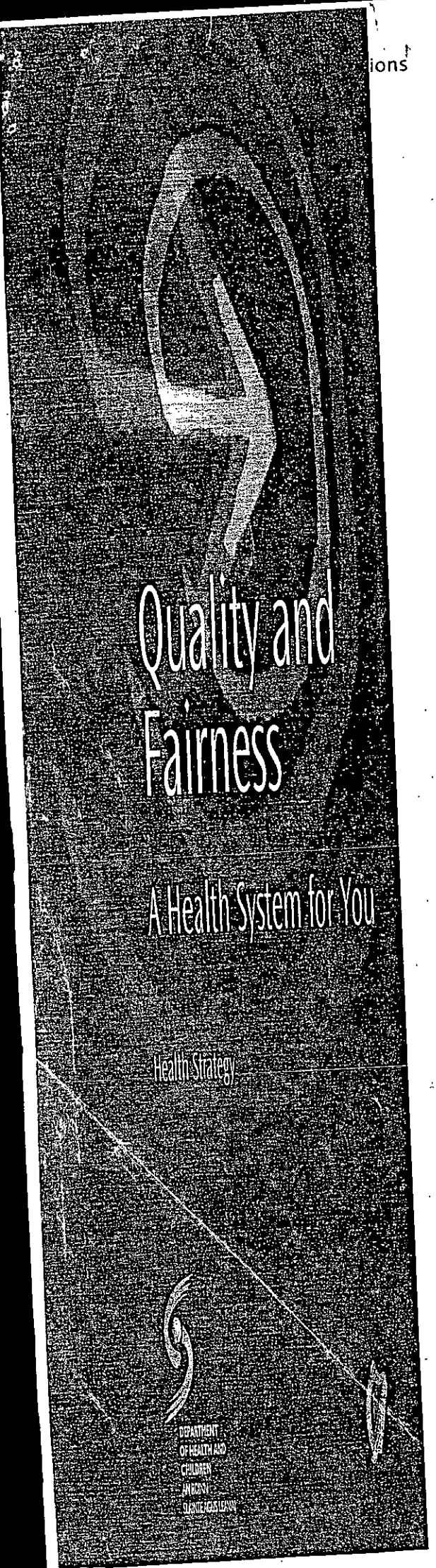

Frequently Asked Questions

Medical Register and Fitness to Practice

Q: What are you doing to protect the public from unregistered doctors, or doctors who have been struck off the register?

- The Medical Council is the authority responsible for the provision of registration and control of persons engaged in the practice of medicine.

- The Council protects the interests of the public when dealing with registered medical practitioners. The principal roles of the Council include assuring the quality of undergraduate and postgraduate training, registering doctors, disciplinary procedures and providing guidance on professional standards and ethical conduct.

- The Medical Practitioners Act, 1978 is currently under review. The review is being carried out takes into consideration various developments in the medical field and the role of the Medical Council. The revised Medical Practitioners Act will take account of the concerns raised by various interest groups.

- The Medical Council has also made significant progress towards the introduction of competency standards for Irish doctors.

- The Council has recently appointed a Director of Competence Assurance who will work with the Medical Council, the professional bodies and an external reviewer. The detail will be developed in close consultation with key stakeholders, including doctors and their representatives, and they will be engaged in both a formal and informal manner in developing competency structures.

Funding

Q: How much will the Strategy cost to implement?

A: Just over £10 billion over seven years (2001 prices). £6.1 billion capital and £4 billion non-capital.

Q. What is the breakdown of this figure between main services (hospitals, Primary care, etc.?)

A:

Health Strategy related Non-capital Expenditure 2002-2008

	Total Strategy (£ million)
Personnel	658.5
Acute Hospitals	707.2
Childcare	129.5
Continuing Care	1,366.9
Primary Care	661.2
Strategic Development	517.8
Total	**4041.0**

Health Strategy related Capital Expenditure 2002-2008

	Total Strategy (£ million)
Primary Care Model	1,155.0
Children's Services	115.0
Additional Beds (Bed Capacity)	1,000.0
Older People	1,163.0
Equipment Maintenance & Replacement	750.0
Other Capital Expenditure	1,936.5
Total	**6119.5**

Q: Is the money available?

A: Govt has 'agreed that the necessary capital and non capital resources ... will be made available over the lifetime of the Strategy, subject to maintaining a prudent overall fiscal position and to compatibility with other competing demands over the years ahead'. (Govt decision, 20 Nov 2001).

Q: Why are you staying with the same funding method (general taxation)?

A: Govt looked carefully at the alternatives (social insurance and private health insurance). VFM report analysed these in detail. Govt has concluded they offer no clear advantages over the present system – much upheaval with little benefit for patients. Instead we're concentrating on reforming the present system:

- funding linked clearly to service plans,
- focus on outcomes,
- expansion of casemix budgeting,
- annual statements on funding processes and criteria.

Q: If the funding situation is as tight as it seems, surely this undermines completely the implementation of the Strategy?

- General position on funding the Strategy already outlined.
- Important to note that many of the 121 actions outlined do not require additional funding or at least not in the immediate future. The strategy is about doing things differently and culture change as well as about expansion and new developments The actions may be broken down roughly into the following categories

-Health Promotion	6%
-New Legislation/Policy reviews	20%
-Improved processes/Quality	40%
-Expansion and development of services	34%

Also there is a limit to the amount of funding which the health services can absorb. For example, there will be a time lag in regard to achieving the increased numbers of staff outlined in the strategy, as people will have to be trained. Equally it will take time to provide for the capital infrastructure outlined in the strategy and this will postpone the need for associated revenue costs.

Progress since 1994: Health Strategy *Shaping a healthier future*

Q: What difference did the 1994 Health Strategy *Shaping a healthier future* make?

A: It mapped out where and how we should set priorities.

- It used the concept of health gain and social gain, and argued that we should ensure that resources are given to services that helped to add to health gain and social gain. It was concerned with reorienting services in this direction.

- The 1994 Strategy highlighted premature mortality and its causes – cancer, cardiovascular disease and accidents. It was followed by strategies on cancer and cardiovascular disease, which set the path for further addressing these illnesses.

- Above all, it set the scene for substantial improvements in health and personal social services, as described below. The development of these services has been set clearly in the context of the 1994 Strategy.

Recent Progress: Activity and Services

Q: Health spending has doubled since 1997. What have we got to show for it?

A: A significant amount. Highlights include:

- Falling Waiting Lists:

- In June 2001 there were **26,659** on the waiting list for elective treatment
- This represents a **fall of 16%** on the June 2000 figure.
- It represents **less than 3%** of the forecast **total hospital discharges of close to 920,000** this year (in-patients plus day cases).
- Considerable progress has been made in reducing waiting times in target specialities. For example between June 2000 and June 2001 the number of **children** waiting for **more than 6 months** for:
  - **Cardiac surgery** decreased by **85%,**
  - **Ophthalmology services** decreased by **31%**; and
  - **ENT services** decreased by **25%.**

Number of adults and children on waiting lists by waiting time and speciality
Target specialities only

June 2001	Adults		Children	
	3-12 months	Over 12 months	3-12 months	Over 12 months
Cardiac surgery	204	190	16	10
E.N.T.	1244	2163	380	1153
Gynaecology	715	468	0	0
Ophthalmology	1827	784	114	130
Orthopaedics	2104	2042	43	75
Plastic surgery	538	1108	108	418
Surgery	1920	1103	180	200
Urology	617	808	14	16
Vascular	750	1494	0	0
Total	**9919**	**10160**	**855**	**2002**
	20,079		**2,857**	

- Acute hospital services:

- The number of **in-patients** discharged increased from by **24,000** between 1997 and 2001 (536,000 to 560,000)

- The number of **day cases** increased from **249,000 to 360,000** – an increases of **111,000** (44%).

- **Total number** of people discharged in **2001** was over **920,000** – an increase of **17%** over 1997.

- Acute Hospital Capital Developments:

- Tallaght Hospital, Dublin was opened in 1998.
- In addition, there were major hospital developments at
  St James's Hospital,
  St Luke's Hospital, Dublin;
  University Hospital, Galway;
  Regional Hospitals in Limerick and Galway; and
  Longford-Westmeath Hospital, Mullingar.

- Staffing:

- Significant increases in key staff have been seen in the following areas since 1997:

Medical/dental	700
Nurses	1,800
Paramedics	1,600
Total	**4,100**

- The number of nurse training places has increased by over **50%** to **1,500**

- Cancer:

- Over **£60 million** allocated for cancer treatment services since 1997
- **55** additional consultant posts with support staff have been created since 1997

- Services for people with an intellectual disability:

- **£205 million** allocated for Intellectual Disability
- an additional 1,650 residential places,
- 2,300 day places,
- a 70 per cent increase in respite care places, and
- a reduction of almost 40% in the number of people with intellectual disability cared for in psychiatric hospitals.

- Services for people with a physical or sensory disability:

- **£107 million** allocated for **Physical and Sensory Disability**
- additional 150 residential and respite places,
- 400 day care places, community/home support services as well as additional occupational therapy, speech and language therapy and physiotherapy services.

- Services for older people:

- 400 additional places in community nursing units
- Over 1,000 day places
- Medical card scheme has been extended to people aged 70 years and older.

- Services for children:

- Over £92 million has been invested to create the infrastructure necessary to support expansion of services
- an increase in the provision of high support and special care places from 17 in 1996 to 83 with plans for a further 56 places.
- Family support service developments include the establishment in 17 pilot sites of *Springboard*, a community-based early intervention initiative to support families.

- Services for people with mental illness:

- progress towards a more community-oriented service,
- a reduction in the numbers of long-stay patients in psychiatric hospitals. new acute psychiatric units have been opened in general hospitals in Dublin, Navan, Tallaght, Cork city and Bantry.
- The number of community residences increased to 402 with places increased to 2,003.
- Significant progress has also been made in the development of specialist psychiatric services for children and older people.
- Services for prisoners and the homeless have also been developed since then.

- Carers:

- Additional funding for respite care for carers, carer support groups, training of carers and home care support services.

- Health promotion:

- The wide range of health promotion initiatives include initiatives on
  anti-smoking,
  alcohol consumption,
  nutrition and diet, and
  exercise.
- Publication of the National Health Promotion Strategy 2000-2005

- Dental services:

- Eligibility for public dental services has been extended to all children under 16 years.

Acute Hospitals

Q: How many extra beds for each region and when?

A: 3,000 beds over period to 2011, of which 650 to be provided in 2002. National Hospitals Agency to advise on the location and specialities of the additional beds. Minister makes ultimate decision but has specialist expert advice from the Agency.

Q: How many of these will be in private sector?

A: 200 of the extra 650 beds in 2002 will be contracted with private sector.

- After that beds may be provided either through public or private sector.
- NHA will help promote a strategic relationship with private sector to meet part of the requirement for 3,000 beds over 10 years.
- All extra beds to be for public patients: those in *public* hospitals on a formal designated basis; those in *private* hospitals will be contracted for use by public patients.

Q: Are targets set for reducing waiting times achievable?

A: They can be achieved through:

- Additional capacity in hospital system (+650 beds in 2002 alone) and non acute system (e.g. 1,370 assessment and rehab beds for older people; 600 extra day places; 800 residential places per annum for next 7 years).
- Use of new Treatment Purchase Fund to buy treatments from public hospitals, private hospitals and from abroad.
- Reform of waiting list management (lists managed at speciality level; improved monitoring systems involving GPs; lists broken down to sub-speciality/procedure level).

Q: How will the Treatment Purchase Fund work?

A: National Treatment Purchase Team to be formed immediately. It will carry out a concentrated programme to purchase treatments from here and abroad. Details being worked out currently.

Q: Why set targets for those on hospital waiting lists and not for, e.g., orthodontics?

A: Programme of initiatives are also being taken to address waiting times in other areas, but the problem is at its most serious in relation to acute hospitals, especially where quality of life is seriously affected – e.g. hips, ENT, varicose veins, cataracts. (See separate question on Orthodontics).

Q: You say you will suspend private practice in public hospitals in certain circumstances. How will this work?

A: It's an action to be taken only as a last resort when all other steps to reduce waiting times to within target have failed. Even then, it will not be used if management and consultants can agree an alternative method for restoring/achieving the target maximum waiting time. It's an important signal to emphasise that lengthy waiting times for public patients will not be accepted.

Q: What are you doing about A&E?

A: Significant improvements in the operation of accident and emergency departments. The aim is to expand capacity (extra staff) and to direct patients to the most appropriate form of care. Main initiatives include:

- Additional A and E consultants
- Improved triage procedures
- Minor injury clinics
- Chest pain and respiratory clinics and in-house specialist teams to fast-track patients as appropriate;
- Increased access to diagnostic services
- Appointment of Advanced Nurse Practitioners – to deal with certain groups of patients independently within agreed protocols
- Improved admission protocols to ensure only emergency patients are admitted via the A and E department
- Member of staff to liaise with patients while they await diagnosis and treatment

Q: What about OPD?

A: Strategy sets out a range of initiatives which will be taken to improve the operation of accident and emergency out-patient departments:

- Development of protocols for investigation and referral to hospital OPD in conjunction with GPs
- Allocation of specific individual appointments to each out-patient
- Assessment of out-patient recall rates will be undertaken
- Introduction of nurse-led clinics where feasible.

Eligibility for Services

Q: Newspaper reports suggested the Strategy had provided for 200,000 extra medical cards. It also contained specific improvements to the income guidelines. Where has all this gone?

A: The Strategy contains what the Govt actually decided – not just speculation about what might happen. The Strategy provides for:

- Greatly improved income guidelines for medical cards, to be implemented over the lifetime of the Strategy
- Improved Maternity and Infant Care Scheme (from 2 to 6 visits)
- Improvements to the Nursing Home Subvention Scheme, with the aim of linking it with the Carers' Allowance in an integrated care subvention scheme
- Grant for two weeks' respite care per annum for dependent elderly

Q. There was a lot of speculation about medical cards for children or at least for children aged under 5 years? Why was this not provided for?

A:

- The question of eligibility for medical cards was carefully considered by the Sub Groups on Eligibility and by the Steering Group which oversaw the development of the strategy. It was considered that rather than giving medical cards to a specific group such as children, the link between income and medical cards should be retained. In other words, it was considered more equitable to target medical cards at people on low income. The Government accepted this approach.
- It's important to point out that the planned increase in the guidelines will benefit many children living in low income families. Also as stated in the strategy in improving the income guidelines, priority will be given to families with children and particularly children with a disability.

Q. One of the earlier drafts of the strategy which was leaked indicated that medical cards would be given to people with an intellectual disability. Why was this changed?

A:

- As you will appreciate, there was a huge amount of working and re-working of proposals in preparing the strategy.
- Rather than giving medical cards to a specific group such as those with an intellectual disability, it was decided that the link between income and medical cards should be retained. In other words, it was considered more equitable to target medical cards at people on low incomes.
- In improving the income guidelines, priority will be given to families with children and particularly children with a disability.
- As stated in the Strategy, the working group looking at the feasibility of introducing a cost of disability payment will report during 2002. This will include a review of the wide range of existing allowances and concessions for people with disabilities.

• Reflecting Views of Patients/Clients

Q: You say the Strategy is people-centred. How are you going to give patients/clients a real voice?

A: There are some very important new elements to involving everyone:

- Customer focus of service to be strengthened by
  - Standardised customer service strategies by health boards: to ensure patient satisfaction is measured on a comparable basis
  - Standardised customer care plans by all service providers
  - Statutory framework for complaints – ensuring greater clarity of approach and emphasising scope for local resolution. (In line with what Ombudsman favours for health services).

- Other steps to involve the people in their services:
  - Consumer panels in each health board area
  - Regional advisory panels for mental illness and older people
  - Advocacy services for mentally ill
  - Integrated care planning, including 'key worker' concept for children with a disability and older people

Q. Has the Strategy sorted out the problem highlighted by the Ombudsman in regard to the eligibility of old people for longstay care?

A:

- The Ombudsman, in his report on the Nursing Home Subvention Scheme, claimed that, under the 1970 Health Act, any person in need of nursing home care has a statutory entitlement to the provision of this service by a health board.

- The Department's view is that the Health Act, 1970, (as amended) distinguishes between eligibility for a service and entitlement to a service (although the two terms are often used interchangeably). This view is supported by legal advice available to the Department

- There is a need to clarify this situation and to bring an end to the uncertainty. Legislation will be brought forward during 2002 which will clearly set out older persons' entitlement to services.

Primary Care

Q: Why fix what isn't broken? Why try to change the present system, instead of investing more in it?

A: Why wait until the system breaks down? Actions taken now will ensure that potential problems in the future are reduced or averted. The health services must be pro-active not reactive.

- Primary care is about more than GP services. We want to improve the whole service
- We want to develop a fully integrated service involving all components of primary care – GPs, nurses, midwives, public health nurses, physiotherapists, home care assistants, home helps.
- We will also invest substantial resources in the new model – e.g. in further developing GP Co-operatives – but we need an integrated service based on close teamwork.
- The patient/client should be able to access the service in a people-centred way. This includes self-referral and direct access to team members.
- Model will be described in detail at the launch on Wednesday 28th.

Organisational Issues

Q: Why are you not changing the number of health boards?
A: The Govt has concluded that the number of health boards is not itself the issue. There will always be a need to deliver health services at local level. Instead we need to strengthen the framework of accountability to emphasise the health boards' role in delivering high quality services and value for money. The boards will:

- Be explicitly responsible for driving change at local level
- Take full responsibility for delivering (or arranging) all health and personal social services in their area
- Focus on actual outcomes of services, in line with service plans
- Show the public what they're doing by publishing user-friendly summaries of their service plans

Q: You retain the health boards but then set up an audit of organisations. Surely this is inconsistent?
A: The audit is to cover the structure and function of all health agencies to ensure that there are no overlaps or gaps in functions and that they all play their best part in meeting the goals of the Strategy. It is completely consistent to review the health boards, and all other publicly funded health agencies, in this context.

Q: Will the Health Information and Quality Authority cover the voluntary and private sectors?
A: The intention is to give HIQA as broad a coverage as possible. The details will be worked out when preparing the legislation.

Q: Why not a separate Health Ombudsman for the health services?
A: The Govt is satisfied that the present Ombudsman is the best way to deal the health services. He already does so and has been prominent on a number of health-related issues.

- Aim is to extend the remit of the Ombudsman to cover voluntary hospitals and other agencies. Legal implications of this are being examined.
- Customer focus of service to be strengthened by
    - Standardised customer service strategies by health boards
    - Standardised customer care plans by all service providers
    - Statutory framework for complaints – ensuring greater clarity of approach and scope for local resolution

Q: Will the statutory complaints system for patients cover private/voluntary as well as public services?

A: Legal implications of covering private side need to be examined, but the aim is to be as inclusive as possible.

Q: What is the role of the National Hospitals Agency vis-à-vis health boards as managers of acute hospital services?

A: The NHA will advise the Minister and Department by developing a strategic plan for hospital services (location and speciality) throughout the country. It will have no operational role – it will not own or operate hospitals. Health boards/voluntary hospitals will continue to manage their respective hospitals.

Q: How does role of HIQA relate to other health agencies?

A: The Health Information and Quality Authority is responsible for:

- Developing health information
- Promoting structured programmes of quality assurance
- Reporting on selected programmes or care groups each year
- Overseeing Health Technology Assessment

HIQA will be a statutory body, independent of all health agencies. It will work with relevant agencies (e.g. health boards, NHA etc) to develop and agree standards/models of best practice. It will report on whether these standards are being met, exceeded or not being met. Responsibility for acting on the reports will rest explicitly with the relevant agencies.

Human Resources

Q: You promise extra staff, but how will you recruit and retain them?
A: Strategy contains a series of steps to recruit the required extra staff, starting from training, through to recruitment, development and retention:

- **Doctors:** Extra post-grad places; further international recruitment initiatives; review requirements for permanent registration; further improve the conditions of NCHDs; Task Force on Medical Manpower.
- **Nurses:** 10,000 trained over lifetime of Strategy. Implement final report on Nursing and Midwifery Resource; degree-level education in 2002; further flexible working arrangements; payment of fees in selected degrees, courses and specialised areas of clinical practice; flexible return to nursing courses; continued overseas recruitment drives; more clinical specialist and advanced practitioner posts.
- **Health and Social Care Professionals:** 1330 physios; 985 speech and language; 875 OTs to be trained to meet needs up to 2015 (as per Bacon). Extra social workers, psychologists, dieticians, chiropodists, in line with workforce studies completed/to be done in these areas. Extra training places; scope for conversion courses; scope for support/assistant grades; overseas recruitment drives; information campaigns for potential employees; continue implementation of Expert Group on Various Health Professionals.

Q: Isn't it true we have too many administrators and too few people providing services?
A: Not so. Two-thirds of administrative staff are in front-line positions. They support professional staff by relieving them of administrative work and freeing them up to concentrate on their professional/clinical work. A further 5 per cent deal with legal-related requirements (FoI; registration of births, marriages and deaths) and others deal with key issues relating to service planning and auditing.

Breakdown of admin staff:

o Frontline (64%)	7,914
o Legal/FoI (5%)	618
o IT/Payroll/HR (17%)	2,103
o Admin support (11%)	1,360
o Service managers (3%)	371
o **Total Admin**	**12,366**

Q: How are you going to get to a consultant-provided service? How many extra consultants will be provided?
A: Strategy indicates that 'there will be substantial increases in the number of consultants. The number and location will take account of the advice of the National Task Force on Medical Manpower.. The Task Force will quantify the resource requirements (and costs) that would arise if we moved to a consultant-provided service. It will look at medical staff requirements and associated training requirements.

Q: What are you looking for from another consultant contract? How are you going to get it?

A: Negotiations on a revised contract have commenced. Focus is on a developmental agenda, which would encourage consultants to become more involved in and responsible for management programmes. Concern also is to ensure a fair deal for public patients and to achieve an appropriate balance between public and private practice in public hospitals.

Q: We need the Action Plan for People Management now – not next year. Why did you not do it in the Strategy?

A: Time constraints and a concern to develop the Action Plan on a partnership basis. But the Strategy is specific about the areas which the Action Plan will cover:

- Training and education
- Best practice employment policies
- Managing people effectively
- Improving the quality of working life
- Developing performance management
- Improving IR
- Developing partnership further

Care Groups/Service Areas

Q: Waiting lists for orthodontics are very long. What are you doing about it?

A: **Orthodontic Initiative**

- Extra clinical staff recruited: 2 Consultant Orthodontists, 5 Specialist Orthodontists and 2 permanent Superintendent Radiographers;

- An additional six surgery facility at Loughlinstown Regional Orthodontic Unit and a five surgery facility at St James's Regional Orthodontic Unit have been developed;

- New arrangements for the treatment of patients, both by private specialist orthodontic practitioners and in out-of-hours sessions by health board orthodontists, being explored by Department with health boards.

- New orthodontic units at Navan and Dundalk have been developed and a Consultant Orthodontist has been recruited by the Midland Health Board.

Structural Changes

- Agreement has been reached on the establishment of the grade of Specialist Orthodontist in the public orthodontic service.

- The Dental Council will submit a scheme for the establishment of a grade of auxiliary dental worker to be known as Orthodontic Therapist in the near future.

Training

- Department has funded the recruitment of a Professor in Orthodontics at Cork Dental School to facilitate the development of an approved training programme leading to specialist qualifications in orthodontics. Applications for the post were invited when it was advertised last October.

- In 2001, 6 dentists for the health boards commenced training in the Dublin Dental Hospital for Specialist in Orthodontics qualifications bringing the total number of dentists for the health boards in specialist training to 9;

- Director of Specialist Training for the Irish Committee for Specialist Training has been appointed to assist the different agencies involved in dental specialist training programmes.

Numbers in Treatment

16,107 patients in orthodontic treatment in the health boards as at the end of September 2001.

Q: When will the Travellers Health Strategy be published? How implemented?

A: (See action 20, p68)
For many years and for a variety of reasons, the Traveller community has experienced a level of health which falls far short of that enjoyed by the general population.

The National Travellers Health Strategy focuses on the underlying problems associated with the poor health status of the Traveller community and will set out a realistic and practical plan for specific improvements in that status.

The main proposals in the Strategy are:

- Establishment of active partnerships between Travellers, their representative organisations and health service personnel in the provision of health services.
- Provision of awareness training for health personnel in relation to Traveller culture, including Traveller perspectives on health and illness.
- Strengthening of Traveller Health Units comprising Health Board staff and Traveller representatives, with responsibility for planning and implementing the Strategy in each Health Board.
- Development of initiatives to increase Travellers' awareness of general medical services and to make services more accessible, having regard to Travellers' lifestyle.
- Provision of designated Public Health Nurses in each Health Board to work specifically with Traveller communities.
- A Traveller Needs Assessment and Health Status Study the results of which will inform appropriate actions on Travellers' health.
- Replication of the successful "Primary Health Care for Travellers" Project, which established a model for Traveller participation in the development of health services.
- Establishment of a permanent liaison mechanism between the Department of Health and Children and the Department of the Environment and Local Government and including representatives from Traveller organisations, to collaborate in efforts to improve Travellers' living conditions on halting sites.

The strategy will be submitted to Government in December and will be published as soon as possible.

Q: What is being done to help Autistic people and their families?

- Between 2000 and 2001, additional revenue and capital funding amounting to £151.7m provided to enhance the services for persons with autism and those with an intellectual disability.

- This funding has provided around 840 new residential places, 296 new respite places and over 1,500 new day places, in addition to the enhancement of other services as outlined.

Health Related Support Services for Children;

- These services include diagnosis, assessment, pre-school and out-reach support for children of school going age.

- Between 1998 and 2000, additional funding of £5m allocated specifically to enhance these services for children with autism.

- A further £3.5m allocated in 2001 for these services for both children with autism and those with intellectual disabilities.

- Department is working with the health boards to develop an information system which will provide data on the number of persons with autism and their needs.

Report of the Task Force on Autism

- The Department of Education and Science published the Report of the Task Force on Autism today.

- This Department welcomed the initiative taken by the Minister for Education and Science in establishing the Task Force and will be examining the recommendations as they relate to the health services.

- Health services have been and will continue to work with the Department of Education and Science to support the educational services for children with autism.

- The initiatives which are currently being taken by both Departments address
  - the shortages in the key professions supporting the delivery of services, and
  - an ongoing investment programme in both the educational and health related support services

  will ensure an enhanced level of support for children with autism and other special educational needs.

Medical Register and Fitness to Practice

Q: What are you doing to protect the public from unregistered doctors, or doctors who have been struck off the register?

- The Medical Council is the authority responsible for the provision of registration and control of persons engaged in the practice of medicine.

- The Council protects the interests of the public when dealing with registered medical practitioners. The principal roles of the Council include assuring the quality of undergraduate and postgraduate training, registering doctors, disciplinary procedures and providing guidance on professional standards and ethical conduct.

- The Medical Practitioners Act, 1978 is currently under review. The review is being carried out takes into consideration various developments in the medical field and the role of the Medical Council. The revised Medical Practitioners Act will take account of the concerns raised by various interest groups.

- The Medical Council has also made significant progress towards the introduction of competency standards for Irish doctors.

- The Council has recently appointed a Director of Competence Assurance who will work with the Medical Council, the professional bodies and an external reviewer. The detail will be developed in close consultation with key stakeholders, including doctors and their representatives, and they will be engaged in both a formal and informal manner in developing competency structures.

Q: How will the NAPS health targets be achieved?

A: (Action 18 – page 66/7)
A range of measures will be put in place to achieve the NAPS and Health Targets. These include the following:

- Primary health care will be significantly strengthened through multidisciplinary working and local case management.

- Better access will be provided for patients to diagnostic and treatment services through their GP by increasing the services carried out universally in general practice.

- The difference between public and private patients in waiting times for acute hospital inpatient care will be reduced (check against inputs from other units on waiting lists).

- Nationally standardised rules for eligibility for community support services will be put in place.

- There will be increased emphasis on a multi-sectoral approach to health with a twin focus on strengthening partnerships for health and on health impact assessment.

- Protocols and systems will be developed in order to allow relevant groups to be identified in a sensitive manner to ensure that the NAPS Health targets are clearly addressed throughout the system.

- A research and data framework will be put in place to enable targets to be addressed and progress monitored and evaluated, existing targets to be reviewed and new targets to be set where appropriate.

Q: What's in the Strategy for each care group?

A: A range of additional services, together with endorsement of existing strategies. For example: (See Briefing Document)