

Cardiovascular Disease Strategy Status Conference

27 September, 2007

Organised by the Irish Heart Foundation in the Royal Marine Hotel, Dun Laoghaire

INTRODUCTION

The Irish Heart Foundation (IHF) hosted a Cardiovascular Disease Strategy Status Conference at the Royal Marine Hotel, Dun Laoghaire on 27 September 2007. The conference acted as a forum for key stakeholders to review the progress of the 1999 Cardiovascular Strategy – *Building Healthier Hearts* and to highlight challenges that lie ahead in progressing it.

The overall message from the conference was ‘a lot done, but much more to do’. While progress has been made in enhancing the infrastructure necessary to improve cardiovascular health in terms of treatment and prevention, the conference pointed to deficits in areas such as staffing and hospital facilities (for example, there is still a major shortfall in the number of cardiologists needed), and problems in tackling demographic and epidemiological changes. These include the rise in incidence of obesity and diabetes, the fact that older people with heart disease are living longer and the need for further efforts to reduce smoking.

An audit of progress on the implementation of the Cardiovascular Strategy called “*Ireland: Take Heart*” was presented. The report showed there is a need to take the Strategy into its next phase and highlighted initiatives taken by the Department of Health and Children and the HSE in this regard.

90 individuals who represented the medical profession, the Department of Health and Children, public health, the Health Services Executive, patients and other interested parties attended the conference. The Minister for Health & Children, Mary Harney opened the meeting.

The purpose of the meeting was to gather all stakeholders to assess the progress made on the recommendations from the 1999 Cardiovascular Strategy and to consider the priorities for the future. This was facilitated by a series of presentations on the current situation delivered by experts across six areas of heart care. These were followed up with workshops on each area.

A discussion followed which included a presentation by Professor Hannah McGee from the Royal College of Surgeons on the “next steps” to be taken. The recommendations that emerged in the workshops are presented in this document together with a summary of the conference proceedings.

This conference has identified the measures, strategies and policies required to effectively tackle cardiovascular disease in Ireland and suggested the way in which these can be implemented.

SUMMARY OF RECOMMENDATIONS

Workshops were held on six areas of priority including Health Promotion, Primary Care, Pre-Hospital Care, Hospital Services & Rehabilitation, Heart Failure and Audit & Surveillance. The following list is a summary of the main recommendations that arose from the dedicated workshops.

1. Appointment of additional consultants to provide adequate services and to spearhead development and change
2. Development of stroke services nationally
3. National roll-out of the Heartwatch programme
4. Development of chronic heart failure GP programmes
5. Provision of heart failure clinics in hospitals and chest pain units in A&E in all major hospitals
6. Public education to create greater public awareness of the warning symptoms of CVD including stroke
7. Development of a national heart disease registry
8. Development of a national tobacco framework and increase the number of smoking cessation services
9. Provision of practical, summarised guidelines for GP use on the endorsement of international practice
10. Synergise heart failure and cardiac rehabilitation services

OPENING REMARKS

Professor Eoin O'Brien, President, Irish Heart Foundation

Irish Heart Foundation (IHF) President Professor Eoin O'Brien welcomed the audience, particularly the Minister for Health and Children, Mary Harney, officials from the Department of Health and the Health Service Executive, colleagues from the IHF and colleagues from various interests in cardiovascular health and disease. He also thanked Tracey Egan from the IHF for organising the event.

Prof O'Brien said the conference was an historical occasion. He said: "We are dealing with a very common disease; 37 per cent of all deaths in Ireland are due to cardiovascular disease."

Prof O'Brien said he wanted to make a plea for the totality of cardiovascular disease. He said: "We should not dissect CVD into different categories. We have to remember that arterial disease is the basis of most cardiovascular disorders; it is the arterial wall that is diseased." Parts of the body affected by arterial disease include the heart, brain, kidneys (failure) and the lower limbs.

He believed we must refocus on the issue of lifestyle versus disease modification. There had been a tendency in the past to concentrate on lifestyle modification, and there is nothing wrong with that. However, we now have drug treatments that allow us to focus more on disease and we have got to get the balance right between lifestyle and disease modification.

Recent guidelines from the European Society of Hypertension and the European Society of Cardiology say that lifestyle measures are unproven in preventing cardiovascular complications in hypertensive patients and long-term compliance with their implementation is notoriously low. The guidelines state that they should never delay the implementation of drug treatments, especially in patients at higher risk.

Recent guidelines from the American Heart Association emphasise that modification of lifestyle should not delay drug treatment. If we are to await evaluation of results of lifestyle modification, valuable time will be lost in reducing long-term risk by failing to address high blood pressure or hyperlipidaemia.

Prof O'Brien said what these recommendations are really saying is that we, of course should implement lifestyle modification but we never delay drug treatment, and we do not say to patients: "modify your lifestyle and come back in six months and then I will consider treatment". That six months may be the most valuable period for drug treatment to reduce hypertension, hypercholesterolaemia or whatever the dominant risk will be."

Prof O'Brien said hypertension is a major public health problem and perhaps poses the biggest single risk globally. The WHO ranks it with smoking, AIDS, and cancer. Blood pressure control is essential if we are to reduce the incidence of stroke and it has been established that the number of brain attacks could be reduced by 60 per cent. The IHF, he said, recently developed a seven-part study on stroke.

As to the future, we must remind ourselves, Prof O'Brien said, that 65-year-olds are destined to increase in number by over 100,000 between 1996 and 2011, to constitute eventually 14 per cent of the Irish population.

It is estimated that at 60 years of age 80 per cent of people may have some added risk associated with a relatively high blood pressure level.

Prof O'Brien said: "We have the problem that the triumph of longevity may be negated by disability and that is something that we do not want. We do not want an elderly population who are disabled by stroke and other illnesses such as heart failure. So the challenge that we face today, the challenge of all cardiovascular policy and strategy for the future is to have increased longevity but also to have a good quality of life and to be able to devise means of doing that."

Launch of conference by Mary Harney TD, Minister for Health and Children

The Minister for Health and Children, Mary Harney, said her Department had recently put together a group, under the Chairmanship of Prof Hannah McGee, which includes key stakeholders in the field of cardiovascular health. This group will look at the current position on the implementation of the 1999 Cardiovascular Strategy.

She said resources are necessary to improve health services but we must focus those resources on specific actions. The new Departmental group will, she said, also look at the issue of stroke.

The fact that there is only one dedicated stroke unit, at the Mater Hospital in Dublin, is a major deficit in the facilities and services for stroke patients.

The management of chronic illness is a major challenge for healthcare systems in Ireland and in most of the developed world. People are living longer and the challenge is to make sure that people can lead healthier and good quality lives.

She wished the conference every success and looked forward to the deliberations of Prof McGee's new group which is due to report next April. This process will be able to take forward many of the items to be discussed at this conference, not just by way of aspirations in policy documents but in action at a practical level to improve the outcome for cardiovascular patients in Ireland.

LAUNCH OF “IRELAND TAKE HEART” – AN AUDIT OF THE CARDIOVASCULAR STRATEGY

Dr Patrick Doorley, Director of Population Health, HSE

Dr Patrick Doorley set the background for the launch of the audit and outlined some important epidemiological points in terms of changing patterns in heart health in Ireland over the past two decades. He said there had been a 54 per cent decrease in age-standardised death rates from heart disease over the past 20 years or so. This represented a major public health success story in this country.

In 2002 the average life expectancy at birth was 75 years for men and 80 years for women, with further improvements reported in new provisional CSO figures. This represents quite an extraordinary transformation of health in this country, Dr Doorley felt that this was influenced partly by the decrease in the death rates from heart disease and to a lesser extent by the decrease in death rates from cancer. We are now catching up with the rest of Western Europe in terms of heart disease death rates and that is very good news.

Better management and prevention of chronic illness offers a tremendous opportunity to compress that inevitable period of illness and disability towards the end of life so that older people are living with heart disease rather than dying from it.

Dr Doorley said this means that although people may need more treatment, they will be more active, contributing more to society, and able to work longer. The big challenge to achieve this is providing for better prevention and better management of all chronic illnesses.

He discussed the major influences, which have impacted on the decrease in cardiac death rates in recent years, including better treatments and improvements in lifestyle. There is also a negative contribution from diabetes and obesity. These have the potential, Dr Doorley said, to slow down the progress we are making in improving death rates from coronary heart disease and could potentially reverse that process.

He outlined recent health promotion activities undertaken by the HSE, including smoking cessation programmes, work in schools on health promotion, working with the Community Games, now sponsored by the HSE, to promote physical activity in communities and the prescription of physical activity by GPs in some areas on a pilot basis.

Pointing to Heartwatch, the primary care-based secondary prevention programme (part of the Cardiovascular Strategy), Dr Doorley said this had been successful in reducing levels of blood pressure and cholesterol and that had saved lives. It has, however, been less successful in tackling physical activity and obesity, which is understandable as it is very difficult to change peoples' lifestyles.

Ambulance response times have improved and there are now defibrillators in ambulances. Treatments have improved; with improvements in the 'door to needle' time for thrombolytic treatment. Now 95 per cent of hospitals have cardiac rehabilitation facilities and there has been an increase in the availability of echocardiograms.

In terms of current initiatives, the HSE is putting in place primary care teams of doctors, nurses, social workers and dietitians who will work together to improve heart disease outcomes.

In summary, the audit shows great progress in terms of services, said Dr Doorley. The health service can claim almost half the credit for the 54 per cent decrease in deaths over 20 years, a figure of around 3,700. With an investment, which was relatively modest we have had a clear, measurable improvement in the health of the population.

Dr Doorley said health promotion is not just about hectoring people to change their lifestyle. The whole environment, including the social and policy environment, is extremely important.

Those who are best off in our society have the best health experience and those who are worst off have the worst experience. This is an important challenge, which needs to be tackled and which requires action outside as well as within the health service.

Dr Doorley said the March 2004 smoking ban was followed by a 1.0-1.5 per cent decrease in smoking prevalence but the smoking rate is beginning to increase again, so the smoking issue has certainly not gone away. We badly need an increase in tobacco taxation now. He referred to the need for engagement with the private sector. While this sector has done a lot to increase the availability of healthy options, there were areas of serious concern.

Current food labelling is baffling in terms of informing people about the nutritional content of food, and we need a 'traffic light' system, which would clearly inform consumers whether a food has high fat/salt/sugar content.

Dr Siobhan Jennings, HSE Population Health Directorate and lead author of the Audit

Dr Siobhan Jennings presented information gleaned from the implementation of the Cardiovascular Strategy: Building Healthier Hearts, from its publication in 1999 to 2005.

The publication of the strategy was supposed to be followed on by dedicated funding from the Department of Health, through extra taxation on tobacco. On epidemiological trends, Dr Jennings first looked at the decline in cardiovascular disease death rates. The decline in the past decade has been at a faster rate than in the previous decade.

She said that while the decline in the cardiovascular death rate had also been occurring in other developed countries, it is by no means a given for it to continue to decline. The United States is experiencing a plateau in mortality from heart disease, largely because of the obesity epidemic, and Finland is also seeing a blunting of its decline in coronary heart disease mortality, largely due to economic difficulties.

Looking at the EU 15, Ireland has recorded a steep comparative decline in death rates in recent years. We have overtaken Finland and on premature mortality we are likely to overtake the UK if current trends continue. Research shows that in most developed countries the reason for the reduction in death rates is 60 per cent due to improved risk factors such as smoking and better diet, and 40 per cent due to improvements in treatment.

Dr Jennings said, however that we have missed out on a death rate reduction by about 14 per cent because our risk factors have worsened in terms of obesity, sedentary lifestyle and in terms of resultant diabetes. Looking at figures within Ireland, the two ‘hotspot’ heart disease mortality areas in the early to mid-1990s were the north-east and south of the country (corresponding to the old health board areas). Eight to 10 years later, the north-east (NEHB) has improved and is now on an average level compared to the rest of the country and the south (SHB area) remains a hotspot area.

In Ireland, in the period encompassing five years before and after the publication of the Cardiovascular Strategy in 1999, there has been a decline of about 23.4 per cent in age-standardised mortality for coronary heart disease, more or less similar for males and females. As regards hospitalisation rates between 1998 and 2004, an east-west divide is evident if you exclude the Dublin area, with people in the east more likely to be admitted than those in the west of the country.

Smoking rates in the population have declined from 32 per cent in 1998 to 27 per cent in 2002, but there is some variation in different parts of the country.

Dr Jennings outlined the amount of exchequer investment in the Cardiovascular Strategy. A total of €72 million was invested in the system as a result of dedicated funding. This money essentially bought a lot of staff, with 820 staff put in place in cardiovascular services.

Dr Jennings then discussed six key areas relating to the implementation of the Cardiovascular Strategy:

1) *Health Promotion*

The smoking ban was one of the most significant health promotion initiatives during the implementation period of the Strategy and smoking cessation and support services improved during this period. A lot of work was done on settings-based promotion activities, which were established in schools, hospitals, workplaces and in the community. We have had risk factor surveys such as Slan (in 1998, 2002 and 2007), which gave a good snapshot of overall health status and heart health status.

The Food Safety Authority of Ireland (FSAI) has achieved a voluntary commitment by food producers to reduce salt in bread and other food products. However, Dr Jennings pointed out that a lot remains to be done in the health promotion area, for example in obesity, particularly childhood obesity. Smoking, in spite of some progress in this area, still needs attention, as one quarter of the adult population in Ireland still smokes.

While alcohol has a lesser effect on the coronary vasculature, it is very relevant for the vasculature overall, and action needs to be taken to tackle excessive alcohol consumption. The full implementation of the two taskforce reports on alcohol is key in this regard. There has been a slight decrease in fat intake in recent years and there has been a considerable increase in fruit and vegetable intake.

2) *Primary Care*

Probably the biggest success of the strategy has been in the secondary prevention of heart disease. The Heartwatch secondary prevention programme, does, however only involve

20 per cent of GP practices. This project led to improvements in blood pressure and cholesterol levels, a reduction in smoking rates in the patient cohort and overall, 81 deaths were averted. Parallel with the Heartwatch programme, there has been a two to four-fold increase in the prescribing of cardiovascular drugs in 2002 to 2005.

However, there was almost no change in body mass index (BMI) and exercise levels. There has been an increase in prescribing in the evidence-based cardiovascular therapies. There has also been a lot of work done on training programmes within the primary and community care community, and there has been progress on integrating health promotion and primary care, and primary care and hospital care, in areas such as brief interventions and diagnostics.

There are, said Dr Jennings, plenty of areas requiring further attention. Apart from the Heartwatch programme, a lot of other positive things happened locally and regionally but there was no national pulling together of all the work done. We need to move on the Heartwatch programme so that all patients can avail of it. With more cardiac patients surviving, heart failure care will become an increasing problem within hospitals and primary care.

We have a considerable amount of work to do on high risk primary prevention in diabetes, hypertension and hypercholesterolaemia.

3) *Pre-Hospital Care*

A considerable mix of initiatives took place under this heading.

Dr Jennings pointed out that automated external defibrillators (AEDs) are more widely available than before. Emergency Medical Technicians and Advanced Paramedic Grades have been put in place. A number of first response programmes have been initiated and we have had agreement on an electronic patient record, although not a full roll-out of this yet.

The gaps that remain in this area include the need for more coordination of pre-hospital care/intervention training and this may be achieved through the recent Sudden Cardiac Death Taskforce report. We also need to improve early reperfusion; areas requiring attention under this heading include pre-hospital thrombolysis and primary PCI. The administration of the ambulance system also needs further attention.

Another challenge, said Dr Jennings, is to get patients to recognise the symptoms of a cardiovascular event and to seek help quickly. There has been positive progress in the area of first response but this needs to be built upon.

4) *Hospital Sector*

Dr Jennings pointed to a number of successes in the hospital sector in the implementation of the Strategy. Most hospitals are now able to perform thrombolysis in their emergency departments and in some rural hospitals there is a link directly from ambulance to coronary care.

A good deal of cardiac investigation is now taking place. Included among these is increased access for GPs to diagnostics and a greater use of angioplasty and angiography. 22 additional cardiologists have been appointed but there is still a deficit of 30 additional cardiologist posts to be filled. These are urgently needed.

The key gaps in hospital care include: meeting continuing needs in terms of pre-hospital care; examining where we can position primary PCI services; the need to ease pressure on existing acute cardiac services, filling manpower deficits, including in consultants and specialist nurses; and providing facilities for resuscitation training at hospital level.

3) *Cardiac Rehabilitation*

Key successes under this heading include the fact that almost all hospitals now have phase three rehabilitation programmes, with a concomitant major increase in staffing and patient throughput.

Key gaps under this heading relate to the fact that the services that have been initiated and developed are now under considerable pressure. Not all eligible patients can get into phase three programmes in a timely manner.

Community-based phase four rehabilitation needs to be developed and integrated with secondary prevention in primary care.

5) *Surveillance, Audit and Research*

Key successes under this heading include developing the European Cardiology Audit and Registration Data Standards (CARDS) system, Dr Jennings said. We also have the SLAN report, providing three important snapshots in relation to risk factors for cardiovascular disease (the third of these is due to be published in late 2007).

Other successes include the Coronary Heart Attack Ireland Register (CHAIR), working in eight hospitals in the south of the country; the development of performance indicators and the availability of European Society of Cardiology (ESC) guidelines.

However, there are still major gaps in this area. We still cannot link records; this is an absolute essential. The ideal method would be through a unique personal identifier. This type of system would enable us to link deaths with admissions, prescribing etc and get meaningful information from databases we already hold. Dr Jennings stressed that we also need a national structure for surveillance and audit.

Conclusion

Dr Jennings said there have been a lot of achievements under the Strategy but many items were outstanding. We now need an action plan within Ireland to move on with the next Strategy phase. This will be done in a different environment compared to when the 1999 Strategy was launched. There has been health sector reform, both in the HSE and Department of Health.

We now have a commitment to making primary care teams work throughout Ireland. Dr Jennings said we are moving forward in our approach to looking at chronic disease and we need to progress ways of managing chronic disease. The Minister for Health has recently initiated a policy group on cardiovascular health and an expert advisory group is planned for the HSE. Things are certainly looking a lot better than they were 18 months ago in terms of being able to push things forward.

To conclude, we have seen a lot of improvements in terms of infrastructure, activity and outcome. We have a number of challenges and to some extent we now have the burden of our own success - patients surviving who now need care; new pressures on services and

the obesity epidemic. To use a political phrase, Dr Jennings said, there has been a lot done but an awful lot more to do.

THE CURRENT SITUATION – CARDIOVASCULAR STRATEGY, RESPONDING TO CHANGE

Dr Brian Maurer, Medical Director, Irish Heart Foundation

The morning session of the conference concluded with a trenchant and succinct critique of the progress of the Cardiovascular Strategy, the current state of services in Ireland and Government healthcare policy and planning, by Dr Maurer.

He said some of the objectives of the Cardiovascular Strategy have become outdated, some have been overtaken by events and some have been implemented. Things have improved, but he asked why had we had not performed better.

Concepts in professional care are changing; for example the diminution in coronary artery bypass surgery and the increasing use of interventions such as angioplasty. It is difficult to plan for the future when care is an evolving process.

We need to look at why there is resistance to implement new therapeutic strategies and we need to meet the challenge of changing patterns of disease; for example, acute myocardial infarction is declining and is being replaced by new problems.

Dr Maurer said we also need to look at planning and investment and ensure that we are getting the best return.

However, he said if any business in Ireland was organised financially like our healthcare system it would have been declared bankrupt many years ago. In fact, the system as it stands does frequently become bankrupt and has to be bailed out each year as a result of inadequately planned budgeting.

Pointing to deficits in the implementation of the Cardiovascular Strategy, he gave as an example the failure to appoint the full necessary complement of consultant cardiologists.

In addition, information technology is non-existent in many of our hospitals, although the provision of investigative facilities has improved. He queried why Heartwatch has only been rolled out in 20 per cent of general practices and speculated that this may have been due to ‘cold feet’ in the Department of Health or unresolved industrial relations difficulties.

Dr Maurer said the failure to fully implement such programmes cannot all be down to professional resistance; it lies with management and professional planners who cannot seem to work with medical practitioners.

Short-term budgeting is the bane of hospital services; whereby a hospital budget is based on the previous year’s activity. Hospitals are not told what their allocation is until nine months of the year have passed and there is always a crisis reaction to budgetary failures. This non-existent financial planning leads to staff demoralisation.

Dr Maurer pointed to what he felt was a failure of accountability in the system and political inconsistency, with a frequent political failure of nerve when local interests get in the way of service planning.

He felt we have a ‘crazy’ health finance system undermined by lack of accountability, with nobody being responsible for the mess that exists. This had three strands, the Department of Finance, which funds or often does not fund service developments, the Department of Health, which plans developments and the HSE which tries to implement them, with no one group being accountable for failure to implement policy.

Dr Maurer outlined some of the activities of the Irish Heart Foundation in recent years, including a major national stroke audit, involvement in the implementation of the Cardiovascular Strategy and the Sudden Cardiac Death taskforce report, and initiatives in areas such as obesity, hypertension and exercise.

He stressed that in tackling heart disease, we need to look outside the healthcare area and examine wider social issues such as making our roads safer so that people can exercise in safety.

THE CURRENT SITUATION – PRIMARY CARE

Professor Colin Bradley, Department of General Practice, UCC

Prof Bradley said the Cardiovascular Strategy had led to a transformation from a primary care perspective. While there had been gains, he felt it had not moved on as well as it might have done because of a lack of conviction in the Irish healthcare system about the capacity and potential of primary care.

He pointed out that the Primary Care Strategy, published in 2001, has not yet come to full fruition and this has been a source of disappointment. The lack of progress on this particular strategy has prevented the primary care aspects of the Cardiovascular Strategy from being fully implemented.

A major plus has been the Heartwatch primary care-based secondary prevention programme, which covers 20 per cent of GP practices. A disappointment in relation to this, however, Prof Bradley said, is that we seem to live in ‘the land of the eternal pilot’, and we seem to lack the ability to implement a programme nationally.

He said Heartwatch was not implemented for the whole population and even in practices where it was implemented, the effort seemed to be driven by data requirements rather than clinical outcomes.

While Heartwatch did score successes in terms of clinical outcomes and prescribing, it was less successful in areas such as lifestyle and in reducing BMI. Prof Bradley said major progress had been made in smoking cessation; efforts need to be redoubled in terms of diet and alcohol and in terms of primary care staff training and education in order to implement the Strategy. He pointed to the success of the GP exercise prescribing programme but again this was a pilot and has not been rolled out nationally.

THE CURRENT SITUATION – HEALTH PROMOTION (1)

Dr Owen Metcalfe, Institute of Public Health in Ireland

Dr Metcalfe pointed out that in 1987 there were 20 people working in health promotion in Ireland, whereas now we have 350 health promotion posts in the country, and since the publication of the 1999 Cardiovascular Strategy we have seen a major increase in the health promotion budget and we have had a Health Promotion Strategy published.

He said he had no doubt that the increases in health promotion staffing have been thanks to the 1999 Strategy. However, while much has been achieved in terms of health promotion, we must move forward and develop health promotion further.

He said that information and intelligence was improving (eg the Slan studies) but we still have a data deficit, eg. we do not have data on an adequately regular basis, we do not have disaggregated data and we do not have sufficient capacity to analyse the data in many respects. He gave examples of the importance of having good data in terms of diabetes epidemiology and measuring inequalities in healthcare.

Dr Metcalfe referred to a vacuum existing in health promotion policy at present. Success and future progress depends on having the information and the evidence to support decision-makers in making evidence-based policy.

He stressed that the principles of equity are fundamental with regard to empowerment, with regard to community engagement, and stressed one of the messages of the audit, which was that effective heart health activity must conform to best principles of health promotion practice.

HEALTH PROMOTION (2)

Dr Catherine Murphy, Assistant Director of Population Health (Health Promotion), HSE

Dr Murphy outlined that since the publication of the Strategy, key executive functions had transferred from the Department of Health and Children to the HSE, which was established in January 2005.

A health promotion function was established as a key component of the Population Health Directorate of the HSE. A key function was the social marketing function, which involved rolling out the national health promotion campaign, and components of this, which are particularly important in terms of cardiovascular health, are the campaigns on tobacco, alcohol, obesity and breastfeeding.

Dr Murphy also outlined the transition from the Department of Health to the HSE of the national health promotion programmes, many of which had key elements in terms of promoting cardiovascular health. An example of this is the GP exercise referral programme which has been piloted in the south of the country.

The HSE also implements policy in key areas; for example in terms of the Taskforce on Alcohol and the Taskforce on Obesity. She stressed the importance of the HSE's promotion work with Government Departments, voluntary agencies and other groups. An important function of the HSE in the health promotion field is developing key

partnerships with voluntary bodies and community groups, for example with the Irish Heart Foundation, the Sports Council and through sponsorship of the Community Games. Dr Murphy said another key function of the HSE was in advocacy in a number of areas including tobacco and alcohol.

Dr Murphy said that these activities were against the background of the Transformation Programme in the HSE and one of the key driver programmes in this will be improving the health of the population.

Forthcoming projects will include a health promotion strategy, a strategic action plan on breastfeeding and a national tobacco framework. She stressed the importance of taxation increases on alcohol and tobacco, as these have been shown to reduce consumption.

Dr Murphy also pointed to the overarching need for an intersectoral and interdepartmental approach to health promotion and for the need for ongoing increases in investment in health promotion.

THE CURRENT SITUATION – PRE-HOSPITAL CARE

Dr Geoff King, Director, Pre-Hospital Emergency Care Council (PHECC)

Dr King outlined the progress on pre-hospital care recommendations in the 1999 Strategy which included expanding CPR training; the introduction of legislation to allow emergency medical technicians (EMTs) to administer cardiac drugs; the wider availability of automated external defibrillators (AEDS); the establishment of paramedic and advanced paramedic grades; the development of first responder programmes; and the subsequent publication of the report of the Taskforce on Sudden Cardiac Death and a focus on implementing its recommendations.

He said that while much had been achieved in the pre-hospital care area, there was still a good deal of work to do. Dr King said we now have just under 100 registered advanced paramedics in Ireland, but there is a need to increase these numbers further. Statutory standards have been developed for all aspects of pre-hospital care, from CPR/AED in the community right up to career ambulance personnel, and clinical practice guidelines for all aspects of pre-hospital care are due to be published shortly.

There are now nearly 2,000 staff on the statutory register which covers advanced paramedics, paramedics and EMTs.

Future challenges include progressing further responder education. While the initial emphasis has been on the education of career grade staff, we are not utilising people in the community as well as we should. We also need to utilise co-responders such as the Fire Service and the Gardai in a more effective manner.

THE CURRENT SITUATION – HOSPITAL SERVICES AND REHABILITATION

Dr Peter Crean, Consultant Cardiologist, St James's Hospital, Dublin

Dr Crean emphasised that while we have seen an impressive reduction in cardiovascular deaths in this country, this brings with it an increased workload for cardiac services, with patients living longer and an increased prevalence of heart disease, especially in the older age group.

Two current trends in acute cardiac services are patients presenting with acute myocardial infarction with blocked arteries on top of a ruptured plaque presenting with ST segment elevation infarction and increasingly, patients who are presenting with unstable angina and non-ST segment elevation infarction. These patients are initially at low risk when in the hospital but are at high risk in the following year. Patients with non Q-wave infarction are bringing increased workloads to cardiac units; they need to be seen early, to be risk-stratified early and to have intervention carried out early.

The number of procedures, for example, in the catheterisation lab, are continually increasing. For example the biggest increase in procedures we are seeing in angioplasties, is in the older age group. However, as a result of these developments, patients' quality of life has improved dramatically. Hospitals are now doing much more complex procedures than before and we are treating patients with acute infarction with coronary angioplasty. Drug-eluting stents have transformed cardiac care in recent years and have had a huge effect on re-hospitalisation.

Dr Crean listed current needs, including protected day beds for certain cardiac procedures and investigations; the development of dedicated heart attack centres; a roll-out of heart failure units along the model of Dr Ken Mc Donald's unit in St Vincent's in Dublin; chest pain assessment units, and there was a need to address staffing at all levels, as well as hospital capacity

He said the funding for developments under the Cardiovascular Strategy did not appear to be ring-fenced and much of the funding seemed to disappear three to four years into the programme of implementation. We seemed to lose our way a few years into the implementation of the programme. This should provide a lesson in terms of the future progression of the Strategy.

THE CURRENT SITUATION – HEART FAILURE

Dr Ken Mc Donald, Consultant Cardiologist, St Vincent’s University Hospital

Dr Mc Donald told the conference that heart failure (HF) is not terminal disease but is a chronic condition which is very prevalent. Using the malignancy analogy we can begin to use terms from oncology such as ‘cure’ and remission’ and apply them to certain components of our HF population.

He pointed out that up to 90,000 people in Ireland have heart failure alone, not including those with asymptomatic left ventricular dysfunction, which would bring the estimated figure up to 250,000. The vast majority of the symptomatic HF population and all of the asymptomatic do not receive attention; the analogy would be to wait until a patient had macroscopic complications of diabetes before they get full multidisciplinary care.

Heart failure services in Ireland are fractured and relatively rare. One in five of the population with HF will be admitted to hospital and many will be readmitted. There are 20,000 hospitalisations in Ireland each year as a result of heart failure. If tomorrow we applied nationally what we currently applied in certain selected hospitals we would potentially halve that figure. This would be done by investing in staffing and reorganising our structures of care.

Recent research from the St Vincent’s Heart Failure Unit has shown how management in a dedicated multidisciplinary unit can lead to significant improvements in heart function in 50 per cent of cases and 20 per cent can show normalisation of heart function.

Progress to date in implementing the heart failure recommendations in the Strategy has been sporadic, especially in terms of developing properly structured HF services around the country. Only a minority of HF patients are currently admitted to services that can look after them properly; there are large areas of Ireland where heart failure services have not been developed. Dr Mc Donald pointed to the need to invest in diagnostics such as blood natriuretic peptide (BNP) tests, which can out-rule heart failure; this needs to be made more widely available to GPs.

HF management needs to be hospital physician-led with a multidisciplinary approach, and strong links to general practice and the community sector. Dr Mc Donald called for a national review of heart failure service needs.

THE CURRENT SITUATION – AUDIT AND SURVEILLANCE

Dr Peter Kearney, Consultant Cardiologist, Cork University Hospital

Prof Kearney outlined the audit and surveillance aspects of the 1999 Strategy, mentioning the development of projects such as the Coronary Heart Attack Ireland (CHAIR) register in the south, the European Cardiology Audit and Registration Data Standards (CARDS), the SLAN surveys and the HIPE scheme.

He spoke of the need to establish a heart disease register in Ireland, pointing to the dearth of information on cardiac disease incidence, prevalence and management in the country.

He pointed to the diminution in the Cardiac Surgery Register, despite the importance of the need for audit in this area.

In spite of the progress made in the Strategy, accessing high quality data remains a very difficult task and overall the progress in this area has been generally less than satisfactory.

Dr Kearney said we need to prioritise areas of importance for data registration. Representivity is a key factor; and there is a need for private hospitals to become more involved in data collection systems and audit. The introduction of an unique patient identifier would be a useful tool.

WORKSHOP REPORTS

List of Workshops:

Health Promotion	chaired by Maria Lordon Dunphy, HSE
Primary Care	chaired by Anna Marie Lannigan, HSE
Pre-Hospital Care	chaired by Brendan Cavanagh, PHECC
Hospital Services & Rehabilitation	chaired by Dr Mary Hynes, HSE
Heart Failure	chaired by Dr David Weakliam, HSE
Audit & Surveillance	chaired by Wendy Walsh, HSE

WORKSHOP REPORT – HEALTH PROMOTION

Facilitated by Maria Lordon Dunphy, HSE

The main issues raised in this workshop were:

1. The top priority for health improvement is intersectoral working. The government has committed to setting up an intergovernmental group to address chronic disease and health improvement. It is very important to get cardiovascular disease and cardiovascular health onto the agenda of that group and to be clear what is wanted from the group. It is also important to get all of the other departments, such as transport, looking at health issues.
2. Partnership is also a priority. Because so many of the determinants in health promotion are outside the health services it is important to get the partnerships with other sectors working. Clarity and focus in how partnerships are engaged, influenced and evaluated was seen as an issue. Developing a systematic way to move things forward and a ‘tool kit’ nationally to do that would be beneficial. Engaging with the private sector and working with the private sector to address health issues was identified as an area that needs focus. This could help to highlight issues such as food labelling, marketing of food to children and other issues.
3. More investment in this area is needed as we are coming from a very low base of funding.
 - a. Work that needs to be done includes building capacity in key areas, especially in the provision of staff. Of particular attention:
 - b. We need to develop a national tobacco framework and have added smoking cessation services right around the country. There are very high levels of smoking in disadvantaged areas and we need to be very focused and targeted in how we provide our smoking cessation services.
 - c. There are plans to develop national physical activity guidelines and a physical activity plan with all stakeholders to look at addressing risk factors for obesity, cardiovascular disease, etc. Important that the impact of the environment on levels of physical activity is taken into account
4. Advocacy for healthy public policy is a priority. There is a need for investment to perform health impact assessments.
5. Addressing health inequality needs a clear focus, not just on differences in status, but also in cases where there are variations in terms of service delivery from the clinical side and from the prevention side. This will be addressed in a national action plan on health inequalities.
6. Investment is needed for national coordinators for the Cardiovascular Strategy. Coordinators are needed to develop standardised approaches across the country now that we have one organisation, the HSE, to develop quality, standardised approaches to health promotion in all of our settings.

7. Investment is needed in research to look at outcomes e.g. data collection, monitoring and surveillance.

WORKSHOP REPORT – PRIMARY CARE

Facilitated by Anna Marie Lannigan, HSE

The main issues raised under this heading were:

1. Primary prevention: high risk people should be brought into the Heartwatch programme and secondary prevention is not sufficient.
2. There is concern at the failure to coordinate a number of documents and strategies. Stroke was highlighted, as its aspects of prevention are common to those for coronary disease. There is a danger of having everything in a different silo. There is a need for national policy coordination.
3. Linkages between different settings. Between primary care and the hospitals there is still major lack of integration and it has to be at a national policy level before it can be implemented at a local level.
4. Heartwatch needs a new dataset. A lot of time is spent inputting the data and getting it right, but there is not sufficient focus on the outcomes and what is hoped to be achieved.
5. IT investment is needed at a national policy level. It cannot be ad hoc but needs to be coordinated.
6. We need national coordinators of cardiovascular posts.
7. Where do the Cardiovascular Strategy and Heartwatch programme sit with the primary care teams currently being rolled out? At network level, where is the seamless service happening?
8. There are many strategies and advisory groups, for example on primary care, diabetes, obesity, alcohol, with a lot in common. But how do you work it locally if at national level the policies aren't consistent and talking to each other?
9. We need a policy on pilot schemes and their evaluation and to set deadlines for when they cease or roll out.
10. We need a national standards programme in education and training.
11. National guidelines should be set up to decide which of the excellent evidence-based international guidelines should be endorsed for Ireland. This body would also look at new and emerging technologies that are coming online internationally. Ambulatory blood pressure measurement is a case in point, as decisions have to be made if it is to be made available to all GPs.

Once guidelines are adopted they need to be implemented and audited. They need to be monitored locally.

12. There should be universal access to all primary prevention services and they should be free at the point of access.
13. Heartwatch is a success. It may need to be improved but it does need to be rolled out.
14. Nurse cardiovascular facilitator posts need to be filled along with GP coordinators, which should focus specifically on cardiovascular work.
15. Universal GP access to diagnostic services is required.
16. We must maximise the role of practice nurses as part of chronic illness management in primary care and in particular to deliver heart health.
17. Better access to resuscitation training is needed.

WORKSHOP PRE-HOSPITAL CARE

Facilitated by Mr Brendan Cavanagh, PHECC

Five priority recommendations were suggested under this heading.

1. We need to educate the community in the awareness of the symptoms, who to contact and what to do. Training in CPR and defibrillation should be provided if appropriate. The provision of AEDs in the community should continue, and CPR is integral to AED programmes. It was agreed that priority locations should be as recommended by the Sudden Cardiac Death Taskforce.
2. Control centres need to be consistent nationally and the advice provided by the control centres needs to be consistent for acute cardiac conditions and stroke events. Prioritisation of despatching needs to be consistent. Advice from GP coops and other areas should also be consistent and there should be protocols, guidelines and education.
3. Corresponding agencies, which essentially refers to the uniformed agencies such as the Gardai and the fire service, are important to get on board. There are pilot schemes in the Gardai and in a few fire services. It is important to prioritise these agencies in the areas where they are needed by the ambulance services to get prompt pre-hospital care.
4. Specific prioritisation is needed in the community first responder teams, especially those schemes that need to be linked to the ambulance service. Schemes are needed in remote locations or perhaps in locations that are not remote, but where the ambulance service in those locations is sparse.

5. Comprehensive information collection and analysis to address monitoring and improving response times is needed.

WORKSHOP REPORT – HOSPITAL SERVICES & REHABILITATION

Facilitated by Dr Mary Hynes, HSE

The main points made at this workshop were:

1. There is a growing demand for ambulatory care in community and hospital settings and there is difficulty in meeting that demand. We need to have standards for assessments, for how they are carried out and interpreted and how they are acted upon. We must provide some assessment space in other hospitals outside acute hospitals. If ambulatory care is more available to GPs, then fewer patients will present to A&E and there will be improved continuity of care. Heart clinics could be set up in hospitals that would do the non-invasive assessment for the hospital, the community and provide rapid assessment for GPs.
2. There should be dedicated acute chest pain assessment unit located in the A&E in some of the larger teaching hospitals and they should be 24-hour. Patients presenting with chest pain to A&E should undergo an acute chest pain assessment. In other hospitals, it could be incorporated into the medical assessment unit under the area of cardiology.
3. Interventional cardiology targets in the Cardiovascular Strategy need to be revised upwards to a substantial degree. Also, there is a need to move to primary interventional treatment for reperfusion. Some centres need to be selected that will provide this on a 24- hour basis and this links into the pre-hospital area with issues around transport.
4. Although rehabilitation in a high proportion of hospitals, there is very limited staffing, so there are unacceptable waiting times for cardiac rehabilitation. The components for a rehabilitation team are almost identical to those needed for heart failure so there is potential for synergy. There are opportunities to strengthen both cardiac rehabilitation and heart failure units.
5. We need to modernise coronary care, and the current model of combined care units is out of date. There is a need for stand-alone intensive coronary care units. Linked to this, in post-intensive cardiac care there needs to be dedicated cardiac beds for patients to move into, with experienced nursing staff.
6. Manpower is a major issue. There is a need for greatly increased numbers of cardiac technicians. Training was discussed, as was means to encourage technicians to enter the cardiology field. It was also suggested that the recruitment of cardiologists could be fast- tracked. Training of administrative and managerial support is needed too.

WORKSHOP REPORT – HEART FAILURE

Facilitated by Dr David Weakliam, Health Service Executive

A number of recommendations were made in this workshop:

1. The most important priority, it was decided, is to define heart failure programmes and what is needed in the form of a disease management programme. Some elements of what should be contained in the programme came through in the discussions.
 - It should set the standard as to what is required to deliver best practice in heart failure.
 - It was suggested that it is best not to have one programme that you roll out across the country, but within the programme you define what is needed. Then different models can be implemented according to the location.
 - Also, it is best to build on existing programmes and learn from what is already happening in Ireland.
 - A heart failure programme needs to cover the spectrum of primary care and to be co-led by GPs and specialists to ensure a multidisciplinary approach.
 - There is a need to develop GPs with specialist interest in heart failure.
 - The importance of the GP facilitator was emphasised.
 - Communication and information is key.
 - Access to diagnostics in primary care is important.
2. There is a need to get commitment and implement heart failure programmes nationally and a need to get all stakeholders on board.
3. There is a need to expand a Heartwatch-type programme in terms of coverage and to cover people who are at risk of heart failure. The value of prevention for those at risk of heart failure and also the opportunity to bring people in contact with primary care with increased diagnosis was stressed.
4. There is a need to link in with chronic disease management and the opportunity for a joined-up approach of management. Through the programme there would be access to diagnosis and access to a cardiologist in the team, so it would be a good entry point for people with a diagnosis of heart failure.
5. We do not have the evidence base to manage people with impending heart failure. There is a need for research in this area.
6. Resourcing heart failure services is vital and we need to look at staffing in each area. There is a good deal of information available in the the St Vincent's Hospital heart failure service model .

7. There is a need for a database for heart disease generally and for proper systems for information.
8. We need to develop services allied to cardiac rehabilitation. Some trained staff can be involved in both programmes.

WORKSHOP REPORT – AUDIT & SURVEILLANCE

Facilitated by Wendy Walsh, HSE

The main issues emerging from this workshop were:

1. Data should inform direction' must be the mantra.
2. We must build on what is already out there.
3. Data collection is still piecemeal. We still have no national coverage.
4. We need to focus on the areas of priority, eg heart failure, and these need audit and surveillance. This is where the resources should go.
5. We need to develop a national heart disease registry; this still just a vision.
6. There were concerns voiced re security, staffing and costs. It was suggested that using a unique patient identifier would overcome the security issue. The cost would be offset by efficiency and quality gains.
7. Political will is needed on this, especially around using the PPS number as an identifier.
8. We need a commitment from the private sector. As well as a financial commitment, we need a commitment to quality.

THE FUTURE – NEXT STEPS

Professor Hannah McGee, Royal College of Surgeons in Ireland

The conference concluded with a look at the next steps to be taken, by Professor Hannah McGee of the Royal College of Surgeons of Ireland. Prof McGee is Chair of the recently established Cardiovascular Health Policy Group, appointed by the Minister for Health and Children.

Professor McGee said about 10 years on from the publication of the Cardiovascular Strategy and we now have new structures, such as the HSE and HIQA, and a whole range of strategies – for example the sudden cardiac death and health information strategies – and new mechanisms of thinking about ill-health including cardiovascular health.

She said chronic disease management is a phrase that was not much in use in the 1990s but now we are thinking in terms of primary care teams, revascularisation and rehabilitation. We are also trying to manage both lifestyle modification and disease modification and the evidence here and in other countries is that both pay off reasonably equally.

Prof McGee said the benefit of cardiovascular disease prevention is that anything done in cardiovascular disease is going to have an impact on most of the other major chronic diseases. Cardiovascular health is a marker for what really happens in the wider health system.

Professor McGee's policy group's remit is to set a vision for cardiovascular health in the form of a precise policy framework. The document is to be completed by the end of April 2008. Terms of reference for the policy group will take on board the audit of the implementation of the Cardiovascular Strategy and the recent audit of stroke services funded by the Irish Heart Foundation.

The aim of the Cardiovascular Health Policy Group is to develop a quality framework for the prevention, detection and treatment of cardiovascular disease, including stroke and peripheral vascular disease, that will ensure an integrated and quality-assured approach to their management. It includes the integration of quality assurance across actions that are currently been taken.

Populations of patients with coronary disease, stroke and peripheral vascular disease will be examined to see which aspects are similar and different in relation to prevention, diagnosis and treatment in those groups.

Data will be available to the policy group from various reports including the Cardiovascular Audit and Stroke Audit. The Slan 2007 survey will be available to the group ahead of publication.

DELEGATE LIST

Ms Kathleen Bennett,	Trinity Centre for Health Sciences
Ms Regina Black,	HSE
Professor Colin Bradley,	University College Cork
Ms Marie Branigan,	HSE
Ms Emer Burke,	Croi
Ms Sarah Cain,	Irish Heart Foundation
Ms Trish Caren,	St Michael's Hospital
Mr Brendan Cavanagh,	HSE
Ms Anna Clarke,	Diabetes Federation of Ireland
Dr Mary Codd,	Mater Hospital & UCD
Dr Patrick Collier,	St Vincent's University Hospital
Dr Niall Colwell,	South Tipperary General Hospital
Dr Claire Connolly,	NUI
Mr Alan Coyne,	HSE
Dr Peter Crean,	St James Hospital
Ms Caroline Cullen,	Irish Heart Foundation
Ms Martine Delaney,	Cork University Hospital
Dr John Devlin,	Chief Medical Officer's Office
Dr Pauline Diamond,	Mater Private Hospital
Dr Patrick Doorley,	HSE
Ms Catherine Dwyer,	Waterford Regional Hospital
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Ms Kay Karim,	Kerry General Hospital
Dr Peter Kearney,	Cork University Hospital
Dr Paul Keelan,	Our Lady of Lourdes Hospital
Ms Bernadette Kiberd,	HSE – Dublin North West
Ms Marian Kiernan,	HSE
Dr Geoff King,	Pre-Hospital Emergency Care Council
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