

East of England Lipid Optimisation and Familial Hypercholesterolaemia Group (LOAFH)

Position Statement on Lipid Lowering Strategies

Executive Summary

This position statement, developed by the East of England Lipid Optimisation and Familial Hypercholesterolaemia (LOAFH) group in collaboration with over 90 stakeholders from all six ICBs across the region—including GPs, consultants, pharmacists, clinical leaders, analysts, commissioners, programme managers, academic staff, and specialist clinicians—outlines a comprehensive strategy to improve lipid management and enhance the detection and treatment of Familial Hypercholesterolaemia (FH) across the East of England.

Key Recommendations

- Systematically identify high-risk patients for cardiovascular disease, using practice register search tools and proactive population health approaches to minimise geographical variation in care.
- **Optimise lipid-lowering therapy**, including appropriate statin dosing, increased use of inclisiran for high-risk patients with simplified guidance to support adoption, and icosapent ethyl as an adjunctive therapy for patients with elevated triglycerides.

- **Promote patient-centred care**, with an emphasis on personalised treatment plans rather than rigid adherence to extreme LDL-lowering targets.
- Familial Hypercholesterolaemia (FH). Prioritise as a public health issue and improve access to genetic testing—e.g. inclusion of SNP scores if provided in the FH panel and enabling primary care access to genetic testing requests.
- **Raise awareness of FH within primary care**, including education for GPs and embedding FH into care pathways.
- **Strengthen patient engagement**, using tools such as automated AccuRx messaging to improve communication, support shared decision-making, and enhance follow-up.
- **Provide stronger support for primary care**, including funding, streamlined pathways, and collaboration with Integrated Care Boards and provider companies to scale up proven interventions.
- **Conduct sustained public health campaigns** to improve awareness, engagement, and adoption of lipid-lowering initiatives across the healthcare system.
- Adopt and scale up successful regional initiatives, such as the Eclipse Live digital FH hub, POCDOC point-of-care lipid testing, and community-led lipid clinics.

These recommendations aim to bridge the gap between evidence and practice, reduce the burden of cardiovascular disease, and deliver equitable, high-quality lipid care across the East of England.

Introduction:

The LOAFH group comprises lipidologists, general practitioners (GPs), pharmacists, clinicians, and commissioners working together to improve the diagnosis and treatment of patients with FH and to manage hyperlipidaemia in the East of England. A series of meetings were held to examine clinical evidence and available resources for implementing best practices. We also highlighted regional initiatives aimed at improving lipid management. Despite a wealth of evidence showing that better lipid management leads to improved outcomes, including reduced mortality and hospitalisation from cardiovascular disease (CVD), population-level lipid management remains suboptimal.

Cardiovascular disease (CVD) is the leading contributor to life expectancy inequality in England. Every 1 mmol/L reduction in LDL cholesterol translates into a 20% decrease in CVD risk.

However, <u>CVDPREVENT</u> data for the East of England highlights a significant gap in achieving NHS goals for lipid management, particularly in the prevention of cardiovascular disease, treatment of established cardiovascular conditions, and detection of patients with Familial Hypercholesterolaemia.

For example:

CVDP009CHOL: Patients with GP recorded CVD (narrow definition), who are currently treated with lipid lowering therapy.



Familial Hypercholesterolaemia (FH)

FH is significantly underdiagnosed, with fewer than 10% of cases currently identified. Individuals with undiagnosed FH face high lifetime cardiovascular risk. However, limited commissioning, under-resourced clinics, and lack of systematic identification strategies hamper progress.

While the health service has many tools to address these issues, national commissioning is limited, with funding restricted to the GP Quality and Outcomes Framework (QOF) for patients who have already experienced a cardiovascular event.

Additionally, there are only five specialist lipid clinics in the East of England, each staffed by a single consultant. The NHS Health Check programme helps identify individuals at high cardiovascular risk, but overburdened general practices are left to manage these patients. Systematic patient searches for those at high risk are entirely possible, but there is currently no national funding to support this.

There are examples of excellent practice in the East of England, and replicating these initiatives regionally could lead to a significant reduction in risk associated with high lipid levels.

Lipid management pathway

Health Innovation East established LOAFH and has been disseminating lipid management education through webinars and supporting several regional initiatives. The group has also reviewed NICE's lipid management guidance and European Society of Cardiology recommendations to inform its approach.

The group reviewed the **NHS Accelerated Access Collaborative (AAC) Lipid Management Pathway** and considered its recommendations for improving lipid management across the healthcare system.

The clear conclusion is that there is a significant gap between evidence-based best practices and their actual implementation in clinical settings.

The following diagrammatic pathway illustrates the number of steps required to ensure good lipid management.



In order to address the gap between evidence and practice LOAFH offers the following recommendations:

1. Systematically identify high risk patients for cardiovascular disease

The health service should systematically identify patients at high risk for cardiovascular disease. There are currently no national mechanisms for this beyond NHS health checks.

Achieving this requires commissioning at scale, either through Integrated Care Boards (ICBs) or NHS England, or by engaging with the pharmaceutical industry to support primary care.

Several tools are available to search practice registers and communicate effectively with patients, particularly using remote methods. These include EMIS, SystmOne, Ardens, Eclipse Live, and AccuRx. Primary Care Networks (PCNs) and GP provider companies can facilitate or use their in-house tools to achieve this.

We need to be mindful however that uptake of NHS health checks is lower in more deprived populations and that includes cholesterol testing. **Initiatives are required to reach out to deprived populations.** An example of this is the installation of SISU stations in deprived areas and Point of Care (PocDoc) testing for lipids.

2. Optimise lipid-lowering therapy

There are now a wide range of therapeutic interventions available to clinicians and patients.

Statins remain the first line treatment. However, while atorvastatin 80mg is the recommended first-line treatment for secondary prevention of established cardiovascular disease, local lipidologists have raised concerns about its tolerability. Therefore, its role should be evaluated against other therapies that may offer better outcomes with fewer side effects.

For instance, evidence suggests that atorvastatin 40mg combined with **ezetimibe** 10mg is more effective than atorvastatin 80mg, especially when patients are not fully adherent to the latter regimen. Studies have shown that this combination yields better results in terms of efficacy and patient tolerability.

- Efficacy and Safety of Ezetimibe Added on to Atorvastatin (40 mg) Compared With Uptitration of Atorvastatin (to 80 mg) in Hypercholesterolemic Patients at High Risk of Coronary Heart Disease -Ajconline.org
- The comparative efficacy of ezetimibe added to atorvastatin 10 mg versus uptitration to atorvastatin 40 mg in subgroups of patients aged 65 to 74 years or greater than or equal to 75 years <u>PubMed Central</u>
- Efficacy and Tolerability of Ezetimibe/Atorvastatin Fixed-dose Combination Versus Atorvastatin Monotherapy in Hypercholesterolemia: A Phase III, Randomized, Active-controlled Study in Chinese Patients - <u>ScienceDirect</u>

Inclisiran, a small interfering RNA therapy targeting PCSK9, has proven highly effective in reducing LDL cholesterol by up to 50%, offering significant cardiovascular risk reduction for high-risk patients. However, its adoption in primary care has been slow due to concerns about cost, treatment complexity, and lack of familiarity. Inclisiran requires biannual injections, which may seem less convenient compared to daily oral therapies.

To improve adoption, simplified guidelines are needed to clarify when and how inclisiran should be used. Additionally, providing support through training, clear patient selection criteria, and education for both healthcare providers and patients will help increase its uptake, ensuring broader access to this effective treatment.

Bempedoic acid provides a modest LDL reduction (25%), but side effects such as gout limit its widespread use. Inclisiran, which offers a 50% reduction in LDL and improved patient compliance with minimal side effects, is recommended as a preferred option over bempedoic acid.

Consideration should also be given to bypassing intermediate treatments (e.g. ezetimibe) when more clinically appropriate medications, like inclisiran, could be used to optimise lipid-lowering therapy in secondary prevention.

Icosapent ethyl, a highly purified form of eicosapentaenoic acid (EPA), has shown significant promise in reducing cardiovascular events in patients with elevated triglyceride levels, particularly in those with established cardiovascular disease or diabetes. Studies such as the **REDUCE-IT trial** have demonstrated that icosapent ethyl reduces the risk of major cardiovascular events, including heart attack, stroke, and cardiovascular death, by approximately 25%. It does so by reducing inflammation, improving endothelial function, and stabilizing atherosclerotic plaques. While icosapent ethyl is not a first-line treatment for lipid management, it can be considered as an adjunctive therapy in high-risk patients, especially those with persistent elevated triglycerides despite statin therapy. Its use should be tailored to individual patient profiles, particularly in those who meet the specific criteria outlined by clinical guidelines.

3. Promote patient-centred care

A senior lipidologist in the LOAFH group advocated for **pragmatic LDL targets**, with NICE's guideline of LDL <2 for secondary prevention being a realistic and achievable goal. The group emphasised a holistic approach, balancing LDL targets with management of other risk factors such as blood pressure and lifestyle factors.

Personalised care, reflecting individual risk profiles, was prioritised over rigid adherence to extreme LDL-lowering targets (<1.4). However, this should be balanced against the clear message that the lower the cholesterol level the better.

4. Familial Hypercholesterolaemia

FH must be recognised as both a **clinical and public health** priority. Tools like Ardens and Eclipse were praised for their role in facilitating practice engagement and streamlining patient identification and follow-up processes however a sustained public health campaign to enhance awareness and adoption of lipidlowering initiatives across healthcare settings was strongly recommended.

5. Strengthen patient Engagement

Effective patient engagement strategies are crucial. Tools like automated ACCURX messaging were noted for their effectiveness in disseminating patient information, initiating meaningful conversations, and ensuring follow-up. **Shared decision-making** and robust patient education are essential components of successful engagement.

Listening to patients and addressing their concerns, especially regarding side effects, helps build trust and promotes adherence to treatment plans.

6. Provide stronger support for primary care

General practice is under significant pressure and lacks the capacity to achieve optimal lipid management outcomes, despite having the necessary clinical tools. To empower practices, enhanced funding, systematic prioritisation, and better support structures are critical.

Incentivising primary care for their expanded role in lipid management should be prioritised to ensure that lipid optimisation is adequately addressed.

7. Guidelines and Pathways

The management of lipid therapies in a dedicated hub would be helpful. There are pockets of practice conforming with this in our area.

Guidelines should focus on clear targets but also consider the cost to general practice when adhering to them.

There is also a need to improve the accuracy and accessibility of FH genetic testing and reduce bottlenecks in testing processes.

Care pathways should be simplified to integrate automated tools for patient identification and follow-up, reducing clinician burden.

8.Population Health Management (PHM) / Proactive Care

Expand the use of tools like Ardens and Eclipse to support **proactive patient management.** Consider integrating this work into the general practice contract or incentivising practices to support lipid management.

Funding mechanisms should be put in place to alleviate resource constraints and enable lipid management initiatives, including the administration of inclisiran.

Collaboration with pharmaceutical companies could enhance resource accessibility and streamline implementation efforts.

Regional examples of good practice that could be adopted at scale:

- 1. Norfolk and Waveney Eclipse Live project and FH hub-A digital FH Hub using the Eclipse Live platform to remotely stratify FH risk and optimise lipid management.
- 2. BLMK Community Lipid Clinic A community-led service improving access to FH identification and lipid optimisation for high-risk patients.
- 3. POCDOC project A point-of-care cholesterol testing pilot using lateral flow technology to improve lipid management in primary care.
- 4. Collaborated Lipids Fund SNEE ICS A pilot introducing Inclisiran, an injectable lipid-lowering therapy, into primary care settings.
- 5. Healthy Hearts project (NEE) A programme enhancing cholesterol and hypertension management to reduce cardiovascular events.
- 6. Granta PCN Lipid Project A primary care initiative improving access to lipid management and optimising treatment pathways for ASCVD patients.
- 7. Child-Parent FH screening A pilot screening programme identifying FH in children and supporting family-based genetic testing and treatment.

Conclusion:

Effective lipid management—especially for patients with FH or established CVD is vital to reducing cardiovascular events, mortality, and health inequalities.

Despite the wealth of evidence supporting lipid-lowering therapies, there remains a significant gap between best practices and their implementation in clinical settings. The adoption of evidence-based guidelines, such as those from NICE and the Accelerated Access Collaborative, is essential to address these challenges.

Key priorities include the systematic identification of high-risk patients, optimised use of statins, the timely incorporation of newer therapies like inclisiran, and a strong focus on patient education, are vital for improving outcomes.

Equally important is the need to streamline treatment pathways, strengthen primary care capacity, and establish sustainable funding models to support delivery. These measures will enable the broader and more equitable adoption of effective lipid-lowering interventions

By bridging the gap between evidence and practice, we can significantly reduce the burden of cardiovascular disease and improve the quality of care for patients across the East of England and beyond.