



*The Institute of  
Obstetricians & Gynaecologists*

**The Future of  
Maternity & Gynaecology  
Services  
in Ireland  
2006 – 2016**

Report from Institute Subgroup

December 2006





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## Foreword

The radical proposals for change in the delivery of health care contained in the "National Task Force on Medical Staffing" (Hanley 2003) stimulated the Institute to undertake this review.

The views expressed reflect a long tradition of advocacy for the highest standards of care in women's health, which in earlier times resulted in the establishment of three Dublin Maternity Hospitals, and the subsequent well recognised world-wide reputation for excellence. It is from such beginnings of proactivity in women's health that the Institute wishes to encourage policy makers to ensure that the highest standards of care are, in future, achieved throughout the whole obstetrical and gynaecological service.

Public services of a specialist nature commenced with these Lying-in Hospitals, but it was not until the 1970's that specialist services extended to the whole country. The Health Boards in association with Comhairle na nOspidéal, which set standards for appointments, oversaw the establishment of units with a minimum of three consultants associated with similar paediatric units. Unfortunately the pace of these developments was slow, and thus there is still a considerable deficit in services in comparison with the other major specialties of Medicine and Surgery.

This review uncovers much that is undesirable: poor infrastructure with considerable operational difficulties, even in some cases very awkward access to facilities for emergency caesarean section. Overcrowding, lack of privacy and long waiting times are recurrent complaints when a prompt friendly service is what is required. For some units, recent technological developments and sub-specialisation, although welcome, make it impossible for small numbers of consultants to provide the range of services the public knows about and expects.

Twenty-two Units provide specialist care; all their services are necessary. There is a wide variation in the services they provide, as they are necessarily limited by size and staff numbers. It is clear that proposals about the organisation of workloads and work practices, staffing, and networks, as well as infrastructure would lead to a coordinated integrated service with the greatest opportunity of access to quality clinical care.

The Institute hopes that policy makers will regard this document as a blueprint for the changes necessary to bring about easy access to appropriate care in complex circumstances, as well as providing the highest standard of care close to home. It recognises that these proposals have considerable resource implications but is of the view that the benefits will prove their worth.

In conclusion, the Institute is indebted to all who spoke with or met with the Subgroup, or submitted written observations. The Subgroup and its Chairman impressed by their willingness to travel long distances and take part in long tedious discussions despite heavy personal clinical workloads. By their commitment to the task set and their spirit of contribution a report has been produced. Their endeavours are gratefully acknowledged.

John T Gallagher Immediate Past Chairman  
Michael F O'Hare Chairman

## **GLOSSARY**

1.	CSCST	-	Certificate of Satisfactory Completion of Specialist Training
2.	CSO	-	Central Statistics Office
3.	EBCOG	-	European Board & College of Obstetrics and Gynaecology
4.	FET	-	Frozen Embryo Transfer
5.	FIGO	-	International Federation of Gynaecology and Obstetrics
6.	ICSI	-	Intracytoplasmic Sperm Injection
7.	IVF	-	In Vitro Fertilisation
8.	NHO	-	National Hospitals Office
10.	RCOG	-	Royal College of Obstetricians and Gynaecologists
11.	RCPI	-	Royal College of Physicians of Ireland
12.	SHO	-	Senior House Officer
13.	SpR	-	Specialist Registrar
14.	WTE	-	Whole Time Equivalents
15.	ICGP	-	Irish College of General Practitioners

# Chapter 1

## Introduction

# 1. Introduction

## 1.1 Background

The primary objectives of obstetricians and gynaecologists practising in Ireland are to ensure:

- *The safety and wellbeing of women and babies during pregnancy, labour and following delivery*
- *The life-long gynaecological health of women*

These objectives are shared with other healthcare professionals, including midwives, nurses, general practitioners, paediatricians, and anaesthetists.

The Institute of Obstetricians and Gynaecologists is the professional body which speaks on behalf of Obstetrics and Gynaecology. It was incorporated into The Royal College of Physicians of Ireland in 1976.

The Institute is a member of the International Federation of Gynaecology and Obstetrics (FIGO) and is represented on the Council of the European Board and College of Obstetrics and Gynaecology (EBCOG).

## 1.2 Objectives of the Institute

The ultimate aim of the Institute is to ensure that the highest quality obstetrics and gynaecology care is delivered to patients in Ireland.

The objectives of the Institute of Obstetricians and Gynaecologists are to:

- Endeavour to raise professional standards in obstetrics and gynaecology in Ireland and to promote education, study and research;
- Represent obstetrical and gynaecological opinion in Ireland in a professional, advisory and administrative capacity;
- Act as the advisory body in Ireland in matters relating to education, training, research and administration in the specialty of obstetrics and gynaecology.

The Hospital Recognition Committee of the Institute inspects hospitals in Ireland for recognition of training for both the MRCPI (Obstetrics and Gynaecology) and the MRCOG. The Institute conducts the MRCPI (Obstetrics and Gynaecology) examination and the Diploma in Obstetrics and Women's Health.

The Institute, through the Postgraduate Training Committee, carries responsibility for the Higher Professional Training Programme of Specialist Registrars and certifies completion of Specialist Training for entry to the Specialist Register of the Medical Council of Ireland.

## 1.3 Institute's policy on the future of maternity & gynaecology services in Ireland

In late 2004, the Institute of Obstetricians and Gynaecologists decided to undertake a review to define the Institute's policy on the future of maternity and gynaecology services in Ireland, in the light of the wider health reforms, recent and ongoing deliberations on



# 1. Introduction

the future shape of acute hospital services in general, and of regional maternity and gynaecology services in particular.

As the professional body for obstetricians and gynaecologists, the Institute's policy on the future of maternity and gynaecology services in Ireland, outlined in this document, focuses primarily on services provided by consultant obstetricians and gynaecologists.

The Executive Council of the Institute set up a Subgroup to undertake the review with a specific remit as follows:

- Review of maternity and gynaecology services in Ireland.
- Review of training structures nationally.
- Recommendations and output of the Subgroup to be as specific as possible about location and scope of services, while maintaining consensus.
- The outcome of the review will become Institute policy.
- The overall timeframe for development is ten years.

In developing this document, the Institute has engaged with a wide range of stakeholders involved in maternity services in Ireland, and has taken into consideration all views expressed to it. Appendix A1 lists the individuals met by the Subgroup during the visits to maternity units. Appendix A2 lists individuals who made written submissions to the Institute Subgroup.

Towards the end of the process, the report of Judge Maureen Harding Clark into medical practices at Our Lady of Lourdes Hospital, Drogheda was published. The Lourdes Inquiry had been ongoing in parallel to the Institute's work on developing a policy for the future of maternity and gynaecology services. The Institute welcomes the findings and recommendations of the report of Judge Harding Clark. The Institute also recognises the significant resource implications associated with implementing its recommendations.

***This document outlines the view of the Institute of Obstetricians and Gynaecologists on the future of maternity and gynaecology services in Ireland.***

***The primary aim of this document is to improve maternity and gynaecology services for women, babies and families in Ireland.***

## 1.4 Relevant demographic trends in Ireland

***The population of Ireland is undergoing a period of strong growth.***

Ireland has the fastest-growing population in Europe, according to the latest Central Statistics Office (CSO) figures on population, migration and labour force.

Over the last 30 years, the population of the Republic of Ireland has experienced dramatic growth, increasing by almost one million over this period. In 2004, the population reached the 4 million mark. The CSO has projected that the population will increase to more than 5 million within 15 years if current growth rates continue. The excess of births over deaths has doubled in the past ten years. The table overleaf shows the projected population growth from 2006 to 2036.

# 1. Introduction

**Table 1.1 Central Statistics Office (CSO) Population Projections 2006 – 2036 (000's)**

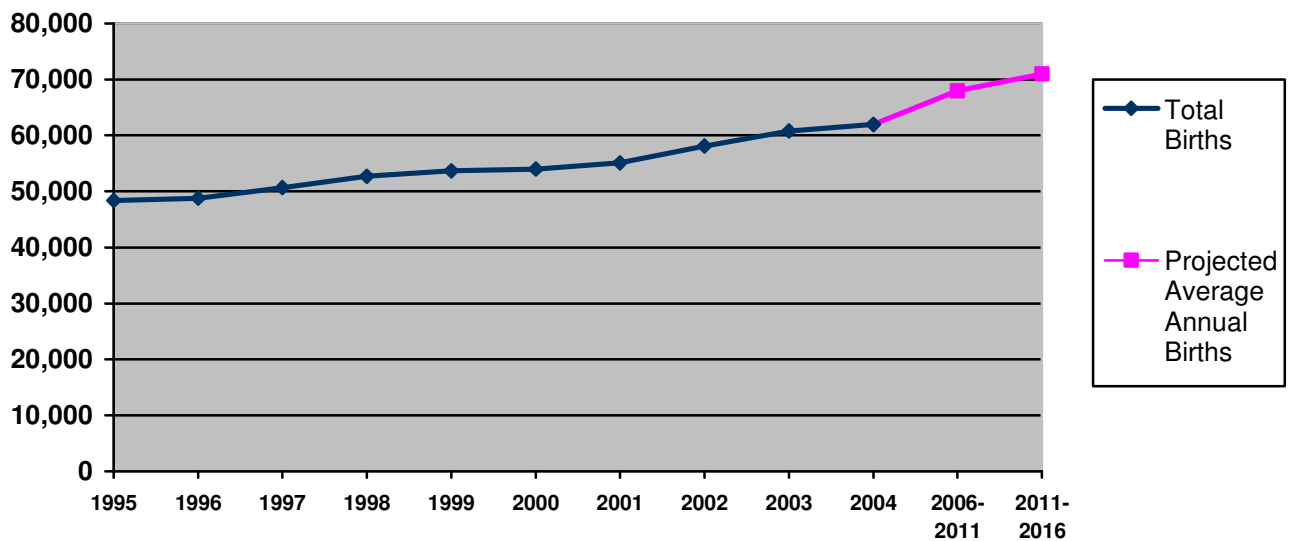
Year	2006	2011	2016	2021	2026	2031	2036
Population	4,167	4,505	4,854	5,140	5,399	5,613	5,820

Source: CSO population and labour force projections 2006-2036 (December 2004)

**The number of babies born in Ireland has been steadily increasing for the past ten years and is expected to continue to rise based on recent projections from the CSO.**

There has been an increase in demand for maternity services, which reflects the significantly increasing birth rates in Ireland. In light of the projections for even higher birth rates, it is inevitable that the demand for maternity services will continue to increase over the next ten years.

**Figure 1.1 Central Statistics Office Population Projections 2006 - 2016**



Source: CSO population and migration estimates (April 2005) & CSO population and labour force projections 2006-2016 (December 2004)

# 1. Introduction

## 1.5 Consultant staffing in Obstetrics and Gynaecology

Data from the most recent NHO Comhairle Report shows evidence of long-term under-investment in Consultant Obstetrician and Gynaecologist numbers.

**Table 1.2 Consultant staffing numbers 1975 - 2005**

CONSULTANT STAFFING 1975 TO 2005									
As at	1st May 1975	1st May 1978	1st May 1981	1st May 1985	1st May 1988	1st May 1992	1st January 1995	1st January 2001	23rd Nov 2005
Comhairle na nOspidéal	First Report	Second Report	Third Report	Fourth Report	Fifth Report	Sixth Report	Seventh Report	Eighth Report	Ninth Report
Term of Office	Sept 1972 to December 1975	January 1976 to December 1978	June 1979 to May 1982	June 1982 to May 1985	September 1985 to September 1988	July 1989 to June 1992	August 1992 to June 1995	December 1996 to December 2000	January 2001 to December 2005*
Specialty									
Anaesthesia	134	137	167	160	163	178	182	241	254
Emergency Medicine	0	0	0	0	0	11	13	21	52
Medicine	145	176	199	198	196	199	212	264	307
Obstetrics/ Gynaecology	93	90	103	96	85	82	83	99	105
Paediatrics	33	41	50	54	56	59	64	84	112
Pathology	85	82	94	90	86	92	95	140	183
Psychiatry	187	166	162	201	185	189	199	246	308
Radiology	71	75	88	95	93	97	99	147	186
Surgery	239	249	267	266	245	251	259	308	371
<b>Total</b>	<b>967</b>	<b>1,016</b>	<b>1,149</b>	<b>1,150</b>	<b>1,089</b>	<b>1,158</b>	<b>1,218</b>	<b>1,560</b>	<b>2,006</b>

*Source: Comhairle na nOspidéal, 2005*



# Chapter 2

## Methodology

## 2. Methodology

### 2.1 Institute Subgroup

A Subgroup of the Institute Executive was established in 2004 to lead this initiative. Members of the Subgroup were:

- Dr. Henry Bourke, St Luke's General Hospital, Kilkenny
- Dr. Bridgette Byrne, Coombe Women's Hospital, Dublin
- Dr. Patricia Crowley, Coombe Women's Hospital, Dublin and National Director of Training in Obstetrics and Gynaecology
- Dr. John T Gallagher, Chairman of Institute of Obstetricians and Gynaecologists 2002-2005
- Prof. John Higgins, Cork University Maternity Hospital / University College Cork, and Chair of Institute Subgroup
- Dr. Peter McKenna, Rotunda Hospital, Dublin
- Dr. Meabh Ni Bhuinneain, Mayo General Hospital, Castlebar
- Dr. Michael O'Hare, Chairman of the Institute of Obstetricians & Gynaecologists 2005 - (Co-opted in December 2005)
- Dr. Mary Wingfield, National Maternity Hospital (Co-opted in December 2005)

### 2.2 Site visits

In late 2004 and early 2005, members of the Subgroup visited each of the 22 maternity units in Ireland. During these visits, the Subgroup members met and held discussions with local obstetricians and gynaecologists in the hospital, the Director of Nursing and Midwifery (or equivalent) and Management representatives in the hospital and had a tour of the hospital facilities.

A list of the individuals met in each hospital is included in Appendix A1.

### 2.3 Consultation

In May - June 2005 the Subgroup embarked on a period of further consultation. The Subgroup had meetings with the:

- Faculty of Paediatrics, RCPI – Neonatal sub-committee
- Masters of the three maternity hospitals in Dublin
- Department of Health and Children: Paul Barron, Assistant Secretary in the Acute Hospitals Division; Denis O'Sullivan and Paul McKiernan, Acute Hospital Services; Dr John Devlin, Deputy Chief Medical Officer; Mary O'Neill, Public Health Nurse Advisor
- Pat McLoughlin, NHO Director
- The Junior Obstetrics & Gynaecology Society (JOGS)
- Comhairle na nOspidéal

The Subgroup requested, and received, written submissions from a range of patient groups, professional organisations and individual health professionals. The large number of submissions received from midwives around the country was much appreciated by the Subgroup. Please see Appendix A2 for a list of individuals from whom written submissions were received.

## 2. Methodology

### 2.4 Subgroup working sessions & Institute Executive discussions

Following the site visits and consultation period, the Institute Subgroup held a number of structured working sessions to discuss and formulate the output.

The Subgroup was supported by Prospectus Strategy Consultants. This support included advising the Subgroup on the process, facilitating meetings and drafting the Institute's policy document.

A draft discussion document was submitted to the Executive by the Subgroup in October 2005. The draft document was also circulated to all members of the Institute.

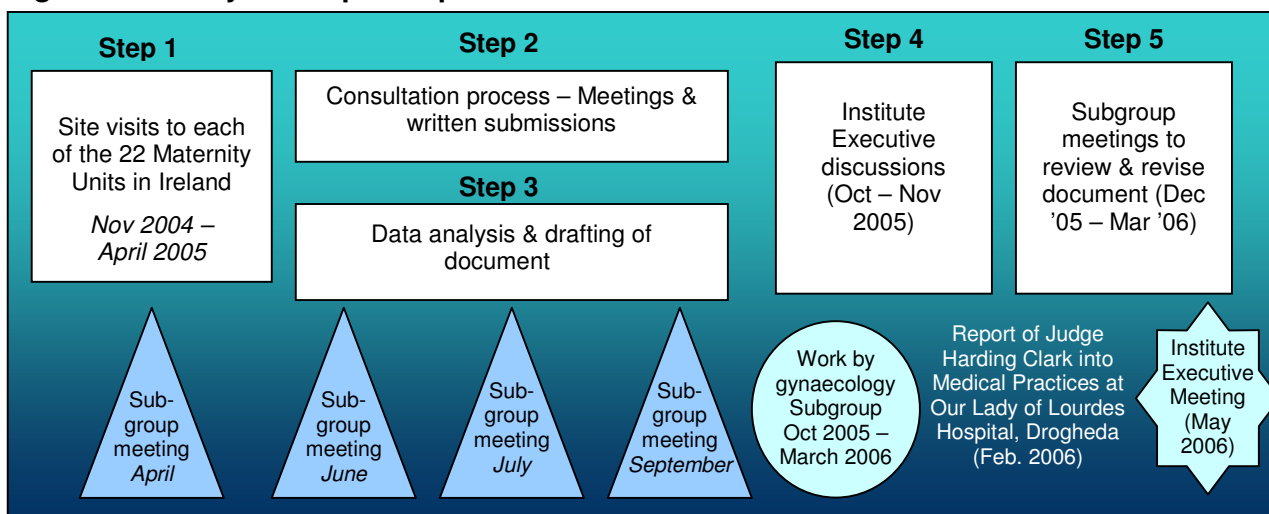
As a result of discussions at the Executive and consultations with the full Institute membership, a decision was made to expand the scope of the review to examine gynaecology services in more detail.

In October 2005, Dr Mary Wingfield was asked to review the gynaecology aspects of the draft document. A gynaecology Subgroup was established in November 2005 with representatives from each gynaecology subspecialty (Drs G Flannelly, N Gleeson, K Hickey, M Ni Bhuiinneain, R O'Connor, B O'Reilly, M Wingfield). A postal questionnaire was sent to all members of the Institute of Obstetricians and Gynaecologists in an attempt to gain further information about current gynaecological services and also to ascertain members' views on how these services might be developed. The gynaecology Subgroup met on three occasions and expanded the recommendations for general gynaecology and developed guidelines for each of the gynaecological subspecialties. (see Appendix A4).

The Subgroup subsequently reviewed and revised the draft policy document, taking on board recommendations from the gynaecology subgroup and additional suggestions from Institute members and other stakeholders. The Subgroup resubmitted the draft policy document to the Executive in April 2006.

### 2.5 Overview of Policy Development Process

Figure 2.1 Policy development process







**Chapter 3**  
**Overview of Current**  
**Maternity & Gynaecology**  
**Services**

## 3. Overview of current maternity & gynaecological services

### 3.1 Current maternity and gynaecology units

This chapter provides an overview of the current maternity and gynaecology units in Ireland. The tables on the following pages summarise the key data gathered from each of the units. For each unit, the tables indicate:

#### **Table 3.1 – Obstetric activity levels & medical staffing**

- Obstetric activity levels - Number of births per annum
- Medical Staffing:
  - Consultants – Whole Time Equivalents (WTE)
  - SpRs (Specialist Registrars)
  - Registrars
  - SHOs (Senior House Officers)

#### **Table 3.2 – Maternity & gynaecology facilities assessed**

- Dedicated caesarean section theatre
- Dedicated gynaecological ward
- Protected gynaecological beds
- Dedicated gynaecological theatre
- Colposcopy service
- Outpatient hysteroscopy
- Urodynamics testing

#### **Table 3.3 – Obstetric referral pathways**

- Guidelines regarding the transfer out of patients
- Whether or not the unit refers out perinatal cases
- Whether or not the unit takes in perinatal referrals

#### **Data Sources**

Data was provided to the Institute Subgroup by each hospital, during the Subgroup visits and subsequently validated by those hospitals. The hospitals were requested to provide the most recent data available.

Some additional information on gynaecological activity, staffing and facilities was obtained subsequently and added to the original data gathered.

It proved impossible to obtain accurate data with regard to numbers of gynaecological procedures, particularly as the means of documenting surgery varied from hospital to hospital. Because of this and also the fact that numbers of theatre procedures do not always reflect total gynaecological activity, e.g. outpatient treatments, it was decided not to include these figures.

#### **Midwifery**

Midwifery staff are currently deployed across obstetric, gynaecology, neonatal and paediatric areas in hospital based maternity units.

There are clear variations in the quantum and mix of midwifery/nursing staff across the 22 maternity units and no national references for staffing standards. Section 3.2 provides a summary of the key issues raised by midwives in relation to current maternity services.

### 3. Overview of current maternity & gynaecological services

#### **Scanning**

In the vast majority of units, ultrasound scanning is led by obstetricians, but a number of other models are used in some units.

#### **Gynaecology Services**

Gynaecology services are provided in all of the hospitals outlined in Tables 3.1, 3.2 and 3.3. In the vast majority of these hospitals the same consultants and medical staff provide obstetrics and gynaecology care.

A number of private hospitals provide substantial gynaecology services.

In addition, public gynaecology services in general hospitals are linked to local obstetric services. The main links are outlined below:

#### **Dublin**

- Mater Hospital
  - Beaumont Hospital
  - Blanchardstown Hospital
- } Linked to the Rotunda, Dublin
- St. James's Hospital
  - Adelaide & Meath Hospital, Incorporating the National Children's Hospital (AMNCH)
- } Linked to the Coombe, Dublin
- St. Vincent's Hospital Group (incl. St. Michael's Hospital and Loughlinstown Hospital)
- } Linked to Holles St, Dublin

#### **Limerick**

- Mid-West Regional Hospital
  - St John's Hospital
- } Linked to St Munchin's, Limerick

#### **Cork**

- Mercy University Hospital
  - South Infirmary – Victoria University Hospital
- } Linked to Cork University Maternity Hospital

#### **Monaghan General Hospital**

} Linked to Cavan General Hospital

#### **Louth County Hospital, Dundalk**

#### **Our Lady's Hospital, Navan**

} Linked to Our Lady of Lourdes Hospital, Drogheda

All assisted reproduction services are currently provided only in the private sector. A total of eight units provide these services, as shown in table 3.4. Three units are linked to public hospitals (Rotunda, UCHG and NMH) but are nevertheless privately funded.

### 3. Overview of current maternity & gynaecological services

**Table 3.1 – Obstetric activity levels & medical staffing**

Hospitals	No. of births (per annum)	Medical Staffing			
		Consultants – WTE	SpRs	Registrars	SHOs
Beaumont Hospital		1.2			
Blackrock Clinic		N/A			
Bons Secours Hospital, Cork		N/A			
Bons Secours Hospital, Tralee		N/A			
Cavan General Hospital	1,371	3	0	5	6
Coombe Women's Hospital	8,018	9.8	5	5	7
Cork University Maternity Hospital *	7,050	8.9	3	5	10
Connolly Hospital		0.4			
Kerry General Hospital, Tralee	1,563	3	0	3 – 2 filled	5
Letterkenny General Hospital	1,700	3	0	4	5
Louth County Hospital		N/A			
Mater Misericordiae Hospital		1.5			
Mater Private Hospital		N/A			
Mayo General Hospital, Castlebar	1,564	3	0	5	5
Mercy University Hospital, Cork		0.5			
Portlaoise –Midland Regional Hospital	1,400	3	0	5	2
Midwestern Regional Hospital, Limerick		1.8			
Midland Regional Hospital, Mullingar	2,031	3	1	5	5
Monaghan General Hospital		N/A			
Mount Carmel Hospital, Dublin	1,400	5	0	0	0
National Maternity Hospital, Holles Street	8,255	9.1	6	3	6
Our Lady's Hospital, Navan		N/A			
Our Lady of Lourdes Hospital, Drogheda	3,404	7	0	7	7
Portiuncula Hospital	1,722	3	0	4	5
Rotunda Hospital	6,731	9.2	5	3.5	7
Sligo General Hospital	1,324	3	0	4	4
South Infirmary Victoria University Hospital, Cork		1	1		3
South Tipperary General Hospital, Clonmel	951	3	0	3	4
St. Columcille's Hospital, Loughlinstown		1.1			
St James's Hospital, Dublin		1.8			
St John's Hospital Limerick		0.9			
St Luke's General Hospital, Kilkenny	1,603	3	0	3	4
St Munchin's Maternity Hospital, Limerick	4,542	4.3	2	4	11
St Vincent's Healthcare Group (St Vincent's University Hospital, St Michael's Hospital, Dun Laoghaire, St Vincent's Private Hospital)		2.0			
Tallaght Hospital		1.1			
Temple Street Hospital		0.4			
University College Hospital, Galway	3,200	4	3	3	7
Waterford General Hospital	2,276	3	0	5	4
Wexford General Hospital	1,840	3	0	4	4
<b>TOTALS</b>	<b>61,945</b>	<b>107</b>	<b>25</b>	<b>79.5</b>	<b>111</b>

\* includes obstetric services in St. Finbarr's, Erinville and Bon Secours Hospitals and gynaecology at CUH

### 3. Overview of current maternity & gynaecological services

**Table 3.2 – Maternity & gynaecology facilities**

Hospital Name	Dedicated CS theatre	Dedicated gynae theatre/ theatre sessions	Dedicated gynae ward	Protected gynae beds	Colposcopy	Outpatient Hysteroscopy	Urodynamics	Number of Gynae beds
Beaumont Hospital	N/A	Y	N	N	Y	Y	Y	
Blackrock Clinic	N/A	N	N	Y	N	N	N	N/A
Bons Secours Hospital Cork	Y	Y	Y	Y	Y	N	Y	
Bons Secours Hospital Tralee	N/A	N	N	Y	N	N	N	*23(4)
Cavan General Hospital	Y	Y	N	Y	Y	N	N	8
Coombe Women's Hospital	N	Y	Y	Y	Y	N	Y	45
Cork University Maternity Hospital - CUH, St Finbarr's, Erinville	Y	N	Y	Y	N	N	Y	10
James Connolly Memorial Hospital	N/A	Y	N	N	N	N	N	
Kerry General Hospital, Tralee	N	Y	N	N	Y	Y	Y	12
Letterkenny General Hospital	N	Y	N	N	Y	N	Y	19
Louth County Hospital	N/A	Y	N	Y	N	N	N	*0(4)
Mater Misericordiae Dublin	N/A	Y	N	N	N	Y	Y	
Mater Private Hospital	N/A	Y	N	Y	N	N	N	
Mayo General Hospital, Castlebar	N	Y	Y	N	Y	Y	Y	16
Mercy University Hospital Cork	N/A	Y	N	Y	N	N	N	
Midland General Hospital Portlaoise	N	Y	N	N	Y	N	N	
Midland Regional Hospital Mullingar	N	Y	N	N	N	Y	N	16
Mid-Western Regional Hospital Limerick	N/A	Y	N	N	N	N	Y	25
Monaghan General Hospital	N/A	Y	N	Y	N	N	N	
Mount Carmel Hospital Dublin	N	Y	N	Y	N	N	N	
National Maternity Hospital, Holles Street	N	Y	Y	Y	Y	Y	Y	23
Our Lady of Lourdes Hospital Drogheda	N	Y	N	N	N	N	Y	14
Our Lady's Hospital Navan	N/A	Y	N	Y	N	N	N	*0(4)
Portiuncula Hospital	Y	Y	N	N	Y	N	N	0
Rotunda Hospital	Y	Y	Y	Y	Y	Y	N	*24(5)
Sligo General Hospital	N	Y	N	N	Y	N	N	12
South Infirmary Victoria University Hospital Cork	N/A	Y	Y	Y	N	N	N	21
South Tipperary General Hospital Clonmel	N	Y	N	N	Y	Y	Y	10
St Colmcilles Loughlinstown	N/A	Y	N	Y	N	N	N	
St James' Hospital Dublin	N/A	Y	N	N	Y	N	Y	
St Johns Hospital Limerick	N/A	Y	N	N	N	N	N	
St Luke's General Hospital Kilkenny	N	Y	N	N	N	N	N	14
St Michael's Hospital Dun Laoghaire	N/A	Y	N	Y	N	N	N	
St Munchin's Maternity Hospital Limerick	Y	N/A	N/A	N/A	Y	Y	N	25
St Vincents Private Hospital	N/A	Y	N	Y	N	N	N	
St. Vincents University Hospital	N/A	Y	Y	N	N	N	Y	
Tallaght Hospital	N/A	Y	N	N	Y	Y	Y	9
University College Hospital Galway	Y	Y	Y	Y	Y	N	Y	*19(11)
Waterford General Hospital	Y	Y	N	N	Y	N	Y	13
Wexford General Hospital	N	Y	Y	N	Y	N	Y	14

\*Day beds are denoted in brackets

### 3. Overview of current maternity & gynaecological services

**Table 3.3 – Obstetric Referral Pathways**

Hospitals	Referral Pathways		
	Do guidelines exist re. transfer out of patients?	Do they refer out perinatal cases?	Do they take perinatal referrals?
Cavan General Hospital	Yes for maternity lead unit and Monaghan General to Cavan General. No for Cavan General to elsewhere	Yes	Yes
Coombe Women's Hospital	No	No	Yes
Cork University Maternity Hospital - CUH, St Finbarr's, Erinville	No	Yes – for confirmed fetal abnormality	Yes
Kerry General Hospital, Tralee	No	Yes	No
Letterkenny General Hospital	No	Yes	No
Mayo General Hospital, Castlebar	No	Yes	No
Midland General Hospital - Portlaois	No	Yes	No
Midland Regional Hospital, Mullingar	No	Yes	No
Mount Carmel Hospital, Dublin	Yes	Yes	No
National Maternity Hospital, Holles Street	No	No	Yes
Our Lady of Lourdes Hospital, Drogheda	Yes	No	Yes
Portiuncula Hospital	No	Yes	No
Rotunda Hospital	No	No	Yes
Sligo General Hospital	No	No	Yes
South Tipperary General Hospital, Clonmel	Yes	Yes	No
St Luke's General Hospital, Kilkenny	No	Yes	No
St Munchin's Maternity Hospital, Limerick	No	No	Yes
University College Hospital, Galway	No	Yes	Yes
Waterford General Hospital	No	Yes	Yes
Wexford General Hospital	In progress	Yes	No

### 3. Overview of current maternity & gynaecological services

**Table 3.4 –Assisted Reproduction Services (IVF Units, 2005 figures)**

IVF Unit	No. of first consultations	Ovulation induction cycles	IUI	IVF + ICSI	FET
Assisted Conception Unit, Clane General Hospital	324	300	360	216	63
Cork Fertility Centre	590	410	616	487	58
Galway Fertility Clinic	670	2030	190	428	45
HARI (Rotunda)	-	216	167	716	231
Kilkenny Clinic	-	-	67	44	15
Merrion Fertility Clinic (Holles Street)	507	61	269	129	40
Morehampton Clinic, Donnybrook	49	0	48	0	0
Sims Clinic, Rathgar	752	312	264	660	212

IUI = intrauterine insemination

IVF + ICSI = in vitro fertilization + intracytoplasmic sperm injection

FET = frozen embryo transfer

### 3. Overview of current maternity & gynaecological services

#### 3.2 Issues & concerns in relation to current maternity services

The key issues and concerns raised with the Institute Subgroup during the consultation process are summarised below:

- Patients' dissatisfaction with services, arising from, for example:
  - Geographic issues for women not living close to maternity units e.g. dangers of travelling long distances, inconvenience in accessing antenatal care, isolation from family support, lack of access to care after birth
  - Lack of choice in types of care
  - Inconsistency in the frequency of antenatal visits
  - Limited postnatal depression support services
  - Social inclusion issues e.g. for Travellers, homeless families, and families from non-Irish backgrounds
  - The specific needs of people with physical or sensory disabilities
- There is dissatisfaction amongst many health professionals with the current arrangement for maternity services nationally, relating to both resource allocation and the prioritisation of the care of women and babies within the current health reform programme
- Many consultant obstetricians in smaller units expressed their sense of professional isolation. Obstetricians in smaller units felt that their views on the development of services were not being given due consideration.
- Frustration was expressed in many smaller units at the lack of structures available to facilitate both *in utero* and neonatal transfers
- In many of the 22 maternity units, the labour ward and other wards and facilities are significantly substandard. Significant infrastructural deficits were identified by the Subgroup during its visits to the different units.
- Despite improvements in perinatal mortality rates over the last 20 years, perinatal mortality rates could be *further* improved in Ireland
- Neonatal outcomes could also be improved, as indicated by benchmarking of Irish data on the outcome of premature very low birth weight infants against international data, within the Vermont Oxford Neonatal Network. The benchmarking has also highlighted variation in outcomes between centres providing neonatal care in Ireland
- There are currently significant deficits in consultant numbers, and delays in the approval and appointment of additional new consultant posts and the replacement of existing posts upon retirement. Data from the most recent NHO Comhairle Report (December 2005) shows evidence of long-term under-investment in consultant obstetrician and gynaecologist numbers (See Table 1.2)
- Ireland has fallen behind in research and innovation in the area of obstetrics and gynaecology
- Midwifery/nursing staffing levels are perceived to be inadequate in most units and no standardised staffing model has been agreed nationally. The following issues were raised by midwives in submissions made to the Subgroup:



### 3. Overview of current maternity & gynaecological services

- Changes in recruitment and retention, and job satisfaction of midwives, are issues in the majority of units
- Career advancement and continuing education for midwives is also highly variable. In some locations, there are clinical midwife specialists (ultrasonography, diabetes, colposcopy) in post, and advanced practitioners in training
- Midwives in most localities would like to offer a choice of models of care to the expectant mother and her family. There are examples of team midwifery, midwifery led care, Domino schemes etc. in several maternity units. However, there are clear variations in the schemes available nationwide and obvious disparity in access between regions.
- Midwives have identified a lack of clinical governance and strategic planning pertaining to their specialty at national and local levels
- In addition to the challenges in midwifery manpower, the majority of midwives highlighted patient choice, facilities and extended postnatal care services as priorities for future development

#### 3.3 Issues & concerns in relation to current gynaecology services

The main issues and concerns raised by Institute members, in their responses to the postal surveys on gynaecology services circulated by the gynaecology subgroup, can be summarised as follows:

- There is a general view among gynaecologists that Irish practice is lagging behind other European countries, particularly in the areas of minimal access surgery and outpatient surgical treatment
- Lack of protected gynaecology beds, especially in large general hospitals
- Shortage of nurses/ midwives experienced in gynaecology, especially in large general hospitals
- Poor facilities and equipment in gynaecology theatres in maternity hospitals compared to general hospitals
- Inadequate outpatient hysteroscopy facilities
- Lack of urodynamics facilities
- Poor privacy
- Inadequate bathroom facilities
- No national cervical screening programme
- No public funding for assisted reproduction services



**Chapter 4**  
**Recommendations and  
standards for the future  
development of maternity &  
gynaecology services in  
Ireland: 2006 - 2016**

## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

### Context & timeframe

Maternity and gynaecology services in Ireland have experienced significant rationalisation over the last thirty years, including, for example:

- The closure of maternity services in Ennis, Loughlinstown, Monaghan, Dundalk and Tullamore
- The closure of several units in district hospitals in the charge of General Practitioners, in places such as Ballina, Belmullet, Carlow, Dungarvan and Gorey
- The closure of some private maternity services, such as Aut Even Hospital.

**The recommendations outlined in this chapter are designed to improve the safety and wellbeing of women and babies, and the life-long gynaecological health of women in Ireland. The recommendations should apply to all units providing maternity and gynaecology care, and are consistent with the recommendations of the report of Judge Harding Clark.**

The Institute recognises that implementation of many of these recommendations will have significant service delivery, training and resource implications. Each unit will need time and support to implement the recommendations and standards.

**Some of the recommendations should, and must, be implemented within a short timeframe (within the next 1-2 years); others may take longer to implement.**

The Institute expects that maternity and gynaecology services generally, and each individual unit, should make steady progress towards achieving the recommendations and standards outlined in this document, with the aim of having the recommendations fully in place by 2016.

**By 2016, maternity and gynaecology units will have to meet the standards outlined in this document in order to have training posts recognised by the Institute of Obstetricians and Gynaecologists.**

### 4.1 Patient care

#### 1. *Patients availing of maternity and gynaecology services should:*

- Be treated politely and considerately
- Be involved in and informed about decisions
- Receive care based on clinical effectiveness
- Receive care provided by trained and revalidated team members
- Know that privacy, dignity and confidentiality will be respected
- Receive information about their care, where appropriate, in writing and in the relevant language
- Expect a consultation that is appointment based and unhurried

#### 2. **Consultations should take place in a single room** which cannot be entered while any gynaecological examination is in progress

## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

3. Patients should be offered the option of having a **chaperone available** during intimate examinations, irrespective of the gender of the gynaecologist/obstetrician
4. Patients should be provided with **private, warm and comfortable changing facilities**
5. Easily understood **literature and diagrams should be provided** for women undergoing invasive procedures such as colposcopy and urodynamic investigations

### 4.2 Clinical maternity networks

#### Clinical Maternity Networks

##### Rationale for Networks

*The development of clinical maternity networks is particularly important for the future provision of services in smaller maternity units.*

*The purpose of the networks is to:*

- Enhance clinical governance
- Provide professional support to clinicians in the networks
- Improve access to quality care for women and babies
- Provide a framework for training and to allow strategic development of sub-specialities within each network

Clinical Maternity Networks should be established with each network consisting of:

- **A referral centre(s)** - for neonates and women at particular risk of severe obstetrical or medical complications
- **A number of maternity units**

#### Purpose and scope of clinical maternity networks

6. **Clinical maternity networks should be developed throughout the country** (as outlined in the summary box above)

Women should, be able to receive their care as near to home as possible and they should also know in advance, if a problem were to arise with their baby, where and how care will then be provided. **Women should still have the option of attending a hospital of their choice (outside their own network)**

The networks should enable the concentration of skills and expertise required for the care of women and babies receiving longer and more complex care.

7. **The networks should have a common framework for clinical governance** agreed across the network, including for example:
  - Common protocols, standards, clinical guidelines and pathways of care
  - A joint approach to clinical audit, incident reporting and clinical training
  - Professional development across the network
  - Exchange of sessions (clinical, administrative and/or educational) between units

## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

8. Each maternity and gynaecology unit should implement a **comprehensive approach to clinical governance and audit**, which takes on board the recommendations from the Report of Judge Harding Clark into medical practices at Our Lady of Lourdes Hospital, Drogheda.
9. **Perinatal audit should function across the network**, with joint perinatal meetings for hospitals within the network, at least twice yearly – in addition to the usual ongoing weekly or monthly perinatal meetings of each unit
10. **Perinatal pathology services should be organised using the network framework**
11. **Five clinical maternity networks should be established - examples of possible networks are outlined below.**

	<i>Approximate number of deliveries in network per annum (2004):</i>
<p><b>Network A – Galway</b>  <i>Referral Centre:</i> University College Hospital, Galway  <i>Maternity Units:</i>                      Portiuncula Hospital                      Mayo General Hospital, Castlebar                      Sligo General Hospital                      Letterkenny General Hospital*</p>	} <b>A. 9,500</b>
<p><b>Network B - Cork</b>  <i>Referral Centre:</i> Cork University Maternity Hospital  <i>Maternity Units:</i>                      South Tipperary General Hospital, Clonmel                      Waterford General Hospital                      Kerry General Hospital, Tralee</p>	} <b>B. 11,800</b>
<p><b>Network C – National Maternity Hospital***</b>  <i>Referral Centre:</i> National Maternity Hospital, Holles Street  <i>Maternity Units:</i>                      Wexford General Hospital                      St. Luke’s General Hospital, Kilkenny</p>	} <b>C. 12,200</b>
<p><b>Network D – Coombe***</b>  <i>Referral Centre:</i> Coombe Women’s Hospital  <i>Maternity Units:</i>                      Midland General Hospital, Portlaoise                      Midland Regional Hospital, Mullingar</p>	} <b>D. 11,900</b>
<p><b>Network E – Rotunda***</b>  <i>Referral Centre:</i> Rotunda Hospital  <i>Maternity Units:</i>                      Cavan General Hospital                      Our Lady of Lourdes Hospital, Drogheda**</p>	} <b>E. 12,000</b>

\* For the purposes of training and clinical governance **Letterkenny General Hospital** should be linked to University College Hospital, Galway, Network A. Letterkenny General Hospital should be linked to Altnagelvin for *in utero* and neonatal referrals. This will require

## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

discussions between the HSE and Northern Ireland's Department of Health, Social Services and Public Safety, and it would build on the existing collaborative arrangements for funding neonatal care in Altnagelvin.

**\*\* Our Lady of Lourdes Hospital, Drogheda** provides a full neonatal intensive care service and receives referrals from Cavan hospital.

**\*\*\* Mount Carmel Hospital** should participate in one of the three Dublin networks - to be decided by the parties involved.

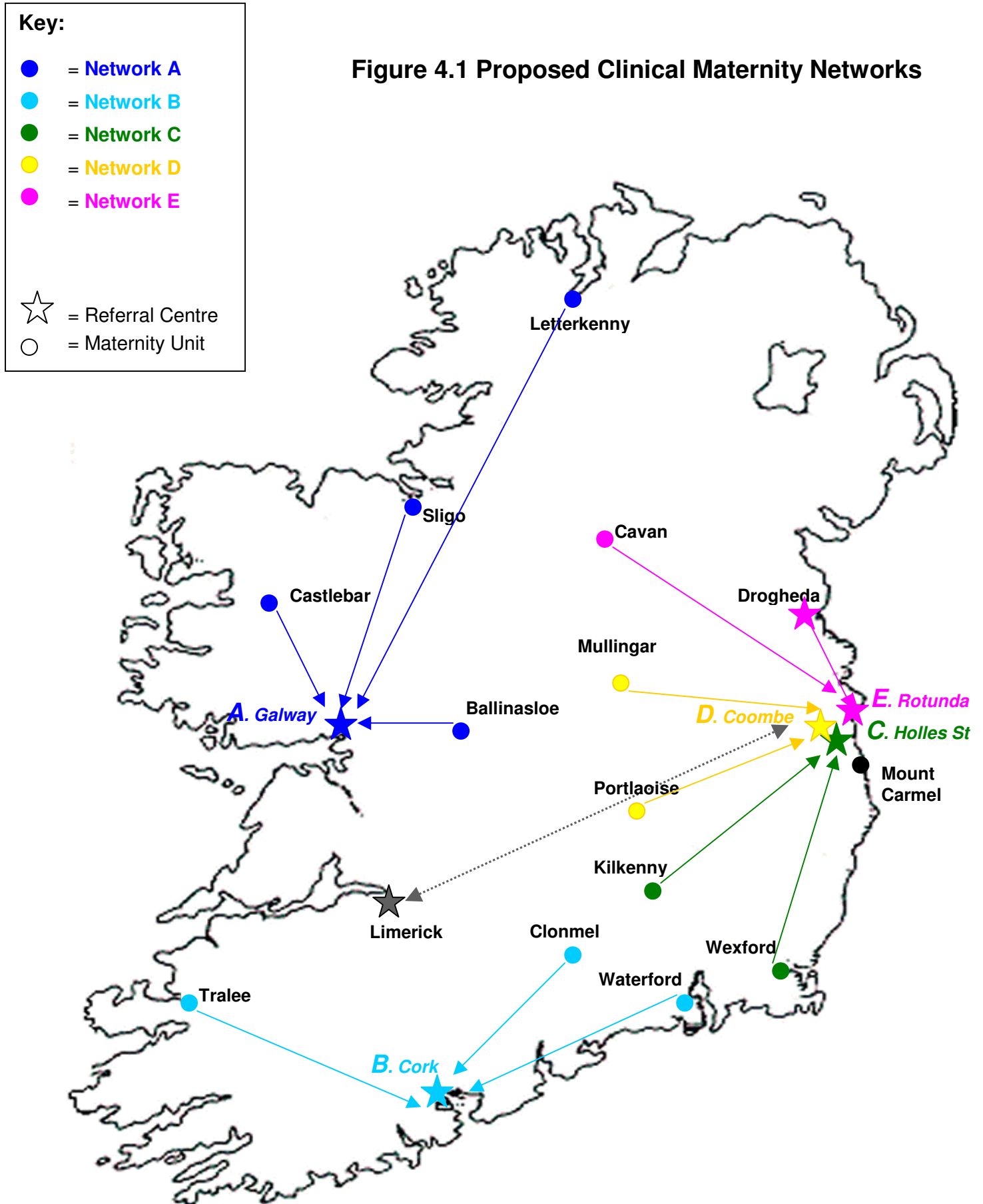
**St. Munchin's Maternity Hospital, Limerick** provides a full neonatal intensive care service and it is proposed would network with one of the Dublin maternity hospitals, forming a network with two referral centres.

**The proposed development of a National Children's Hospital** co-located with a maternity hospital has the potential to alter the referral patterns in a number of sub-specialties, particularly in the Dublin region.

- 12. A number of services should continue to be developed and delivered on a national basis**
- 13. The option should be given to patients in the border regions to access services on either side of the border**

## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

Figure 4.1 Proposed Clinical Maternity Networks





## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

### Referrals

**14. *The following cases should typically be referred out of maternity units to the designated referral centres in the network:***

- a) Women likely to require delivery at less than 32 weeks of gestation should generally be transferred to the referral centre in advance of the birth of their baby.
  - 32 weeks is a minimum agreed gestation. Clinicians in maternity units may choose to refer women or infants at later gestation, following discussion between the referral centre and the maternity unit regarding availability of local resources, expertise and personnel
- b) Women at risk of severe obstetrical or medical complications
- c) Neonates - Babies born at less than 32 weeks gestation
- d) Neonates - For babies at more than 32 weeks gestation who then go on to require neonatal intensive care

Individual networks may modify these recommendations based on the expertise within individual units. Close communication between consultant obstetricians, paediatricians and neonatologists should underpin all decisions to ensure optimal care for women and infants in each clinical network.

**15. *For babies transferred for longer-term intensive care, the networks should facilitate early return to the local maternity unit when the baby is recovering***

- This would make best use of the overall capacity of the system, and develop and maintain skills, expertise and paediatric training in neonatal intensive care in all neonatal units

### National perinatal transport system

**16. *A national perinatal transport system should be established to:***

- Track the availability of neonatal beds
- Manage the transport system for maternal and neonatal transfer, preferably within each network
  - The transport system should cover the movement of critically ill women and babies to the referral centre, 24 hours a day, and transport babies/women back to the maternity unit nearer their home

The establishment of a national perinatal transport system would require:

- The appointment of a National Co-ordinator(s) with dedicated sessions
- Real-time records of neonatal bed availability in centres
- Dedicated neonatal SpR staff (on a roster basis) for the transport system

**The transport services should be located on three sites – in Dublin, Cork and Galway**

## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

### Roles and structures within the network

17. **A Network Committee should be established to take the lead on clinical governance in the network. The network should consist of one consultant, nominated by each maternity unit, one representative of midwifery/nursing from each unit and one management representative from each unit**
- Consultant representatives should be nominated for a period of two years
  - A consultant chairperson should be appointed from among the consultant members of the Committee. The chairperson post should rotate between the different units in the network every two years
  - The role of the committee, led by the chairperson, would be to facilitate the development of the network. This would involve for example:
    - Coordinating the development of clinical guidelines and protocols throughout the network
    - Facilitating continuing professional development within the network
    - Chairing the twice yearly perinatal and gynaecology meetings within the network

### 4.3 Maternity & Gynaecology Units

#### Maternity & gynaecology services

18. **In addition to routine antenatal care and general gynaecological services (elective and emergency), the following services should be available locally in every gynaecology and/or maternity service:**
- Early pregnancy clinics
  - Basic and intermediate ultrasound scanning
  - Investigation of subfertility
  - Colposcopy clinics
  - Urodynamics
  - Transvaginal ultrasound
  - Outpatient hysteroscopy

***(Some services may be spread across two or more adjacent hospitals but must be accessible for all patients)***

#### Consultant obstetrician & gynaecologist staffing

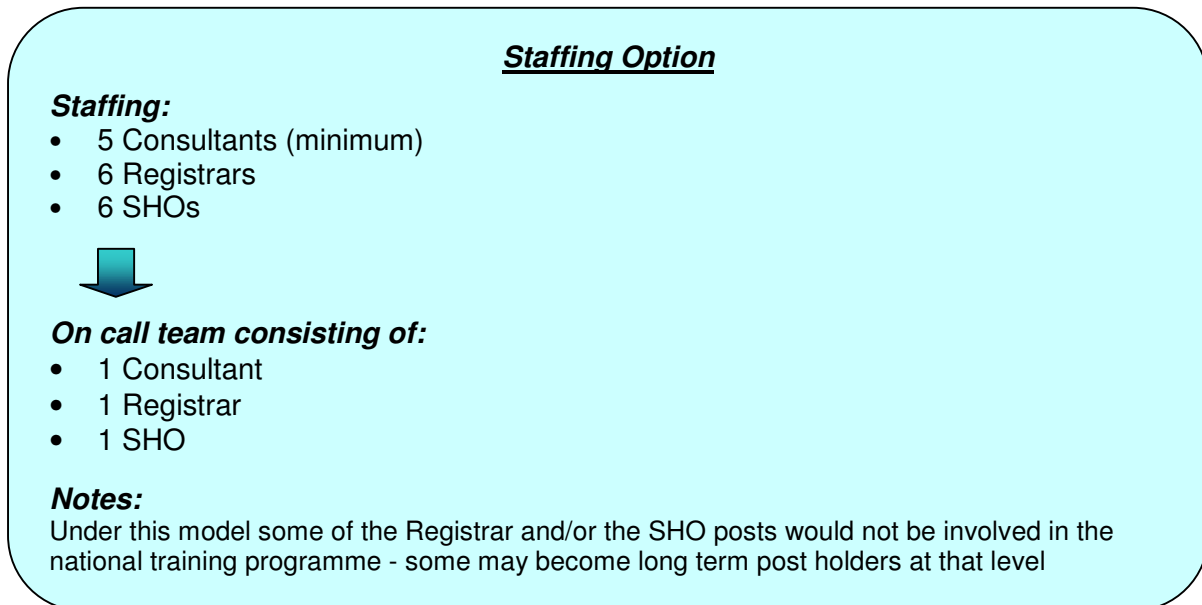
19. **Consultant obstetricians and gynaecologists should continue to contribute to the care of all pregnant women**
- The training in, and practice of, obstetrics and gynaecology requires expertise in, and ongoing exposure to, normal pregnancies

## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

### 20. Medical staffing of maternity and gynaecology units

*This is an area where complete agreement did not emerge from discussions. Several staffing models were considered. The option shown below is the model preferred by the majority of current consultants.*

**Figure 4.2 Medical Staffing Options in Maternity and Gynaecology Units**



**Notwithstanding the staffing model outlined above, individual maternity units should have the opportunity to pilot alternative models of medical staffing which could include:**

- A higher number of consultants
- Fewer total NCHDs but more trainees from the Irish training programme
- Enhanced roles for midwifery
- Novel roster patterns for on-call

**21. Flexible working arrangements for consultants and trainees** (e.g. limited sessions, job sharing) **are considered essential for future consultant and medical staffing**, and should be facilitated by local arrangements

### Multidisciplinary approach and clinical support services

**22. All maternity and gynaecology units should support a multidisciplinary approach to the care of women and babies**

**23. Each maternity and gynaecology unit should have ready access to the full range of medical specialties**

**24. There should be appropriate anaesthetic cover** including:

- 24 hour epidural cover
- Anaesthetic NCHDs on site 24 hours per day

## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

25. Expectant women, in all units, should have **access to**:
- **Social work**
  - **Physiotherapy**
  - **Dietetics** etc.

### Ultrasound

26. ***Antenatal ultrasound services should be provided under the direction of obstetricians and gynaecologists***

- To ensure that future consultant obstetricians and gynaecologists have the necessary skills in this area, there should be a compulsory training module in basic ultrasound for obstetrics and gynaecology trainees

### Collaboration with Midwifery and Nursing

The Institute recognises the crucial role that midwives play in pregnancy, and particularly in relation to 'normal' pregnancies

27. ***An adequately resourced Domino service should be developed in all maternity units***

- A Domino service which is widely available would help to address the demand for home births, whilst ensuring safe care for women and babies
- Given the current infrastructure available, the Institute recommends that pregnant women should be counselled in favour of birth within a maternity unit

28. ***New models of care for pregnant women should be developed on the basis of local arrangements between midwifery and consultant obstetricians and gynaecologists, within the context of the clinical governance of the maternity networks***

- The key role of obstetricians and gynaecologists is to ensure the safety and wellbeing of women and babies. This role involves **close collaboration with midwives and nurses**
- In particular the Institute supports the development of new career paths for midwifery, including further development of clinical midwife specialists and advanced midwife practitioners. These changes might allow novel on call roster staffing models to develop.

29. ***An agreed national staffing model for midwifery and nursing should be developed, to be applied across all maternity and gynaecology units*** (for example, the Ball Birthrate Plus System)

### Collaboration with General Practitioners

The Institute recognises that General Practitioners have a very important role in the provision of shared care services. In addition, the role of the General Practitioner is particularly important in preconceptual counselling, early pregnancy care and in the postpartum period.

## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

**30. An agreed guideline should be developed between the Institute and the Irish College of General Practitioners to allow uniform policies to be developed.**

### Infrastructure and facilities

**31. There should be the following basic infrastructure in each maternity/gynaecology unit:**

- A labour ward, with a dedicated obstetrics theatre either in or immediately adjacent to the labour ward
- Dedicated adequate theatre sessions for gynaecology (separate from emergency obstetrics)
- Dedicated obstetrics wards
- Dedicated separate gynaecology wards (staffed by nursing/midwifery staff trained in gynaecology)
- A dedicated 24 hour assessment area for obstetrics and gynaecology emergency cases
- A dedicated outpatient area for obstetrics and gynaecology, to encompass specific facilities for:
  - *An early pregnancy clinic*
  - *Colposcopy clinic*
  - *Outpatient hysteroscopy*
  - *Ultrasound scanning*
- Single rooms in outpatient areas
- Day surgery facilities
- Adequate privacy and bathroom facilities
- Outpatient facilities and inpatient and day surgery theatre list for each consultant

**32. There should be access to 24 hour laboratory services**, including for example:

- Haematology
- Biochemistry
- Microbiology

**33. There should be easy access to advanced imaging**

**34. There should be easy access to an Intensive Care Unit**

**35. There should be suitable accommodation** for the partner/family of the woman and baby, and for the bereaved

**36. All maternity and gynaecology units should be accessible**

- Units should be physically accessible so that patients can easily access the services

## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

- Units should also be socially accessible so that patients from different countries and cultures can easily access the services (for example, access to interpreters, signage, etc.)

### 4.4 Referral centres

*In addition to satisfying the Institute standards pertaining to maternity and gynaecology units (section 4.3), referral centres must also meet the standards outlined below:*

#### Consultant staffing

37. *There should be 24 hour on site, on call consultant obstetric cover in the labour ward of units handling 6,000 deliveries per annum or more*
- **This should be agreed on a local basis** (consideration should be given to the number and age profile of consultants)
  - It should be phased in **incrementally**, starting with protected consultant sessions for labour wards
  - It is envisaged that units will require a complement of **at least 20 consultants (WTE) on the roster** to be able to provide 24 hour labour ward cover
  - The consultant roster should include transition year trainees with the consultant on call from home

#### Clinical support services and infrastructure

Referral centres should have:

38. The **skill set, expertise and resources** to look after complex maternal and fetal problems and very small / sick babies.
39. **An obstetric high dependency unit, with immediate access to intensive care beds as / when necessary**
40. **Ready access to maternal-fetal medicine services**
41. **Pathology / pathologists with special interest in perinatal pathology**

## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

### 4.5 Gynaecology

42. **Development of gynaecology services should be based on the network system**, with most gynaecology services provided within the network
43. **Complex elective gynaecology cases** should be managed in hospitals where the full range of medical and surgical specialties are available
44. **Each maternity and gynaecology unit\* should have at least one consultant with a special interest in:**
  - Urogynaecology
  - Minimal access surgery
  - Reproductive medicine
  - Colposcopy

*\* Some services may be spread across two or more adjacent hospitals but must be accessible for patients*

45. **Each clinical network should have subspecialist gynaecology services in:**
  - Urogynaecology
  - Minimal access surgery
  - Reproductive medicine
  - Gynaecological oncology
46. As consultant numbers are expanded within the network, **appointments should be made on a strategic basis to allow for the development of gynaecological subspecialties**

This should lead to:

  - Two way exchange of sessions (clinical, administrative and/or educational)
  - A joint approach to clinical audit, incident reporting and clinical training
  - In service training of consultants and trainees in specialist gynaecology skills e.g. minimally invasive surgery
  - Gynaecological pathology services being organised using the network
47. **Gynaecological audit should function across the network**, with joint gynaecological audit meetings for hospitals within the network, at least twice yearly

48. **Assisted reproduction services should be publicly funded.**

**Guidelines for each of the gynaecological subspecialties are included in Appendix A4**

### 4.6 Training

**The primary objective of the obstetrics and gynaecology training programme is to train quality consultants for all the maternity and gynaecology units in Ireland.** The training programme should also provide training for postgraduates from other countries

The training programme, career opportunities and ultimately the consultant posts need to be attractive so that high quality obstetrics and gynaecology trainees can be recruited

#### 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

49. ***At least 200 full-time consultant obstetrician gynaecologists will be required in Ireland in 10 years time*** to provide the consultant staffing levels necessary in maternity and gynaecology units and referral centres. **Notwithstanding the basic staffing models outlined in recommendations number 20 and number 37 the Institute recommends that there should be at least one consultant per 350 births in a maternity unit.** This should allow the three units with between 3,000 and 4,500 births to provide dedicated consultant cover on the labour ward for 40 hours per week.
50. ***The proportion of obstetrics and gynaecology medical staff who are consultants (rather than trainee / NCHD posts) should increase substantially***
51. ***During the transition period between now and 2016, the obstetrics and gynaecology postgraduate training programme will need to be substantially expanded to build up the increased consultant complement required, to accommodate the growing number of consultants and trainees with flexible working arrangements, and to replace retiring consultants*** (see Appendix A5 for retirements due among consultants)
- The implications for the training programme of the increasing numbers required at SHO and SpR level to deliver this number of consultant obstetricians and gynaecologists within 10 years, will need to be identified and addressed
52. ***Intern posts in obstetrics & gynaecology should be established in maternity and gynaecology units***
- With a rotation for approximately 2 – 3 months as outlined in the recent Medical Council guidelines.
53. There should be a ***defined curriculum for postgraduate training in obstetrics and gynaecology, with a modular approach to training***
- Training for SHOs and Junior Registrars (Year 3) provided around compulsory modules
  - Training for SpRs provided around compulsory and optional modules
54. ***There should be a national SHO training scheme, based on the clinical maternity networks.*** Appointment to this scheme should use a centralised matching system, facilitated by the Institute of Obstetricians and Gynaecologists
- SHOs to do a maximum of 12 consecutive months rotation in the one hospital
55. ***SHO training should be followed by Junior Registrar training.*** Junior registrar training may be completed within the same clinical maternity network
56. ***There should be competitive entry to the SpR programme with MRCPI Part 2 (or equivalent) being a requirement for entry***
57. ***The SpR training programme should be completed over a minimum of 5 years***
- Years 1 and 5 must be completed in Ireland
  - Years 1 and 2 will be based within an individual network
  - 'Out-of-programme' experience should be optional but encouraged
  - The final year of the training programme (year five SpR) must be completed in Ireland
    - This is a transition year between trainee and consultant
    - The SpR should be given the opportunity to take on more responsibility
      - For example, in larger units they could be the senior person on call in house, with a consultant on call at home



## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

58. The location of trainees during the SpR programme will be defined by the National Training Director
59. Trainees should be encouraged to use the 'out of programme' time to pursue research, leading to a higher degree by thesis, or to undergo subspecialist or special skills training. These activities could take place in Ireland or overseas
60. Trainees in the Irish system should be encouraged to take the MRCOG examination during the SpR programme
61. The formal exit assessment at the end of SpR training - leading to a Certificate of Satisfactory Completion of Specialist Training (CSCST) – **should continue**
62. Representatives from the different hospitals within the network should be involved in the interview process for SHOs and SpRs
63. There should be obstetrics and gynaecology trainees working towards CSCST in all maternity and gynaecology units
64. Trainees should be actively encouraged to train overseas for part of their training. This is particularly important for subspecialty training.

Table 4.3 Summary of Proposed Obstetrics and Gynaecology Training Programme

Post Graduate Training in Obstetrics & Gynaecology	Exams	Curriculum	Entry into programme	Location
Intern	MRCPI Part 1*	Defined curriculum around core modules	Competitive entry into SHO training programme ↓	Based within a network
SHO – Year 1				
SHO – Year 2				
Junior Registrar – Year 3	MRCPI Part 2*	Defined curriculum around core and optional modules	Competitive entry into SpR training programme ↓	Based within a 2nd network
SpR – Year 1				
SpR – Year 2	Formal Exit Assessment*		Based Nationally	
SpR – Year 3				
SpR – Year 4				
SpR – Year 5				

\* = Essential Requirement

## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

### 4.7 National Perinatal Epidemiology Centre

65. ***The National Perinatal Epidemiology Centre, which will be based at the new UCC BUPA Ireland Research Centre in Cork University Maternity Hospital, should become fully operational. Its overall objective is to translate outcome data from Irish maternity hospitals and evidence-based best practice into improved clinical services for Irish patients***

The specific roles of the Centre will be:

- To collaborate with government agencies (including the ESRI) to collate outcome data from maternity hospitals in Ireland
- To evaluate outcome data from all maternity units including:
  - Maternity and perinatal mortality
  - Birth defects
  - Outcomes of fertility
- To publish the analysis of perinatal data and outcomes, on an annual basis
- To develop clinical protocols/guidelines based on analysis of data
- To act as a resource for the Minister and the Department for Health and Children

The modus operandi of the Centre will be based on the Australian State system with committees to ensure conclusive involvement of clinicians from different units.

66. ***Two immediate tasks of the National Perinatal Epidemiology Centre should be to co-ordinate:***

- The development of a national maternity chart
- A nationally agreed perinatal outcome-data set

67. ***There should be a standardised approach to data collection across all of the networks, with one labour ward system; this will require the development of appropriate IT systems***

### 4.8 Research & Innovation

68. ***Research and innovation should be fostered in obstetrics and gynaecology in Ireland, because ultimately it leads to excellence in care for women and babies. This should be achieved by:***

- The establishment of earmarked “funding streams” for obstetrics and gynaecology (e.g. Health Research Board; Science Foundation Ireland)
- Strengthening relationships with the university sector
- Securing funding for research projects specifically targeting obstetrics and gynaecology

## 4. Recommendations and standards for the future development of maternity & gynaecology services in Ireland: 2006 - 2016

- Allowing academic obstetricians and gynaecologists the option to practise only within their subspecialty (subject to local agreement with their hospital)

The expansion in consultant numbers, the development of clinical maternity networks, national maternity charts and common data systems should facilitate research and innovation in obstetrics and gynaecology



**Chapter 5**  
**Role of the Institute in  
planning maternity &  
gynaecology services in  
Ireland**

## 5. Role of the Institute in planning maternity services in Ireland

Currently, the Institute structures consist of:

A number of individual roles:

- A Chairman (elected by the members)
- A Secretary
- A Treasurer
- An Executive
- A meetings convenor

A number of committees:

- A Standing Committee
- A Training Committee
- An Examination Committee
- A Hospital Recognition Committee

The Subgroup, established to drive the development of the Institute's policy on the Future of Maternity & Gynaecology Services in Ireland, recommends that ***the Institute should review and update the standing orders of the Institute*** to reflect the recent health reforms and the development of clinical networks

The Subgroup also recommends that a new committee should be established within the Institute – ***a Professional Development and Planning Committee***

Possible functions of the Professional Development and Planning Committee include:

- Implementation of this policy document and liaison with relevant statutory, professional and other bodies in relation to this
- Leading professional development within the specialty

The Subgroup recommends that the Institute should ***seek funding from the Department of Health and Children to:***

- **Put in place dedicated support staff at a senior level within the Institute** (to include, as a minimum, a full-time manager and 2 additional full-time administrative / secretarial support staff)
- **Buy out protected sessions for the Institute Chairman and Chairs of committees**

Finally, the Subgroup recommends that the Institute should **facilitate the development of national guidelines for each subspecialty.**

# Appendices

## Appendix A1 - Individuals met by Institute sub-group during visits to Maternity Units

The Subgroup met the following individuals during visits to the 22 maternity units around the country.

Hospital	Institute Members	General Management	Representative/s of nursing and midwifery
Cavan General Hospital	S Aziz/ Hussain/ Muktar	General Manager, Kevin Molloy	Assistant Director of Nursing, Patricia Hughes
Coombe Women's Hospital	S Daly/C Fitzpatrick/M Turner/J Drumm/M Joyce/M O'Connell/C Regan/B Stuart/H O'Connor/P Bowman	-	-
Cork – St Finbar's, Erinville, Bons Scours, South Infirmary – Victoria, Mercy University	J Higgins/B O'Reilly/M Ismai/D Corr/ T. O'Connor/B Kerkhoff/A Curtain/J Waterstone/R Greene/J Coulter/V Fenton	Commissioning Manager, Nora Geary	Acting Director of Midwifery, Monica Harrington
Kerry General Hospital, Tralee	M McCaffrey/P Hughes/T Harim	Anne Hickey + General Manager	Director of Nursing, Richard Walsh
Letterkenny General Hospital	B Davidson/C King/E Aboud	-	Clinical Midwife Manager III, Evelyn Smith + Assistant Director of Nursing, Cynthia Furey
Limerick City Hospitals	A Dempsey/G Burke/K Hickey/U Fahy/M Skehan	Hospital Administrator, Eamonn Leahy	Clinical Midwife Managers, Noreen Keane, Margaret Quigley
Mayo General Hospital, Castlebar	M Ni Bhuinneain /D Corcoran	General Manager, Tony Canavan	Director of Nursing, Josephine Tiernan
Midland General Hospital, Portlaoise	J Corristine / Hosam El Kinny	-	Divisional Nurse Manager, Dolores Booth Clinical Midwife Manager, Connie Mc Donogh
Midland Regional Hospital, Mullingar	M Gannon/D Mortell	N/A	Clinical Midwife Manager, Marie Colbert
Mount Carmel Hospital, Dublin	V Donnelly/K O'Connor/ G Rafferty/P Tunney	Chief Executive, Michael Dowling Director of Nursing, Kay Gleeson Clinical Midwife Manager, Eileen Heffernan	Assistant Director of Nursing, Teresa McClusky
National Maternity Hospital, Holles Street	M Robson/O Sheil/P McParland	-	Director of Nursing / Midwifery, Mary Boyd
Our Lady of Lourdes Hospital, Drogheda	M Milner/S Higgins/ F Lynch/M Rabee	Assistant General Manager, Roisin McGuire	Assistant Director of Nursing, Colette McCann
Portiuncula Hospital	M O'Dowd/ M Brassil	General Manager, Bridgetta McHugh + Director of Resources, Denis Minton	Acting Director of Nursing & Midwifery, Rosaleen Cahill
Rotunda Hospital	P McKenna/CB Kinsella/ SC Smith/M Geary/M Darling/M Holohan/G Connolly/R Gleeson	Secretary Manager, Fintan Fagan	Director of Midwifery/Nursing, Pauline Treanor
Sligo General Hospital	B Gill/ E Gubara	Unit Nursing Officer, Oonagh McDermott	Clinical Midwife Manager III, Therese Gallagher
South Tipperary General Hospital, Clonmel	R Howard/B Powell / Abdel Haq	Manager Breda Kavanagh	Director of Nursing, Robert Quinn
St Luke's General Hospital, Kilkenny	H. Bourke/A. Moran	Assistant General Manager, Mr. Pat Shortall	Director of Nursing/ Clinical Midwife Manager II, Edwina O'Keefe
University College Hospital, Galway	R O'Connor/ G.Gaffney/ J.Morrison/ M.Mylotte	Ms. Bridget Howley	Assistant Director of Nursing, Una Carr + Director of Nursing, Mary McHugh
Waterford General Hospital	E O'Donnell/J Stratton/ J Bermingham	Manager & CNN III Maternity Ann Ellis	Manager & CNN III Maternity, Ann Ellis
Wexford General Hospital	F Gardeil/C Murphy	Teresa Hanrahan	Clinical Midwife Manager II, Helen McLoughlin



## Appendix A2 - Individuals who made submissions to the Institute Subgroup

### Individual submissions

#### Surname, Title, First Name, Department, Hospital

1. Bonnar, Prof John – Professor Emeritus, Trinity College Dublin
2. Bourke, Dr Henry, Consultant Obstetrician & Gynaecologist, St Luke's Kilkenny
3. Boyd, Ms Mary, Director of Midwifery & Senior Midwifery Management Team, National Maternity Hospital
4. Brassil, Dr Michael, Portiuncula Hospital
5. Burke, Dr Gerry, Limerick City Hospitals
6. Carr, Ms Una, Divisional Midwife/Nurse,
7. Carrigy, President Anne, Bord Altranais
8. (+ 24) Clinical Midwife Managers, Mayo
9. Crotty, Dr Tom – on behalf of The Faculty of Pathology, RCPI
10. Crowley-Murphy, Ms Margaret, A/Principal Midwifery Tutor, Limerick Regional
11. Crowley-Murphy, Ms Margaret, School of Midwifery, Limerick
12. Eogan, Dr Maeve ; Donnelly, Dr. Jennifer; Russell, Dr. Noirin – Junior Obstetrics & Gynaecology Society (JOGS) – two submissions
13. Greene, Dr Richard, Cork University Hospital
14. (+ 22) Hayes, Dr Mary, Head, Dept of Histopathologist/ Cons. Histopathologist, University College Cork
15. Hickey, Ms Carmel, Maternity Unit, Portiuncula Hospital
16. Hussain, Dr Ahmed, Consultant Obstetrician & Gynaecologist, Cavan
17. Keane, Ms Noreen, Assistant Director of Midwifery,
18. Larkin, Ms Patricia, Principal Tutor, Regional School of Midwifery, Waterford
19. McMinn, Dr Joanna – on behalf of The National Women's Council of Ireland
20. Mooney, Dr Eoghan, Consultant Histopathologist, National Maternity Hospital, Holles Street
21. Murphy, Dr Brendan P. & McMenamin, Prof. J. – Faculty of Paediatrics
22. Murphy, Ms Moira, Office of Director of Midwifery/Nursing, Coombe
23. O'Brien, Ms Mary-Ann, Clinical Midwifery Manager, St Munchin's Limerick
24. O'Connor, Dr Rory, Consultant Obstetrician & Gynaecologist, Galway
25. O'Doherty, Ms Mary, Midwifery Tutor, Limerick
26. O'Dowd, Dr Michael, Consultant Obstetrician & Gynaecologist, Portiuncula
27. (+ 11) Parfrey, Prof Nollaig, Prof of Pathology/Cons. Histopathologist, University College Cork
28. Quigley, Ms Margaret, Assistant Director of Midwifery, Regional Maternity Hospital
29. Robson, Dr Michael, Master, Holles Street Hospital
30. Smith, Ms Ann-Marie – on behalf of Cuidiú – Irish Childbirth Trust
31. (+ 7) Staunton, Ms Ann-Marie, Assistant Director of Nursing, Mayo
32. Wingfield, Dr Mary, Merrion Fertility Clinic
33. Ní Riain, Dr Ailís, MICGP, (Director – Women's Health Programme) ICGP

## Appendix A2 - Individuals who made submissions to the Institute Subgroup

### Group submissions

#### Surname, Title, First Name, Department, Hospital

34. Coen, Ms. Eithne, Professional Development, NMPDU  
Ellis, Ms. Ann, Assistant Director of Nursing & Midwifery, Waterford  
McLoughlin, Ms. Helen CMM3, Wexford  
Purcell, Ms. Ailish, CMM3, Clonmel  
Reid, Ms. Bernadette, CMM3, Waterford  
Ryan, Ms. Kathleen, CMM3, Kilkenny

Joint  
submission

35. Clune, Ms. Eithne, CMM2, Limerick  
Hickey, Ms. Anne, Nurse Service Manager, Kerry  
Quirke, Ms. May, CNM3, Kerry  
Walsh, Mr. Richard, Director of Nursing, Kerry

Joint  
submission

## Appendix A3 - Data on live births, stratified by gestational age and birth weight

### Number of live births stratified by gestational age (for the year, 2000)

	Live births
All	54,239
<b>Gestational Age</b>	
< 24 weeks	30
24-28 weeks	205
29-31 weeks	275
32-34 weeks	752
35-37 weeks	3,730
> 37 weeks	48,739
Not stated	508

### Number and % of VLBW births stratified by birth weight, gestational age & birth location (2003)

	1/2003-12/2003 No. (%)
<b>BIRTH WEIGHT (gm)</b>	
401-500	7 (1)
501-750	75 (16)
751-1000	104 (22)
1001-1250	129 (27)
1251-1500	159 (34)
TOTAL INFANTS	474 (100)
<b>GESTATIONAL AGE (weeks)</b>	
< 24	17 (4)
24-26	112 (24)
27-29	145 (31)
30-32	145 (31)
> 32	55 (12)
INVALID GA	0 (0)
TOTAL GA	474 (100)
<b>BIRTH LOCATION</b>	
INBORN	413 (87)
OUTBORN	61 (13)
MISSING LOCATION	0 (0)

Source:RCPI, Faculty of Paediatrics, Neonatal Sub-committee

## Guidelines for Urogynaecology

### Referral patterns

- All patients should have access to a continence advisory service.
- All GP's should have access to an integrated continence service including direct access to a continence adviser, physiotherapy and a hospital-based urogynaecology service.

### Secondary level care

- Each maternity & gynaecology unit should have one Consultant with a special interest in urogynaecology.
- Each maternity & gynaecology unit should be equipped and staffed to perform urodynamics.
- Each maternity & gynaecology unit should be able to manage primary prolapse and incontinence procedures and should have easy access to a tertiary urogynaecology service.
- Each maternity & gynaecology unit should have regular internal audit of results of surgeries and ensure that the unit is registered with external quality assurance (as will be proposed by the Continence Foundation of Ireland).
- The Continence Foundation of Ireland intends producing national clinical guidelines and a national surgical database and would encourage all consultants with an interest to join.

### Tertiary level care

- Each clinical network should have specialist services in urogynaecology, equipped to perform all complex urogynaecology tests and surgical techniques.
- Each clinical network should have a minimum of one consultant who has undergone subspecialty training in urogynaecology.
- Each specialist service should provide services for the investigation and management of women with anal incontinence.
- Each specialist service should have a continence adviser, dietician, physiotherapist and urodynamicist working with urogynaecology as part of an integrated continence service with links to the community, primary care and the other hospital specialties including urology, colorectal, elderly care and neurology.
- Each specialist service should provide training in urogynaecology to at least RCOG special skills module standard. Larger centres should either provide full subspecialty training or contribute towards a training program.

The British Society of Urogynaecology (RCOG) has defined a specialist in urogynaecology as follows:

### Definition of Urogynaecologist

- Dedicated Urogynaecology Clinic or equivalent per week including secondary and tertiary referrals, as part of a multidisciplinary service.
- Evidence of training in a Unit, which provides the full range of investigations and treatments required for training.
- Urodynamics experience eg Special Skills Training.
- Regular Urodynamic sessions (minimum of one per month) either personally or in a supervisory capacity.
- Provide three clinical sessions in Urogynaecology per week.
- Surgery: One major urogynaecology procedure associated with pelvic floor dysfunction i.e. incontinence and prolapse per working week per year.
- Audit e.g. BSUG surgical audit.
- Three-yearly review (as per membership requirement for BSUG)

*Authors – Dr. Barry O'Reilly and Dr. Rory O'Connor*

### Guidelines for Colposcopy

#### Referral patterns

- All smear takers (GPs, well woman centres, family planning centres, gynaecologists) should have access to a local colposcopy service.

#### Secondary/Tertiary level care

- Each maternity & gynaecology service should have at least one Consultant with a special interest in colposcopy. (where there are two units close to each other, one colposcopy service may be sufficient but it must be accessible for all patients)
- Each colposcopist should be BSCCP certified, see at least 50 new abnormal cytology referrals /year, and attend a BSCCP recognised colposcopy meeting every 3 years.
- There should be a designated lead colposcopist, appropriately supported.
- Each colposcopy clinic should aspire to the quality standards of the ICSP (Irish cervical screening program).
- Each unit should have adequate nursing, secretarial, and clerical support.
- Equipment should include colposcope & couch, sterilising facilities, resuscitation trolley, safety guidelines on laser/diathermy equipment, IT equipment & software for data collection. TV monitoring for patients/ teaching is desirable.
- There should be written protocols that include recommended national guidelines.
- Data collection should comply with KC65 returns in the UK.
- There should be a regular audit of service to compare with local protocols and national targets.
- There should be regular multidisciplinary team meetings to include Cyto/Histopathologist and Colposcopist.
- Appropriate waiting times for colposcopy should be:
  - < 8 weeks for an abnormal smear
  - < 4 weeks for CIN2/3
  - < 2 weeks for ?invasion/glandular neoplasia.

#### References

- Report of the Department of Health Cervical Screening Committee 1996
- Colposcopy and Programme Management – Guidelines for the NHS Cervical Screening Programme 2004

*Author – Dr. Grainne Flannelly*

## Guidelines for Reproductive Medicine

### General standards

- Both partners should attend for consultations, particularly those where treatment options are being discussed. Women should also be given an opportunity to discuss sensitive issues alone.
- Couples should be seen in a private environment separate to pregnant women (outpatient clinics and operating theatres).

### Referral patterns

- Couples should be offered initial investigation including assessment of ovulation, semen analysis and a test of tubal patency.
- If the female partner is greater than 38 years or where no easily remediable cause is found, direct referral to a tertiary specialist service should be considered.

### Secondary level care

- Each maternity & gynaecology unit should have at least one Consultant with a special interest in reproductive medicine.
- Each maternity & gynaecology unit should be equipped to perform the initial investigations detailed above.
- All those undertaking diagnostic laparoscopy for infertility should have the capability and facilities to treat minimal/ mild endometriosis and simple adhesions.
- All units offering investigation and treatment of fertility problems should have access to appropriate counselling and dietetic services.
- Women undergoing treatment with clomiphene citrate or gonadotrophins should be managed in a centre which has the facilities and expertise to perform transvaginal ultrasound monitoring of ovulation.
- Any hospital/centre providing semen analysis must ensure that staff are appropriately trained, that there is regular internal audit of results and that the unit is registered with an external quality assurance system.

### Tertiary level care

- Each clinical network should have a specialist fertility service equipped to perform all assisted reproduction techniques (incl IUI, IVF and ICSI).
- Each clinical network should have a minimum of one consultant who has undergone subspecialty training in reproductive medicine.
- As of April 2006, all assisted reproduction units must be registered with the Irish Medicines Board and comply with the requirements of the EU directive on tissue establishments.
- All assisted reproduction units should adopt internationally accepted standards.
- The Institute should develop national clinical guidelines and standards.
- Each specialist service should provide training in reproductive medicine to at least RCOG special skills module standard. Larger centres should provide full subspecialty training.
- Access to assisted reproduction in Ireland is currently inequitable, i.e. it is available only in the private sector. As this is now a recognised medical treatment, it should be a publicly funded service.

### References

- UK NICE (National Institute for Clinical Excellence) 2004
- UK HFEA (Human Fertilisation and Embryology Authority) Code of Practice 2003
- Various RCOG guidelines and recommendations

*Author – Dr. Mary Wingfield*

## Guidelines for Minimal Access Surgery

### Minimum standards

- All practicing gynaecologists should be in a position to perform diagnostic laparoscopic and hysteroscopic procedures (Level 1 procedures Appendix i)
- All units offering a gynaecological service should have the equipment to perform diagnostic laparoscopy and hysteroscopy
- All gynaecological trainees should be deemed proficient in the performance of diagnostic laparoscopy and hysteroscopy prior to awarding of CSCT
- All equipment utilised during the performance of laparoscopic and hysteroscopic procedures should be of a minimal agreed standard.
- All units should give consideration to the use of single patient use equipment.

### Secondary Level Care

- Each maternity and gynaecology unit should have one consultant with a special interest in minimal access surgery.
- Each maternity and gynaecology unit should have the equipment and expertise available to perform Level 1-3 laparoscopic procedures, and level 1-2 hysteroscopic procedures (Appendix ii).
- All maternity and gynaecology units should have the equipment and expertise to allow the laparoscopic management of ectopic pregnancies. These units should be in a position to allow these procedures to be performed during routine working hours.
- All maternity and gynaecologic units should have the equipment and expertise to allow the management of minimal endometriosis and simple adhesions.
- All maternity and gynaecology units should be in a position to manage simple adnexal pathology laparoscopically.

### Tertiary Level Care

- Each clinical network should have a specialist endoscopic centre equipped to perform level 4-6 laparoscopic procedures and level 3 hysteroscopic procedures
- Each clinical network should have a minimum of one consultant who has undergone advanced endoscopic training
- Each specialist service should provide training in level 1-4 laparoscopic and hysteroscopic surgical training to at least RCOG special skill standard

### Appendix i

[www.rcog.org.uk/resources/Public/pdf/laparoscopic\\_surgery.pdf](http://www.rcog.org.uk/resources/Public/pdf/laparoscopic_surgery.pdf)

[www.rcog.org.uk/resources/Public/pdf/Advanced\\_Hysteroscopic\\_Surgery.pdf](http://www.rcog.org.uk/resources/Public/pdf/Advanced_Hysteroscopic_Surgery.pdf)

### Appendix ii Level of skill

#### Laparoscopy

##### Skill Level 1

The minimum requirement is the supervised performance of 40 or more diagnostic laparoscopic procedures before unsupervised operating. Such a level should be achieved during registrar training.

##### Skill Level 2

The minimum requirement is the supervised performance of 20 simple operative procedures such as tubal ligation, simple cyst aspiration, simple adhesiolysis, and/or ablation of minor stage (AFS III) endometriosis before performing unsupervised surgery. This level should also be achieved during registrar training.

##### Skill Level 3

Laparoscopic ovarian cystectomy and oophorectomy when there is normal anatomy. Laparoscopic salpingotomy or salpingectomy for the treatment of ectopic pregnancy. All trainees who obtained their CSCT should be able to perform the above 3 levels of laparoscopic surgery.

##### Skill Level 4

Laparoscopically assisted vaginal hysterectomy (LAVH) and excisional surgery for AFS score level 3 endometriosis. Level 4 procedures should be carried out under supervision until it is recognised that training is judged to be satisfactory. This may take anywhere from 10 to more than 50 procedures before appropriate skills have been developed.

##### Skill Level 5

This level is an advanced level. This includes total laparoscopic hysterectomy, laparoscopic Burch and laparoscopic myomectomy.

##### Skill Level 6

Procedures at this level are as follows: laparoscopic pelvic floor repair, AFS level 4 endometriosis surgery. This is excisional surgery and not ablation. Laparoscopic removal of residual ovaries with significant distortion of the anatomy. Laparoscopic oncological procedures such as laparoscopic pelvic lymph node and para-aortic lymph node dissection and radical hysterectomy. To perform level 5 and 6 surgery, as well as laparoscopic suturing, surgeons should have completed formal preceptorships or Fellowship training under the supervision of appropriately skilled laparoscopic surgeons.

#### Hysteroscopy

Level I: Diagnostic hysteroscopy.

Level II: Polypectomy, removal of pedunculated myomas, section of partial septa, lysis of mild or moderate synechiae.

Level III: Lysis of severe synechiae, section of complete septa, removal of myomas with intramural extension.

Author – Dr. Ray O'Sullivan

### Guidelines for Gynaecological Oncology

#### The organisation of cancer services

The Government document "Cancer services in Ireland: A National Strategy" represented a new initiative in the delivery of cancer care in this country. This arose because of concerns regarding the quality of treatment, perceived variations in the quality of care and inequity of access to high quality care. The aim was to reduce the number of deaths from cancer in the under 65-age group. It dealt with education and prevention of cancer by behaviour modification, screening and early detection as well as improvement in the treatment of established cancers. With specific reference to cancer treatment it described the need for the identification and implementation of best practice. This theme was further developed and subdivided into three vital areas

1. The revision of the structure of cancer services to allow well organized, co-ordinate and patient focused pathways of referral
2. Improved communication with clear and accurate information given to patients and their families and the development of closer links between the hospitals and the community
3. The provision for evaluating the effectiveness of cancer services with the facilitation of periodic audit

The re-organisation of cancer services remains one of the priority areas identified by the new HSE who in conjunction with the cancer forum are still evaluating the best approach. While there have been some improvements in the area of cancer since the publication of this document the mortality rates for cancer in Ireland continue to rise and are greater than other European countries.

#### Gynaecological Cancers

Cancers of the ovary, endometrium and cervix are the fourth fifth and sixth most common cancers in women. Despite this the average GP will see only one new patient with ovarian cancer about every five years and patients with other gynaecological cancers less frequently<sup>1</sup>. These cancers are usually more common in older women but cervical cancer in particular is equally common in younger women<sup>2</sup>. Symptoms, management and prognosis differ between sites but the most important primary treatment for the majority of women is surgery. Surgical specialisation and adherence to treatment protocols affect outcome. Observational evidence from studies in Scotland and the West Midlands confirm that for ovarian cancer, Specialist Gynaecologists achieved a significantly better survival than general surgeons<sup>3-5</sup> for women with cancer of the ovary. Recognition of women at risk of gynaecological cancer and referral and early review to a specialised service is of fundamental importance in the management of women at risk of gynaecological cancer.

In Ireland gynaecological cancer services have evolved rather than been planned and there is much room for improvement. Priority areas include

1. Services should be provided in an integrated organised fashion with a recognised centre which operates within a network of peripheral units. Agreed pathways of referral, investigation and treatment pathways should exist within the networks reducing the chance of variations in clinical practice. The focus of the care should be to provide the woman with access within a reasonable period of time to high quality cancer care to maximise both cure rates and quality of life.
2. There should be access to high quality diagnosis and treatment within a reasonable period of time and that care should be as close as possible to home when consistent with high quality care.
3. Gynaecological cancer centres should be staffed by gynaecologists who have completed subspecialty training in gynaecology oncology including modules in radiotherapy, medical oncology and palliative care. There should be greater flexibility on job descriptions – with the focus being improved mortality rates for cancer patients as opposed to filling labour ward rotas or provision of antenatal care for low risk women.
4. Gynaecology Oncology involves carers of more than one discipline and these should operate as a team. There should be close communication and co-operation with availability of multidisciplinary clinics, conferences. There should be mechanisms in place to facilitate early treatment and sensible and sensitive follow-up procedures. Clear information should be given to the patient about the treatment options and there should be good communication between carers, patients and families. Again job descriptions should reflect these needs and allow for protected time.
5. Participation in audit and trials should be strongly encouraged.
6. In 2006 a National Cervical Screening Programme still does not exist. The Institute should take a strong leadership role in making sure this long overdue initiative is delivered.

#### Reference List

1. NHS Centre for reviews and Dissemination. Management of Gynaecological cancers. *Effective Health Care* 1999;5:1-12.
2. Irish Cancer Registry. Cancer Statistics in Ireland. 1999.
3. Junor EJ, Hole DJ, Gillis CR. Management of Ovarian Cancer: referral to a multidisciplinary team matters. *Br J Cancer* 1994;70:363-70.
4. Junor EJ, Hole DJ. Specialist Gynaecologists and survival outcome in ovarian cancer: A Scottish National Study of 1866 patients. *Br J Obstet Gynaecol* 2000.
5. Kehoe S, Powell J, Wilson S. The influence of the operating surgeon's specialisation on patient survival in ovarian cancer. *Br J Cancer* 1994;70:1014-7.

Author - Dr. Grainne Flannelly



## Appendix A5 – Retirements due in Obstetrics & Gynaecology (Comhairle Na nOspidéal, 2005)

This table is based on consultants retiring on reaching 65 years of age. However, it is recognised that many consultants now avail of historic rest days (up to one year) prior to retirement and also that some consultants retire before reaching 65.

Year Due	Anes-thesia	Emergency Medicine	Medicine	Obstetrics/ Gynaecology	Paediatrics	Pathology	Psychiatry	Radiology	Surgery	Total
2005	2	0	0	0	0	0	1	0	2	5
2006	5	0	7	3	0	4	0	2	3	24
2007	2	0	9	3	0	3	6	3	10	36
2008	5	1	6	2	2	3	3	7	7	36
2009	8	1	5	3	1	4	1	3	6	32
2010	5	1	4	5	2	3	4	1	11	36
2011	8	0	10	4	8	7	4	5	7	53
2012	4	0	7	1	3	3	7	6	6	37
2013	3	2	9	1	5	3	5	6	17	51
2014	6	0	9	2	0	6	16	3	13	55
2015	13	0	8	3	4	6	4	7	15	60
2016	14	2	7	2	3	5	10	3	13	59
2017	5	0	8	2	3	2	8	6	7	41
2018	6	0	7	3	2	4	6	6	9	43
2019	8	0	11	3	3	1	5	0	12	43
2020	9	2	8	4	8	5	14	1	11	62
2021	8	2	9	2	2	6	12	9	25	75
2022	10	0	13	4	3	7	15	5	12	69
2023	15	3	11	8	1	8	11	6	13	76
2024	16	1	13	6	2	8	15	7	12	80
2025	10	2	19	3	5	7	9	8	9	72
2026	18	3	21	7	2	3	8	6	15	83
2027	8	4	8	3	3	8	9	7	14	65
2028	8	2	17	5	2	5	17	8	12	76
2029	12	2	13	3	2	9	12	7	10	70
2030	12	3	16	0	4	6	11	6	14	72
2031	13	3	17	5	5	8	8	7	4	70
2032	6	3	15	3	3	4	7	4	7	52
2033	5	4	11	1	1	3	3	3	3	34
2034	5	1	7	0	5	6	1	3	5	33
2035	1	0	3	0	1	2	1	4	0	12
2036	0	0	2	0	0	0	1	1	0	4
2037	0	0	1	0	0	0	1	1	0	2

Source: Comhairle na nOspidéal, 2005

