is essential that the barriers to full training accreditation should be addressed in order that the future development of the specialty in Ireland is not hindered.

7

SUMMARY & CONCLUDING REMARKS

- 7.1 In formulating the foregoing specific recommendations for the development of plastic surgery services, Comhairle na nOspidéal has endeavoured to be pragmatic in recognising existing services which are already there 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 has been made for a significant enhancement of plastic surgery services and a substantial expansion in related consultant staffing. This report details a plan for the development of plastic surgery services and consultant staffing in Ireland over the next decade or so. Comhairle na nOspidéal believes that the recommendations set out in the previous section are in the best interests of patients who are entitled to the best service that modern hospital medicine has to offer, judged by international standards.
- 7.2 Comhairle na nOspidéal feels that implementation of the its recommendations will go a long way towards improving the current levels of plastic surgery services and consultant staffing. It hopes that the increased number of consultants and the recommended organisational framework – with the development of regional plastic surgery centres – will facilitate the provision of enhanced plastic surgery services nationwide.
- 7.3 Comhairle na nOspidéal recognises that implementation of the recommendations set out in the report will take time. Hospital authorities should take account of these recommendations in formulating plans for the development of plastic surgery services. Implementation of the committee's recommendations will also require detailed planning by those involved in the organisation and delivery of plastic surgery service. Commitment on the part of all staff involved and increased or redirected resources will be necessary also. Comhairle na nOspidéal strongly believes that the implementation of the recommendations of this review will have real benefits for patient care.

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Appendix A – List of Questions Posed to All Health Boards and Relevant Public Voluntary Hospitals

- (a) list of plastic 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 plastic 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 plastic 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 plastic 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 plastic surgery and the need, if any, for more than one centre for e.g. burns, cleft palate etc.

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 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
Representatives of the Oral and Maxillofacial Surgeons Group
Professor S Gelbier Head of the Department of Dental Public Health and Community Dental Education, King's College

Further submissions were received from:

Mr M. J. Earley Consultant Plastic Surgeon, Mater Hospital / Children's University Hospital,
Temple St.
Mr. B. Kneafsey Consultant Plastic Surgeon
Mr. C. Marks Consultant Neurosurgeon, Cork University Hospital
Mr. D. Allcutt Consultant Neurosurgeon, Beaumont Hospital Irish Association of Plastic Surgeons
Irish OMFS Group

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						Total
	ERHA	SEHB	SHB	MWHB	WHB	MHB	
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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