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I am delighted to note the achievements in implementing the Cardiovascular Health Strategy, as set out in this first Progress Report from the Heart Health Task Force.

Heart disease is the single biggest killer in Ireland today. Living with heart disease is an everyday reality for thousands of Irish people and their families. That is why in July, 1999 the Government launched a blueprint – *Building Healthier Hearts*, to address this important cause of sickness and death.

In the two years since the Cardiovascular Health Strategy was published the Government has allocated an additional £27m (€34.3) to fund the implementation of its recommendations. The implementation of the Strategy has just begun and provides a good foundation on which additional and necessary developments can be built.

This Report highlights the additional services that have been developed from this investment. It is clear that a lot has been achieved but it is equally clear that a lot more needs to be done.

I would like to thank the Heart Health Task Force, under the chairmanship of Dr. John Bowman, for their commitment to giving overall direction and impetus to the implementation and review of the Cardiovascular Health Strategy. I would also like to thank the Advisory Forum, which is chaired by Dr. Jane Wilde, and the members of the many regional committees. Jointly these committees have ensured that momentum is maintained in the implementation, review and evaluation of cardiovascular health policy in line with the recommendations of the report of the Cardiovascular Health Strategy Group.

The Government will do everything within its resources to ensure that this momentum is maintained to achieve comprehensive implementation of the Cardiovascular Health Strategy.

Micheál Martin T.D.  
Minister for Health & Children
I am pleased, on behalf of the Heart Health Task Force, to produce this first Progress Report on the implementation of the Cardiovascular Health Strategy – *Building Healthier Hearts*. This report sets out progress since the launch of the Strategy in July 1999 up to June 2001.

It will be noted in the report that there have been considerable achievements since 1999 in the prevention, detection and treatment of cardiovascular disease. Progress has been achieved in a cohesive, coherent and effective manner. This can be attributed directly to the quality of the template provided in the Strategy, the many structures established to oversee its implementation, the additional resources provided and the dedication of all involved in its delivery.

As Chair of the Heart Health Task Force, I would like to pay tribute to the members of the Task Force for their time, expertise and dedication to implementing the Strategy. In particular, I would like to commend them for their efforts in beginning to address the multisectoral actions necessary for heart health in Ireland. I would like to thank Dr. Jane Wilde, Chair of the Advisory Forum on Cardiovascular Health and the members of the Forum for professional, technical and efficient advice on the Strategy’s implementation. The work of the Task Force could not have run so smoothly without the excellent service provided to it by the Secretariat and also the support of Mr. Chris Fitzgerald, Principal Officer at the Department of Health and Children and Dr. Emer Shelley, National Heart Health Advisor. The success achieved to date would not have been possible without the input of all concerned.

Recognition must also be given to the many people who are represented on the regional structures of the health boards for their management of the implementation process at regional level.

This is the first of a series of reports that will set out and evaluate progress in the implementation of the Cardiovascular Health Strategy. This *Progress Report July 1999 – June 2001* is being submitted to the Joint Oireachtas Committee on Health and Children as required under the terms of reference of the Heart Health Task Force.

**Dr. John Bowman**

Chair, Heart Health Task Force
In accordance with its terms of reference, the Heart Health Task Force submits its first progress report to the Joint Oireachtas Committee on Health and Children. This report refers to progress from the launch of the Strategy in July 1999 to June 2001 and aims to:

- briefly overview the epidemiology of cardiovascular diseases in Ireland,
- set out the background to the Cardiovascular Health Strategy,
- summarise allocated funding and its distribution to date,
- describe progress to date in the range of health services included in the Strategy, namely health promotion, primary care, pre-hospital care, hospital care and cardiac rehabilitation, as well as in information systems, audit and evaluation, and
- set out the priorities for further implementation of the Strategy.

A detailed report is presented below and a summary of progress by recommendation is attached at Appendix A.
There have been important changes in death and sickness rates from the cardiovascular diseases in Ireland in recent years. While death rates have declined, the number of people with chronic diseases living in the community has increased. This is presenting major challenges for the health services but has implications also for planning other services for older people.

In 1980-1982 50.5% of all deaths in Ireland were attributed to the circulatory diseases (including coronary heart disease [CHD], stroke and diseases of other blood vessels). This compares to 42% of deaths in 1997-1999. The changing mortality patterns are shown in Figures 1 to 5. Since the early 1980s there has been a decrease in total mortality rates from all causes (figure 1).

This was partly due to a reduction in mortality from CHD (figure 2) and the continuing decline in death rates from stroke (figure 3). The decline in CHD death rates has been particularly striking.

**FIGURE 2** Ischaemic heart disease death rates (per 100,000), all ages, 1974-1999

**FIGURE 3** Stroke death rates (per 100,000), all ages, 1980-1999
in the under 65s (figures 4 and 5) but has occurred also at older ages (table 1). Since the early
1980s CHD death rates have decreased by 24% and 26% in Irish men and women in the 75 to 79
year age group.

| SECTION 2 |

**FIGURE 4** Ischaemic heart disease death rates (per 100,000), males < 65 years, Ireland and EU, 1974 - 1999

*EU data from WHO Health for All database.

**FIGURE 5** Ischaemic heart disease death rates (per 100,000), females < 65 years, Ireland and EU, 1974 - 1999
The Irish data together with research in other countries suggest that the epidemic of coronary artery disease continues to evolve:

- patients are older at onset,
- the rate of sudden deaths has decreased and there are fewer completed infarctions at presentation,
- length of survival after presentation has increased,
- at population level there is a higher prevalence of those at very high risk of recurrence of symptoms, with increasing need for further acute care, repeat procedures and ongoing disease management, and secondary prevention,
- the prevalence of heart failure in the oldest age groups has increased greatly, particularly in women, and
- increased prevalence of obesity, partly due to decreased physical activity levels, is associated with increased risk of diabetes and the accompanying risk of vascular disease.

It is of concern that the decrease in mortality has been unequal in different social groups. *Inequalities in Mortality* a report by the Institute of Public Health on mortality throughout Ireland from 1989 to 1999, found that in this part of the island of Ireland, death rates from circulatory diseases were almost three times higher in the semi-and unskilled working classes compared to professionals. While CHD mortality has decreased at all ages, it should be remembered that we continue to have high mortality rates when compared to other developed countries. It is emphasised that the cardiovascular diseases remain an important cause of mortality and morbidity in middle age in Ireland. While the trends described are to be welcomed, they will continue to have a major impact on the demand for health and other services for older people in the years to come. Health promotion to increase the length of healthy, active life presents many challenges to us at societal level.

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>All causes</td>
<td>-19.5%</td>
<td>-22%</td>
</tr>
<tr>
<td>CHD* all ages</td>
<td>-34%</td>
<td>-30%</td>
</tr>
<tr>
<td>CHD &lt; 65 years</td>
<td>-51%</td>
<td>-58%</td>
</tr>
<tr>
<td>CHD 65 – 69</td>
<td>-40%</td>
<td>-46%</td>
</tr>
<tr>
<td>CHD 70 – 74</td>
<td>-32%</td>
<td>-37%</td>
</tr>
<tr>
<td>CHD 75 – 79</td>
<td>-24%</td>
<td>-26%</td>
</tr>
</tbody>
</table>

*CHD = coronary (or ischaemic) heart disease
The three principal modifiable risk factors for CHD are smoking, raised levels of cholesterol in the blood and raised blood pressure, all of which have a relationship to lifestyle, including diet and physical activity. While individuals have responsibility for their own health behaviours, social and economic inequalities play an important part in the development of the disease. Measures to reduce such inequalities must therefore also be addressed.

In order to reduce such inequalities and to achieve health and social gain in relation to cardiovascular diseases, a comprehensive strategy was developed which was accepted and endorsed by Government (Government decision S180/20/10/0058 of 7 July, 1999). An Taoiseach, Mr. Bertie Ahern T.D., launched the report of the Cardiovascular Health Strategy Group, *Building Healthier Hearts*, in July 1999. The Cardiovascular Health Strategy addressed the common aspects of prevention of all of these diseases, as well as the treatment and rehabilitation of patients with CHD. The following overall aims were identified:

- to reduce the risk factor profile in the general population,
- to detect those at high risk,
- to deal effectively with those who have clinical disease, and
- ensure the best survival and quality of life outcome for those who recover from an acute attack.

This report is very comprehensive and its recommendations are far reaching. The Department of Health and Children has set a medium-term objective to bring our levels of premature deaths from cardiovascular disease in line with the EU average at a minimum and a long-term objective of reducing our rates to those of the best performers in the EU. The Strategy document, which contains 211 evidence-based recommendations, is designed to systematically achieve these objectives. Implementation of these recommendations will provide real progress in health promotion (which is much broader than the health services), primary care, pre-hospital care, hospital care and cardiac rehabilitation, and in information systems, audit and evaluation of services.
As a measure of the Government’s commitment to the Cardiovascular Health Strategy Report, structures were put in place at national, regional and local level to support its implementation. The structures take into account the need to ensure a high level of engagement from all concerned and to sustain a co-ordinated programme over a long period. The structures for implementation are:

- Ministerial Group chaired by the Minister for Health and Children,
- Joint Oireachtas Committee on Health and Children,
- Heart Health Task Force,
- Advisory Forum on Cardiovascular Health,
- Regional cardiovascular committees at health board level, and
- Inter-divisional Working Group on Cardiovascular Health within the Department of Health and Children.

The key structures to support the implementation process and provide expert advice are the Heart Health Task Force and the Advisory Forum. The terms of reference for the Task Force and Advisory Forum and their membership are set out at Appendix B.

The Task Force has responsibility for reviewing short, medium and long-term objectives proposed by the various Government Departments and other statutory bodies charged with achieving timely and co-ordinated implementation of detailed elements of the Cardiovascular Health Strategy. In addition, it is charged with implementing the multisectoral recommendations contained in the Strategy. The Advisory Forum advises the Task Force and the Department of Health and Children on prioritisation of the recommendations and on best practice in cardiovascular disease prevention, detection, treatment and rehabilitation.
The Advisory Forum agreed that the best way to make progress on its work was through the establishment of the following Working Groups:

- Hospital Working Group,
- Cardiac Rehabilitation Working Group,
- Primary Care Working Group, and
- Health Promotion Working Group.

There is geographic variation in mortality from CHD, unequal population spread across health board areas and unequal access to services. To take account of these factors, to ensure the effective implementation of the Strategy within each region and to ensure co-ordinated implementation of the Strategy at both national and local level, all health boards were requested to establish regional structures for implementation. In line with the strategic management approach within the public sector, responsibility for the recommended health service developments rests with the health boards.

### 4.1 National Conference November 1999

Following the launch of the Strategy, a major national conference for stakeholders was held in Dublin Castle on 5th November 1999, to discuss the report of the Cardiovascular Health Strategy Group. The objectives of the conference were:

- to present the findings and recommendations of the Report of the Cardiovascular Health Strategy Group, and
- to discuss the recommendations with representatives of organisations which will be involved with their implementation.

The conference was hosted by the Minister for Health and Children, Mr. Brian Cowen T.D.. Mr. David Byrne, EU Commissioner for Food Safety and Public Health, gave the keynote address. In this address the Commissioner recognised the concerns relating to cardiovascular disease in Ireland vis à vis other Member States.

Mr. Byrne outlined the health promotion strategies of the European Commission in relation to smoking, nutrition and physical activity and emphasised the need to tackle health determinants, both through policies which support healthy choices and by specific prevention actions. An
outline of the Strategy was presented as well as a paper on sociological considerations related to heart health in Ireland. There were presentations on exercise, smoking and nutrition, as well as on other modifiable risk factors related to heart disease.

The 254 delegates moved into nine separate workshops. The workshop topics were youth, exercise, nutrition, smoking, developing general practice to meet future needs, developing evidence-based practice, facilitating research and evaluation, eliminating inequalities and ‘communicating the message’. In each case the topic was reviewed in the context of the relevant recommendations in the Report and the discussion was intended to provide guidance to the Task Force and the Advisory Forum in determining priorities for implementation.

The conference endorsed the approach of the Government in implementing the Strategy. Because many of the recommendations in relation to health promotion fall outside the remit of the health services, the conference recognised that a partnership model is the best approach to effect change in lifestyle and health behaviours.
The Government decision of 7 July, 1999 authorising the publication of *Building Healthier Hearts* agreed that while no revenue measure would be formally dedicated to the Strategy, funding would be provided, in whole or in part, by increased taxation on tobacco consumption and/or a levy on tobacco companies. To date the Strategy has been funded from the increased taxation on tobacco from the 1999 budget. The Government has allocated a total sum of £27 million (€34.28m) towards the implementation of the Cardiovascular Health Strategy – £12 million (€15.24m) in 2000 and £15 million (€19.05m) in 2001. *Appendix C* contains details of national initiatives and allocations to health authority/boards for 2000 and 2001.

The National Development Plan is providing some additional funding for capital projects being undertaken by health boards as required for implementation of the Strategy.

### 5.1 2000 Funding

£12 million (€15.24m) was allocated in 2000 to fund initiatives to implement the recommendations in *Building Healthier Hearts* in a planned and structured manner. Each of the health boards received a financial allocation of £1 million (€1.27m), with the exception of the Eastern Regional Health Authority which received £3 million (€3.8m). £2 million (€2.54m) was used to implement initiatives at a national level. The use of this funding for national initiatives allowed health boards to use their funding for local priority service developments.

In relation to the prioritisation of expenditure during 2000, health boards were requested that, as far as possible, the basic infrastructure (staff and equipment) should be put in place during the first year. Health boards were informed of the national initiatives envisaged for 2000 and that initiatives at regional and local level should support national programmes. However, it was also emphasised that individual boards should tailor their proposals to meet local needs. The proposals from boards were brought to the attention of the Advisory Forum after which individual plans for each board were agreed.
5.2 2001 Funding

In 2001 the Advisory Forum identified the principles of a funding framework for the Strategy. These included:

- health boards should receive money to ensure priority service areas are developed, in accordance with the Strategy’s recommendations,
- some funding should be available for innovative projects,
- co-operation between boards for development of services should be encouraged, especially for services not required to be provided by each board, and
- equity, quality and accountability should be sustained.

Based on this advice, national priorities for service development during 2001 were identified and notified to health boards. Health boards planned service developments in accordance with national priorities. Thus, funding to each health board for 2001 was based on national priorities and local needs. This approach to the distribution of funding ensures that priority service needs are being addressed throughout the country while responding to local needs. Again in 2001 an additional £2 million (€2.54m) will be used to implement initiatives at a national level.

The Advisory Forum and its Working Groups are currently drawing up national priority areas for service developments for 2002 and beyond.
Progress to date

Introduction

Progress in implementing the Strategy is described for health promotion, primary care, pre-hospital services, hospital services, cardiac rehabilitation, and information and systems, audit and evaluation. In the year 2000, Cardiovascular Health Strategy funding supported a wide range of initiatives and a total of 288 posts were filled. The details of these are set out in Appendix D.

6.1 Health Promotion

The Strategy recognises that intensive efforts will be required to prevent cardiovascular disease at a population level. There are 58 recommendations on health promotion. The importance of integration of national, regional and local campaigns, of sustained initiatives and attention to disadvantaged communities is recognised by the Strategy. Specific recommendations address smoking, diet and nutrition, physical activity, alcohol and blood pressure.

Key players in health promotion are the Department of Health and Children, the Department of Education and Science, the other Government Departments listed in Shaping a Healthier Future which have a stated role in cross-sectoral initiatives, the health promotion departments of the regional authority/health boards, other agencies with a responsibility in this area, such as the Food Safety Authority of Ireland, and the voluntary sector.

The Advisory Forum and the National Heart Health Alliance held a one day workshop to identify for each health promotion recommendation

- the lead agency to implement the recommendation,
- key tasks required to implement the recommendation, and
- the key stakeholders.

The report of the workshop will inform the setting of priorities for implementation of the Strategy's health promotion recommendations.

During 2000 a broad range of activity occurred at national, regional and multisectoral levels. These are described in the following pages.
6.1.1 National Initiatives

a) Ireland Needs a Change of Heart

In accordance with recommendation 5.7, a mass media campaign was developed to address the entire community but with particular emphasis on social classes 5 and 6. The campaign, Ireland needs a Change of Heart, comprises two phases and Phase One was launched on 20th September 2000. The two main aims of this campaign are to:

- raise public awareness of the comparatively high rates of heart disease in Ireland and of the lifestyle factors which increase risk of cardiovascular disease, i.e. smoking, diet and raised blood cholesterol, raised blood pressure and physical inactivity, and
- raise public awareness of a national five year programme to reduce the incidence of heart disease in Ireland.

Phase One was the six week launch phase and comprised advertising on TV, outdoor posters and radio. Events were run at regional level and local media contributed, to coincide with the launch phase. A 16 page Handy Guide to a Healthy Heart was distributed to every household in the country during October/November, 2000. The overall content and language in this guide is positive and encouraging and aims to give practical tips to convince the public that they can, either on their own or with help, improve their heart health through their lifestyle. A ‘media and influentials pack’ was circulated to about 1,000 key people who can contribute to influencing people’s lifestyle and health behaviours.

Phase Two of Ireland needs a Change of Heart commenced in June 2001 and will involve a national media campaign with initiatives at local level, primarily through the health boards. The key theme for Phase Two is physical activity and the key audiences are older people, young people and those who are sedentary. The intention is to adopt a ‘settings approach’ at local level in schools, workplaces and communities.

b) Other National Health Promotion Campaigns

It has been estimated that there are 7,000 smoking-related deaths each year – all of which are preventable. The largest number of these deaths is attributed to cardiovascular disease. The national ongoing Break the Habit campaign targets the whole population to encourage smokers to stop smoking and non-smokers not to start. Given the concern about the increased prevalence
of smoking among teenage girls and young women, a special component of the Break the Habit campaign was developed during 2000 to target teenage girls and was partly funded by the Strategy. The campaign is called the NICO campaign. The rationale of the campaign is that nationally:

- almost half of Irish children have tried a cigarette,
- by the age of 15 to 17 years one third of all boys and girls are smoking between 3 and 6 cigarettes a day,
- by the age of 15 years more girls smoke than boys,
- 80% of all smokers become addicted by 16 years of age,
- girls are less likely to quit when they are addicted,
- by the age of 17, 40% of girls (28% of boys) from low income backgrounds are smokers, and
- 50% of today’s young smokers will die prematurely from smoking-related diseases.

The NICO campaign concentrates on issues which are more immediately important to young women, such as their appearance. The simple message of this campaign is that smokers are less attractive and it uses a range of ‘anti-cosmetics’ presented by a character called ‘NICO’. The NICO campaign uses TV, radio and outdoor advertising and highlights the unappealing aspects of smoking.

Other national health promotion campaigns address key lifestyle issues associated with heart disease, such as the National Healthy Eating Campaign, the annual focal point of which is National Healthy Eating Week. Progress in implementing the National Alcohol Policy has been made, inter alia, by creating greater public awareness of the alcohol issue in Ireland.

### 6.1.2 Regional Initiatives

At regional level a broad range of service developments and initiatives occurred in 2000. These can be summarised as follows:

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**a) Tobacco**

A multi-faceted response to smoking is recommended in the Strategy to reduce the numbers taking up the habit and to encourage current smokers to quit. A number of boards expanded their smoking cessation resources by the recruitment of additional smoking cessation officers and smoke...
free co-ordinators to support individuals and to provide advice regarding smoking policies and legislation. In addition, a number of boards introduced specific initiatives e.g. the Western Health Board implemented the *You Quit We Pay* programme which provided nicotine replacement medications free to participants. The North West trained post-primary teachers as smoking cessation leaders and the South East introduced the *Smoke Free Carlow* project.

**RECOMMENDATIONS 5.23, 5.24**

b) Nutrition

A number of boards appointed additional nutritionists whose role is to provide staff training, support health promotion initiatives and provide patient counselling services. A number of health boards implemented special nutrition initiatives e.g. the Western Health Board ran a Children’s Healthy Eating Calendar art competition and in the North West the ‘Eat Well Be Well’ programme was expanded in Sligo/Leitrim.

**RECOMMENDATIONS 5.31, 5.32**

c) Physical Activity

About half of the health boards appointed physical activity co-ordinators to provide advice and support in a number of settings, including schools, workplaces and communities. Many boards developed specific programmes including the North East which supported Sí na Sláinte and the Southern and Mid Western which developed a GP Exercise Referral Scheme. The PACE programme in the Western Health Board devised a programme to support each participant’s preferred activity.

**RECOMMENDATIONS 5.41, 5.42**

d) Hospital

The ERHA funded staff for hospitals to target risk factor reduction among patients and staff. A health promotion officer was also recruited in Sligo General Hospital.

e) Others

A number of health promotion officers were recruited and a number of boards used funding with existing staff to:
• disseminate information about the Strategy and assess training needs, and
• co-ordinate health promotion in the workplace, school and other settings
  in relation to heart health.

The Department of Health and Children is currently seeking approval to recruit health promotion
officers to co-ordinate initiatives.

RECOMMENDATIONS 5.27, 5.32

6.1.3 Multisectoral Dimension to Health Promotion

The 58 health promotion recommendations in the Cardiovascular Health Strategy are wide-ranging
and many fall outside the remit of the health services. Responsibility for implementing the
multisectoral recommendations lies with the Heart Health Task Force.

The Chair of the Task Force wrote to each of the relevant government departments and agencies
asking them to review these recommendations in relation to their own organisation’s areas of
responsibility. The Department of Health and Children is currently undertaking a review of these
recommendations, in collaboration with the relevant government and state bodies.

The task of developing the role of other government departments, social partners and other
agencies in the implementation of the multisectoral recommendations is complex. A summary of
the progress to date in this area is set out below and further work is planned and will be

a) Education

There are many recommendations relating to the education system – RECOMMENDATIONS 5.9,
5.10, 5.13, 5.35(3) & 10.19. In response to the request from the Chair, the Department of
Education and Science endorsed the recommendations and agreed to co-operate with their
implementation. The National Council for Curriculum and Assessment (NCCA) has reviewed the
provision of health education in schools and has proposed the introduction of the subject Social,
Personal and Health Education (SPHE) to the curriculum of all schools at primary and secondary
levels. The syllabi and curriculum guidelines produced by the NCCA deal with issues of healthy
eating and physical activity, among others. The introduction of SPHE in secondary schools
commenced in September 2000 and will continue over a three year period. The implementation
for primary schools is occurring as the new curriculum for these schools is introduced.
In general the Department of Education and Science highlighted that the introduction of the SPHE to school curricula will increase the emphasis on health promotion in schools and gradually there will be a greater consistency of approach among schools. That Department has identified that SPHE is an area of emphasis for 2001 and networking with health board personnel will be further developed.

b) Community Support for Disadvantaged Groups

Some recommendations concern the promotion of cardiovascular health and the promotion of healthy diet and lifestyle, specifically focusing on promotion in disadvantaged communities and people on low incomes RECOMMENDATIONS 5.12, 5.14, 5.31, 5.35(6) & 5.35(7).

The Department of Social, Community and Family Affairs recognises the strong links between poverty and ill-health generally. It has identified a number of programmes under its remit that can play a supporting role in a targeted strategy towards the implementation of these recommendations. The Department would favourably consider a request for further resources should community groups involved in these programmes wish to participate in tackling problems of cardiovascular disease. The relevant programmes are:

- Community Development Programme,
- Family & Community Services Resource Centre Programme,
- Programme of Core-funding to locally-based Community and Family Groups, and
- Money Advice and Budgeting Service.

c) Planning Process

Assessment of the health impact of planning decisions related to housing, transport and leisure facilities as well as the accessibility of safe and sufficient footpaths and leisure facilities are recommended in the Strategy – RECOMMENDATIONS 5.5 & 5.45. These recommendations aim to ensure that facilities are readily available for health-enhancing physical activity.

While implementation at local level is a matter for local authorities, the Department of the Environment and Local Government has highlighted that the planning system does take account of health issues. In particular the Planning and Development Act, 2000 provides that in future all local authority development plans must include objectives for, *inter alia*:
• the integration of the planning and sustainable development functions with the social, community and cultural requirements of the area and its population; such requirements could include the provision of safe and accessible footpaths and cycle paths,

• the preservation, improvement and extension of amenities and recreational amenities; recreational amenities could include various types of leisure facilities, including playing fields, sports centres, etc., and

• facilitating the provision and siting of services and facilities necessary for the community, including recreational facilities and open spaces.

d) Tobacco Controls

(i) Finance

RECOMMENDATION 5.22 refers to the removal of tobacco from the Consumer Price Index (CPI), that the annual increase in the price of tobacco should be substantially above inflation and that additional tax collected from tobacco sales should be used for national education initiatives.

RECOMMENDATION 5.23 refers to funding from the National Lottery for a national quit smoking programme.

The Chair of the Heart Health Task Force forwarded a pre-budget submission to the Minister for Finance on behalf of the Task Force in November 2000. This submission outlined the views of the Task Force that as tobacco consumption among young people is price-sensitive, every effort should be made to increase the price of tobacco in line with the 50p increase of 1999. In addition, it was stated that tobacco should be removed forthwith from the list of items in the CPI in accordance with recommendation 5.22(1).

In his Budget speech, the Minister for Finance commented that he saw merit in the proposition that tobacco be excluded from the calculation of the inflation rate. As the composition of the CPI is a matter for the Central Statistics Office, under the aegis of the Department of the Taoiseach, the Minister has asked that the issue be examined by the Department of Finance in consultation with the Central Statistics Office and the Revenue Commissioners.

The Minister for Finance is also taking action in 2001 to offset the reduction in the VAT rate, so that the price of tobacco will not fall.
On 28 February 2001 the Minister for Health and Children announced Government approval for
the drafting of a Public Health and Tobacco Bill to give effect to the proposals in the policy
document “Towards a Tobacco Free Society”, launched in March 2000. This new Tobacco Bill
which represents the most comprehensive anti-tobacco legislation ever published in this country
was published on 1 August 2001. The Minister for Health and Children proposes to introduce
the Bill in the Oireachtas at the earliest possible date.

Accordingly on the 1st day of August, 2001 the age limit at which tobacco products can legally
be sold to young persons was raised from sixteen years to eighteen years. The maximum fine on
persons convicted of selling to underage persons was also increased from £500 (€635) to
£2000 (€2539).

The main new provisions contained in the new Public Health (Tobacco) Bill, 2001 are:

- the establishment of the Tobacco Control Agency,
- a comprehensive ban on tobacco advertising, including in-store advertising and
displays, and on all forms of sponsorship by the tobacco industry,
- registration of tobacco retailers and tougher penalties for those convicted of
underage sales,
- a ban on retail sales of packs of cigarettes of less than twenty,
- tighter controls on the sale of tobacco products from vending machines,
- a ban on the sale of confectionery, normally intended for children, which
resembles tobacco products,
- disclosure to the public of all aspects of tobacco, including toxicity and
addictiveness, and
- a ban on the sale or supply of a tobacco product which does not bear a number
in such form as may be prescribed by the Minister that enables the lot or batch
from which the product originated and the date and place of its manufacture to
be ascertained.
e) Workplace

The Irish Congress of Trade Unions (ICTU) met with the Minister for Health and Children in September, 2000. ICTU welcomed a proposal to appoint a co-ordinator to promote healthier workplaces. Following this appointment, the ICTU will be represented on a National Partnership Committee to promote healthier workplaces which will also involve IBEC and other relevant State agencies.

In the meantime the ICTU commissioned a 32 page booklet on workplace stress for workers and union representatives. This includes guidelines on stress reduction and healthier lifestyles.

6.2 Primary Care

The Cardiovascular Health Strategy makes 55 recommendations on primary care. Examples include:

- developing the role of the public health nurse,
- adopting a structured approach in general practice for risk assessment and prevention in those identified as being at high risk,
- developing a structured approach to the care of those with chronic cardiovascular disease, including secondary prevention, and
- promoting the role of GPs in pre-hospital care.

The key players include general practitioners, practice nurses and public health nurses, local health promotion services and occupational health services.

6.2.1 National Initiatives

During 2000 the Heart Health Task Force endorsed a recommendation from the Advisory Forum that nicotine replacement therapy (NRT) should be included in the list of drugs which may be prescribed within the GMS scheme (RECOMMENDATION 6.29). The Minister for Health and Children announced the introduction of NRT for GMS patients from April 2001. £3m (€3.81m) was made available through the GMS to fund this initiative.

At national level, planning for the first phase of a secondary prevention programme in general
practice began in 2000; this involves patients with diagnosed CHD and is in accordance with recommendations contained in Chapter 6 of the Strategy. Notwithstanding this, two boards (the North Eastern and South Eastern) established a primary care initiative ahead of the first phase of the national programme. The local developments are co-ordinated by the health board primary care units and dietetic, smoking cessation and nursing resources have been put in place to support the projects.

The Steering Committee for the national General Practice Secondary Prevention Programme is a sub-group of the Advisory Forum. The Committee has had discussions with all interested parties with a view to agreeing the implementation of the first phase of the programme in 2001. It is planned that boards which have started such projects will adopt the national protocol when that has been agreed.

6.2.2 Regional Initiatives

At regional level funding was used for a range of measures including the purchase of training equipment, defibrillators and ECG transmission equipment for placement in general practice. In some boards this assisted with the implementation of cardiopulmonary resuscitation (CPR) training for medical and nursing staff.

A number of public health nurses and dietitians were recruited in 2000 to provide training and advice on health promotion and disease prevention in the community. It is envisaged that these nurses will be involved in the first phase of the Secondary Prevention Programme in General Practice.

In some health boards training was provided for general practitioners and practice nurses in brief intervention techniques for patient counselling and in information technology.

RECOMMENDATIONS 6.9, 6.10, 6.16, 6.17, 6.18, 6.21, 6.22, 6.23, 6.24, 6.25
The Strategy contained 18 recommendations on pre-hospital care. These include:

- the establishment of a national ambulance advisory council on a statutory basis,
- better response times and supporting information systems,
- public education to raise awareness of symptoms of impending heart attack, and
- schemes for pre-hospital thrombolysis.

### 6.3.1 National Initiatives

At national level the National Ambulance Advisory Council has been replaced, on a statutory basis, by the Pre-Hospital Emergency Care Council (PHECC). £250,000 (€317,435) was made available for this purpose in 2000. The Council is an independent statutory agency with responsibilities for standards, education and training in pre-hospital care. As part of its work plan the Council has adopted a set of Standard Operational Procedures for the Ambulance service, which includes the administration of emergency cardiac drugs.

**RECOMMENDATIONS 7.1 & 7.2**

### 6.3.2 Regional Initiatives

In all regions the upgrading of equipment, especially defibrillators, as well as staff and community training in life support were the main elements of investment during 2000. Immediate care training was provided to hospital staff as well as to community-based staff, including GPs and practice nurses. The Western Health Board commenced the CARE project that trains members of the public in these skills.

The most disadvantaged in gaining access to early intervention and treatment, through all the links of the Survival Chain, are those resident in rural communities due to the fact that they are furthest away from hospital services. In recognition of this, a number of geographically large boards introduced projects to facilitate early response to chest pain or suspected coronary attack for
people in isolated areas. In the South a first responder scheme was developed in Dingle and in the North West the existing Donegal pre-hospital project was expanded through the purchase of equipment and extended to Sligo/Leitrim.

Resuscitation training officers were recruited in a number of health boards. They will provide resuscitation services, including training, for staff in acute hospitals and in the community.

### 6.4 Hospital Services

There are 46 recommendations in relation to acute hospital services. The Strategy recommended additional consultant cardiologists, support staff and upgraded facilities to meet the needs of a modern cardiology service which is equally accessible to all. Recommended developments include: improved access to diagnostic and invasive treatments; appropriate staffing levels for acute hospitals, regional and tertiary referral centres, and paediatric cardiology, including skilled nurses, technical staff and secretarial staff.

#### 6.4.1 National Initiatives

Following discussion by the Advisory Forum, a Working Group was established to develop an action plan for the orderly development of additional consultant cardiology posts. The Chairman of the Group, Dr. Tom Pierce, was appointed by Comhairle na nOspidéal and the Group includes nominated representatives from Comhairle, the Advisory Forum and the Department of Health and Children. Its terms of reference include:

- quantification of the shortfall in the total complement of consultant cardiologist posts at national and regional level,
- identification of hospitals suitable for designation as regional centres having regard to the relevant Strategy recommendations and taking demographic and geographic considerations and the location of tertiary care centres into account, and
- the development of a national plan outlining formal referral links to regional and tertiary centres from all acute hospitals not providing a specialist service.
The Working Group produced an interim report in May 2001 so that funding could be sought to fill the first of these posts during 2002.

At national level £243,000 (€308,546) was provided for cardiac technician training. This resourced employers to take on additional student technicians who will be available as a back-up in the hospitals while they are enrolled on the part-time course at the Dublin Institute of Technology, Kevin Street. Employers were surveyed as to whether they wished to participate in the scheme. The cost per student was £11,500 (€14,602) and 21 additional students were employed. Feedback from employers has been very positive, with many highlighting that these students are making a very definite contribution to the work of departments.

6.4.2 Regional Initiatives

During 2000, health boards upgraded equipment and staffing levels to improve the quality of service to patients. The list of equipment upgraded is very extensive and includes invasive and non-invasive diagnostic equipment.

By the end of 2000 the shortage of coronary care nurses had been reduced, further improving the promptness and quality of service to patients. Other staff recruited included resuscitation officers, health promotion staff, cardiac technicians and other nursing staff. There was a strong emphasis on increasing the number of trained cardiac technicians, as above, to provide for the expansion of diagnostic cardiology services throughout the country.

Specific developments included:

- a pacemaker service in the South Eastern Health Board,
- angioplasty services in the Mid Western Health Board,
- the provision of diagnostic coronary angiography at Sligo General Hospital on a sessional basis,
- an extension of the catheterisation laboratory in Cork University Hospital in September 2000 that acts as a tertiary centre for invasive diagnostic procedures, and
- chest pain assessment facilities were considerably enhanced in the ERHA region.
6.5 Cardiac Rehabilitation

There are 10 recommendations on cardiac rehabilitation in the Cardiovascular Health Strategy. In summary these called for a cardiac rehabilitation service in all acute hospitals. The service should be multidisciplinary, exercise-based and involve family members.

6.5.1 National Initiatives

The Cardiac Rehabilitation Working Group of the Advisory Forum discussed the appropriate career structure for cardiac rehabilitation co-ordinators. This is currently being considered by the Health Services Employers Agency. The Advisory Forum is also considering manpower planning for cardiac rehabilitation co-ordinators and whether or not clinical training could be done in regional centres.

6.5.2 Regional Initiatives

Cardiac rehabilitation services were limited at the time of the publication of the Strategy. Given the requirements for hospital equipment and other staff, not all regions prioritised this service during 2000. The ERHA and the Western, South Eastern and Midland Health Boards employed cardiac rehabilitation staff and expanded the cardiac rehabilitation service in their regions. Many of these boards also purchased equipment necessary for cardiac rehabilitation and employed other support staff, including physiotherapists, occupational therapists and dietitians.

Cardiac rehabilitation is a national priority for service development in 2001.
6.6 Information Systems, Audit and Evaluation

The Strategy makes 21 recommendations in relation to information systems, audit and evaluation. The collection, analysis and dissemination of information related to recommendations and their implementation is an integral part of the Strategy. The establishment of an information system in coronary care is recommended, for example, as well as the extension of the Irish Cardiac Surgery Register to include all cardio-thoracic surgeons. It is also recommended that lifestyle and risk factors should be regularly surveyed.

6.6.1 National Initiatives

The Strategy recognised (Recommendation 10.11) that the establishment of a register of patients presenting with symptoms of acute myocardial infarction in Ireland would facilitate effective management of health resources in this country. Such a database would also provide a useful research tool for studying the epidemiology and treatment of coronary heart disease. At national level the Coronary Heart Attack Ireland Register (CHAIR) project was to be piloted in 2000 in the Southern Health Board. A number of operational issues delayed the start of this pilot phase which is now planned to commence during 2001.

The Irish Cardiac Surgery Register was established in 1983 and played an important role in tracking cardiac surgical procedures and outcomes. Since 1993 the Register has not included data from some surgeons. In pursuance of Recommendation 10.15 in the Strategy, the aim is to re-establish the register with a wider remit than heretofore. It is expected that the new register will be developed during 2001 and will, following consultation,

- encompass both surgical and cardiological procedures,
- provide information to support clinical audit, and
- support service planning at institutional, regional and national levels.
6.6.2 Regional Initiatives

By early 2001 all health boards had appointed a Cardiovascular Health Strategy Co-ordinator. The Co-ordinators act as a liaison between the services and agencies with a role in the implementation of the Strategy at local level, taking account of national priorities.

During 2000 a number of boards appointed research and information officers to undertake evaluation of Strategy initiatives.

6.7 Protocols

There are a number of recommendations that relate to national guidelines and protocols. The Advisory Forum has commenced discussions about the development and implementation of protocols.

6.8 Research

A number of Strategy recommendations call for further research. Some organisations have made submissions or informal enquiries about accessing Cardiovascular Health Strategy funding for health services research. In order to formalise arrangements to provide support to such groups, £250,000 (€317,435) has been set aside from national Cardiovascular Health Strategy funds in 2001. The purpose of this funding is:

- to address recommendations which are not specifically the remit of the Department of Health and Children, health boards or of any one organisation,
- to engage health professionals in monitoring, clinical audit and evaluation of their work, and
- to encourage coalitions of professional organisations, academic departments and health boards in the development, implementation and evaluation of programmes.
The Government decision of 7 July, 1999 (S180/20/10/0058) provided for a strengthened Unit of general civil service posts and health professionals within the Department of Health and Children which would provide support to the implementation structures and incorporate policy responsibilities for health promotion and disease prevention. An additional Assistant Principal, Executive Officer and Clerical Officer have been recruited. A National Heart Health Advisor has also been contracted to support the work of the Department and the implementation structures and approval to appoint further professionals, health promotion officers, a nutritionist, a nurse and research officers is currently being sought.
An additional £1.5 million (£19.05m) has been allocated in 2001 to continue the implementation of the Cardiovascular Health Strategy.

As in 2000, most of the funds have been allocated to health boards but a proportion will be retained for national initiatives (see Appendix B). The following national priority areas for service development were notified to health boards and are being developed during 2001.

### 7.1 Health Promotion

Structures and resources are being put in place to ensure that health boards can build on the next phases of the national campaigns on heart healthy behaviours, including *Ireland needs a Change of Heart* (R.5.7). In addition, resources for health promotion are relevant in the hospital setting, *e.g.* for staff health promotion and support for smoking cessation. Health boards are also addressing the reduction of smoking (R5.27 & R6.30), healthy eating (R5.32) and physical activity (R5.42).

### 7.2 Primary Care

Health Boards are aiming during 2001 to ensure that necessary infrastructure for primary care is put into place, including community dieticians (R6.18) and training for community-based health professionals, having due regard to national protocols to be developed (R6.35). The appointment of co-ordinators of patient care (R8.11) is being considered to support the implementation of protocols for patient care in the community and hospital settings.
7.3 **Pre-Hospital Services**

Health Boards are addressing the following priority recommendations:

- that all ambulances be provided with automatic external defibrillators (*R7.11*),
- that all patients with a suspected acute myocardial infarction benefit from administration of aspirin (*R7.18*), and
- the implementation of an information system and clinical audit programme (*R7.3*).

7.4 **Hospital Services**

Health boards are addressing the recruitment of resuscitation training officers (*R8.1*). Subject to the outcome of the Working Group on consultant posts referred to above, boards are reviewing facilities for assessing and treating patients with coronary heart disease (*R8.17, R8.18, R8.19, R8.41, R8.42, R8.43*).

7.5 **Cardiac Rehabilitation**

Health Boards are ensuring that services are being developed so that every hospital that treats patients with heart disease provides a cardiac rehabilitation service (*R9.1*).

7.6 **Information Systems, Audit and Evaluation**

All initiatives receiving funds will be required to ensure that new information systems are compatible with a basic data set to be agreed nationally.
Appendix a

Progress on each recommendation

OVERVIEW OF CARDIOVASCULAR DISEASE

2.1
The treatment of stroke and other vascular diseases is not being considered by the implementation structures for the Cardiovascular Health Strategy.

CARDIOVASCULAR DISEASE IN IRELAND

4.1
While no national research was commissioned under the Cardiovascular Health Strategy in 2000, a number of research reports were published which have provided very beneficial data for the implementation of the Strategy, such as the Cork and Kerry Diabetes & Heart Disease Study by University College Cork. Research will be commissioned by the Cardiovascular Health Strategy later in 2001.

5.1
An additional Assistant Principal, Executive Officer and Clerical Officer have been recruited for the Cardiovascular Health Strategy. A National Heart Health Advisor has been contracted to support the work of the Department and the implementation structures and two further professionals, a health promotion officer and nutritionist are currently being sought. A number of contract posts in relation to physical activity, environment and disadvantaged, research and nursing are being considered.

5.2
A substantial proportion of Strategy expenditure to date was allocated to health promotion. Up to 70 additional staff including health promotion officers, nutritionists and other staff have been employed to carry out additional work in this area, including supporting the national campaign, Ireland needs a Change of Heart.

5.3
Has been discussed by the Heart Health Task Force and is being considered also in the context of the national health strategy.

5.4 & 5.5
These recommendations are also recommended in the Health Promotion Strategy 2000 to 2005. These recommendations are being considered by the structures established to implement the Health Promotion Strategy.

5.6
This recommendation will be brought to the attention of the Joint Oireachtas Committee on Health and Children during 2001/2002.

5.7
A national Ireland needs a Change of Heart campaign has been developed and launched. Health boards have been encouraged and funded to undertake parallel local initiatives.

5.8
Guidelines and protocols for health promotion should be included when protocols of patient care are discussed by the Advisory Forum during 2001.

5.9 & 5.10
Have been discussed by the Task Force but no...
action taken in 2000. Some reviews of health promotion in schools have been carried out by health boards.

5.11 Health promotion in the workplace continues to be developed.

5.12 Focused, sustained health promotion programmes are required to meet the needs of disadvantaged groups and communities. With the recruitment of a health promotion officer for disadvantage and the environment, the evidence-based work undertaken to date will be strengthened.

5.13 Ongoing.

5.14 Discussed by the Task Force but no specific action taken during 2000.

5.15, 5.16, 5.17, 5.18 & 5.19 Have been discussed and are being prioritised for 2002.

5.20 The first SLÁN survey published in 1999 provided data on smoking prevalence. Data are collected frequently as part of the Break the Habit, anti-smoking campaign. Another SLÁN survey is due to be undertaken in 2002.

5.21 On 28 February 2001 the Minister for Health and Children announced Government approval for the drafting of a Public Health and Tobacco Bill to give effect to the proposals in the policy document Towards a Tobacco Free Society, launched in March 2000. From the 1st day of August, 2001 the age limit at which tobacco products can legally be sold to young persons was raised from sixteen years to eighteen years.

5.22 In 2000 an additional 50p (63c) per packet of 20 cigarettes was levied on cigarettes and the additional funding was allocated for use to address health issues caused by tobacco use. The Minister for Finance has established a group between his department, the Revenue Commissioners and the CSO to look at the issue of removal of tobacco from the CPI.

5.23 The Health Promotion Unit of the Department of Health and Children runs the national anti-smoking campaign Break the Habit. A related campaign NICO was added in 2000, targeted towards teenage girls. The national programme is run in conjunction with local health boards.

5.24 Teenage girls were targeted in 2000, through the NICO campaign. General anti-smoking messages are targeted at all the population, including adults and pregnant women. No specific national campaign has been undertaken or is planned aimed at parents.

5.25 Discussed at the Task Force and will be pursued through 2001 onwards.

5.26 Some boards do undertake audits of smoking control policies in the health services and the establishment of the Tobacco Control Agency will provide a structured framework for the co-ordination of such an audit.

5.27 Health promotion officers have been employed by many boards to co-ordinate anti-smoking initiatives. Other boards unable to appoint these staff have prioritised their recruitment for 2001. Approval is being sought to recruit the tobacco health promotion officer for the Health Promotion Unit, Department of Health and Children.
5.28
The establishment of the Office of Tobacco Control provides a structure for the implementation of this recommendation.

5.29 & 5.30
Discussed by the Task Force but no progress to report during 2000. Since the Strategy was published, the Food Safety Promotion Board (FSPB) has been established and has a remit in the area of nutrition health promotion. Discussions have commenced between the Department and the FSPB to consider their respective roles in this area.

5.31
The national Healthy Eating Campaign, the focal point of which is National Healthy Eating Week, continued during 2000 with a particular focus on low income groups.

5.32
Health boards have employed 14 additional nutritionists during 2000 and the Department of Health and Children are seeking approval to recruit a senior dietitian in 2001.

5.33
No progress during 2000. This will be discussed by the Task Force.

5.34
The planning of the healthy eating campaign every year, in consultation with the widest sectors of society, considers all approaches to promoting healthy eating. This will be raised at the Task Force for further discussion.

5.35
(1) & (2)
All State receptions run by the Department of Health and Children aim to have healthy food choices, as far as possible. A group is being established by the Department of Health and Children in 2001 to look at catering and nutritional guidelines in hospitals.

(3), (4), (5), (6), & (7)
Will be advanced through the Task Force from 2001.

5.36
Both Bord Iascaigh Mhara and An Bord Glas do promote the consumption of fish and fruit and vegetables, respectively. The Task Force will establish closer links with both bodies.

5.37, 5.38 & 5.39
Healthy weight is part of the physical activity and healthy eating campaigns. However no specific campaign has been developed to limit weight increase. Halting the rise in overweight and obesity is a priority policy area for 2002 onwards.

5.40
Will be addressed as part of the primary care initiative to assess people at risk of heart disease in the community.

5.41
The Irish Sports Council is represented on the Task Force.

5.42
This report is currently being reviewed and a final report is expected during 2001.

5.43
To be discussed by the Task Force.

5.44
To be discussed by the Task Force.

5.45
To be discussed by the Task Force.

5.46
To be discussed by the Task Force.

5.47, 5.48, 5.49, 5.50 & 5.51
A review of the National Alcohol Policy is underway to establish a new five year action plan.
5.52
No national programmes have been developed. However health promotion campaigns in relation to healthy eating, physical activity and alcohol consumption contribute to maintaining blood pressure at healthy levels.

5.53
To be discussed by the Task Force.

5.54
No national programmes have been developed.

5.55
No progress to date.

5.56, 5.57 & 5.58
Some funding is available for evaluation and all campaigns are the subject of research and evaluation. These recommendations will be considered further in future years.

6.1, 6.2 6.3 & 6.4
19 additional PHNs were recruited during 2000 and additional funding was allocated for their training. A review of staffing and technological and clerical support as well as dedicated national co-ordination of PHNs’ health promotion activities did not commence in 2000.

6.5
General practitioners contribute in a variety of ways to health promotion initiatives at local level.

6.6
This is an area that will be developed over the coming years.

6.7
The European recommendations have been accepted as the basis for the proposed Secondary Prevention in General Practice (R6.23).

6.8, 6.9, 6.10, 6.11, 6.12, 6.13, 6.14, 6.15, 6.16, & 6.17
It has been agreed that the Secondary Prevention Programme will be developed as a priority. Discussions on structures and protocols for this are relevant to the future involvement of general practitioners in primary prevention of heart disease.

6.18
Four additional community dietitians were recruited in 2000 to work specifically on cardiovascular disease.

6.19 & 6.20
Not addressed during 2000 but will be progressed over future years.

6.21, 6.22, 6.23, 6.24, 6.25 & 6.26
A proposal for the First Phase of a Programme for Secondary Prevention of Cardiovascular Disease in General Practice has been submitted by the Irish College of General Practitioners and the Irish Heart Foundation and is being discussed with all interested parties.

6.27
Up to £100,000 (€126,973) was spent in 2000 on staff training for primary care and further training is planned. Smoking cessation, healthy eating, physical activity, relaxation and stress management form part of the planned training for community-based staff.

6.28
Education materials were not developed during 2000 but are under consideration to support training programmes.

6.29
NRT is available free of charge to all GMS patients from 1 April 2001.

6.30
Additional smoking cessation clinics have been developed throughout the country during 2000.
6.31
A national smoking quitline is in existence.

6.32
This will be brought to the attention of the Office of Tobacco Control.

6.33 to 6.43
Up to £100,000 (€126,973) was spent in 2000 on staff training for primary care. Further training is planned for the future. Smoking cessation, healthy eating, physical activity, relaxation and stress management form part of the planned training for community-based staff.

6.44 to 6.47
Targets are being agreed for blood pressure and blood cholesterol, as part of the proposal for Secondary Prevention of Cardiovascular Disease in General Practice (R6.23). Research into why patients with identified raised blood pressure do not receive optimum treatment has been identified as a priority issue for research. The proposed programme in General Practice will raise awareness in all health sectors of the importance of secondary prevention.

6.48 to 6.52
The Advisory Forum did not consider protocols or guidelines during 2000 but has prioritised these areas for 2001.

6.53 to 6.55
Priority has been given to discussion of the proposal for the Programme for Secondary Prevention of Cardiovascular Disease in General Practice.

7.1
The Pre-Hospital Emergency Care Council (PHECC) was established in 2000.

7.2, 7.3 & 7.3
Boards did review these areas of their services during 2000 and some invested in their development. It is a priority to have these areas addressed by the end of 2002.

7.5 to 7.10
These recommendations have been discussed between the Department of Health and Children and the Irish Heart Foundation (IHF). The IHF has undertaken a review of CPR training and its findings are currently being considered by the Department of Health and Children.

7.11
This was prioritised and reported by boards to have been achieved in 2000.

7.12
The Department will consider this recommendation in consultation with the PHECC (R7.1).

7.13
Up to £150,000 (€190,460) was spent in 2000 on training and equipment in the pre-hospital setting.

7.14
The Department of Health and Children gave initial consideration to this during 2000.

7.15
The IHF undertook an examination of ACLS training in 2000 and presented its findings in 2001. These are being considered by the Department of Health and Children.

7.16
To be discussed by the Advisory Forum.

7.17
The Department will consider this recommendation in consultation with the PHECC.

7.18
This is a priority for 2001 development by boards.
8.1
9 additional resuscitation officers were recruited to hospitals in 2000.

8.2
These recommendations have been discussed between the Department of Health and Children and the Irish Heart Foundation (IHF). The IHF has undertaken a review of CPR training and its findings are currently being considered by the Department of Health and Children.

8.3
To be discussed by the Advisory Forum.

8.4
Hospital services aim to treat patients as efficiently as possible and the additional staffing and resources to hospitals in 2000 makes this recommendation easier to achieve.

8.5
No progress at national level during 2000. However the national coronary care information system (CHAIR project) was advanced during 2000.

8.6
Some health boards have discussed issues relating to the administration of aspirin and thrombolysis to patients with suspected myocardial infarction.

8.7
Ongoing.

8.8
To be discussed by the Advisory Forum.

8.9
To be discussed by the Advisory Forum.

8.10
To be discussed by the Advisory Forum.

8.11
To be discussed by the Advisory Forum.

8.12
Ongoing.

8.13
To be discussed by the Advisory Forum.

8.14
The Advisory Forum established a Working Group in early 2001, chaired by Comhairle na nOspidéal, to assess the additional cardiology requirements, having regard to the implementation of the recommendations in Building Healthier Hearts. An interim report has been received by the Advisory Forum setting out the recommendations for 2002. The final report setting out recommendations from 2003 onwards is awaited.

8.15
Being considered by all boards as part of their service development and capital development plans.

8.16
All boards are reviewing their fast track policies for thrombolysis.

8.17 & 8.18
Ongoing and forms part of the capital development programme for boards. The Southern Health Board in CUH expanded its catherisation laboratories in 2000 and in 2001 Sligo General Hospital began a mobile catherisation laboratory service.

8.19 & 8.20
See 8.14 above.

8.21
Ongoing.

8.22 to 8.30
See 8.14 above.

8.31 & 8.32
To be considered by the Advisory Forum.
8.33 Cardiovascular committees have been established by each health board.

8.34 to 8.35 These will be considered by the Working Group on consultant cardiology appointments.

8.36 & 8.37 To be considered in the context of the Working Group report on consultant cardiology.

8.38 to 8.40 These will be considered by the Working Group on consultant cardiology appointments.

8.41 to 8.43 An additional 110 hospital staff were employed during 2000, including about 30 nurses, 20 laboratory staff and 13 secretarial staff.

8.44 Discussions on the CHAIR project were ongoing during 2000 and it is expected that the pilot of CHAIR will commence in 2001. Funding of about £225,000 (€285,691) has been allocated to the Southern Health Board for this purpose.

8.45 Ongoing.

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**CARDIAC REHABILITATION**


9.3 Being developed at regional level as part of programme development.

9.4 Trained co-ordinators are desirable, in as far as is practicable. The grading of co-ordinators is being considered by the Department of Health and Children and the Health Services Employers Agency.

9.5 To be undertaken by the Department of Health and Children in consultation with the Irish Association for Cardiac Rehabilitation (IACR)

9.6 to 9.9 Hospital-based services are a priority in the first instance, then the extension of schemes to the community setting.

9.10 An additional 44 staff were employed during 2000 to develop cardiac rehabilitation services.

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**INFORMATION, SYSTEMS, AUDIT AND EDUCATION**

All recommendations are being considered by the Advisory Forum from 2001 onwards.

10.11 Discussions on the CHAIR project were ongoing during 2000 and it is expected that the pilot of CHAIR will commence in 2001. Funding of £225,000 (€285,691) has been allocated to the Southern Health Board for this purpose.
Appendix b

Terms of reference and membership of heart health task force and advisory forum on cardiovascular health

1. HEART HEALTH TASK FORCE

The Heart Health Task Force, under the chairmanship of Dr. John Bowman, was set up to give overall direction and impetus to the implementation and review of the Cardiovascular Health Strategy and in particular to:

- take measures to ensure that momentum is maintained in the implementation, review and evaluation of cardiovascular health policy in line with the recommendations of the report of the Cardiovascular Health Strategy Group;

- review short, medium and long-term objectives proposed by the various Government Departments and other statutory bodies charged with achieving timely and co-ordinated implementation of detailed elements of the Cardiovascular Health Strategy;

- report to a Ministerial sub-group chaired by the Minister for Health and Children, on a quarterly basis;

- submit an annual progress report to the Joint Oireachtas Committee on Health and Children.

1.2 MEMBERSHIP OF THE HEART HEALTH TASK FORCE

- Chairman
  Dr. John Bowman

- Department of Health & Children
  Mr. Michael Kelly
  Dr. Jim Kiely

- Department of Finance
  Mr. John Hurley

- Department of Social, Community & Family Affairs
  Mr. Eddie Sullivan

- Department of Education & Science
  Mr. John Dennehy

- Department of Tourism, Sport & Recreation
  Ms. Margaret Hayes

- Department of the Environment & Local Government
  Mr. Jimmy Farrelly

- Department of Agriculture, Food and Rural Development
  Mr. John Malone

- Chair of Advisory Forum
  Dr. Jane Wilde

- Health Board CEOs
  Dr. Sheelah Ryan  Western Health Board
  Mr. Pat Donnelly  South Western Area Health Board

- City & County Managers
  Mr. Derek Brady  Dunlaoire/Rathdown Co Council
  Mr. Eddie Breen  Waterford Corporation

- Voluntary sector
  Ms Maureen Mulvihill  Irish Heart Foundation
  Dr. Luke Clancy  ASH Ireland
2. ADVISORY FORUM ON CARDIOVASCULAR HEALTH

An independent Advisory Forum, under the chairmanship of Dr. Jane Wilde, is supporting the work of the Heart Health Task Force. The Advisory Forum advises the Heart Health Task Force on

* best practice in cardiovascular disease prevention, detection, treatment and rehabilitation
* the evaluation of the effectiveness and quality of cardiovascular services
* the co-ordination of research into cardiovascular disease

It also advises the Department of Health and Children on major policy issues which arose from the implementation of the Strategy and the development and implementation of protocols for the treatment and care of cardiovascular patients.

2.1 MEMBERSHIP OF ADVISORY FORUM

**CHAIR:**
Dr. Jane Wilde, Director, Institute of Public Health

Dr. Eibhlín Connolly, Deputy Chief Medical Officer, Department of Health & Children

Dr. Sean Denyer, Director of Public Health, North Western Health Board.

Ms. Sharon Foley, Health Promotion Manager, Midland Health Board

Prof. John H Horgan, Consultant Cardiologist, Beaumont Hospital, Dublin

Mr. John Lahiff, Co-ordinator of Health Promoting Schools, Marino Institute of Education, Dublin

Ms. Carmel Mangan, Director of Nursing, Blackrock Clinic, Dublin

Prof. Andrew Murphy, Department of General Practice, NUI, Galway

Prof. Hannah Walsh, Consultant Cardiologist, St James’s Hospital, Dublin

In attendance from the Department of Health & Children
Mr. Chris Fitzgerald
Dr. Emer Shelley
Mr. Brian Brogan
Ms. Patsy Carr
Ms. Ursula O’Hanlon
Mr. Paul Flanagan
Appendix C

Allocation of funding to health authority/boards & national initiatives

1. DISTRIBUTION OF FUNDING TO HEALTH AUTHORITY/BOARDS

<table>
<thead>
<tr>
<th>Health Authority/Board</th>
<th>Allocation in 2000 £ MILLION</th>
<th>Allocation in 2000 € MILLION</th>
<th>Allocation in 2001 £ MILLION</th>
<th>Allocation in 2001 € MILLION</th>
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<td>1.27</td>
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<tr>
<td>North Eastern Health Board</td>
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<tr>
<td>North Western Health Board</td>
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<tr>
<td>South Eastern health Board</td>
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<tr>
<td>Southern Health Board</td>
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<td>2.20</td>
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<td>Western Health Board</td>
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<td>1.00</td>
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</tbody>
</table>

2. NATIONAL INITIATIVES

2.1 2000 FUNDING

In 2000, £2 million (€2.54) was retained for national initiatives. The following breakdown of expenditure incurred:

<table>
<thead>
<tr>
<th>Description</th>
<th>£</th>
<th>€</th>
</tr>
</thead>
<tbody>
<tr>
<td>National mass media campaign <em>Ireland needs a Change of Heart</em> and some funding towards an anti-smoking campaign targeted specifically at young girls</td>
<td>1,000,000</td>
<td>1,269,738</td>
</tr>
<tr>
<td>Slí na Sláinte</td>
<td>50,000</td>
<td>63,486</td>
</tr>
<tr>
<td>National Heart Alliance Conference</td>
<td>17,000</td>
<td>21,586</td>
</tr>
<tr>
<td>Cardiac technician training</td>
<td>243,000</td>
<td>308,546</td>
</tr>
<tr>
<td>PHECC set-up costs</td>
<td>250,000</td>
<td>317,436</td>
</tr>
<tr>
<td>STAG</td>
<td>50,000</td>
<td>63,486</td>
</tr>
<tr>
<td>Lecturer in Royal College of Surgeons of Ireland</td>
<td>15,000</td>
<td>19,046</td>
</tr>
<tr>
<td>Order of Malta</td>
<td>10,000</td>
<td>12,697</td>
</tr>
<tr>
<td>50% cost of pharacoepidemologist at St James’s</td>
<td>10,000</td>
<td>12,697</td>
</tr>
<tr>
<td>Cardiac waiting lists</td>
<td>100,000</td>
<td>126,973</td>
</tr>
<tr>
<td>Staffing and consultancy</td>
<td>170,000</td>
<td>215,855</td>
</tr>
<tr>
<td>Health Promoting Hospitals Network</td>
<td>50,000</td>
<td>63,486</td>
</tr>
<tr>
<td>Venues and associated costs for meetings</td>
<td>35,000</td>
<td>44,440</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,000,000</strong></td>
<td><strong>2,539,476</strong></td>
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</tbody>
</table>
2.2 2001 FUNDING

The Inter-divisional Working Group identified the following national initiatives to be undertaken in 2001. As with 2000, £2m (£2.54m) was set aside in 2001 for these national initiatives. In general, these national initiatives have grown out of the work of the Advisory Forum and its sub-groups.

- The first phase of a programme in general practice for the secondary prevention of cardiovascular disease
- The provision of nicotine replacement therapy to GMS patients – not being funded by Cardiovascular Health Strategy funds
- A Working Group will be established to develop a five year action plan for the orderly development of consultant-led services
- A pilot coronary heart attack register (CHAIR project)
- Health promotion campaign Ireland needs a Change of Heart Phase 2
- The re-establishment of a national cardiac surgery register
- Research, evaluation and clinical audit initiative
- Staffing/committees
Appendix D

Cardiovascular strategy – building healthier hearts

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Total posts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care &amp; Pre-Hospital</strong></td>
<td>36</td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>19</td>
</tr>
<tr>
<td>Community Nutritionists</td>
<td>5</td>
</tr>
<tr>
<td>Ambulance Crews</td>
<td>5</td>
</tr>
<tr>
<td>Doctor</td>
<td>2</td>
</tr>
<tr>
<td>Support Staff</td>
<td>5</td>
</tr>
<tr>
<td><strong>Hospitals</strong></td>
<td>116</td>
</tr>
<tr>
<td>Dietitians</td>
<td>11</td>
</tr>
<tr>
<td>Technicians</td>
<td>24</td>
</tr>
<tr>
<td>Nurses</td>
<td>40</td>
</tr>
<tr>
<td>Resuscitation Officers</td>
<td>9</td>
</tr>
<tr>
<td>Technical Support Staff</td>
<td>19</td>
</tr>
<tr>
<td>Secretarial/Clerical</td>
<td>13</td>
</tr>
<tr>
<td><strong>Cardiac Rehabilitation</strong></td>
<td>38</td>
</tr>
<tr>
<td>Co-ordinators</td>
<td>17</td>
</tr>
<tr>
<td>Physiotherapy/Occupational therapy</td>
<td>7</td>
</tr>
<tr>
<td>Dietitians</td>
<td>6</td>
</tr>
<tr>
<td>Support Staff</td>
<td>8</td>
</tr>
<tr>
<td><strong>Health Promotion</strong></td>
<td>70</td>
</tr>
<tr>
<td>Health Promotion Officers</td>
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</tr>
<tr>
<td>Smoking</td>
<td>12</td>
</tr>
<tr>
<td>Nutrition</td>
<td>14</td>
</tr>
<tr>
<td>Physical Activity/Workplace &amp; General</td>
<td>28</td>
</tr>
<tr>
<td>Environmental Health</td>
<td>5</td>
</tr>
<tr>
<td>Support Staff</td>
<td>11</td>
</tr>
<tr>
<td><strong>Audit/and Health Board Co-ordination</strong></td>
<td>28</td>
</tr>
<tr>
<td>Administration</td>
<td>23</td>
</tr>
<tr>
<td>Research</td>
<td>5</td>
</tr>
</tbody>
</table>
ABBREVIATIONS

ACLS  Advanced Cardiac Life Support
CARE  Community Action in Response to Emergencies
CHAIR Coronary Heart Attack Ireland Register
CHD  Coronary Heart Disease
CPI  Consumer Price Index
CPR  Cardiopulmonary resuscitation
CSO  Central Statistics Office
CUH  Cork University Hospital
ECG  Electrocardiogram
ERHA Eastern Regional Health Authority
FSPB Food Safety Promotion Board
GMS  General Medical Services
IARC Irish Association for Cardiac Rehabilitation
IBEC Irish Business and Employers Confederation
ICTU Irish Congress of Trade Unions
IHF  Irish Heart Foundation
NCCA National Council for Curriculum Assessment
NRT  Nicotine replacement therapy
PACE Personal Assistance in Choosing Exercise
PHECC Pre-Hospital Emergency Care Council
PHN  Public health nurse
SLAN Survey of Lifestyles, Attitudes and Nutrition
SPHE Social, Personal and Health Education
STAG Smoking Target Action Group