Implementation of the Cardiovascular Health Strategy

work programme 2001-2004

ADVISORY FORUM ON CARDIOVASCULAR HEALTH

Introduction

This Work Programme 2001-2004 sets out the priorities in implementing the 211 recommendations in the Cardiovascular Health Strategy Report *"Building Healthier Hearts"*. This document, compiled by the Advisory Forum on Cardiovascular Health, will assist the Heart Health Task Force, the Department of Health and Children, the health boards and other key stakeholders in the implementation process.

This Work Programme will support:

- A cohesive, coherent and effective implementation process;
- Service planning by the Department of Health and Children, health boards and other agencies;
- Identification of the timing and estimation of the resources necessary to implement the Cardiovascular Health Strategy; and
- Identification of necessary linkages with government departments and voluntary organisations.

Prioritisation of the recommendations has been an important aspect of the work of the sub-groups of the Advisory Forum on Cardiovascular Health. Advice from the Forum and its sub-groups informed the planning and funding process for implementing the Cardiovascular Health Strategy in 2001 and 2002. In this regard, recommendations under 2001 in the Work Programme refer to those prioritised since the launch of the Strategy to the end of 2001.

Some of the sub-groups were assisted in identifying priorities by consultation meetings. The Sub-group on Health Promotion held such a meeting in association with the National Heart Alliance in December 2000. The Hospital sub-group was informed by a meeting with key stakeholders organised by the Irish Heart Foundation in association with the Advisory Forum in May 2001. While the Primary Care sub-group had identified priorities early in 2001, the process was informed by a similar Irish Heart Foundation / Forum meeting held in October 2001. The Advisory Forum and its sub-groups are grateful to the National Heart Alliance, the Irish Heart Foundation and the many people who gave willingly of their time and expertise in the consultative process.

The Advisory Forum wishes to draw attention to the following recommendations, which are of fundamental importance in implementing the Cardiovascular Health Strategy.

R5.3 The development of a physical and social environment which 'makes the healthier choice the easier choice' should be a priority for all government, statutory and voluntary agencies.

R5.4 A health impact assessment should be carried out when government departments, including Finance, and other agencies such as local authorities are formulating policy and making decisions which may be related to or affect human health.

R6.21 Secondary prevention for most patients with cardiovascular disease should be provided in the general practice setting.

> The Advisory Forum believes that consideration should be given each year to incremental capacity building of general practice through the support of practice nurses whose remit would be largely devoted to the management of cardiovascular disease.

R7.14 The necessary legislation should be enacted to enable EMTs (emergency medical technicians) to administer cardiac care drugs.

R8.38 All tertiary referral centres should have a minimum of five consultant cardiologists. Selected centres should have specialists in EPS (electrophysiology studies).

R8.39 Regional centres which are performing diagnostic tests, including angiography, and inserting pacemakers, should have at least two cardiologists.

R8.40 Each acute general hospital should have a physician with appropriate training in cardiology.

R9.1 Every hospital that treats patients with heart disease should provide a cardiac rehabilitation service.

R10.1 A cardiovascular disease surveillance system should be established.

The overall implementation of the Cardiovascular Health Strategy will be given a major impetus by the publication of the national health strategy. Implementation of the recommendations on information systems will need to be set in the context of the forthcoming national health information strategy. The Advisory Forum on Cardiovascular Health looks forward to contributing to strategic developments in services for health promotion, disease prevention, treatment and rehabilitation of patients, and to the establishment of a surveillance system for cardiovascular diseases in Ireland, to complete the implementation of the Cardiovascular Health Strategy.

This Work Programme provides an explicit basis for planning, monitoring and evaluating the implementation of the Cardiovascular Health Strategy, based on consultation with key stakeholders. Some of the recommendations have already been implemented and for others substantial progress has been made. While there will inevitably be unanticipated difficulties and delays in some aspects of implementation, the Advisory Forum and its sub-groups will endeavor to support the process in every way possible. This Work Programme will form a template against which progress and success by all of the agencies involved can be assessed.

Dr. Jane Wilde Chairperson, Advisory Forum
Members of the Forum: Dr. Sean Denyer, Ms. Sharon Foley, Prof. John H. Horgan, Mr. John Lahiff, Ms. Carmel Mangan, Prof. Hannah McGee, Prof. Andrew Murphy, Mr. Aonghus O'Donnell, Prof. Michael Walsh and Dr. Eibhlín Connolly.

November 2001

2001

Health Promotion

2001		
Health Promotion	**Rec. No.**	**Recommendation**
	R5.1	The Health Promotion Unit of the Department of Health and Children should be substantially empowered. It should have additional professional staff to support implementation of health promotion strategies recommended in this document. Staff should include the health promotion co-ordinator and senior dietician recommended in R5.27 and R5.32.
	R5.3	The development of a physical and social environment which 'makes the healthier choice the easier choice', should be a priority for all government, statutory and voluntary agencies.
	R5.7	National mass media campaigns should be integrated with regional and local programmes so as to maximise the effectiveness of each type of approach.
	R5.10	The implementation of health education programmes in schools should be monitored. A networking and audit system should be put in place to promote the exchange of information and the development of quality standards by schools and teachers.
	R5.21(2)	The legislation on the sale of tobacco to minors should be amended to empower environmental health officers to enforce the legislation. The age at which it is illegal to sell tobacco to minors should be increased to 18 years.
	R5.23	There should be an annual national 'quit smoking' programme, with sponsorship from appropriate sources, including the National Lottery. This should be integrated with regional and local health promotion initiatives, including counselling services.
	R5.25	Sporting organisations should be encouraged to ban smoking by spectators during sporting events.

	R5.26	The Department of Health and Children should undertake a regular audit of the implementation of smoking control policies in the health services.
	R5.27	Ten health promotion officers should be appointed (one per health board and one per area in the proposed Eastern Health Authority region) to co-ordinate health promotion to reduce smoking prevalence at local level. One senior health promotion officer should be appointed to the Health Promotion Unit in the Department of Health and Children to co-ordinate these initiatives. Three sets of three-year targets should be set and there should be an annual audit of progress in achieving the targets.
	R5.29	The Food Safety Authority of Ireland should review progress on the implementation of 'Recommendations for a Food and Nutrition Policy for Ireland.'
	R5.31	Targeted, focussed, sustained programmes should be implemented to promote healthy eating, especially for those on low incomes and in other at risk groups.
	R5.32	A further ten community dietitians should be employed by the health boards in the next three years. Existing professional expertise in the Health Promotion Unit of the Department of Health and Children should be expanded; a fulltime senior dietitian should be appointed to further develop nutrition policy and co-ordinate health promotion by community dietitians.
	R5.35(1)	Healthy food choices should be offered on menus when food is provided in State-funded organisations. Minimum standards should be established, included in catering contracts and assessed by catering audits.
	R5.35(3)	School 'tuck shops' should offer high starch foods such as sandwiches, bread rolls or scones, fruit, fruit juices and other healthy food choices. Where in-school catering is provided, a range of food should be offered, including healthy food choices.
	R5.41	The Cardiovascular Health Strategy Group endorses the Sports Council's proposals in 'Targeting Sporting Change in Ireland' to promote sport among young people and adults.

	R5.42	The Cardiovascular Health Strategy Group supports the health boards' physical activity strategy.
	R5.44	National Lottery funding for sporting organisations should be contingent on involvement through those organisations of people at all levels of ability.
	R5.45	Local authorities should provide sufficient footpaths, which are accessible, safe and well-maintained. They should provide accessible leisure facilities, where appropriate in association with community or commercial organisations, and become involved in the promotion of physical activity.
	R5.47	The Cardiovascular Health Strategy Group welcomes the National Alcohol Policy.
	R5.48	The HPU of the Department of Health and Children should define its timetable for implementation of the National Alcohol Policy and co-ordinate activities at national level.
	R5.49	Legislation on the sale of alcohol to persons aged under 18 years should be enforced.
	R5.50	Advertisements for alcohol, containers of alcoholic drink (bottles, cans etc.) and off-licence premises should carry a written warning about the effects of excess alcohol on health.
	R5.51	Progress in implementing the National Alcohol Policy and in attaining its targets should be assessed as part of the proposed audit of progress in improving health behaviours.
	R5.56	Additional funding for monitoring and evaluation should be available to the Health Promotion Unit of the Department of Health and Children.
	R5.57	A set of indicators should be agreed nationally to assess progress in attaining targets relevant to cardiovascular disease.
	R5.58	Health promotion practitioners should be supported to agree quality standards and to undertake process evaluation and practice audit.

2001

Primary Care

2001	
Primary Care	**The commencement of the first phase of a national programme in general practice for the secondary prevention of cardiovascular disease.**

Primary Care	Rec. No.	Recommendation
	R6.29	Nicotine Replacement Therapy should be included in the list of drugs which maybe prescribed within the GMS scheme.
	R6.40	Where an appropriate choice of leisure facilities is available, a pilot exercise prescription programme should be implemented in general practice for those identified as being at high risk of cardiovascular disease.

Note: Several recommendations will be addressed in this first phase of the secondary prevention programme.

The Advisory Forum believes that consideration should be given each year to incremental capacity building of general practice through the support of practice nurses whose remit would be largely devoted to the management of cardiovascular disease.

2001

Pre-hospital Care

2001		
Pre-hospital Care	**Rec. No.**	**Recommendation**
	R7.1	The NAAC should be established on a statutory basis with responsibility for developing professional and performance standards for ambulance services and personnel.
	R7.14	The necessary legislation should be enacted to enable EMTs to administer cardiac care drugs.
	R7.11	The remaining ambulances, which are not currently equipped with an AED, should be provided with one as a matter of urgency. Unresolved issues in the provision of ambulance services for Dublin should be resolved forthwith.

2001

Hospital Services

2001		
Hospital Services	**Rec. No.**	**Recommendation**
	R8.1	A resuscitation training officer should be appointed in each general hospital and at least one wholetime resuscitation training officer per health board area.
	R8.3	A 'call to needle' time of ninety minutes should be accepted as the audit standard in Ireland.
	R8.4	Patients requiring thrombolysis should receive it within 30 minutes of arrival at the Accident and Emergency Department.
	R8.6	Each health board should convene a group to establish protocols for the efficient administration of aspirin and thrombolysis to AMI patients.
	R8.9	Secondary prevention, including support for necessary lifestyle changes, should be an integral component of care in all patients with cardiovascular disease.
	R8.12	Risk factors for recurrence should be assessed and appropriately managed in all patients with cardiovascular disease.
	R8.14	Each hospital admitting patients with acute cardiac problems should have an appropriately trained physician.
	R8.17	Health boards and hospitals should examine the facilities available for the assessment of acute chest pain in order to provide timely access to cardiac assessment for patients with recent onset of chest pain and to avoid unnecessary admissions.
	R8.18	Each hospital admitting patients with acute cardiac problems should have a Cardiac Investigation Area with appropriate staff and facilities.
	R8.19	Each acute hospital should have echocardiography facilities. Each such hospital should have a physician with training to carry out these investigations. Each region should have one cardiologist with special expertise in echocardiography.

	R8.22	Angiographic facilities should be provided as close as possible to the population served. A cardiac catheterisation service should be developed or specific referral arrangements agreed for those health boards in which there is no such service at present.
	R8.23	Day case facilities should be made available specifically for angiography and maintained as an essential component of this service.
	R8.34	There should be formal referral arrangements between acute general hospitals, regional and tertiary centres to facilitate access to more sophisticated diagnostic and treatment services.
	R8.35	Particular attention should be paid to the coordination of services in the Eastern region. There should be a balance in the distribution of specialist expertise across geographic areas within the Region.
	R8.41	Each hospital that admits patients with acute cardiac conditions should ensure that competent staff are on duty at night and at the weekend to care for such patients.
	R8.42	Nursing staffing levels should be examined as a matter of urgency. Appropriate steps should be taken to acquire and retain the skilled nursing staff necessary for a modern cardiology service.
	R8.43	Technical and secretarial staff should be appointed to support the proposed developments in cardiology services.

2001

Cardiac Rehabilitation

2001		
Cardiac Rehabilitation	**Rec. No.**	**Recommendation**
	R9.1	Every hospital that treats patients with heart disease should provide a cardiac rehabilitation service.
	R9.2	The programme should be multidisciplinary and usually exercise-based. Information should be provided in a variety of formats and family members should be involved.
	R9.3	Consultant leadership is necessary to develop and maintain programmes. This should most appropriately be provided by a cardiologist or by a senior doctor dealing with cardiac patients.
	R9.4	All rehabilitation programmes should have a trained co-ordinator. An appropriate grading should be applied to these posts within the health service.
	R9.5	A standard format of audit should be agreed nationally to allow comparison between programmes. Individual programmes should evaluate their outcome.
	R9.6	Phase 1 (in-hospital) cardiac rehabilitation should be part of the routine management of cardiac patients, with protocols and audit mechanisms to ensure that full coverage of relevant issues is achieved for each patient.
	R9.8	Phase 3 (intermediate post-discharge) cardiac rehabilitation has been extensively researched. We recommend the model widely used internationally.
	R9.10	Provision of adequate funding for staff training, equipment and facilities needs to be made available as a matter of urgency.

2001

Information Systems, Audit and Research

2001		
Information Systems Audit and Research	**Rec. No.**	**Recommendation**
	R10.11	A pilot study of the development of a hospital-based register should proceed immediately. The lessons from this study should be used to establish a hospital-based register of coronary care.
	R10.12	A patient-based information system should be established in at least one hospital referral centre to track patients from initial diagnosis.
	R10.21	Funding should be made available to undertake the priority research identified in this report.

2002

Health Promotion

2002		
Health Promotion	**Rec. No.**	**Recommendation**
	R5.2	Health services must be reoriented to place a greater emphasis on health promotion and disease prevention. An implementation programme to achieve this must be established and a meaningful additional budget allocation must be provided to fund this change.
	R5.4	A health impact assessment should be carried out when government departments, including Finance, and other agencies such as local authorities are formulating policy and making decisions which may be related to or affect human health.
	R5.5	Criteria should be agreed to assess the health impact of planning decisions relating to housing, transport and leisure facilities.
	R5.6	The Joint Oireachtas Committee on Health and Children should monitor the effect on health of policy and planning decisions of all government departments.
	R5.9	Health education curriculum and materials for Social and Personal Health Education and other relevant subjects should be reviewed to ensure coverage throughout the school years of healthy eating, physical activity, avoidance of tobacco and the effects of alcohol.
	R5.11	The Cardiovascular Health Strategy Group endorses the recommendations of the Sub-committee on Health Promotion in the Workplace of the National Consultative Committee on Health Promotion.
	R5.12	Evidence-based, focussed, sustained initiatives should be developed to promote cardiovascular health in disadvantaged groups and communities.
	R5.13	The Cardiovascular Health Strategy Group endorses the recommendations of the Sub-committee on Young People of the National Consultative Committee on Health Promotion.
	R5.15	Community health promotion programmes should facilitate appropriate involvement of local general practice and hospital personnel.

	R5.16	Community-based health promotion initiatives should be developed for older people at high risk or with detected cardiovascular disease. Appropriate liaison should be established between such programmes and health services personnel providing cardiac rehabilitation services and those providing clinical services for older people.
	R5.17	Evidence-based health promotion programmes should be incorporated into the health services provided to older people and to pregnant women.
	R5.18	There should be special initiatives to provide a health promoting environment for health services personnel. The experience gained can be utilised in the development of good health promotion practice in other workplaces.
	R5.19	Health services staff should be supported to develop and maintain heart healthy lifestyles.
	R5.20	It is recommended that data on tobacco smoking prevalence in adults be collected on an annual basis.
	R5.21(1)	The Department of Health and Children and the Department of Justice should review existing tobacco control legislation and take the necessary steps to ensure it is fully implemented. Legislation should be extended to other areas such as the workplace, eating areas in public houses and all areas where children gather to protect people from exposure to environmental tobacco smoke.
	R5.21(3)	A licensing system should be operated for the sale of tobacco products. Loss of the licence should be a sanction for breaches of the law or of the conditions attached to the licence.
	R5.22(1)	Tobacco should be removed forthwith from the list of items in the Consumer Price Index.
	R5.22(2)	The annual taxation increase on tobacco should be significantly above that necessary to keep pace with inflation.
	R5.22(3)	The additional tax collected over and above that added to compensate for inflation should be used for new health education initiatives.

	R5.24(1)	Research should be carried out on parents' attitudes to their children smoking.
	R5.24(3)	An ongoing health promotion and media campaign is required to raise awareness among parents, teachers, youth workers and retailers of the importance of supporting children not to start to smoke.
	R5.24(4)	An annual module on smoking should be included in the Social and Personal Health Education (SPHE) programme in schools. Peer led programmes should be implemented as well as other initiatives which have been effective in reducing smoking prevalence in children in other countries.
	R5.28	A Tobacco Task Force should be established with a remit to reduce smoking prevalence in Irish adults and children. All relevant government departments, including Finance, should be involved as well as statutory, business, trade union & voluntary agencies
	R5.30	The Food Safety Authority of Ireland should establish structures and processes to improve communication about nutrition between all relevant agencies.
	R5.34	Creative approaches should be used to market healthy eating messages. Sponsorship from commercial companies could include heart health messages on food products, for example, on breakfast cereal packets or milk cartons.
	R5.35(7)	Innovative solutions are required to increase access to healthy food choices by low income groups and in rural areas, particularly to fish, and fresh fruit and vegetables.
	R5.36	An Bord Iaschaigh Mhara (BIM) should undertake special promotions to increase consumption of oily fish, such as mackerel and herrings. An Bord Glas should increase its initiatives to promote the consumption of fruit and vegetables.
	R5.37	Priority groups for primary prevention to limit weight increase with age should be identified and targeted with health promotion programmes.
	R5.38	When supporting smokers to quit their habit, attention should be paid to the avoidance of excessive weight gain.

	R5.39	Those who are overweight should receive advice from health professionals about avoidance of further weight gain. Training in 'skills for change' should be provided for relevant health professionals (R6.33)
	R5.40	Those who are obese should have their overall risk of cardiovascular disease assessed. They should be counselled and referred to a dietitian for nutrition advice and support (R6.18).
	R5.43	National sporting organisations should provide facilities and establish targets for participation in recreational sports by men and women, young and old.
	R5.46	Information systems should be established to assess progress towards attaining health targets on physical activity.
	R5.53	The Food Safety Authority of Ireland should examine dietary salt intake and advise on a national policy on salt.

2002

Primary Care

2002		
Primary Care	**Rec. No.**	**Recommendation**
	R6.3	A review of staffing and of technological and clerical support in health board health promotion departments should be undertaken by the Department of Health and Children in order to estimate resource requirements to implement these recommendations.
	R6.7	It is recommended that the European Society of Cardiology priorities for prevention of cardiovascular disease in clinical practice be adopted within the health services in Ireland.
	R6.21	Secondary prevention for most patients with cardiovascular disease should be provided in the general practice setting.
	R6.22 (R8.10)	Protocols for shared care of such patients should be agreed at national level with adaptation regionally as appropriate to local circumstances.
	R6.23(1)	Appropriate financial and administrative arrangements should be made to pay for secondary prevention for patients with cardiovascular disease within general practice.
	R6.23(2)	GMS patients should be entered into a 'Follow-up Scheme'.
	R6.23(3)	Patients not covered by the GMS should also be entered into the follow-up Scheme with some financial reimbursement of costs to the patient, either through the GMS or through health insurance schemes.
	R6.24	As with prevention in those identified as being at high risk: R6.24(1) There should be financial incentives for general practitioners to implement computerised information systems for systematic follow-up of patients with cardiovascular disease; R6.24(2) Specially trained practice nurses should provide much of the counselling and follow-up required by these patients; R6.24(3) Counselling and follow-up should be supported by community dietitians.

	R6.25	Patients with diabetes should be included in programmes for prevention of cardiovascular disease in general practice in a manner similar to patients who have known cardiovascular disease.
	R6.26	Protocols should be agreed for shared care (between hospital consultants and general practitioners) of patients with diabetes, including targets for risk factor reduction.
	R6.28	Education materials for each of the stages in the behaviour change process should be available to health professionals to provide to clients who smoke.
	R6.34	Appropriate education materials should be developed for use in primary care. These should include posters, leaflets and videos. Special materials should be available for those with low levels of literacy or on low incomes.
	R6.45	Research should be carried out on the reasons why those identified as having high blood pressure are not being followed-up or are not receiving treatment.
	R6.47	A monitoring system for secondary prevention should be established, compatible with the EUROASPIRE protocol.
	R6.48	Guidelines for the treatment of chronic cardiovascular and related conditions in general practice (angina, heart failure, post-AMI, post-stroke, peripheral vascular disease, diabetes) should be agreed nationally and adapted for use at local level.
	R6.49	Protocols for shared care should be agreed for patients with chronic cardiovascular and related conditions who are referred for assessment and treatment in an acute hospital.

	R6.50	A pilot project should be undertaken to provide improved hospital-based support for general practitioners caring for patients with chronic cardiovascular conditions.
	R6.53	Arrangements should be made with the ICGP to address developments proposed in this report within the continuing medical education system of the College
	R6.54	Funding should be provided for a quality initiative on cardiovascular disease as part of the quality programme of the ICGP.
	R6.55	Funding should be provided for the preparation of an annual report by the ICGP on progress in the implementation of the recommendations of this report.

2002

Pre-hospital Care

2002		
Pre-hospital Care	**Rec. No.**	**Recommendation**
	R7.2(1)	The recommendation of the Ambulance Review Group that there should be a single command and control centre in each health board should be implemented;
	R7.2(2)	Each health board should review its communication systems
	R7.2(3)	Prioritised dispatching should be implemented in each health board.
	R7.3	Emergency ambulance services should implement an information system and clinical audit programmes to assess the extent to which the response to cardiac emergencies in the pre-hospital setting reaches required standards.
	R7.4	Up-to-date information should be obtained on response times by the emergency services. The time to treatment of patients with acute sustained chest pain and the reasons for delays in accessing care must be identified. This baseline information should be used to establish targets for response times and for times to reaching coronary care.
	R7.7	A review of community CPR training programmes should be undertaken to assess progress in providing quality training in a range of settings and to integrate this with other lifestyle and heart health promotion programmes.
	R7.8	Further expansion of community CPR training programmes is recommended in each health board.
	R7.9	CPR training should be provided for relatives of patients with CHD who wish to avail of it.
	R7.10	The potential to link community CPR training schemes with first responder defibrillation schemes should be explored.
	R7.18	Immediate steps should be taken to insure that all patients with a suspected AMI benefit from early administration of aspirin.

2002

Hospital Services

2002		
Hospital Services	**Rec. No.**	**Recommendations**
	R8.10	As in R6.22, protocols should be agreed at national level for shared care of patients with chronic cardiovascular disease, with special attention to secondary prevention.
	R8.15	Each hospital admitting patients with acute cardiac problems should have a CCU with adequate staff and facilities. Where deficiencies exist in CCUs with regard to number of beds, equipment and staffing, such deficiencies should be remedied. Ongoing staff training should be provided, including secondment to tertiary referral centres.
	R8.40	As in R8.14, each acute general hospital should have a physician with appropriate training in cardiology.

2002

Information Systems, Audit and Research

2002		
Information Systems, Audit and Research	**Rec. No.**	**Recommendation**
	R10.1	A cardiovascular disease surveillance system should be established; the surveillance system should: • analyse and report on routinely collected data; • access information from cardiovascular disease registers; • access information from population surveys of disease symptoms and medical history, health behaviour and risk factors for cardiovascular disease; • make information accessible and proactively disseminate it to health professionals and to the public; • provide information to support clinical audit and the planning of health services.
	R10.2	In the hospital setting the cause of death section of the death certificate should be completed by a hospital consultant. Training should be provided to increase knowledge of the process and to raise awareness of its importance.
	R10.3	Research should be undertaken into the quality of evidence on which death certificate diagnosis are made in Ireland. The extent to which an increase in the autopsy rate is required to improve the accuracy of death certificate diagnosis should be investigated.
	R10.4	A national validation exercise should be undertaken using case histories to examine variations in the assignation of cause of death within Ireland.
	R10.19	A protocol should be agreed for surveys of health behaviours among school pupils and young people.
	R10.20	Schemes should be established for clinical audit of the care of patients with cardiovascular disease.

2003

Health Promotion

2003		
Health Promotion	**Rec. No.**	**Recommendation**
	R5.4	A health impact assessment should be carried out when government departments, including Finance, and other agencies such as local authorities are formulating policy and making decisions which may be related to or affect human health.
	R.5.5	Criteria should be agreed to assess the health impact of planning decisions relating to housing, transport and leisure facilities.
	R5.8	The experience of evaluated health promotion projects should be distilled into a set of guidelines for good practice.
	R5.14	A network should be formed of community development projects with a health promotion component to provide opportunities for mutual support and the exchange of information.
	R5.24(2)	Media and education campaigns should be undertaken to discourage adults smoking when babies and children are present.
	R5.33	The feasibility of providing financial incentives towards healthy food choices should be examined, for example, reduced pricing for skim and low fat milk compared with whole milk.

	R5.35(1)	Healthy food choices should be offered on menus when food is provided in State-funded organisations. Minimum standards should be established, included in catering contracts and assessed by catering audits.
	R5.35(2)	Health service institutions should act as models of good practice in the provision of healthy food choices.
	R5.35(4)	Workplace restaurants should be encouraged to provide healthy food choices and to participate in catering audits.
	R5.35(5)	Education initiatives with catering companies should be continued.
	R5.35(6)	Welfare agencies should carry out pilot projects with families on low incomes to enable them to provide sufficient and varied food to meet all their nutritional requirements.

2003

Primary Care

2003		
Primary Care	**Rec. No.**	**Recommendation**
	R6.1	All public health nurses should be supported to further develop their skills in health promotion and to opportunistically contribute to disease prevention in those with whom they come in contact.
	R6.2	Some public health nurses should be assigned to work at least half time in a disease prevention and health promotion role as members of the health boards' health promotion teams. A staffing level of two whole-time equivalents per 100 000 is recommended.
	R6.4	Co-ordination at national and local level is required to maximize the efficiency of health promotion activities by public health nurses, other community based health professionals and health promotion officers.
	R6.11	A process should be agreed with the ICGP to establish patient registers in general practice. There should then be media campaigns to encourage those not covered by the GMS to register with the GP of their choice.
	R6.18(1)	Community dietitians should be employed to support cardiovascular disease risk reduction initiatives in general practice, including training, patient counseling and health promotion. The aim should be to provide 1 clinical community dietitian per 100 000 population over a five year period.
	R6.18(2)	When additional community dietitians are appointed their work for the first five years should be confined to conditions relating to cardiovascular disease – CHD, stroke, hypertension, other atherosclerotic conditions, diabetes mellitus and obesity.
	R6.27	All health professionals should receive training on how they can support clients to quit smoking.
	R6.30	Smoking cessation clinics should be provided throughout the country and their availability should be well publicized. They should be run by either public health nurses or by practice nurses, as agreed locally.

	R6.31	There should be a national telephone advice helpline for people seeking support to quit smoking. The feasibility of involving trained volunteers in this service should be investigated.
	R6.32	The annual report from the Tobacco Task Force (R5.28) should include a progress report on relevant education, materials, training and services for smoking cessation in primary care. This report should be prepared by the national health promotion officer with responsibility for cardiovascular health (R5.27).
	R6.33	General practitioners and practice nurses should receive training to provide advice and support for necessary lifestyle changes to those at high risk or who have had a cardiovascular event; training should address smoking cessation (R6.27), healthy eating and alcohol use, physical activity (R6.38) and stress management.
	R6.35	Training of community-based health professionals should be a priority function of community dietitians (R6.18).
	R6.37	Pilot projects should be undertaken in different locations, metropolitan, urban and rural, to assess the feasibility of running 'lifestyle classes', including information sessions, physical activity training and relaxation techniques for those in cardiovascular risk management programmes.
	R6.38	General practitioners and practice nurses should receive training and have appropriate education materials to provide advice and support to promote safe physical activity in those at high risk or who have had a cardiovascular event (see R6.33 and R6.34).
	R6.39	Physical activity training should be an integral component of the lifestyle classes pilot projects (R6.37).

	R6.41	General practitioners and practice nurses should receive training and have appropriate education materials to provide advice and support to promote relaxation and stress management in those at high risk or who have had a cardiovascular event (see R6.33 and R6.34).
	R6.42	Specially trained practice nurses should provide advice on stress management to people in risk management programmes.
	R6.51	A national protocol should be agreed for the acute care of patients with suspected acute coronary syndromes or stroke. The protocols should be adapted for local use. Protocols should be updated annually.
	R6.52	Information on the provision of thrombolysis by general practitioners should be reviewed. When sufficient information is available, recommendations on general practitioner administration of thrombolysis and defibrillation should be included in national and local treatment protocols.

2003

Pre-hospital Care

2003		
Pre-hospital Care	**Rec. No.**	**Recommendation**
	R7.5	A public education campaign should be undertaken to raise awareness of the symptoms of AMI and of the need to take urgent and appropriate action.
	R7.6	Education should be provided to patients and their relatives as to the appropriate response to ischaemic symptoms not relieved by their usual treatment for angina.
	R7.12	The findings of the Donegal Pre-Hospital Emergency Care Project should be examined by the NAAC and the Department of Health and Children as to their applicability in other parts of the country, especially those which are remote from emergency ambulance services.
	R7.13	Training and equipment should be provided for other professional groups as necessary, particularly in rural areas.
	R7.15	ACLS training and equipment should be provided, as in Donegal, for general practitioners in rural areas at a distance from an ambulance base.
	R7.16	An audit standard of 90 minutes from 'call to needle should be accepted in Ireland.
	R7.17	The lessons learned in the feasibility study of pre-hospital thrombolysis in Donegal should be used to initiate similar schemes in other parts of Ireland where patients live at a distance from an acute hospital.

2003

Hospital Services

2003		
Hospital Services	**Rec. No.**	**Recommendation**
	R8.2	Education campaigns to encourage patients and relatives to seek help soon after the onset of symptoms (R7.5) should also highlight the benefits of taking aspirin.
	R8.7	All patients with heart failure should receive evidence-based treatments, particularly ACE inhibitors. ß-blockers should also be prescribed for patients with mild to moderate heart failure.
	R8.8	Protocols should be agreed for the diagnosis and management of heart failure in different health service settings in Ireland – acute hospitals, general practice and shared care between hospital and primary care.
	R8.11	Different models of providing hospital-based secondary prevention services should be considered by each hospital to ensure that all cardiovascular patients benefit from comprehensive risk assessment and management. Where necessary a co-ordinator of patient care should be appointed to facilitate this.
	R8.16	Each hospital should establish links between the emergency medical service, the Accident and Emergency Department and the CCU to implement 'fast track' policies for thrombolysis to agreed protocols.
	R8.26	Those centres carrying out angioplasty should have appropriate nursing, technical and other staff back-up plus the necessary funding.
	R8.27	A feasibility study should be carried out of the likely number of emergency procedures and the costs of providing an out-of-hours PTCA service.
	R8.30	It is recommended that a cardiologist be appointed in each region with expertise in cardiac pacing. Regional pacing facilities should be established. Permanent pacing rates should be at the European average and more sophisticated physiological pacemaker units should be used.
	R8.32	National protocols should be developed for the application of evidence-based treatment for cardiac diseases.

	R8.33	A cardiovascular committee should be established in each health board region to oversee the provision of all services from primary care to cardiac surgery to ensure equal access by all patients in need of a service. National protocols should be adapted as appropriate to local circumstances. Links should be established between the cardiology services for patients with diabetes, other vascular disease and services for older patients. Particular attention should be paid to clarifying where responsibility lies for provision of secondary prevention and rehabilitation services.
	R8.36	There are a total of three paediatric cardiologists. One further paediatric cardiologist should be appointed to achieve a ratio of one per million total population.
	R8.37	Cardiologists should be appointed to provide a service for patients with Grown-up Congenital Heart Disease and to take a special interest in cardiac diseases of genetic origin.
	R8.38	All tertiary referral centres should have a minimum of five consultant cardiologists. Selected centres should have specialists in EPS.
	R8.39	Regional centres, which are performing diagnostic tests, including angiography, and inserting pacemakers, should have at least two cardiologists.
	R8.44	The CHAIR project to monitor admissions to CCUs should be implemented (R10.11). Other recommendations about cardiovascular disease registers in Chapter 10 should also be implemented; these relate to the establishment of registers of all invasive procedures including angiography, angioplasty and electrophysiology interventions, the development of a patient-based information system and further development of the Irish Cardiac Surgery Register.

2003

Cardiac Rehabilitation

2003		
Cardiac Rehabilitation	**Rec. No.**	**Recommendation**
	R9.7	Phase 2 (early post-discharge) rehabilitation needs further evaluation before definitive management strategies can be recommended. A co-ordinated programme of research is needed to identify needs, current practice in Ireland and elsewhere and possibilities for intervention. Funding is required to conduct this research.

2003

Information Systems, Audit and Research

2003		
Information Systems, Audit and Research	**Rec. No.**	**Recommendation**
	R10.9	Potential sources of data on cardiovascular disease morbidity, such as drug cost reimbursement schemes, should be examined as part of the proposed cardiovascular disease surveillance system.
	R10.10	In order to acquire all relevant data, a population-based CHD and stroke register should be established in a defined geographic area in Ireland.
	R10.13	A national register of angiography should be established.
	R10.14	A national register of angioplasty and other cardiac interventions should be established.
	R10.15	The scope of the Irish Cardiac Surgery Register should be extended to include all cardiothoracic surgeons.
	R10.16	Mechanisms should be established to link records in the coronary care register and the registers of angiography, angioplasty and cardiac surgery.
	R10.17	Health examination surveys should be carried out every four to five years and a health interview survey in the intervening period.
	R10.18	There should be complementary surveys of groups at high risk, for example, those from lower socioeconomic groups or those living in areas with high mortality rates.

2004

Health Promotion

2004

Health Promotion

All the recommendations concerning Health Promotion in the Report of the Cardiovascular Health Strategy Group have been prioritised in the Work Programme for completion by the end of 2003.

2004

Primary Care

2004		
Primary Care	**Rec. No.**	**Recommendation**
	R6.2	Some public health nurses should be assigned to work at least half time in a disease prevention and health promotion role as members of the health boards' health promotion teams. A staffing level of two whole-time equivalents per 100 000 recommended.
	R6.5	The current contribution of general practitioners to the population strategy for primary prevention should be continued and developed as part of the implementation of the recommendations on health promotion in Chapter 5.
	R6.6	Links between health promotion departments in health boards and the GP Units and general practitioners should be strengthened, so as to improve communication and to offer more training and support materials for health promotion.
	R6.8	Responsibility for risk assessment and for the identification and management of those at high risk should lie within primary care, in general practice
	R6.9	Basic risk factors, including family history, past history, current symptoms and treatment, habitual diet, alcohol and exercise habits, and measurement of height, weight, blood pressure and blood cholesterol levels should be included in the overall assessment of risk of cardiovascular disease.

	R6.10(1)	A pilot project should be undertaken to implement the high risk strategy for cardiovascular disease in general practice in Ireland.
	R6.10(2)	The protocol for the risk assessment programme should be developed in consultation with general practitioners in the area covered by the pilot scheme.
	R6.10(3)	A reimbursement system for risk assessment should be agreed with general practitioners in the pilot project. As with other preventive services, general practitioners should be reimbursed for assessing all patients, regardless of their GMS entitlements. The system should be flexible to reward all progress in risk factor assessment, with some additional benefit to those general practitioners who reach agreed targets.

	R6.10(4)	At least 10% of all general practitioners should be involved in the pilot project, spread across all health boards and including urban and rural practices. Each GP in the pilot project should be offered training, after which a personalised contract should be agreed. The process of implementing the scheme should be evaluated after a year. The system should then be extended nationwide, incorporating the lessons learned from the pilot project.
	R6.12	The recommended pilot project (R6.10) should study the process of identification of those at high risk of a future cardiovascular disease event.
	R6.13	General practitioners should be provided with incentives to use computerised information systems for the on-going care of patients who require follow-up for reduction of cardiovascular disease risk.
	R6.14	Within the recommended pilot project (R6.10) special attention should be paid to identifying and assessing risk in those with a strong family history of premature cardiovascular disease.
	R6.15	It is recommended that the targets of the European Society of Cardiology should be adopted in Ireland for management of risk factors in those identified as being at high risk.
	R6.16(1)	The pilot project recommended at R6.10 should provide resources for counselling, follow-up and management of GMS patients identified as being at high risk.
	R6.16(2)	GMS patients should be entered into a 'Follow-up Scheme' and arrangements made for payment for this service.
	R6.16(3)	Patients not covered by the GMS should also be entered into the 'Follow-up Scheme' with some financial reimbursement of costs to the patient, either through the GMS or through health insurance schemes.
	R6.17	Trained practice nurses should be involved in the high risk strategy pilot project. The aim should be to provide one wholetime nurse per 20 000 population.

	R6.19	Those who measure cardiovascular disease risk factors within occupational health schemes should notify general practitioners of the findings of such assessments and should make appropriate arrangements for follow-up and management of those identified as being at high risk.
	R6.20	Those who measure cardiovascular disease risk factors in locations such as pharmacies and mobile clinics should aim to provide a full risk assessment service. Such services should require a licence and be subject to a code of practice.
	R6.36	Community-based alcohol counsellors should have input into the training of community-based health professionals to support moderate use of alcohol. The promotion of moderate alcohol use should be an integral part of cardiovascular risk management programmes.
	R6.43	Relaxation techniques and stress management training should be an integral component of the lifestyle classes pilot projects (R6.37).
	R6.44	Targets for blood pressure recording in general practice should be a component of the risk assessment pilot project (R6.10).
	R6.46	Targets for blood cholesterol recording in general practice should be a component of the risk assessment pilot project.

2004

Hospital Services

2004		
Hospital Services	**Rec. No.**	**Recommendation**
	R8.5	Pending the implementation of a national coronary care information system, a further census of CCUs should be undertaken to assess the extent to which thrombolysis is being given within the time recommended internationally.
	R8.13(1)	All patients with cardiovascular disease in whom there are no contraindications should be on long-term low dose aspirin.
	R8.13(2)	After an AMI all patients in whom there are no contraindications should be on a long-term treatment with a ß-blocking agent.
	R8.13(3)	All patients with left ventricular dysfunction, with or without overt heart failure, particularly post-myocardial infarction, should be on ACE inhibitors.
	R8.20	Regional cardiology centres should have adequate facilities and staff for non–invasive assessment of patients.
	R8.21	As new forms of cardiac investigation become standard, they should be added to hospital facilities.
	R8.24	It is recommended that immediate attention be given by hospitals providing an invasive cardiology service to developing ambulatory cardiology care centres which in the future may be extended to provide day case angioplasty and other interventions.
	R8.25	It is recommended that provision be made for 1 200 PTCA procedures per million population by the year 2002.
	R8.28	It is recommended that cardiologists involved in interventional cardiology should perform at least 100 PTCA procedures per annum.
	R8.29	It is recommended that an EPS service including ablation be developed in selected tertiary referral centres.
	R8.31	National structures should be established to facilitate the orderly development of services in tertiary referral centres.
	R8.45	Protected time should be made available to cardiologists for clinical audit, research, teaching and continuing education.

2004

Cardiac Rehabilitation

2004

Information Systems, Audit and Research

2004		
Cardiac Rehabilitation	**Rec. No.**	**Recommendation**
	R9.9	Phase IV: The Irish Association of Cardiac Rehabilitation strategy in preparation will provide the desired structured approach to long-term management.

2004		
Information Systems, Audit and Research	**Rec. No.**	**Recommendation**
	R10.5	The Annual Report on Vital Statistics should be published within two years following the events to which it relates. There should be more in-depth reporting on mortality trends.
	R10.6	National validation exercises should be undertaken every two years to check the accuracy of HIPE data for cardiovascular disease.
	R10.7	The extension of the HIPE system to the private hospital sector should be encouraged and facilitated.
	R10.8	There should be an annual report from HIPE to disseminate basic information on the data collected.

Summary

Summary of Recommendations 2001-2004				
	2001	2002	2003	2004
	Rec. No	Rec. No	Rec. No	Rec. No
Health Promotion	R5.1, R5.3, R5.7, R5.10, R5.21.2, R5.23, R5.25, R5.26, R5.27, R5.29, R5.31, R5.32, R5.35(1), R5.35(3), R5.41, R5.42, R5.44, R5.45, R5.47, R5.48, R5.49, R5.50, R5.51, R5.56, R5.57, R5.58	R5.2, R5.4, R5.5, R5.6, R5.9, R5.11, R5.12, R5.13, R5.15, R5.16, R5.17, R5.18, R5.19, R5.20, R5.21(1), R5.21(3), R5.22.1, R5.22(2), R5.22(3), R5.24.1, R5.24(3), R5.24(4), R5.28, R5.30, R5.34, R5.35.7, R5.36, R5.37, R5.38, R5.39, R5.40, R5.43, R5.46, R5.53	R5.4, R5.5, R5.8, R5.14, R5.24(2), R5.33, R5.35(1), R5.35(2), R5.35(4),R5.55(5) R5.35(6)	
Primary Care	The commencement of the Initial Implementation Phase of a National Programme in General Practice for Secondary Prevention of Cardiovascular Disease. The support of practice nurses whose remit would be largely devoted to the management of cardiovascular disease. R6.1, R6.3, R6.4, R6.6, R6.11, R6.18(1), R6.18(2), R6.27, R6.28, R6.29, R6.30, R6.31, R6.32, R6.33, R6.34, R6.35,R6.37, R6.38, R6.39, R6.40, R6.41, R6.42, R6.45, R6.47	R6.7, R6.21, R6.22, R6.23(1), R6.23(2), R6.23(3), R6.24.1,R6.24.2, R6.24(3), R6.25, R6.26, R6.48, R6.49, R6.50, R6.53, R6.54, R6.55	R6.51, R6.52	R6.2, R6.5, R6.8, R6.9, R6.10(1), R6.10(2), R6.10(3), R6.10(4), R6.12, R6.13, R6.14, R6.15, R6.1 R6.16(2), R6.16(3), R6.17, R6.19, R6.20, R6.36, R6.43, R6.44, R6.46

Summary of Recommendations 2001-2004				
	2001	**2002**	**2003**	**2004**
	Rec. No	**Rec. No**	**Rec. No**	**Rec. No**
Pre-hospital Care	R7.1, R7.11, R7.14	R7.2(1), R7.2(2), R7.2(3), R7.3, R7.4, R7.7, R7.8, R7.9, R7.10, R7.18	R7.5, R7.6, R7.12, R7.13, R7.15, R7.16, R7.17.	
Hospital Services	R8.1, R8.3, R8.4, R8.6, R8.9, R8.12, R8.14, R8.17, R8.18, R8.19, R8.22, R8.23, R8.34, R8.35, R8.41, R8.42, R8.43	R8.10, R8.15, R8.40.	R8.2, R8.7, R8.8, R8.11, R8.16, R8.26, R8.27, R8.30, R8.32, R8.33, R8.36, R8.37, R8.38, R8.39, R8.44.	R8.5, R8.13.1, R8.13(2), R8.13(3), R8.20, R8.21, R8.24, R8.25, R8.28, R8.29, R8.31, R8.45.
Cardiac Rehabilitation	R9.1, R9.2, R9.3, R9.4, R9.5, R9.6, R9.8, R9.10		R9.7	R9.9
Information Systems, Audit and Research	R10.11, R10.12, R10.21	R10(1), R10(2), R10(3), R10(4), R10.14, R10.19, R10.20	R10.9, R10.10, R10.13, R10.15, R10.16, R10.17, R10.18	R10.5, R10.6, R10.7, R10.8