Royal Cornwall Hospitals
NHS Trust

Adult Lipid Management (Mx) Pathways Clinical Guideline

V1.0

March 2026

1. Aim/Purpose of this Guideline

1.1. This guideline has been created to support HCPs in Kernow/IOS Primary and Secondary Care with Lipid Management.

1.2. Primary CVD prevention Lipid Mx (Appendix 3).

1.3. Secondary CVD prevention Lipid Mx (Appendix 4).

1.4. Managing raised cholesterol pathway (Appendix 5).

1.5. Hypertriglyceridaemia (Appendix 6).

1.6. Lipoprotein (a) [Lp(a)] (Appendix 7):

- When to measure and how to manage if raised (in primary prevention) incl. when to recommend cascade testing.
- Additional info re: Lp(a) and references.

1.7. Genetic cascade testing for Familial Hypercholesterolaemia (FH) (Appendix 8).

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. This is a guide, it is the responsibility of the reviewing healthcare professional (HCP) to ensure that the appropriate lipid-lowering medication/dose adjustments are made according to the patient scenario e.g. renal impairment, hepatic impairment, ethnicity, other concomitant conditions/medications etc.

2.2. This guidance is designed for use in Primary and Secondary care. For simplicity the lipid targets cited are as per NICE guidance, however there are situations where these may not be appropriate and alternative targets are used (e.g. European secondary CVD prevention targets).

2.3. The guidance for this clinical guideline is contained in the flowcharts at the following appendices as linked below:

- Appendix 3: Primary CVD Prevention Lipid Management Pathway
- Appendix 4: Secondary CVD Prevention Lipid Management Pathway
- Appendix 5: High Cholesterol Mx Pathways (High cholesterol in Primary CVD Prevention)
- Appendix 6: Hypertriglyceridaemia (the 'non-acute'/incidental finding)
- Appendix 7: Lipoprotein (a) [Lp(a)]
- Appendix 8: Genetic Cascade Testing for Familial Hypercholesterolaemia (FH)

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Compliance with Lipid Management (Mx) Pathways in accordance with this guideline (or other safe practice).
Lead	Head of Pathology Unit.
Tool	Adherence will be monitored as part of the audit process within the department on a template specific to the topic.
Frequency	Formally monitored every 3 years.
Reporting arrangements	Clinical leads will act on directorate/governance recommendations.
Acting on recommendations and Lead(s)	Shared via Care Group Governance sessions as appropriate.
Change in practice and lessons to be shared	Lessons and changes in practice will be communicated through various channels to relevant staff.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Adult Lipid Management (Mx) Pathways Clinical Guideline V1.0
This document replaces (exact title of previous version):	New Document
Date Issued/Approved:	11 March 2026
Date Valid From:	March 2026
Date Valid To:	March 2029
Directorate / Department responsible (author/owner):	Dr. Rachel Cooper, Consultant in Chemical Pathology/Metabolic Medicine. Sarah Pointon, Pathology Quality and Governance Manager and Health and Safety Lead.
Contact details:	01872 252544
Brief summary of contents:	This guideline has been created to support HCPs in Kernow/IOS Primary and Secondary Care with Lipid Management.
Suggested Keywords:	Lipid, hypercholesterolaemia, familial hypercholesterolaemia, FH, hypertriglyceridaemia, LPAa, lipid, cholesterol, triglyceride.
Target Audience:	**RCHT:** Yes **CFT:** Yes **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Pathology Quality and Governance Committee
Manager confirming approval processes:	Richard Andrzejuk
Name of Governance Lead confirming consultation and ratification:	Kevin Wright
Links to key external standards:	Supporting NICE guidance: Ezetimibe - TA385, Alirocumab - TA393, Evolocumab -

Information Category	Detailed Information
	TA394, Bempedoic acid/Ezetimibe - TA694, Inclisiran - TA733, Icosapent ethyl - TA805, Cardiovascular disease: risk assessment and reduction, including lipid modification – NG238. https://www.england.nhs.uk/aac/publication/statin-intolerance-pathway NHS Accelerated Access Collaborative » Summary of national guidance for lipid managementCegla, J. et al. (2019). HEART UK consensus statement on Lipoprotein(a): A call to action. Atherosclerosis, [online] 291, pp.62–70. doi: https://doi.org/10.1016/j.atherosclerosis.2019.10.011. Kronenberg F et al. Lipoprotein (a) in atherosclerotic cardiovascular disease and aortic stenosis: a European Atherosclerosis Society consensus statement. European Heart Journal. 2022: 0, 1-22. https://www.uhbw.nhs.uk/assets/1/24-952_management_of_lipoprotein_dec_23_redacted.pdf
Related Documents:	None required.
Training Need Identified?	None
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Pathology

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
September 2025	V1.0	Initial document.	Dr. Rachel Cooper, Consultant in Chemical Pathology/Metabolic Medicine.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus six years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Appendix 2. Quality and Equality Impact Assessment (QEIA) Guidance Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

For guidance, please contact the Equality, Diversity and Inclusion Team at rcht.inclusion@nhs.net

1. About the Policy / Service Change:

Information Category	Detailed Information
Individual completing QEIA: (Name, Role, Email)	Dr. Rachel Cooper, Consultant in Chemical Pathology/Metabolic Medicine.
Service Area: (Department, Division)	Pathology, Clinical Support and Cancer Division
Name of document:	Adult Lipid Management (Mx) Pathways Clinical Guideline V1.0
Type of document: (Policy, Strategy, Service Change)	Clinical Guideline
Policy / Service Change Objective(s): (What should it achieve, and for whom?)	To assist and provide guidance on lipid management to ensure best practice as recommended by published national guidance. Increase HCP confidence in lipid management which will result in optimal lipid management in the respective patient cohorts. Reduce the number of AandG/referrals at earlier stages of lipid management.
Does this Policy / Service Change: (Select all that apply)	Eliminate Discrimination? Yes Advance Equal Opportunity? Yes Foster Good Relations? Yes
Which Groups are impacted by this policy? (Select all that apply)	Yes – Workforce. Yes – Patients. No – Visitors. No - System Partners. No - External Organisations. No – Contractors.

2. About the impact:

For each characteristic, please indicate whether you think the impact will be positive, negative or unknown, and provide a brief explanation:

Note: Stating 'This document has no impact on this group' for all characteristics will result in the document not being approved.

Characteristic	Impact	Explanation
Age	Positive	
Sex	Positive	
Gender Reassignment	Positive	
Race, Ethnicity, Culture	Positive	
Disability or Long-term Health Condition	Positive	
Religion or Belief	Positive	
Marriage and Civil Partnership	Positive	
Pregnancy and Maternity	Positive	
Sexual Orientation	Positive	
Armed Forces Community	Positive	
Low Income Households	Positive	

A consultation must take place with appropriate groups to clarify unknown impacts and recommend mitigation of negative impacts.

3. About the Consultation

Information Category	Detailed Information
Which bodies have been consulted? (Not all will be required)	Yes Service Employees. No Employee Network Groups. No Union Representatives. No EDI Team. No Patient / Service Users. No Patient Advisory Group. No Patient Representatives. No Local / National Charities. No System Partners. No External Organisations.

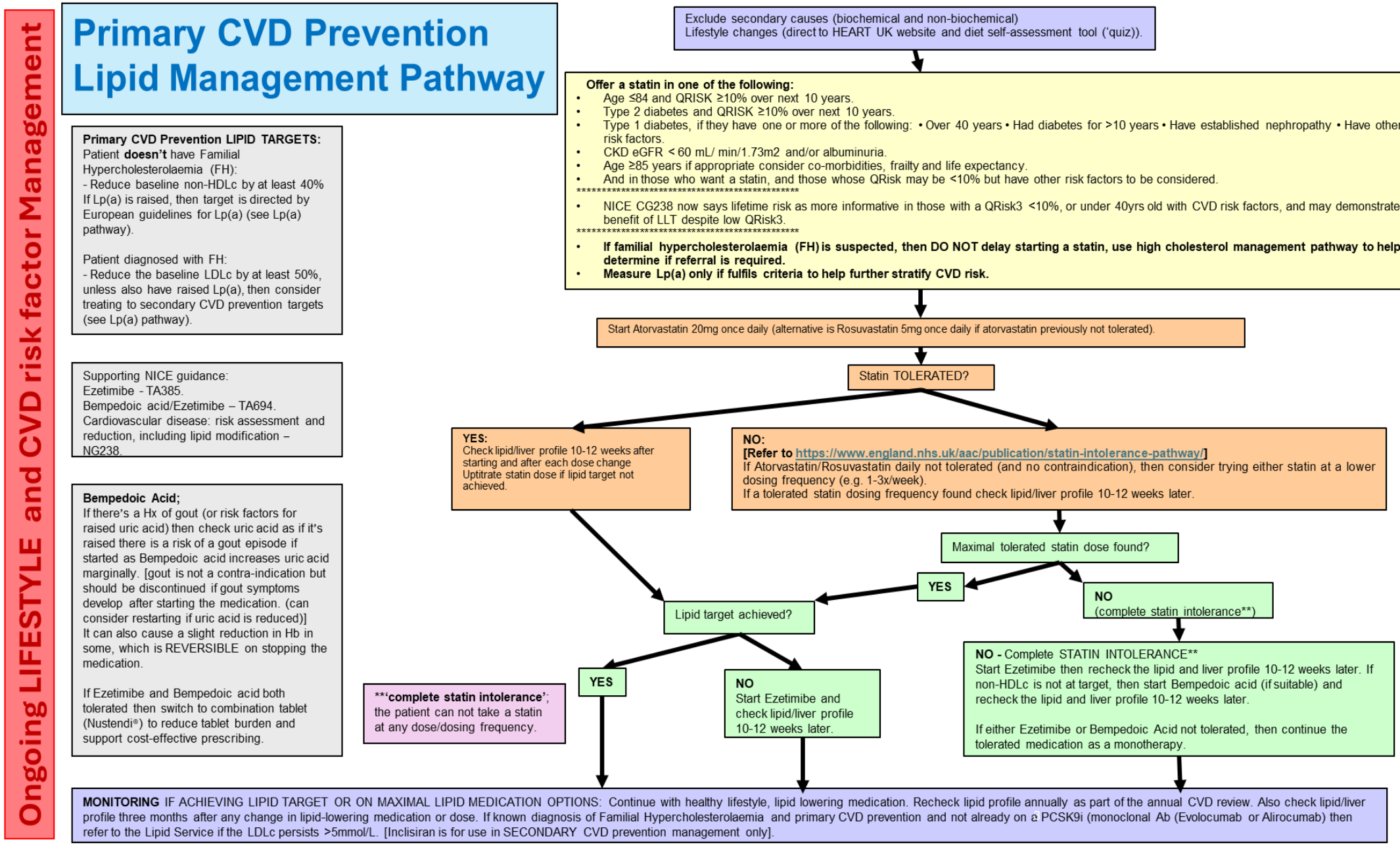
Information Category	Detailed Information
	No Other.

Information Category	Detailed Information
Please list the individuals / groups who have been consulted: (Role, Organisation, Email. Avoid using individual names)	Cornwall Area Prescribing committee (CAPC), clinical chemistry operational meeting, Pathology Directorate. The pathways were also trialed with attendees to a locally held lipid meeting to gain feedback and access usability. Attendees included primary and secondary care HCPs.
Consultation Outcomes: (Positive feedback, new negative impacts, recommendations)	Reviewed and approved by Cornwall Area Prescribing committee (CAPC), clinical chemistry operational meeting, Pathology Directorate.
What action will you now take?	Continue without Amendments
Provide Details:	Agreed
Do any negative impacts remain?	No
Explain rationale for proceeding with negative impacts:	None

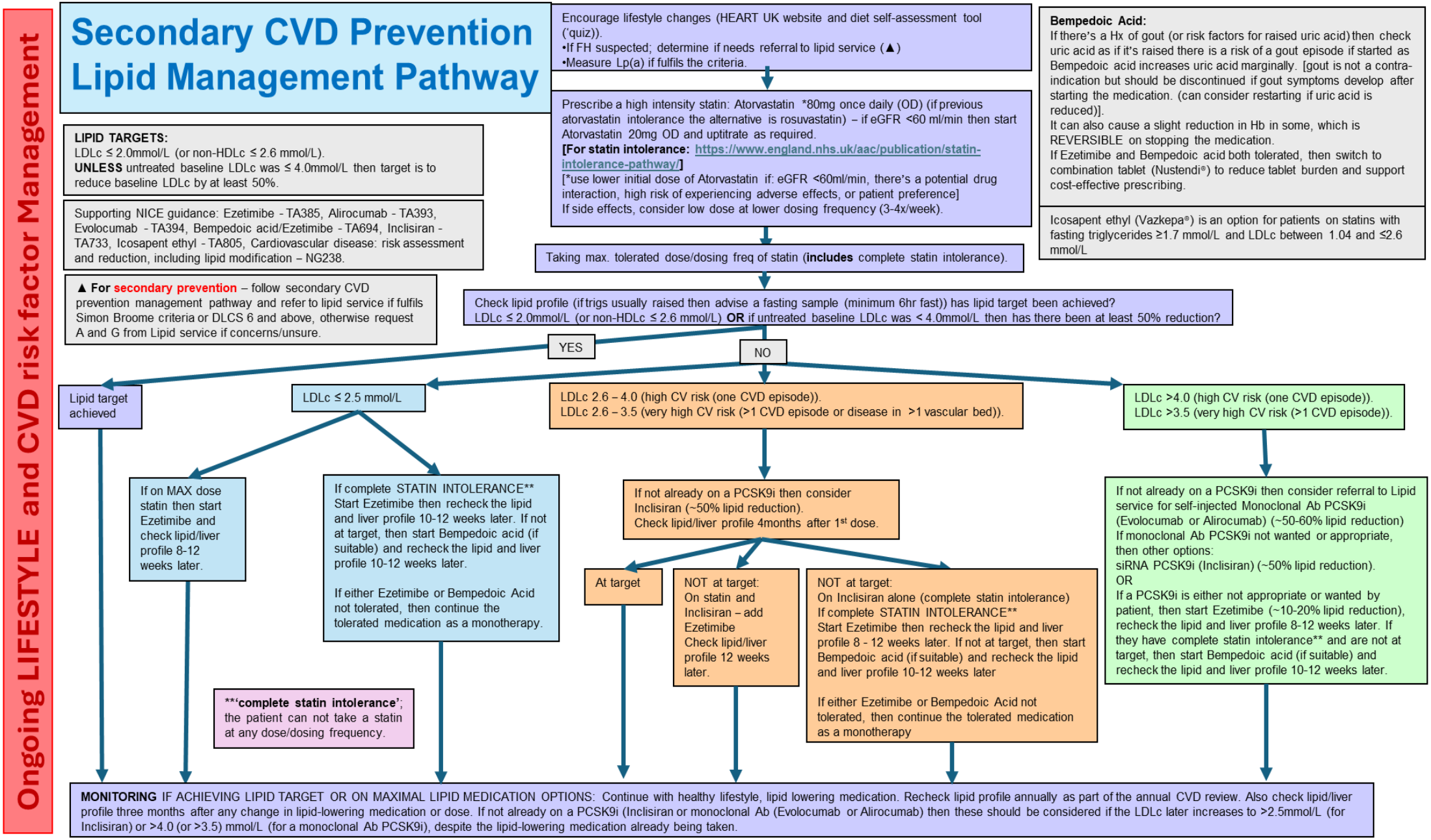
I am confident that this QEIA is an honest reflection of my efforts to comply with the Public Sector Equality Duty, and that all appropriate, necessary actions have been taken to mitigate any negative impacts as far as practicable.

Name:	Dr. Rachel Cooper	Role:	Consultant in Chemical Pathology / Metabolic Medicine.

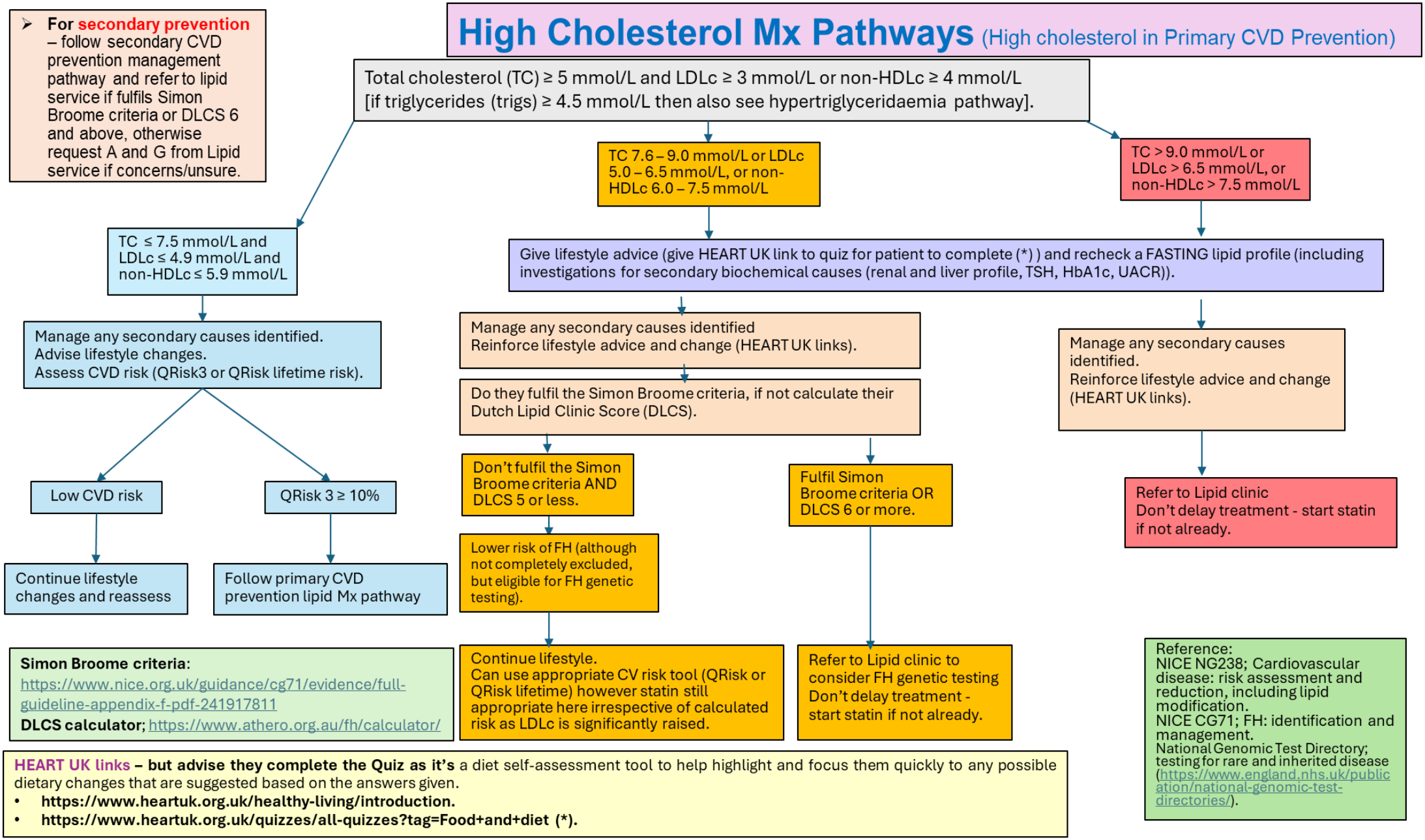
Appendix 3. Primary CVD Prevention Lipid Management Pathway



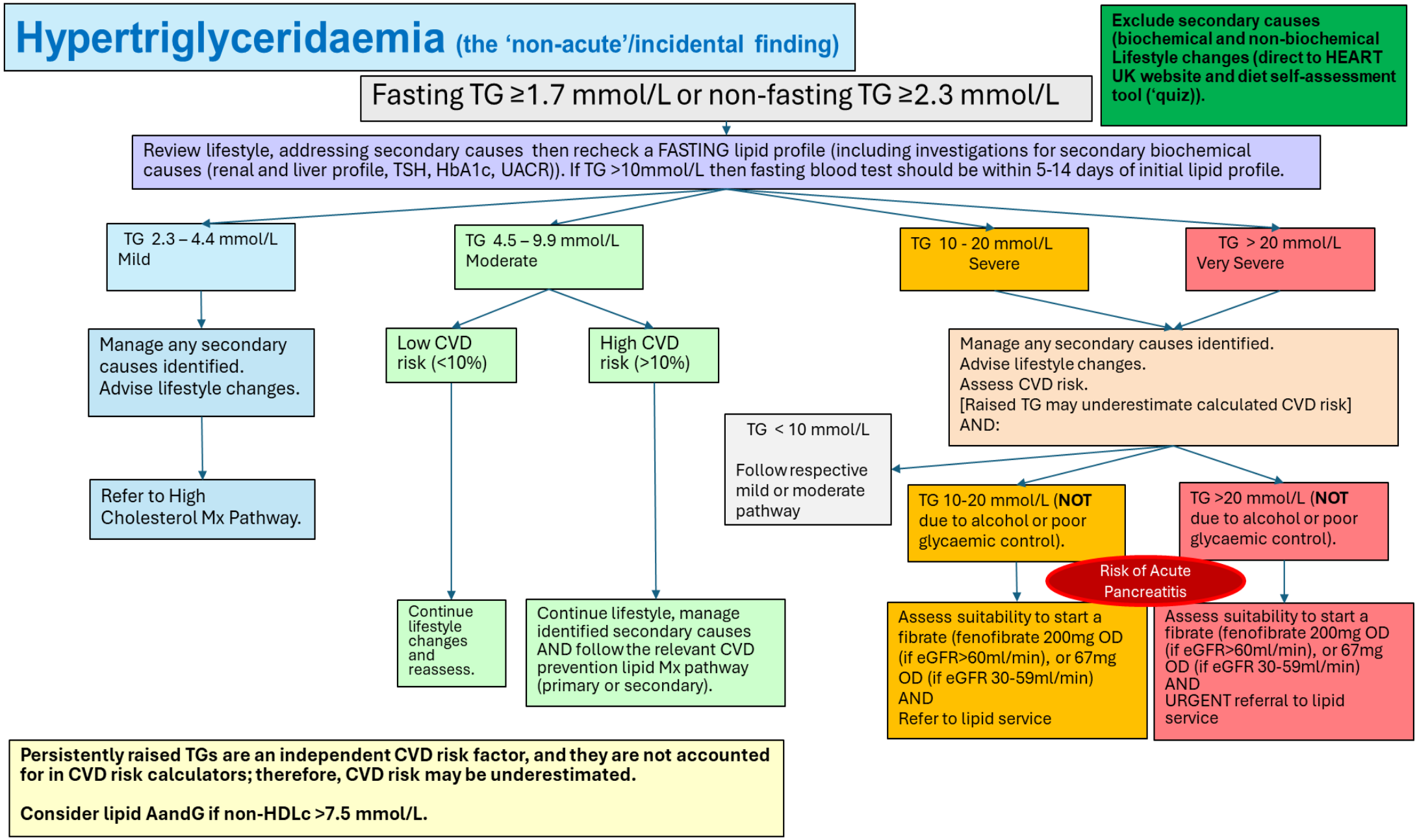
Appendix 4. Secondary CVD Prevention Lipid Management Pathway



Appendix 5. High Cholesterol Mx Pathways (High cholesterol in Primary CVD Prevention)



Appendix 6. Hypertriglyceridaemia (the 'non-acute'/incidental finding)



Persistently raised TGs are an independent CVD risk factor, and they are not accounted for in CVD risk calculators; therefore, CVD risk may be underestimated.

Consider lipid AandG if non-HDLc >7.5 mmol/L.

Appendix 7. Lipoprotein (a) [Lp(a)]

Lipid Mx in primary prevention of CVD in patients with elevated Lp(a). →→→→

As there is no current treatment for raised Lp(a), you only need to measure it once, to aid CVD risk stratification.

Consider measuring Lp(a) **ONLY** in those with:

- A personal or family history of premature atherosclerotic cardiovascular disease (< 60 years of age), or significant history of CVD (recurrent/multiple CVD events).
- First degree relatives with raised serum Lp(a) levels (> 200 nmol/L or >900mg/L).
- Familial hypercholesterolemia (FH), or other genetic dyslipidaemias.
- Calcific aortic valve stenosis.

If **Lp(a) >900mg/L (200nmol/L) then adult first degree relative Lp(a) cascade testing is recommended** (with lipid profile so 10yr risk can be calculated).

a	Impact on CVD	10y CVD risk <5%	10y CVD risk 5-10%	10 CVD risk >10%
Lp(a) <90 nmol/L (<400mg/L)	Minor.	Lifestyle advice.	Lifestyle advice.	Lifestyle advice and Treat to primary prevention target.
Lp(a) 90-200 nmol/L (400-900mg/L)	Moderate.	Lifestyle advice; risk assessment in five years.	Lifestyle advice and Treat to primary prevention target.	Lifestyle advice and Treat to secondary prevention target.
Lp(a) 200-400 nmol/L (900-1800mg/L)	High.	Treat to primary prevention target.	Treat to secondary prevention target.	Lifestyle advice and Treat to secondary prevention target.
Lp(a) ≥400 nmol/L (≥1800mg/L)	Very high (equivalent to heterozygous FH).	Treat to secondary prevention in all and consider referral to lipid service.		

Continued: Appendix 7. Lipoprotein (a) [Lp(a)]

If raised:

- It's an additional independent CVD risk factor (irrespective of lipid profile).
- It's described as 'a piece of velcro stuck to the LDLc' (increased risk of developing premature CVD).
- Nothing currently incl. oral lipid lowering medication and lifestyle etc. influences or reduces it, and an individuals Lp(a) concentration remains relative constant throughout life.
- It's an inherited trait; can at least in part be an explanation for personal or family histories of premature, significant or aggressive CVD.
- The recommended management means that for some primary CVD patients it's suggested to treat to secondary CVD prevention lipid targets, but this is only via using oral lipid-lowering agents. As a result, the target may not always be achieved as being primary CVD prevention, they are not eligible for any injectable PCSK9 inhibitors.

Lp(a) is requestable on Maxims and ICE, measured on a gold top (SST) blood sample.

Different methods are available – explaining the different units seen (nmol/L or mg/L) – the RCHT method is currently reporting as mg/L – we are reviewing this considering the recommendation to only measure Lp(a) using a specific method.

Supporting guidance:

https://www.heartuk.org.uk/genetic-conditions/high-lipoproteina

https://www.heartuk.org.uk/downloads/health-professionals/lp(a)-statement-of-care.pdf

[Cegla, J., Neely, R.Dermot.G., France, M., Ferns, G., Byrne, C.D., Halcox, J., Datta, D., Capps, N., Shoulders, C., Qureshi, N., Rees, A., Main, L., Cramb, R., Viljoen, A., Payne, J. and Soran, H. (2019). HEART UK consensus statement on Lipoprotein(a): A call to action. Atherosclerosis, [online] 291, pp.62–70. doi:https://doi.org/10.1016/j.atherosclerosis.2019.10.011].

Appendix 8. Genetic Cascade Testing for Familial Hypercholesterolaemia (FH)

Please **do not use the lipid profile to decide if a patient should be referred for FH genetic cascade testing**. **ALL** patients with a first, second (and occasionally third) degree relative with a genetically confirmed diagnosis of FH require referral irrespective of the cholesterol, and in these patients you do not need to ensure an up-to-date lipid profile prior to referral. **The presence of a mutation for FH does not determine the degree of hyperlipidaemia** **Supporting guidance:** NICE CG71; FH: identification and management.	If a patient attends the surgery reporting a relative has a diagnosis of FH, then please obtain the following information to determine if they require referral for genetic cascade testing: Please ask the patient to find out the following information: ☑ Does their relative have a **genetically** confirmed diagnosis? [many turn out to have a clinical diagnosis, meaning made using either the Simon Broome criteria or Dutch (or Welsh) Lipid Clinic Score (D/WLCS)]. ☑ If it's a genetic diagnosis, then they need to obtain the following information so cascade testing can be performed: ▪ **EITHER:** Get aCopy of the relatives' genetic test report. ▪ **OR:** Get the following information from the relative: name, date of birth, NHS number, and either their postcode or the lipid service who arranged their genetic testing. This information is required so the Bristol genetics lab can contact the genetics lab where the relatives' sample was tested; they require the result in order to perform cascade testing – they can not perform testing without this information. ☑ With this information the patient can be referred to the Lipid Service for FH genetic cascade testing. ☑ If any queries, please submit lipid A and G request.