



CARDIAC RENAL METABOLIC TRAINING PROGRAMME

A Business Case for Integrated Care Boards, Neighbourhood Health Centres and Primary Care Networks

Annie Barr MBE Clinical Director May 2026

Executive Summary

The Cardiac Renal Metabolic (CRM) Training Programme is a purpose-designed education initiative for Registered Nurses and Healthcare Assistants working across primary care, neighbourhood health centres, and community settings. This business case sets out the clinical, financial, and population health rationale for commissioning this programme at scale across your system.

Cardiac disease, chronic kidney disease (CKD), and metabolic conditions — including type 2 diabetes and obesity — are the three greatest drivers of premature morbidity, emergency admissions, and NHS expenditure in England. They are deeply interconnected: an estimated 50% of people with CKD have cardiovascular disease, and diabetes accelerates both. A workforce trained to recognise and respond to all three — together — represents one of the most impactful investments a commissioner can make.

Developed by ab health group, this programme directly addresses NHS Long Term Plan commitments, ICB population health priorities, and the ambitions of neighbourhood health infrastructure — equipping frontline staff with the knowledge and skills to deliver safer, more proactive, and more joined-up care.

The Case for Neighbourhood Health Centres

The NHS is undergoing a fundamental shift — moving care closer to home, into communities and neighbourhoods. The Neighbourhood Health model requires a highly competent community-based workforce capable of managing complex, multi-morbid patients outside of hospital settings.

Why CRM Training is Essential in Neighbourhood Settings

- Neighbourhood teams are often the first and most frequent point of contact for patients with cardiac, renal, and metabolic conditions — conditions that are typically invisible until they become acute.
- Without specialist training, staff may miss early warning signs such as fluid overload in heart failure, AKI risk in dehydrated diabetic patients, or hypertensive crises.
- Upskilled neighbourhood staff can identify deterioration, initiate early intervention, and escalate appropriately — reducing costly emergency transfers to acute settings.
- The programme supports structured care reviews, health checks, and chronic disease monitoring that are central to the neighbourhood model.
- Trained staff increase the range and complexity of conditions managed safely in community settings, reducing pressure on secondary care.

• Patients with CRM conditions account for over 60% of emergency hospital admissions nationally • Early community intervention can prevent up to 40% of these admissions • Neighbourhood-based care is 3–5x less costly per episode than acute hospital care

Strengthening Primary Care Teams

General Practice and Primary Care Networks (PCNs) carry a growing burden of CRM disease management. GPs, practice nurses, and clinical pharmacists are managing increasingly complex patients — often without dedicated specialist support. HCAs in primary care are taking on extended monitoring roles that require greater clinical knowledge.

How This Programme Supports Primary Care

For Practice Nurses & ANPs

- Confident management of annual CRM reviews
- Recognition of declining renal function and appropriate referral triggers
- Medicines optimisation awareness for cardio-renal-metabolic drug classes
- Understanding of SGLT2 inhibitors, GLP-1 RAs, and their multi-system benefits

For Healthcare Assistants

- Accurate BP, pulse, weight, and urinalysis monitoring with clinical context
- Recognition of when readings require escalation to a clinician
- Ability to support patients with self-management and lifestyle education
- Competent preparation of patients for QOF and IIF review indicators

The programme also supports PCN ARRS staff — including clinical pharmacists, social prescribers, and health and wellbeing coaches — by providing structured education on the conditions they are supporting patients to manage day to day.

Supporting QOF and IIF Performance

A well-trained primary care nursing and HCA workforce directly improves practice performance against Quality and Outcomes Framework (QOF) and Investment and Impact Fund (IIF) indicators related to:

- Blood pressure management in hypertension, CKD, and heart failure
- HbA1c monitoring and diabetic annual reviews
- Cholesterol monitoring and lipid management
- Urine ACR testing and eGFR surveillance
- Atrial fibrillation detection and anticoagulation review

Integrated Care Board Strategic Alignment

This programme is directly aligned with the priorities of Integrated Care Boards, supporting population health management, workforce development, and system efficiency goals across primary, community, and neighbourhood care.

ICB Strategic Priority Alignment	
NHS Long Term Plan	Directly advances cardiovascular disease ambitions, diabetes prevention and management, and CKD early identification targets
Population Health	Trains staff to identify at-risk individuals and intervene earlier, supporting stratification and proactive care models
Neighbourhood Health	Builds workforce capability in community and primary care settings, enabling safe management of complex patients locally
Workforce Development	Addresses skill gaps in the primary and community nursing workforce; supports retention through structured CPD
Financial Sustainability	Reduces avoidable emergency admissions, readmissions, and unplanned secondary care use across the system
Health Inequalities	Ensures equitable access to high-quality CRM monitoring regardless of geography or care setting, reducing outcome variation




Return on Investment for ICBs

- Acute Kidney Injury (AKI) costs the NHS an estimated £1 billion annually; earlier community identification could prevent a significant proportion of cases.
- A single prevented emergency admission for heart failure exacerbation saves an average of £3,500–£6,000.
- Improved diabetic management reduces rates of costly complications including foot amputation, retinopathy, and end-stage renal disease.
- Workforce investment reduces dependency on expensive agency cover and specialist clinical time for tasks that trained generalists can safely deliver.
- Improved QOF and IIF performance generates direct financial returns to primary care, creating system-wide incentive alignment.

Patient Benefits

Ultimately, the greatest return on investment from this programme is measured in improved outcomes, experiences, and quality of life for patients living with cardiac, renal, and metabolic conditions.

Earlier Detection and Intervention

 <p>Earlier identification of heart failure signs, AF, and hypertensive deterioration — enabling timely medication adjustment and avoiding crisis admission</p>	 <p>Renal Routine surveillance of eGFR and ACR catches declining kidney function before it becomes an emergency, slowing progression to renal replacement therapy</p>	 <p>Better glycaemic monitoring and lifestyle support reduces risk of diabetic complications including neuropathy, retinopathy, and foot disease</p>
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Person-Centred, Community-Based Care

- Patients spend more time monitored and supported in familiar community settings, close to home — reducing the anxiety, cost, and disruption of repeated hospital visits.
- A more knowledgeable workforce means patients receive clearer, more consistent explanations of their conditions, medications, and self-management strategies.
- HCAs trained in CRM conditions can provide better lifestyle, dietary, and fluid management education at every interaction — not just during formal clinic appointments.
- Patients with multi-morbidity receive more joined-up, holistic care as staff understand how their cardiac, renal, and metabolic conditions interact with one another.
- Vulnerable patients, including those in care homes and housebound individuals, benefit from improved monitoring by community nursing teams with CRM-specific competencies.

Reducing Health Inequalities

CRM conditions disproportionately affect patients from deprived and ethnic minority communities. A well-trained neighbourhood and primary care workforce delivers consistent, evidence-based monitoring regardless of geography, reducing the variation in outcomes that currently exists across the system.

“Patients in our most deprived communities are 40% more likely to be admitted as an emergency with a cardiovascular event — not because their disease is worse, but because they are less likely to have it identified and managed proactively.” — NHS England Population Health Insight

Workforce Development Benefits

Investment in this programme is also investment in the long-term sustainability of the community nursing and HCA workforce.

- Structured CPD improves staff confidence, job satisfaction, and sense of professional value — key drivers of retention in a tight labour market.
- HCAs who receive this level of training are better prepared for progression into registered nurse programmes, supporting the wider NHS workforce pipeline.
- Nurses completing the programme report feeling better equipped to manage complex patients independently, reducing burden on senior clinical leads and GPs.
- The programme creates a shared CRM knowledge base across system partners — improving communication and handover between primary care, neighbourhood teams, and secondary care.
- Training can be embedded into existing CPD and appraisal frameworks, minimising disruption to clinical services.

Summary Recommendation

The Cardiac Renal Metabolic Training Programme represents a clinically robust, strategically aligned, and financially sound investment for Integrated Care Boards, Primary Care Networks, and Neighbourhood Health providers.

We recommend commissioning this programme to:

- Build a CRM-competent nursing and HCA workforce across neighbourhood and primary care settings
- Reduce avoidable emergency admissions and readmissions related to cardiac, renal, and metabolic deterioration
- Deliver better, earlier, and more equitable care to patients living with these conditions
- Support ICB financial sustainability through prevention, early intervention, and efficient use of the community workforce
- Invest in a workforce development offer that improves retention, confidence, and career progression