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7th May 2021

Deputy Louise O'Reilly, TD
Dáil Éireann
Leinster House
Kildare Street
Dublin 2

RE: PQ 21094/21

To ask the Minister for Health the status of the implementation of recommendation 4.5 of Changing Cardiovascular Health: National Cardiovascular Health Policy 2010 – 2019; the actions that were taken to ensure full implementation; the aspects outstanding; and if he will make a statement on the matter.

Dear Deputy O'Reilly,

The Health Service Executive (HSE) has been requested to reply directly to you in relation to the above parliamentary question, which you submitted to the Minister for Health for response. I have consulted with the National Clinical Programme (NCP) for Diabetes on your question and have been informed that the following outlines the position.

Dyslipidaemia is commonly present in patients with Type 2 diabetes. An increased concentration of low-density lipoprotein (LDL) cholesterol and of total cholesterol is an independent risk factor for cardiovascular morbidity and mortality.

The Model of Integrated Care for Type 2 Diabetes [(1)] recommends that everyone with Type 2 diabetes should have their lipid profile checked at initial diagnosis. If a patient is above the LDL cholesterol target, the lipid profile should be checked every four months in response to changes in lipid-lowering therapy until the patient is stable and within target. Once the patient is stable, within target and on treatment, the lipid profile can be checked annually.

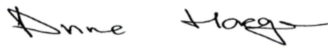
In 2019, the HSE reached agreement[(2)] with the IMO on a number of General Practitioner (GP) contractual reforms including the implementation of the *Chronic Disease Management Programme*[(3)]. The aim of this programme is to take a population level approach to prevention and management of chronic diseases that will benefit over 430,000 General Medical Services (GMS) / General Practitioner Visit Card (GPVC) patients. It will result in improved management of type 2 diabetes in general practice, early detection of complications or new conditions reducing the risk of worsening health and/or hospital admissions and detection of patients at-risk of developing type 2 diabetes with the aim of prevention. Specifically, the Chronic Disease Management Programme provides for two review consultations with the GP annually (both visits preceded by a visit with the practice nurse). These visits comprise an annual review and follow-up visit and requires LDL and total cholesterol to be checked,

with intervention as appropriate. They also include review of smoking status, exercise, alcohol intake, BMI measurement and BP checks. The Chronic Disease Management Programme is currently implemented for GMS patients over the age of 70 years of age with planned expansion to younger age-groups in the next 2-3 years. Currently, the Chronic Disease Management Programme does not cover those non-GMS/ GPVC patients.

In addition, the *HSE Winter Plan 2020*[4] included provisions to commence a targeted reform programme, in line with the vision set out by Sláintecare, known as the *'Enhanced Community Care Programme'*. This programme aims to resource and scale-up community healthcare services, including specialist chronic disease and diabetes services within the community setting. This programme will result in a significant increase in the number of Diabetes Nurse Specialists and Diabetes Dietitians being appointed to cover all community health networks across the country. These posts will support GPs in the implementation of the Chronic Disease Model of Care and will assist with early detection and structured cardiovascular care of people living with diabetes. Roll-out of the Enhanced Community Care Programme commenced in Q4 2020.

I trust this information is of assistance to you, but should you have any further queries please do not hesitate to contact me.

Yours sincerely



Anne Horgan
General Manager

References:

1. Model of Integrated Care for T2DM: https://www.hse.ie/eng/services/list/2/primarycare/east-coast-diabetes-service/management-of-type-2-diabetes/model-of-integrated-care-for-patients-with-type-2-diabetes-%E2%80%93-a-guide-for-health-care-professionals.pdf
2. GP Agreement 2019: https://www.hse.ie/eng/about/who/gmscontracts/2019agreement/agreement-2019.pdf
3. Chronic Disease Management Programme: https://www.hse.ie/eng/about/who/gmscontracts/2019agreement/chronic-disease-management-programme/
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