Position Paper

Consultant workforce planning for obstetrics and gynaecology in the Republic of Ireland 2012-2022.

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Contents

1. Introduction

At the onset it is acknowledged that while workforce planning for consultants in obstetrics and gynaecology is an important priority, it is also important for midwifery and nursing, for the allied healthcare professionals and for all the support staff. Any plans to increase permanent staffing also has wider implications for the training programmes nationally in the different disciplines. As part of the HSE Programme in Obstetrics and Gynaecology, we plan to consider workforce planning in all relevant specialities.

Any strategic workforce planning in Ireland cannot occur in isolation without considering the wider economic challenges facing the country and the health services. In addition, consideration will have to be given to any future reorganisation of work practices, to newer models of clinical care, to the building of new hospitals and to any reconfiguration of existing services. If safety and quality are to be maintained and developed in obstetrics and gynaecology, however, it is clear that changes will have to occur and that we in Ireland have to plan strategically for change.

It is also self evident that there are major professional interdependencies particularly in the maternity services, and that there are interdependencies between trainers and trainees. The safe delivery of maternity care in Ireland is highly dependent on midwifery, and we have been particularly fortunate to date that Ireland has an experienced and highly skilled midwifery profession. Unlike the United States, for example, intrapartum care is delivered predominantly by midwives. Unlike other countries in the EU, routine antenatal sonography is delivered by midwives and not radiographers. There are also interdependencies between hospital care and primary care. Thus, workforce planning in any group cannot occur in isolation, particularly in circumstances where work tasks may be reassigned in the future. Work is already in progress through the programme, for example, in reviewing models of care for pregnant women in an Irish context.

Workforce planning for consultants in obstetrics and gynaecology is an urgent priority for the Programme for a number of reasons. Firstly, there is already evidence that there is a shortage of well-trained consultants (Donnellan, 2010). The number of consultant obstetricians and gynaecologists in Ireland per 100,000 females is the

lowest amongst the wealthy OECD countries (Graph 1). This is in sharp contrast to the number of physicians (Graph 2) and nurses per capita (Graph 3).

Secondly, because it can take up to a decade to train a medical graduate to become a consultant in Ireland there will be no easy or appropriate short-term solutions to future shortages, especially if consultant numbers are to be expanded. In the future, any recruitment of new consultants trained overseas to fill acute shortages in consultant posts is, at many levels, an unsatisfactory solution. The quality of training that a new consultant has received overseas may be uncertain. Furthermore, the recruitment of consultants from developing countries shifts the cost of training to economically poorer countries, while at the same time undermining the quality of maternity services in developing countries. This is unethical for a country that prides itself on providing support for the developing world and it does not comply with WHO recommendations on national medical recruitment (WHO, 2010).

2. The Number of Consultants

Determining the number of consultants required over the next decade is challenging. In the past, attempts have been made to link consultant number to the number of deliveries of babies weighing 500 gms or more in a maternity unit. Such a link is arbitrary and fraught with difficulties.

Firstly, it should be based on the number of wholetime equivalents (WTE) in clinical practice because consultant sessions may be assigned to the universities for academic work or to the health services for management. With the mastership system, and more recently clinical directorships, consultant sessions in obstetrics and gynaecology in Ireland are, in part, spent in management away from clinical practice.

Secondly, the speciality not only includes obstetrics but also gynaecology which has been underdeveloped in the past. Apart from general gynaecological work including emergency gynaecology, there has been over the last generation increasing subspecialisation in gynaecological oncology, urogynaecology, colposcopy, endoscopic surgery and infertility, including assisted reproduction.

The recent Miscarriage Misdiagnosis Review Report (HSE, 2011) highlights inadequacies which need to be addressed in early pregnancy care, including the deployment of additional trained staff, including consultants. These serious inadequacies occurred, in part, because services in obstetrics and gynaecology had

not kept pace with international progress in staff development and training because antenatal care and intrapartum care were prioritised.

There have also been major changes in obstetric practices, for example, the caesarean section rate has risen from 10.6% in 1990 to 26.2% in 2009 with an associated decrease in spontaneous vaginal deliveries (Graphs 4 and 5). The reasons for this increase are complex (O'Dywer and Turner, 2011). Nonetheless, the performance of a caesarean section has to be undertaken by someone who is trained to do so. Another implication of the increased caesarean section rate has been the growing challenge of complex and difficult peripartum hysterectomies for pathological placental bed localisation. The safe performance of such hysterectomies requires the availability of experienced and trained consultants.

Other changes in clinical practice that have increased the workload in our speciality include the increase in the number of women requiring antenatal ultrasound examinations. There has been an expansion in the coloposcopy services with an introduction of the national cervical screening programme (Flannelly, 2010). At the same time, the introduction of the Mirena IUCD has reduced the number of women requiring a laparoscopic sterilisation and hysterectomy for dysfunctional uterine bleeding, which has implications for gynaecological training.

There have been demographic changes which have increased demand on the maternity services for the provision of care (ESRI, 2008; CSO, 2010).

- Ireland has the highest fertility rate in the European Union and, contrary to earlier predictions, the number of births has increased in recent years. Ireland's total fertility rate in 2009 is 8.9 compared with 4.8 for the EU total fertility rate (Graphs 6-8).
- There have been increases in the proportion of primigravidas, an increase in the mean age of mothers and rising levels of maternal obesity. The number of first-time mothers was 41.0% in 2010 compared with 40.4% a decade earlier. The average of mothers per birth registered was 31.4 years in 2010 compared with 30.3 years in the same quarter in 2001.
- Nearly one in five women booking for antenatal care are obese (Fattah et al, 2009).
- Emigration into Ireland during the economic boom also brought with it new clinical challenges, particularly in the area of infectious diseases (Graph 9).

There have been important recent changes in medical staffing. The EU has imposed the European Working Time Directive (EWTD) which has significantly decreased the hours that trainees work and made it difficult to provide speciality specific 24 hour cover on a daily basis. This has been addressed by an increase in the number of non-consultant doctors in obstetrics and gynaecology, but not in the number of specialist registrars on the national training programmes. The introduction of formal structured training, albeit welcome, has also meant that trainees who are away at study days are not available for service delivery. The reduction in hours spent in training may also potentially impact negatively on the clinical experience and skills of future consultants in the speciality.

There have been associated changes in midwifery training with the move from the midwifery schools in the maternity hospitals on to the campus of the universities. There has also been introduction of direct entry into midwifery. What impact these changes in midwifery training will have on the quality of future midwifery practice remains uncertain.

There have also been other changes which have impacted on all other healthcare professionals. There is a growing emphasis on continual professional development and quality assurance, and the need for greater documentation of work practices has increased. There is an emphasis on multidisciplinary meetings and decision-making. Clinical audit has been further expanded. While all of these developments are welcome, they are also time-consuming. The more time the consultants spend away from clinical practice, the greater the challenges in staffing inpatient and outpatient services.

It is impractical to completely benchmark staffing levels in the Irish health service against other developed countries because the services are organised differently. In particular, the skillmix in maternity care varies widely because of the different models of care. There are certain responsibilities that may be delegated by consultants to other members of staff, for example, antenatal care in low risk women. This work may be delegated to either family doctors in primary care or midwifery staff in secondary care. However, there are certain clinical responsibilities that consultants cannot delegate. Furthermore, women who are deemed low risk early in pregnancy can quickly and unpredictably become high risk. A consultant obstetrician and gynaecologist has to be available 24/7 to all pregnant women in all the 19 maternity units.

The basis for the current number of trainees entering the national Higher Specialist Training (HST) scheme in obstetrics and gynaecology is not widely available. It appears that the number are calibrated to replace the current cohort of consultants by matching the number of trainees with anticipated retirements at 65 years of age. However, allowance does not appear to have been made for early retirement on a voluntary basis or through illness. It also does not appear to make allowance for trainees who have trained in Ireland pursuing their speciality abroad in the long-term. There is evidence particularly in smaller maternity units that Ireland is already training fewer consultants than we need for replacement purposes before considering any expansion in consultant numbers.

In the unlikely scenario of Ireland training more consultants than there are consultant posts in public hospitals, there is no barrier to these consultants working in the private sector or working in any of the other 26 EU countries, including Britain, as a recognised specialist in obstetrics and gynaecology. There may be barriers to them working in the health services in English-speaking developed countries outside the EU, but these barriers apply to all foreign graduates. At present there are a large number of foreign graduates delivering core services in obstetrics and gynaecology in Ireland who are not being formally trained, and who are not being provided with the appropriate certification that will facilitate their career as a specialist in the future. Between 2000 and 2008, the numbers of foreign-trained doctors in Ireland increased from 11% to 35% (OECD and WHO, 2010). They are not well served by the present system.

Previous commentaries have suggested that the speciality has changed because of the increasing number of female non-consultants and consultants leading to “feminisation”. Correcting the previous male:female gender imbalance is, first of all, to be welcomed. Objective evidence of any impact of “feminisation” is, however, scant. Furthermore, any changes in work practices may not be related to gender, but may be due to the fact that present day consultants are less likely to be the only source of income for the household than consultants were in the past. Thus, future consultants may be less likely to want to work in the private sector as well as the public sector.

The present numbers training also does not make allowance for whether future consultants (male or female) may prefer to work part-time, for example, for family reasons. Also, there are uncertainties about the retirement age of consultants

in the future. While the pension crisis may result in an increase in retirement age by the government for other public servants, emergency night duty in obstetrics is not an attractive or, indeed healthy, option after 65 years of age.

To date, the speciality has been an attractive career for Irish graduates, in part, because of the high quality of undergraduate teaching in the speciality and, in part, because of an excellent collegiate working environment. If the experience in Britain is anything to go by, this may change in the future (Laurence, 2011). There may be difficulties attracting Irish graduates into the speciality. There may be difficulty attracting Irish-trained consultants to work in particular maternity units where it is perceived that rotas are too onerous, service quality is inadequate or professional relationships are unhappy. It is in the interests of Irish women that we plan strategically to avoid such possibilities. All consultant posts in the country must be an attractive career option for a well-trained consultant.

Recent changes by the HSE in the consultant contract and the downturn in the economy have also increased the public:private ratio in the maternity patients (24.2% in 2010). If service quality is to be maintained, the recent increase in demand for public services, particularly in maternity care, means that the number of consultants needs to be expanded.

3. National Task Force on Medical Staffing

In June 2003, the Report of the National Task Force on Medical Staffing was published by the Department of Health. Its purpose was to devise an implementation plan for reducing substantially the average working hours of non-consultant doctors (NCHDS) to meet the requirement of the European Working Time Directive (EWTD), to plan for the implementation of a consultant-provided service, and to address the medical education and training needs associated with EWTD and the move to a consultant service.

The Task Force's terms of reference charged it with "devising, costing and promoting implementation of a new model of hospital service delivery based on appropriately trained doctors providing patients with the highest quality of service using available resources as equitably, efficiently and effectively as possible". The Report set out 15 key messages. The Report recommended that substantially more consultants should be appointed as part of a team-based consultant-provided

service which would give patients improved access to senior clinical decision makers.

In obstetrics and gynaecology in January 2003, there were 93 permanent consultant and 222 NCHDS in obstetrics and gynaecology in the public sector: a ratio of one consultant for every 2.4 NCHDS.

The Report noted a statement from the Institute of Obstetricians and Gynaecologists that the minimum staffing requirements to provide 24 hour, 365 days per year cover for a maternity unit should "be at least 3 consultant obstetricians with appropriate paediatric and anaesthetic services". The Task Force, however, commented that while the recommendation from the Institute had led to additional consultant appointments and some centralisation of acute obstetric services, it was not based on a consultant-provided service and did not meet EWTD requirements.

The Task Force recommended that to implement EWTD by August 2009 the number of consultants in obstetrics and gynaecology needed to be increased from 93 to 179 nationally. It also recommended that the number of consultants should be 191 by 2013 (it was 116 in 2008 including 3 part-time posts). The Task Force also recommended that health agencies should not attempt to meet the terms of the EWTD by recruiting more NCHDS.

The evidence in 2011 is that the HSE has not implemented the recommendations from the Department of Health Report of 2003 yet, NCHD posts continue to increase (Ryan, 2011). Even if the HSE did decide to implement the Report with immediate effect, the number of trainees coming through the Institute HST programmes are seriously insufficient.

4. Institute Report

In December 2006 the Report from the Institute of Obstetricians and Gynaecologist's subgroup on the Future of Maternity and Gynaecology Services in Ireland from 2006-2016 found the consultant staffing levels in the 2005 Comhairle na nOspideal's report showed an increase in consultant obstetricians and gynaecologists from 93 in 1975 to 105 in 2005. This was a 13% increase in consultants compared to a 210% increase in consultant numbers overall. The Report recommended at least 200 full-time consultants in 10 years time, and that the proportion of trainees should be decreased. It recommended expansion of the number of trainees in HST but, did not specify a number. By 2008, the number of the

consultants reached 116. Part of this increase includes an increase in the number of additional academic sessions funded by the medical schools. It also includes part-time posts. Thus, the number does not reflect WTE. Between 2000 and 2008, the population of the country between 15 and 64 years increased by 19.3% (CSO).

5. KPMG Review

The KPMG Independent Review of Maternity and Gynaecology services in the greater Dublin area published in August 2008 found that there was staff shortages in all three Dublin hospitals in the different medical specialities and midwifery. To meet international standards it recommended that in the greater Dublin area alone an additional 20 obstetricians, 221 midwives, 25 theatre staff and 20 neonatal nurses were required (page 45).

6. International Comparisons

A 2001 Report on NHS Work Force planning in Northern Ireland found that the number of consultants in obstetrics and gynaecology was higher at 5.8 per 100,000 women compared with 4.6 in the Republic of Ireland, despite the fact that fewer women attend their obstetrician privately in the North. More recently, the 2010 OECD healthcare indicators amongst high-income countries found that Ireland had by far the lowest number of consultant obstetricians and gynaecologists per 100,000 women with a rate of 5 per 100,000. The next highest was the Netherlands with 11 per 100,000. However, 1/3rd of the women in the Netherlands deliver their babies at home. Greece, which interestingly is also requiring economic support from the International Monetary Fund and the European Union, has 9 times as many obstetricians and gynaecologists as Ireland.

The OECD has not published comparative data for the number of midwives per 100,000 women. The data, however, does show that in terms of the number of nurses and the number of physicians per population that Ireland is near the OECD average (Graphs 2 and 3). It should also be noted that Ireland, Portugal and the Netherlands report all doctors entitled to practice rather than those actually practicing, which results in an overestimation of consultant levels in Ireland compared with most other OECD countries.

7. FAS Report

In March 2009, a Report was published by the Skills and Labour Market Research Unit, FAS on behalf of the Expert Group on Future Skill Needs. This Report examined all the different medical specialities. It found that if all newly qualified specialists were available to work as consultants in Ireland and the existing density of obstetricians and gynaecologists per population was kept constant over time, the estimated current annual output from the Higher Specialist Training (HST) in the speciality would be sufficient to meet the annual average recruitment requirement.

However, even if all newly qualified specialist obstetricians and gynaecologists from the existing HST capacity were available for employment in Ireland, the numbers qualifying would not be sufficient to achieve the target of 179 set out in the Report of the National Task Force on Medical Staffing. If the target was to be achieved as outlined in the Report, there would be an excess demand for obstetricians and gynaecologists of just fewer than 70.

If the National Task Force target was to be achieved by equal annual increments by 2020, Ireland needs to train an average of seven additional consultants on an annual basis. If all the newly qualified specialists from the existing HST capacity are not available or there is an increase in early retirements amongst consultants, an additional 7 trainees coming through the HST scheme will be inadequate. If the Institute's 2016 target of 200 full-time consultants is to be made, the number of additional trainees completing HST needs to be the order of 9-10/annum.

8. Consultant Skill Mix

Consideration also needs to be given not only to the number of consultants in obstetrics and gynaecology, but also to what consultants do. The 2011 King's Fund Report on staffing in maternity units highlights the potential for "task shifting", the development of midwife-led care and the use of maternity support workers. However, any task shifting will require a more detailed analysis of staffing levels in other disciplines throughout the health services. Also, a reduction in the number of non-consultants working in obstetrics and gynaecology outside the national training scheme should result in a shift of work to consultants.

In recent years there have been developments in subspecialisation within obstetrics and gynaecology. This is a welcome development, particularly in gynaecological oncology. Such subspecialisation should improve the quality of care and clinical outcomes. The appointment of subspecialists to the larger university hospitals is also essential if we are to train the next generation of subspecialists. While overseas experience is invaluable for the development of Irish specialists and of the Irish health services, it should be possible to train all subspecialists in Ireland in the future.

However, not all consultants in the speciality need to be subspecialised and excellent clinical outcomes can be achieved by consultants with a special interest and by the use of appropriate referrals. Indeed, the overproduction of subspecialists may be counterproductive if it dilutes the workload per subspecialist of complex cases, and also undermines clinical experience, training and research opportunities. There will continue to be an ongoing need for well-trained generalists, particularly in the smaller units.

Whether future consultants in Ireland are subspecialised or not, there is a pressing need to further develop both our subspecialty training and special interest skills modules so that we are no longer dependent on overseas training programmes.

In planning to increase the number of consultants, we also need forward planning in terms of the number of subspecialists and where they will be located. For example, in the long-term gynaecological oncologists will be assigned to four cancer centres nationally. Yet all maternity units will require at short notice the availability for gynaecologists with the surgical skills to perform difficult peripartum hysterectomies.

There needs to be coordination between the appointment of new fetomaternal specialists and the planned new National Childrens Hospital. Finally, we need to develop consultants who can provide high quality care in the full range of specialised care e.g. ultrasound, early pregnancy assessment etc. While there should be a common basic training, the development of special skills needs to be tailored to meet the service needs in both large and smaller hospitals. It should be noted that Ireland is the only country in the EU that does not have a maternity unit with < 500 deliveries per annum so that our maternity units are large by comparison with our European counterparts.

In the training of physicians in Ireland it has now become evident that trainees all require training in emergency medicine, and that future consultants in public hospitals who have subspecialised in internal medicine will also have to contribute to the delivery of acute medicine. To maintain the quality of care in obstetrics and gynaecology in Ireland, it is essential that all future consultants are well trained in emergency obstetrics and gynaecology, particularly intrapartum care, and that they contribute to the on call rota, particularly in smaller units with fewer consultants.

It has been advocated, particularly in Britain, that consultants should have dedicated labour ward sessions. However, Ireland traditionally has had a stronger consultant presence in the labour ward than Britain and there is no scientific evidence to show that dedicated consultant sessions improve intrapartum outcomes. Indeed, there is some evidence that it may increase medical interventions such as caesarean section rates.

Consultant sessions in the labour ward limited to three hours may also potentially lead to a deterioration in outcomes due to a lack of continuity of care. Furthermore, emergencies in obstetrics and gynaecology do not arise solely in the labour ward. They may arise in the setting of the emergency department, in the early pregnancy assessment service or following admission to the wards. In an Irish setting there is a stronger case to be made for having dedicated in-house consultant care for all emergencies rather than solely for the labour ward.

9. Locum Appointments

It is mandatory that all 19 maternity units has a consultant obstetrician on call at short notice 24/7 all year. At the same time, consultants are entitled like all other workers to time off, to study leave and to annual leave. There also may be unplanned leave because of illness or family commitments. A feature of consultant staffing outside the large teaching hospitals is the high usage of locum consultants. Indeed, the current services could not be maintained without the use of locums. While many of these locums are well-trained and provide excellent service, the current situation is unsatisfactory. There are often difficulties obtaining suitably qualified locums and there may be uncertainties about the quality of their professional training. The appointment of the additional permanent consultants is preferable. Reduction in the use of locums can fund, in part, the expansion of permanent consultants.

10. Clinical Outcomes

Until recently, the Irish maternity services has enjoyed an excellent reputation nationally and internationally. Based on selective key performance indicators, such as the maternal mortality ratio, we continue to out-perform countries with greater resources. This is due, in part, to the fact that we have highly skilled and experienced staff working with a strongly developed sense of team-work and highly centralised services. In general, we have a well educated healthy population with good access to services. There have also been improvements in the take-up of combined antenatal care between primary care and hospital care (ESRI, 2008).

On the other hand, the confidence of the population and, in particular, the confidence of women in our maternity services has been rocked by a number of organisational scandals such as the caesarean hysterectomy rates in Drogheda, the use of symphysiotomy in the past, and the miscarriage misdiagnosis cases more recently. There have also been a number of high profile medical negligence cases. The Department of Health and other groups have also expressed concerns about the high rate of caesarean section nationally. The main issue, however, is not the caesarean section rate itself but the wide variations in practice throughout the country's 19 maternity hospitals (Turner, 2011; O'Dwyer and Turner, 2011). Confidence in our services needs to be restored and maintained into the future.

11. Financial Implications

At the end of June 2010, the State Claims Agency (SCA) had approximately 4050 claims under management and the total estimated liability against active clinical claims was E693 million (Annual Report, 2010). **The speciality of obstetrics represented 17.5% of the volume and 46.3% (E 321 million) of the cost of all medico-legal claims** (Clinical Indemnity Scheme Newsletter).

On the 12th of October 2010, the Minister for Health Mary Harney reported to the Dail in a written answer that the full cost of funding obstetric claims met by the Clinical Indemnity Scheme was E26.74 million in the "year to date" (giving an annualised figure of E35.7 million). **The contingent liability in respect of obstetric claims for each of the next three years was estimated to be E170 million**

cumulatively. The proportion of obstetric costs is likely to increase in the future because the statute of limitations for obstetric claims is 21 years.

In 2009, the HSE paid E60 million in relation to the CIS. About half of the E60 million relates to obstetric claims in the 19 maternity units nationally and this is likely to keep escalating as an annual cost to the HSE. In September 2009, the McCarthy Report highlighted that individual hospitals make no direct contribution towards claim payments of the CIS as a whole. In a commentary on the Report, the CIS suggested setting the hospital premium on the basis of the number and speciality of the clinicians in each hospital in a risk pool scheme. It also went on to state that **"The only exception to this might be maternity services as more obstetricians per 1000 births would reduce the risk"** (CIS Newsletter, September 2009).

The cost of converting nonconsultant posts outside the formal Institute training schemes in to Specialist Registrars posts is shown in Appendix Three (Table 1) . This is based on the conversion starting in July 2012. The additional costs of the training programme is a matter for negotiation between the HSE and the Institute. The cost of 10 new posts per budgetary year starts at E48,130 in 2012 rising to E387,810 in 2015. Not only should the increased number of trainees increase the base for future consultant appointments, but increased formal training and standardisation of clinical practices amongst nonconsultants should in itself improve the quality of care in all maternity units (Clark et al, 2011).

The cost of appointing 50 additional consultants in a phased way over 6 years between 2012 and 2017 is shown in Appendix Three (Table 2). The salary costs start at E868,000 per annum in 2012 rising to E8,728,000 per annum in 2017. Depending on progress in training new consultants and on economic circumstances nationally, it may be decided to accelerate these phases.

Based on the 2009 figure of E60 million paid by the HSE for the CIS, obstetric claims account for E30 million approx. In 2013, a 6.7% reduction in the 2009 cost of obstetric claims, for example, would more than cover the cost of additional obstetricians. To date, the State has funded the staffing of maternity services and the cost of insuring maternity care separately, without linking the two. This is likely to change in the future.

However, increasing the number of obstetricians in the public services based on medicolegal considerations alone is too narrow a view. The evidence from the OECD shows that **Ireland is seriously out of line compared with other**

developed countries in the number of obstetricians per capita. The key issue is maintaining and improving the quality of care to Irish women and their babies.

The reason for examining the medicolegal costs is that it is evident that the increase in staffing can be achieved nationally in a cost-neutral or indeed cost-saving way. Indeed, the longer the Irish maternity services prevaricate on addressing obstetric training and staffing, the higher the risk of poor service quality, adverse clinical outcomes and escalating legal claims. It is axiomatic that it is preferable for the State to increase its spending on the provision of better quality maternity services than compensating women for substandard care.

12. Conclusions

There already is a remarkably low number of consultant obstetricians and gynaecologists in the country. There is evidence that **the current intake of trainees into the national system will not produce enough trained consultants to replace the existing cohort of consultants in a country.** This is true before considering the implementation of a number of expert reports.

In the current economic climate, inaction in the short-term is the easy option. However, **in the medium and long-term inaction will have serious adverse consequences for the health of women and children.** At best, there will be a deterioration in access for care and a disimprovement in the quality of care. At worst, it will result in an increase in maternal and perinatal morbidity and mortality rates. In particular, **an increased maternal mortality rate would be a heavy price to pay for the failure to plan.**

Any deterioration in the quality of maternity care in the public sector is likely to result in a further escalation of medicolegal costs to the State Claims Agency. In the event of a serious deterioration in mortality rates, the HSE would be faced with no option but to recruit at short notice additional consultants from abroad who may not be adequately trained, which may aggravate matters rather than improve care.

The implementation of a 6 year **expansion in trainees and consultants needs to start now if a potential crisis in the maternity services is to be averted.**

12. Recommendations

1. The number of consultants in obstetrics and gynaecology should be increased in Ireland as recommended by the National Task Force in 2003.
2. The minimum number of consultants per maternity unit should be 5.
3. The number of trainees entering the Higher Specialist Training (HST) in Ireland should be increased above the current numbers by 8-10 per annum.
4. All trainees should be fully trained in emergency obstetrics and gynaecology.
5. The increase in new consultant staffing should be increased at a rate of approximately 5-10 per annum over the next 6 years.
6. Short-term locum appointments to cover planned leave in smaller units should be phased out.
7. The specialisation of consultants in obstetrics and gynaecology need to be reviewed and specialised training further developed.
8. The number of non-consultants who do not receive any HST in Ireland needs to be reduced.
9. The increase in the number of consultants and trainees should occur in parallel with a review of the staffing levels and work practices of other healthcare specialities involved in the delivery of the services.
10. Key performance indicators in obstetrics and gynaecology need to be collected and reviewed to ensure that service quality has been maintained and that clinical risk has been minimised.

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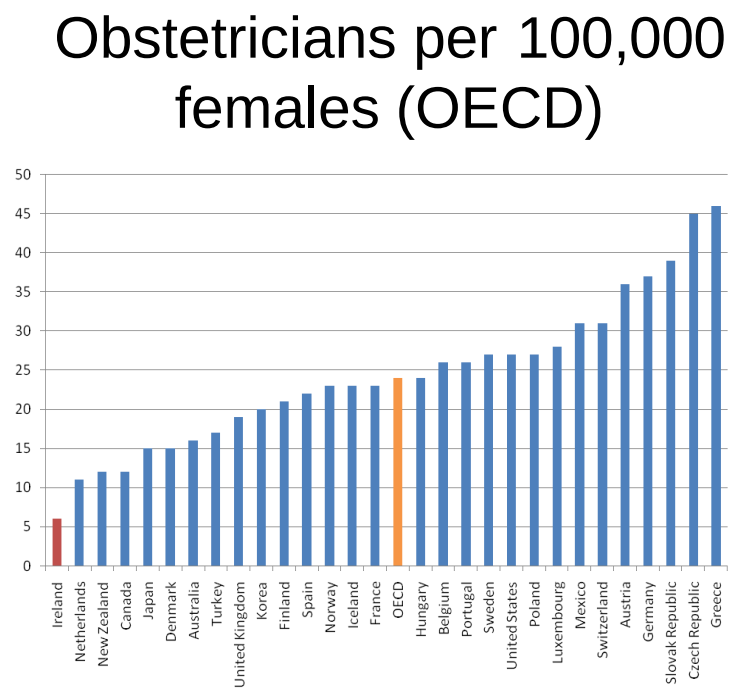
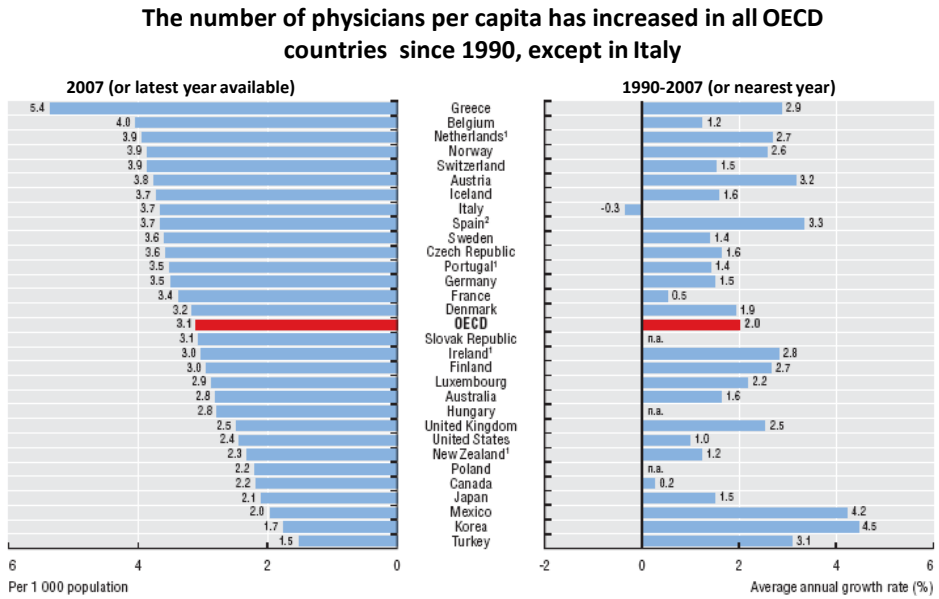
14. Appendices and Graphs

Graph 1



Graph 2

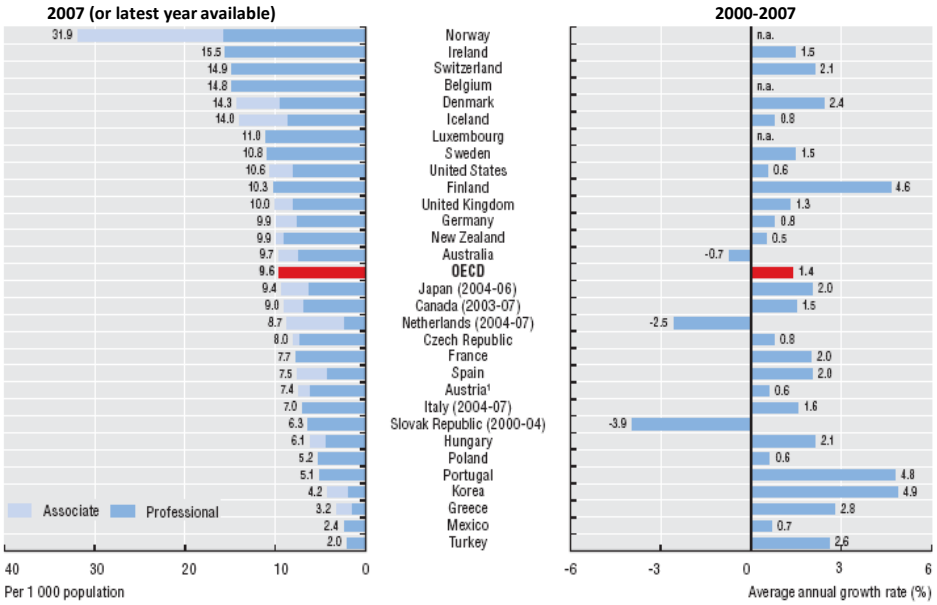


1. Ireland, the Netherlands, New Zealand and Portugal provide the number of all physicians entitled to practise rather than only those practising.
2. Data for Spain include dentists and stomatologists.

***Source*: OECD Health Data 2009, OECD (http://www.oecd.org/health/healthdata).**

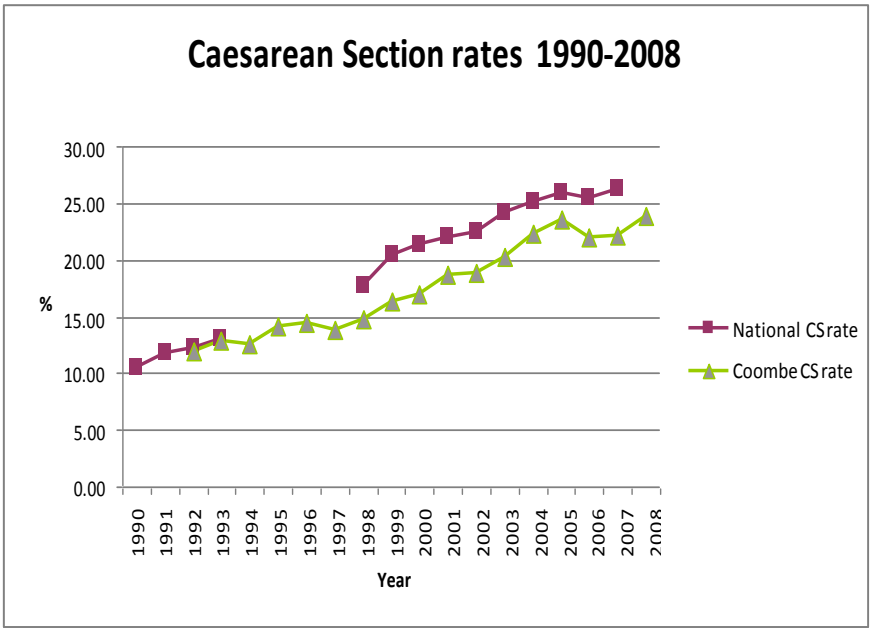
Graph 3

The number of nurses per capita has increased in all OECD countries since 2000, except in Australia, the Netherlands and the Slovak Republic

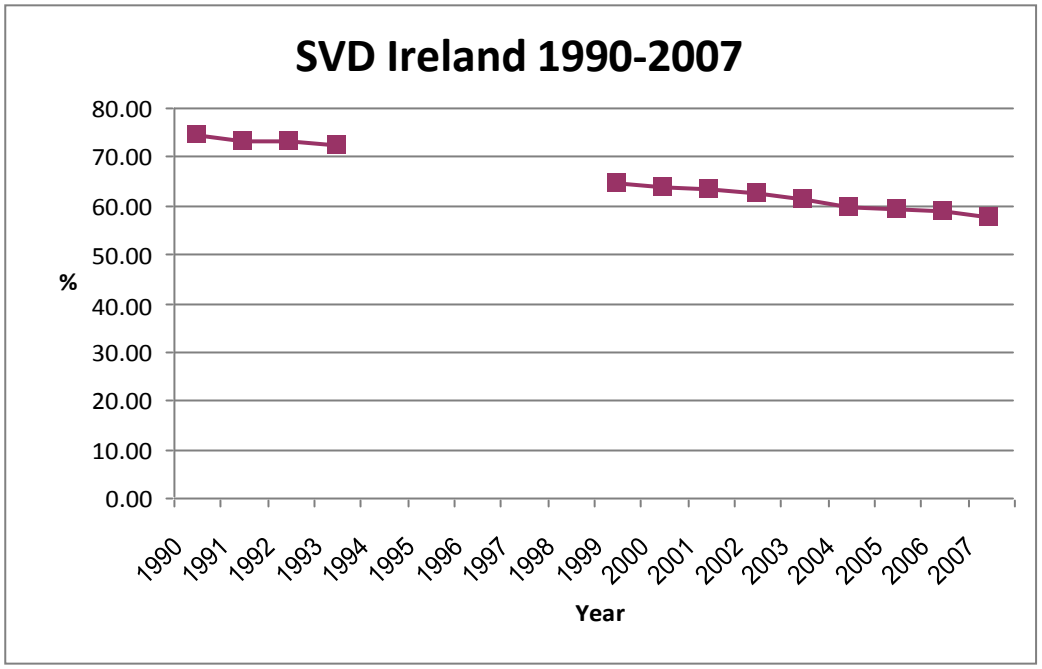


***Source*: OECD Health Data 2009, OECD (http://www.oecd.org/health/healthdata).**

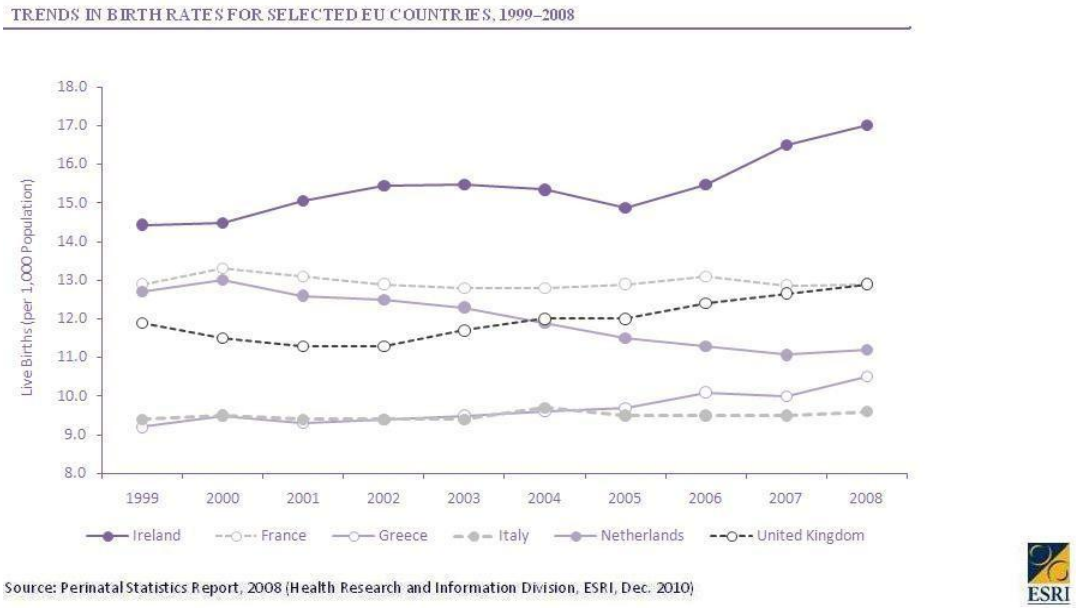
Graph 4



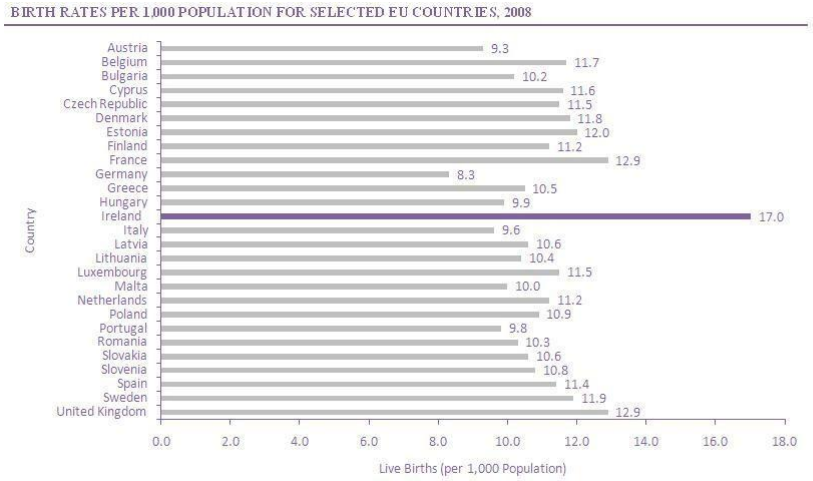
Graph 5: Spontaneous vaginal deliveries (SVD)



Graph 6: EU birth rate trends (ESRI)

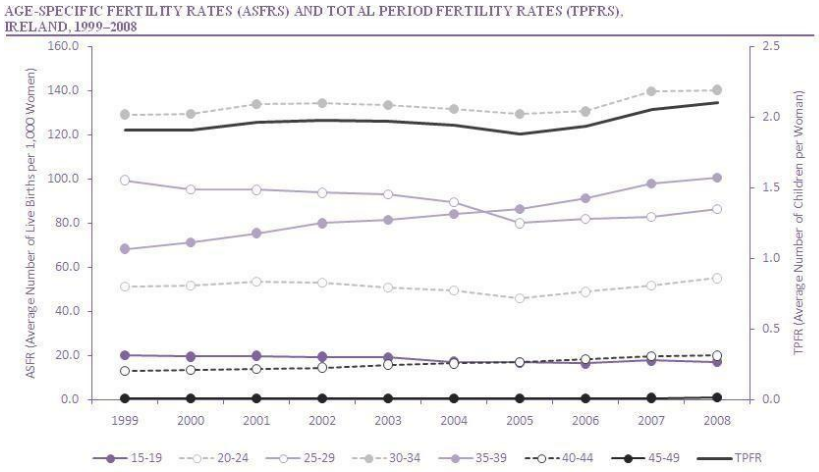


Graph 7: Birth rates per 1000 population (ESRI)



Source: Perinatal Statistics Report, 2008 (Health Research and Information Division, ESRI, Dec. 2010)

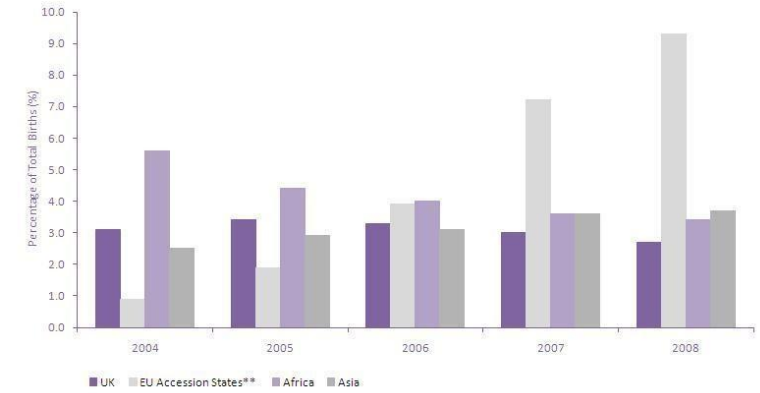
Graph 8: Age-specific fertility rates (ESRI)



Source: Perinatal Statistics Report, 2008 (Health Research and Information Division, ESRI, Dec. 2010)

Graph 9

PERCENTAGE DISTRIBUTION OF BIRTHS BY NATIONALITY FOR NON-IRISH BORN MOTHERS, TOTAL BIRTHS, 2004–2008



Source: Perinatal Statistics Report, 2008 (Health Research and Information Division, ESRI, Dec. 2010)

ESRI

Appendix One

TABLE 1

POPULATION (000s) BY AGE GROUP FOR EACH YEAR, 2000 TO 2009

Age Group	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	% Change 2000-2009	% Change 2008-2009
0-14	828.0	827.5	827.4	834.7	843.8	853.5	864.4	883.8	912.3	937.5	13.2	2.8
15-64	2537.0	2589.7	2653.8	2703.3	2751.7	2821.4	2907.5	2984.7	3028.3	3026.8	19.3	0.0
65+	424.7	429.8	436.0	441.9	449.7	458.9	467.9	470.6	481.6	495.0	16.6	2.8
All Ages	3789.5	3847.2	3917.2	3979.9	4045.2	4133.8	4239.8	4339.0	4422.2	4459.3	17.7	0.8

Appendix Two

TABLE 1

BIRTHS AND FERTILITY, 1999 TO 2008

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	% Change 1999-2008	% Change 2007-2008
Number of Live Births	53,924	54,789	57,854	60,503	61,529	61,972	61,372	64,237	70,620	75,065	39.2	6.3
Birth Rate (per 1,000 population)	14.4	14.5	15.0	15.4	15.5	15.3	14.8	15.2	16.3	17.0	18.0	4.3
Total Fertility Rate	1.91	1.90	1.96	1.98	1.98	1.95	1.88	1.90	2.03	2.10	9.9	3.4

Appendix Three

Table 1: Cost of additional 10 Specialist Registrars per annum (salary only)

Year	Euro	Budgetary year	(Euro)
1	98,260	(2012)	144,100
2	189,940	(2013)	235,975
3	282,010	(2014)	334,910
4	387,810	(2015)	387,810
5 (onwards)	387,810		

Notes

- Salary only
- Based on current salaries
- Based on replacement of registrar posts
- Commencing July 1st, 2012

Table 2: Cost of additional five consultants per annum (new Type B contract)

Year		
2012	(n=5)	E868,000
2013	(n=5)	E1,748,000
2014	(n=10)	E3,496,000
2015	(n=10)	E5,256,000
2016	(n=10)	E6,992,000
2017	(n=10)	E8,728,000 (all 50 posts)

Notes

- Consider replacement of nonconsultant posts
- Consider replacement of locum posts
- Scale E173,620 to E176,000
- Salary only