QUICK GUIDE

Primary care lipid optimisation in secondary prevention – 2025 update

This quick guide has been created and funded by Novartis Pharmaceuticals UK Ltd and discusses Novartis Pharmaceuticals UK Ltd products. It is intended for UK Healthcare Professionals only.Prescribing Information and Adverse Events reporting can be found at the end of this article.This quick guide was originally published in May 2023, and has been updated in line with 2025/26 QOF guidance and information on the new NHSE reimbursement support available for LEQVIO®.

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The 2025/26 Quality and Outcomes Framework (QOF) is the strongest statement to date that primary care must prioritise atherosclerotic cardiovascular disease (CVD) risk reduction, with a significant focus on lipid lowing.[1,2] This is unsurprising given that 7.1% of all UK deaths are due to high cholesterol; our lipid management is currently inadequate, CVD deaths had historically fallen and plateaued in the UK but are now climbing, and most cardiovascular events are preventable.[2,3]

The ambition behind this year's QOF aligns with national drivers including the Darzi report, Cardiac Transformation Programme, and the Health Innovation Network (HIN) Lipid Management Pathways.[4]

The 2025/26 QOF cholesterol indicators (Chol 003 and 004) also reflect NICE guidance (NG238)[5] and are based on the paradigm that lowering low-density lipoprotein cholesterol LDL-C (or non-high-density lipoprotein cholesterol (HDL-C)) *by any means* can significantly reduce cardiovascular events.[6,7] NICE have been clear that a LDL-C of <2.0 mmol/L should be aimed for in patients with established CVD; in other words, we should not simply accept 2.0 mmol/l as satisfactory. The European Society of Cardiology (ESC) target for patients with established CVD is currently 1.4 mmol/L or lower and a reduction in LDL-C of over 50% from baseline for secondary prevention patients.[8]

A LDL-C reduction of 1 mmol/L is associated with a 22% relative risk reduction of a first major cardiovascular event over a 5-year period.*[7] Of deep concern, however, is that around 15% of people in England with established CVD are not on any lipid lowering therapy (LLT) at all and fewer than 50% have an LDL-C <2.0 mmol/L or non-HDL cholesterol <2.6 mmol/L.[9] The latter reflects those on no LLT, prescribed inadequate LLT or poor adherence.

Inadequate LLT reflects people on lower than appropriate doses of high-intensity statins such as atorvastatin or rosuvastatin, those prescribed low-intensity statins such as simvastatin or pravastatin, or those who are not receiving non-statin-based therapies. Fortunately, primary care now has access to a number of LLTs that, when used in combination, can help achieve LDL-C targets both efficiently and effectively.[1] This paradigm in lipid lowering, like hypertension, is combining therapies to reach targets. Full achievement of QOF Chol 004 is unlikely without the use of combination LLTs.

Indicator[1]	Threshold to achieve target		Max points available	
	2024/25	2025/26	2024/25	2025/26
CHOL003. Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, Stroke/TIA or Chronic Kidney Disease Register who are currently prescribed a statin, or where a statin is declined or clinically unsuitable, another lipid-lowering therapy	70-95%	**70-95%**	14	**38**
CHOL004. Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, or Stroke/TIA Register, who have a recording of LDL cholesterol in the preceding 12 months that is lower than 2.0 mmol/L, or where LDL cholesterol is not recorded, a recording of non-HDL-cholesterol in the preceding 12 months that is 2.6 mmol/L or lower	20-35%	**20-50%**	16	**44**

A systematic, sustainable and holistic approach to optimising lipids is essential to help improve outcomes for patients. We should recognise that lifestyle measures must not be ignored. Smoking cessation, exercise, weight management and dietary interventions, as well as medicines management, should all be considered.[2] For example, daily plant stanol esters can further reduce LDL-C by approximately 10%.[10]

To help with more effective prescribing and efficient care delivery, it would be advisable to commence patients on a high-intensity statin as soon as possible after an acute event.[5] The rationale for a high-dose, high-intensity statin can be illustrated by the fact that simvastatin 80 mg is approximately equivalent to atorvastatin 20 mg.[11] Once optimised on the maximum tolerated dose of a statin, patients should be reviewed in two to three months.[5]

Continued overleaf →

LEQVIO® is indicated in adults with primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia, as an adjunct to diet:[12]

- In combination with a statin or statin with other lipid-lowering therapies in patients unable to reach LDL-C goals with the maximum tolerated dose of a statin, or
- Alone or in combination with other lipid-lowering therapies in patients who are statin-intolerant, or for whom a statin is contraindicated

Who might benefit from additional LLT?

Patients should be proactively identified using primary care electronic health records, population health data tools or hospital electronic care records.[13]

Doubling the dose of atorvastatin – for example, from 40 mg to 80 mg – only increases cholesterol lowering by 6%, whereas the addition of an alternative therapy, such as ezetimibe, showed a stronger ability of reducing LDL-C.[14,15] When combined with a statin, ezetimibe reduces LDL-C by a further 15% to 20%.[16] Ezetemibe and bempedoic acid can reduce LDL-C by circa 30%.[17] Clinicians may also consider LEQVIO® (inclisiran), in combination with a maximally tolerated dose of statin, to help secondary prevention patients reach their LDL-C targets.[12,18]

When combined with a statin, LEQVIO® reduces LDL-C by a further ~50%.[12]

LEQVIO® is a subcutaneous injectable therapy that increases hepatocyte LDL-C uptake and lowers levels of LDL-C in the circulation by ~50%.[12]

LEQVIO® showed placebo-adjusted LDL-C reductions of ~50% on average seen as early as 90 days after initiation, on top of a maximally tolerated dose of statin.†[12,18] Time-adjusted LDL-C reductions were 49% (95% CI: −51.6 to −46.8; P<0.001) from baseline between months 3 and 18 relative to placebo.*[12,18]

- After an initial dose and a dose at 3 months, LEQVIO® is administered every 6 months thereafter (all doses are administered by a HCP)[12]
  - The twice-yearly maintenance dosing schedule could improve adherence of patients to treatment[19,20]

In clinical trials, LEQVIO® had a well-tolerated safety profile similar to placebo, apart from injection site reactions (8.2% vs 1.8% with placebo)[16]

Through QOF, primary care has been contractually enabled to identify high-risk patients, systematically recall, and holistically optimise people to reduce their cardiovascular risk.[1] To support delivery, there is an array of therapeutic oral and injectable options beyond statins that may be offered within primary care to help reduce LDL-C levels across our population.

The 2025–2026 QOF recognises the importance of proactive cholesterol management. Of all CV indicators, cholesterol has been given the greatest uplift, acknowledging this priority and the importance placed upon lipid management in primary care.[1]

NHS England has agreed, through the Department of Health and Social Care, that the reimbursement amount for LEQVIO® is increased from £50 to £60 for primary care providers and community pharmacies to reflect incurred costs.[21,22] As a result:

An increased reimbursement supplement is **now available to support LEQVIO® implementation in England**.

This additional support can help patients in achieving and maintaining LDL-C target levels in a way that is **cost effective in the long term**.[21,22] See **https://pccsuk.org/default.aspx** for more information.

***The effect of inclisiran on cardiovascular morbidity and mortality has not yet been determined.**

†Data from the multicentre, double-blind, randomised, placebo-controlled, 18-month ORION-10 (N=1,561) and ORION-11 (N=1,617) clinical trials evaluating adult patients on a maximally tolerated statin with atherosclerotic CVD (ASCVD), and with ASCVD or risk equivalents, respectively. The baseline mean (±) LDL-C levels were 2.70 ± 1.02 mmol/L with LEQVIO® and 2.71 ± 0.96 mmol/L with placebo in ORION-10, and 2.77 ± 1.08 mmol/L with LEQVIO® and 2.68 ± 0.94 mmol/L with placebo in ORION-11. At Month 17, LEQVIO® delivered placebo-corrected LDL-C reductions of 52%, as compared with baseline (−51% with LEQVIO® vs +1% with placebo; 95% CI: −55.7 to −48.8; P<0.001) in ORION-10, and of 50%, as compared with baseline (−46% with LEQVIO® vs +4% with placebo; 95% CI: −53.1 to −46.6; P<0.001) in ORION-11, with respective time-adjusted LDL-C reductions of 54% (−51% with LEQVIO® vs +3% with placebo; 95% CI: −56.2 to −51.3; P<0.001) and of 49% (−46% with LEQVIO® vs +3% with placebo; 95% CI: −51.6 to −46.8; P<0.001) from baseline between Months 3 and 18 relative to placebo.[18]

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Prescribing information is available via the QR code or the following link: https://www.emcpi.com/pi/38848

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