Harrow
Primary Care Networks
West & North London ICB CRM Training Session 1

Cardio-Renal-Metabolic (CRM)

Harrow CRM 3PP / LKN Project Commissioned by:

Harrow Network Partners (HNP) Ltd

Executive Summary

22nd April 2026
West & North London ICB
CRM Training Session 1

Presented by:

Dr Kuldhir Johal (BM DCH MRCGP PGCE MSc)
- Cardio Renal Metabolic (CRM) Clinical Lead for Harrow Network Partners (HNP)
- Clinical IT and Digital Lead of the North West London ICB for Hillingdon
- Primary Care Clinical Lead – EMIS for NWL ICB.
- Council Member of London Clinical Senate
- GP Educator, Brunel Medical School, Brunel University, London
- GP Partner, Oakland Medical Centre, Uxbridge

Dr Madhvi Joshi
- GP Lifestyle Medicine/ Obesity PCI Certified Health Coach
- GP Partner, Headstone Road Surgery, Harrow
- Winner for Healthy Harrow Awards 2026

Rashida Rahman
- Sphere PCN Business Manager
- Digital and Transformation Lead
- CRM Programme Manager, Harrow Network Partners (HNP)

Introduction, aims and context

- Aims of the programme: to reduce risk associated with cardio-metabolic-renal disease, stop onset or slow progression of CKD and stop early deaths from CVD.
- Metrics – staff are well informed regarding CRM, services and incentives available and empowered and supported with clear guidelines to make decisions on CRM patients. Patients will be aware of their condition, understand a CRM approach, know their own numbers and are activated and empowered to make lifestyle changes.

Lifestyle Interventions & Personalised Care

- Mortality is significantly reduced with increasing activity in those with existing CRM conditions, increasing longevity.
- Evidence shows significant negative impact from a poor diet, but a healthy diet is expensive, with the poorest 20% of households needing to spend half their disposable income to eat the Government-recommended diet.
- Health coaching can be a mechanism for encouraging healthy lifestyle choices, utilising behaviour change to empower people to engage in goal setting, be more confident and enable decisions about their future health.
- CRH Hub principles have been recommended.

A logic model was developed based on project team inputs from collaborative workshop in 2024 and built upon via 1:1 stakeholder interviews – to be signed-off by the CRM project Steering Group.

Inputs	Activities	Outputs	Outcomes**	Impact
National 3P funding	Staff training sessions & self-directed learning	# staff trained to deliver CRM consultations / care	Reduction in cardio-renal-metabolic risk amongst cohort	Onset and progression of additional LTCs prevented for patients with a diagnosis of 1 condition
Integrate Care Team support	Case-finding and risk assessment, incl EMIS searches	# patients treated through CRM pathway & discharged	Improved population health in Harrow	ICHD demand does not outweigh capacity in 15-20 years
Workforce across 5 PCNs*	Proactive contact / invitation to selected patients	# CRM consultations delivered	Patients feel more knowledgeable about their health and empowered to manage it	Prevention of heart attacks and strokes
CRM clinic design & pathway	Longer, holistic consultations using health coaching & personalised care techniques	# patients active on MyHealth London platform	Staff feel confident and able to deliver holistic lifestyle medicine using a CRM lens	Staff deliver holistic, integrated care as BAU
EMIS consultation template	Referrals to community resources and services		Improved system integration	ROI and implementation learnings / blueprint allow for spread and scale of model across NW London, with any adaptations
EMIS search logic for 2 defined patient cohorts	Patient education & self-management		Positive return on investment	
Staff training & materials via education framework	Complete EMIS templates		Improved coding of CKD	
Pt educational resources	Monitoring & follow-up appointments		**Balance measure**: increase in system activity/referrals due to proactive care	
SOP for CRM clinics				
Project steering & working group				
PCN MOUs				
Harrow Network Partners				
NW London Renal leadership				
London Kidney Network				
National 3P programme				

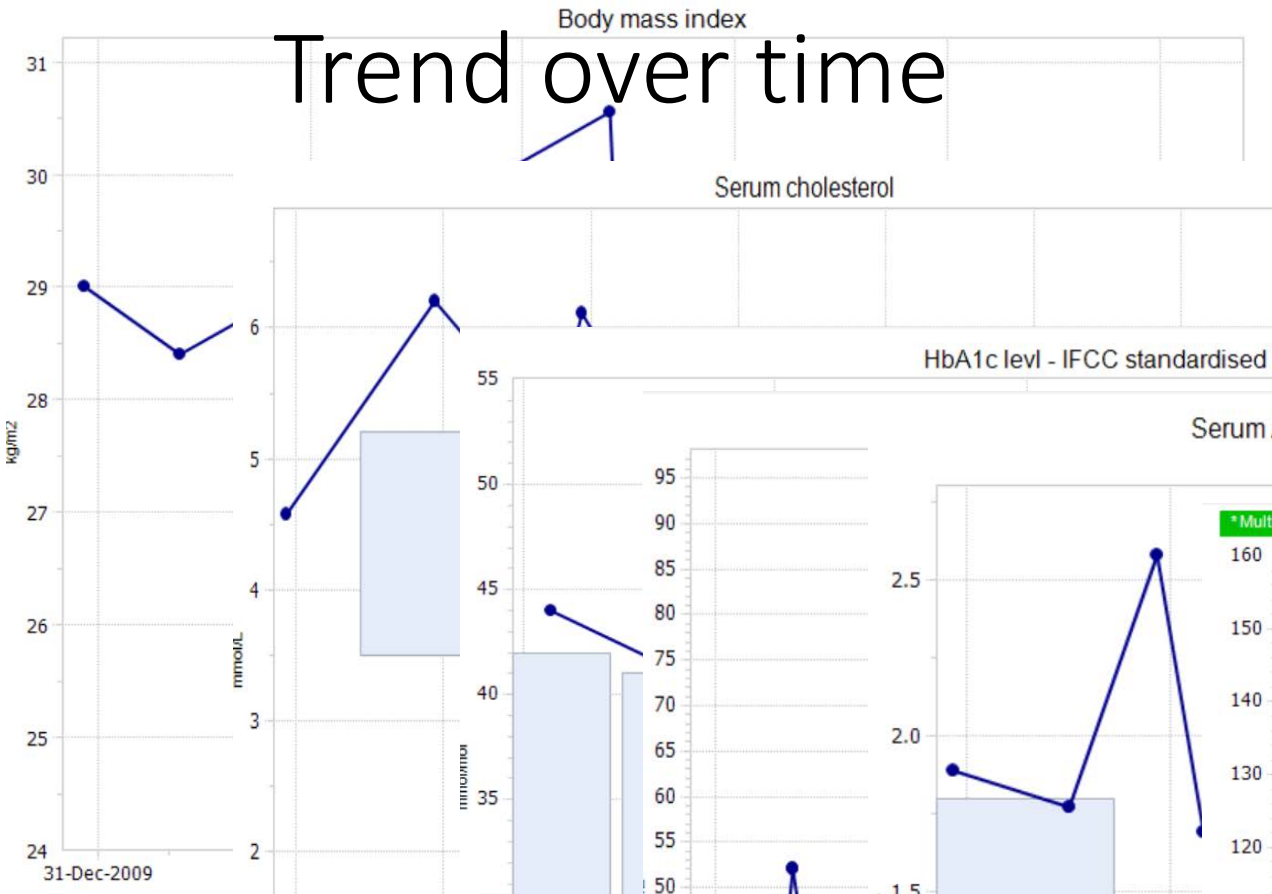
Case Study:-
Male – 61 Yrs – Indian

- **July 2025**
- Ultrasound – Fibrosis stage 3 of the liver
- Shortness of breath – chest pain – awaiting cardiac investigations
- Unsure re statin – had stopped
- Unsure re BP medication – Ramipril 2.5mg – had stopped
- Q – "Do I really need to take these?"
- Interested in self care alone

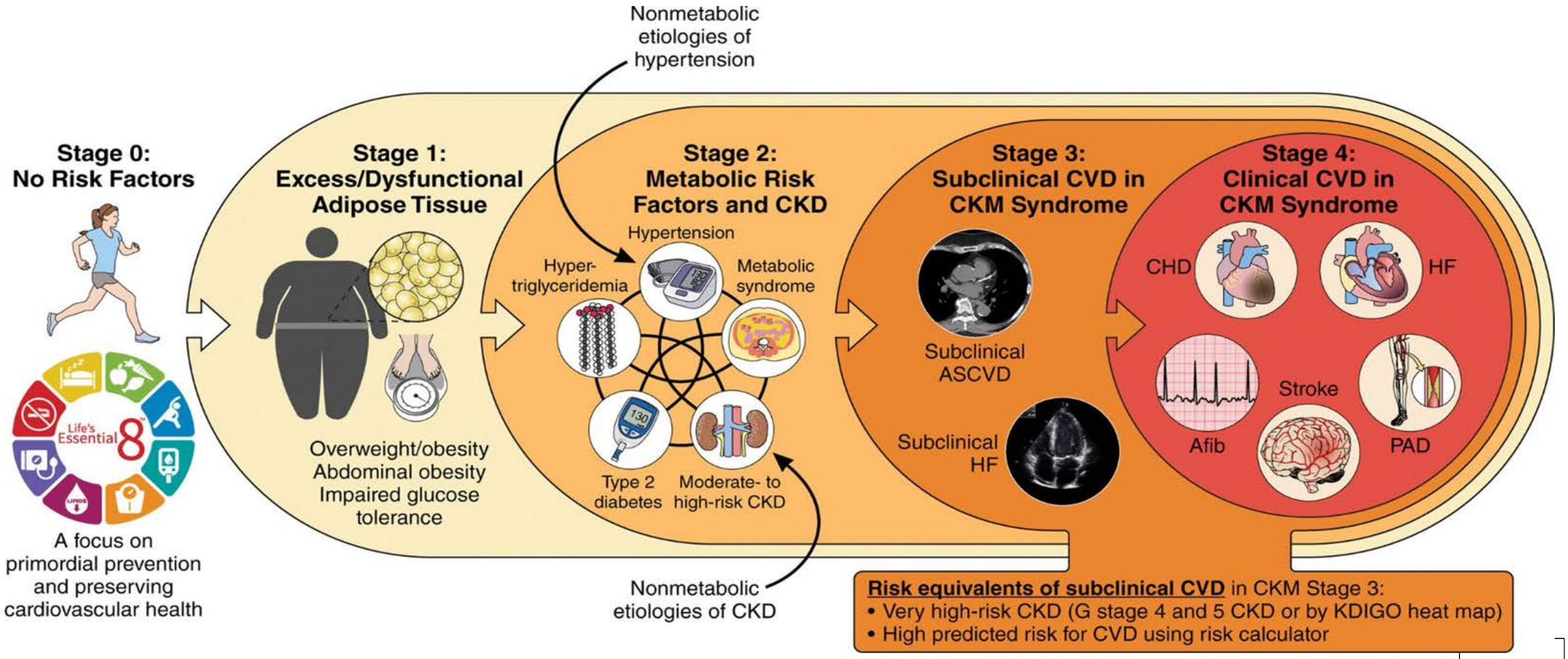
"wait and see"

- "**<u>What mattered to him?"</u>**
- "What can I do to reverse or stop the liver disease?"
- Long consultation – explaining heart age – calculated – 74 live to 79 without an event
- Qrisk3 – 23.4
- Explained Stages 0 to 4 - All interrelated and influence each other
- Went from being Pre-diabetic to Diabetes

Trend over time



CRM delivery model – Understanding Why and How

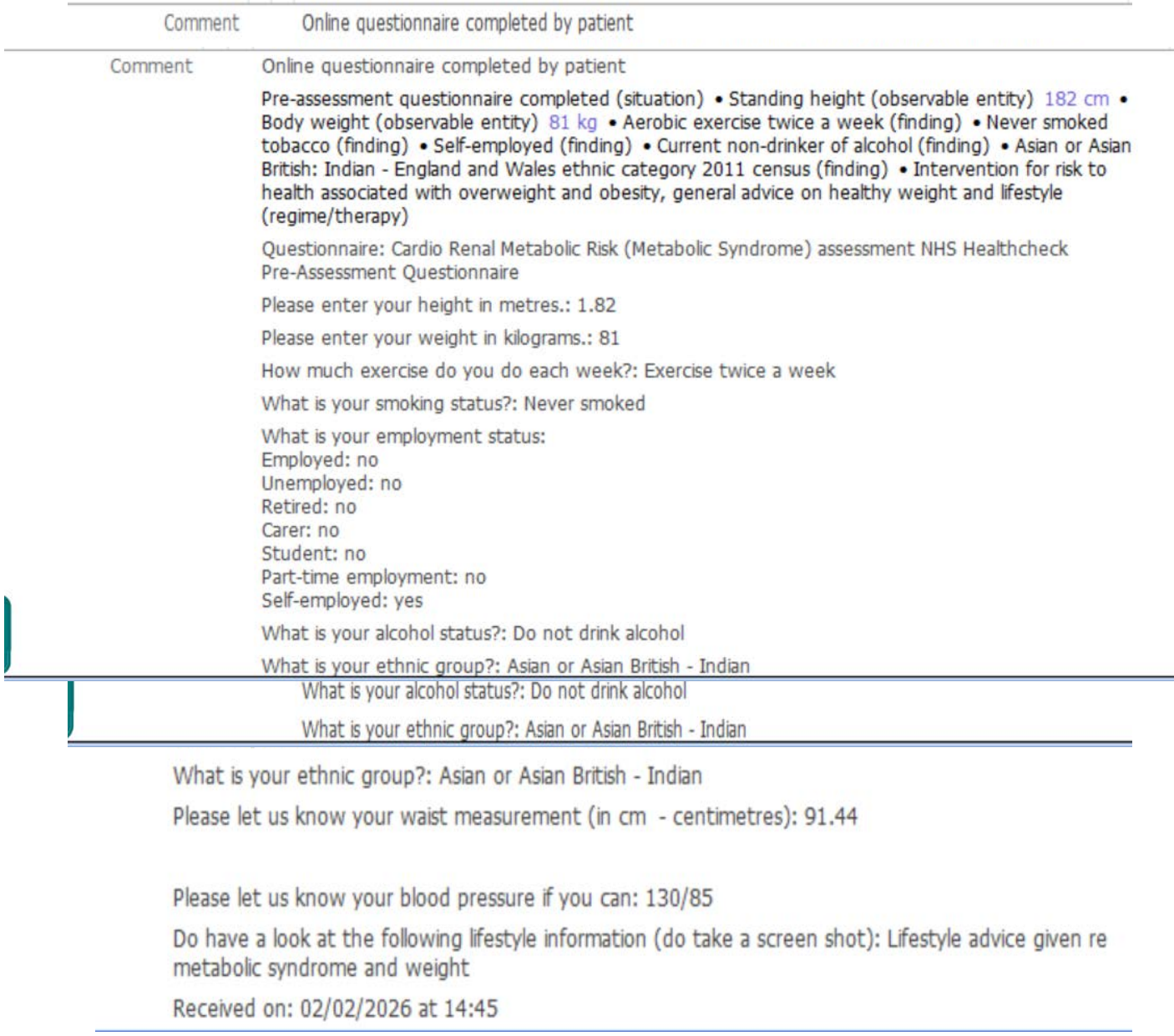


AHA 2023

Jan 2026 – 6 months - later

- Fibroscan – reported as “normal”
- MASH → MAFLD
- Weight 89 → 81
- BMI 25.74 → 24.5
- HbA1c 52 → 44
- BP 121/73 , 130/83
- Waist cm 114 → 91

- Ramipril 2.5mg OD
- Atorvastatin 20mg
- Lost 18 kg Since Oct 2023
- Regular walking – stopped alcohol, reduced sugar
- Heart age 66 live to 81 without an event
- Personalised care in partnership with the patient



Comment	Online questionnaire completed by patient

Comment	Online questionnaire completed by patient
	Pre-assessment questionnaire completed (situation) • Standing height (observable entity) 182 cm • Body weight (observable entity) 81 kg • Aerobic exercise twice a week (finding) • Never smoked tobacco (finding) • Self-employed (finding) • Current non-drinker of alcohol (finding) • Asian or Asian British: Indian - England and Wales ethnic category 2011 census (finding) • Intervention for risk to health associated with overweight and obesity, general advice on healthy weight and lifestyle (regime/therapy)
	Questionnaire: Cardio Renal Metabolic Risk (Metabolic Syndrome) assessment NHS Healthcheck Pre-Assessment Questionnaire
	Please enter your height in metres.: 1.82
	Please enter your weight in kilograms.: 81
	How much exercise do you do each week?: Exercise twice a week
	What is your smoking status?: Never smoked
	What is your employment status: Employed: no Unemployed: no Retired: no Carer: no Student: no Part-time employment: no Self-employed: yes
	What is your alcohol status?: Do not drink alcohol
	What is your ethnic group?: Asian or Asian British - Indian

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Please let us know your waist measurement (in cm - centimetres): 91.44

Please let us know your blood pressure if you can: 130/85

Do have a look at the following lifestyle information (do take a screen shot): Lifestyle advice given re metabolic syndrome and weight

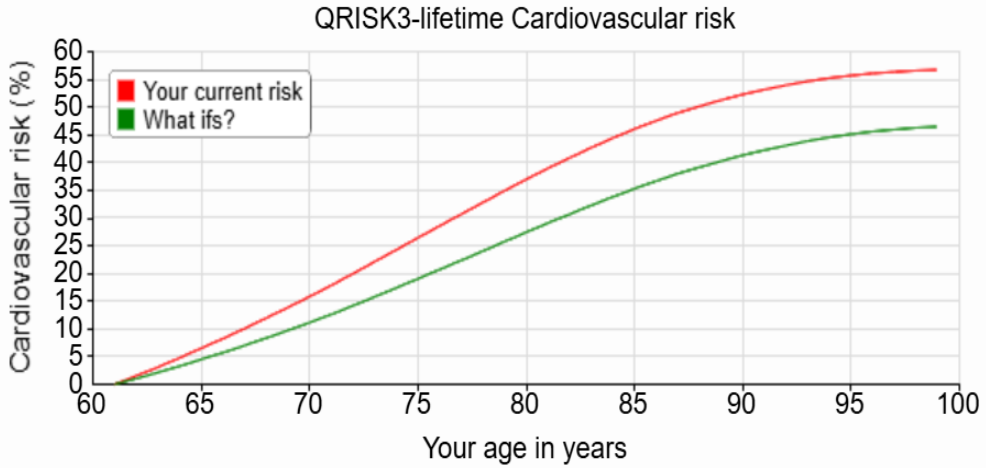
Received on: 02/02/2026 at 14:45

Qrisk Lifetime – has reduced risk by 14%

Where he was starting from….

Your QRISK3-lifetime score

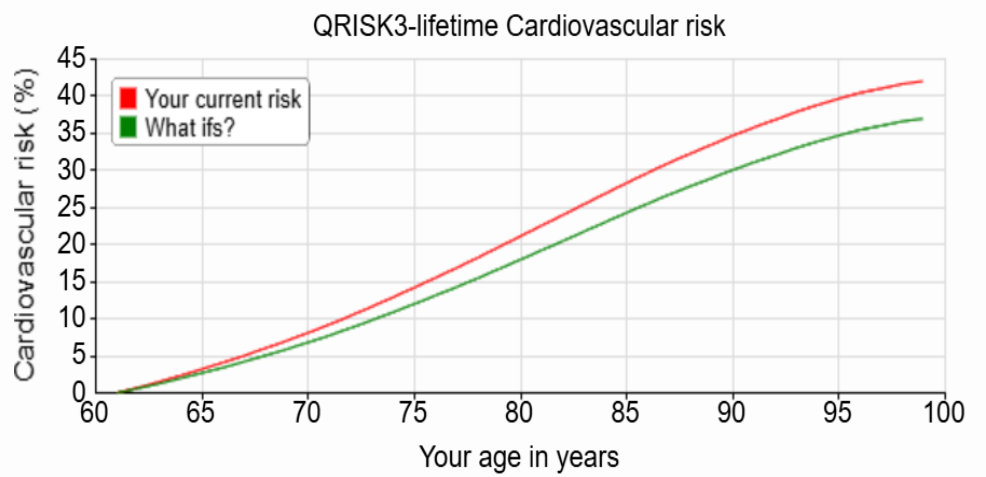
Your lifetime risk (i.e. by the time you are 99)	Current	What if?
	56.7%	46.5%



If he continues to improve Systolic BP, T2M in remission and HbA1C <41, further 6 kg weight loss

Your QRISK3-lifetime score

Your lifetime risk (i.e. by the time you are 99)	Current	What if?
	42%	37%



Harrow CRM Model

Aims of the programme:

- To reduce risk associated with cardio-metabolic-renal disease, stop onset or slow progression of CKD and stop early deaths from CVD.

Metrics:

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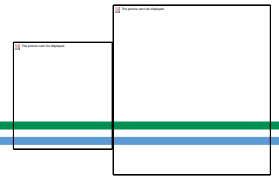
- Patients will be aware of their condition, understand the CRM approach, know their own numbers and are activated and empowered to make lifestyle changes.



Getting started … “Paradigm shift”

Why…

- Recognition of concept of moving away from silo long term conditions to “holistic” care
- Increased understanding for patients - of the interconnectivity of a number of conditions and how truly early intervention can reduce progression and associated risks
- Heart age
- CKD
- Using measures we can all use, height, weight, waist measurement, blood pressure – **ownership is with the patient**

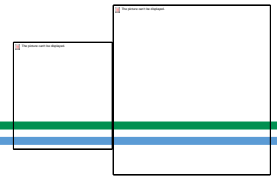
How…

- Brain storming sessions with Integrated system stakeholders – Logic Model
- Understanding the data currently available and contracts
- Mapping and understanding context of patient population at patient, practice and population level – identifying cohorts
- Aligning to and maximising on workforce skillset and local service delivery
- Use of IT enablers, aligned codes sets, pre-assessment template, clinical template, patient lifestyle leaflet, systems quality searches and alignment to CVD prevent/LKN CKD parameters – ICHP – Qualitative and Quantitative analysis

Impact evaluation…

The Harrow CRM delivered the following principles:-

- ✓ **Integrated, holistic care delivers results:** Moving from single-disease silos to multidisciplinary, personalised care for people with overlapping conditions leads to better engagement, more comprehensive reviews, and proactive management.
- ✓ **Scalable with the right support:** The model is feasible and aligns with the NHS Long Term Plan and neighbourhood health, but sustainability depends on dedicated funding, robust training, and formalised resource allocation.
- ✓ **Delivers proven integrated care outcomes:** Full Impact evaluation is in progress to examine this project's impact on CRM outcomes. Early Impact is very positive. However the true success of this project is the collaborative partnership between Primary care, Community providers, Voluntary organisations and Hospital Teams.



Eligibility criteria:- CRM Patient Cohorts in Detail

Harrow CRM Pathway

Patient Identification

- Find pts to invite to CRM using the CRM folder searches for Groups 1, 2
- Exclusion – palliative care/ EOL, Housebound where input likely to have low benefit

Invitation / Preparation

- Check if Blood tests/ BMI/ waist circumference / BP +/-urine ACR within last 3 months.
- Send pre-appointment CRM Health check questionnaire via AccuRx
- Signpost patient to create account on MyHealth London/ Know Diabetes/ NDPP as appropriate.

All patients benefit from care navigators who help coordinate services across different settings.

CRM clinic 1st Appointment

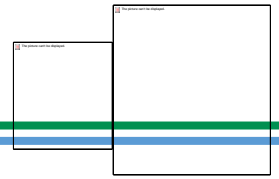
- Prescribing clinician to review health & recent metrics (QRISK/Heart Age/ KFRE/ Fib4 if relevant)
- Review/ optimize medications – explore barriers/ side effects.
- Apply NWL ICS CRM template & co-create Lifestyle Care plan with patient
- Consider referral to IAPT / Tier 2 Weight management/ physio/ social prescribing/VSO / Welfare Employment support etc. according to needs.
- Plan follow up CRM review (minimum x1)

Patients offered an extended length appointment 20-30 mins with CRM prescribing clinician

Follow up 1:1 / group

- Admin call pt to check progress/ identify barriers
- Follow up appointment with HCA to repeat metrics and pre appointment questionnaire + then review by CRM clinician.

Monitoring of HbA1c, lipid levels, BP, and kidney function markers at 3-6 months.



Rashida Rahman, Dr Madhvi Joshi Lead Harrow Network Partners
April 2026

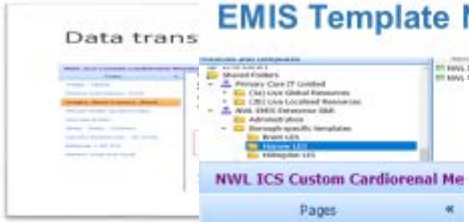
Using digital tools as "enablers" from AccuRx to EMIS

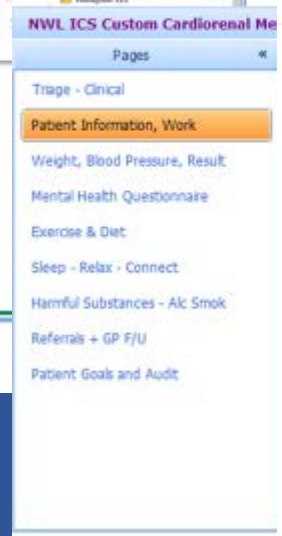
Cardio Renal Metabolic Risk (Metabolic Syndrome) assessment NHS Healthcheck Pre-Assessment Questionnaire

Questionnaire: Cardio
assessment NHS Heal
Please enter your heig
Please enter your weig
How much exercise do
week
What is your smoking
What is your employm
What is your alcohol st
What is your ethnic gro
Northern Irish or British
Please let us know you
Please let us know you
Please let us know you
Do have a look at the f
shot): Lifestyle advice

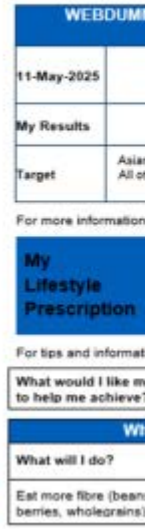
NWL ICS EMIS Template constructed for Obesity and Weight management 2024/25:- Modified to be used for Cardio Renal Metabolic pathway

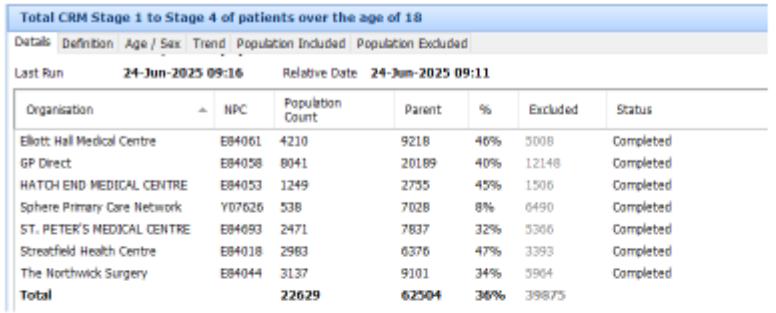
EMIS Template NWL Harrow CRM template

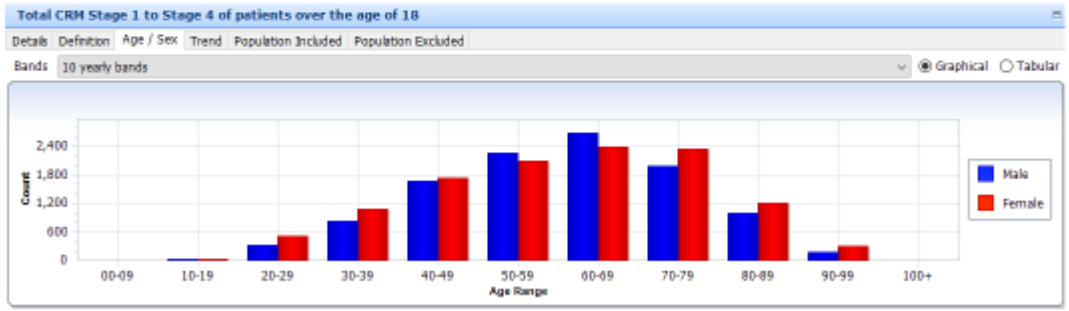




Lifestyle Care Plan







Dr Kuldhir Johal
March 2025

The Power of Personalised Care

Helping people achieve better health outcomes

Personalised Care Awards 2025 LONDON

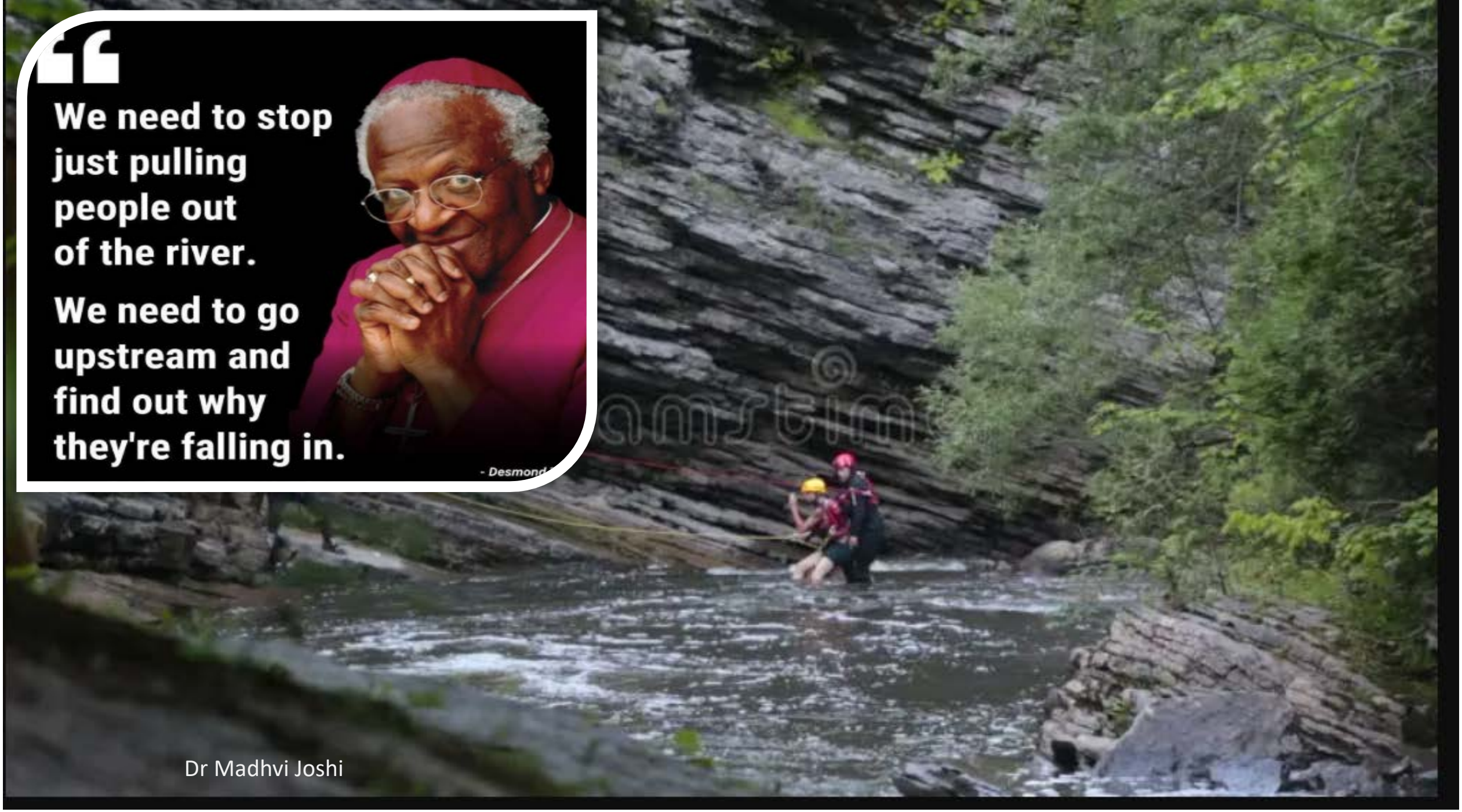
CRM Training

Dr Madhvi Joshi

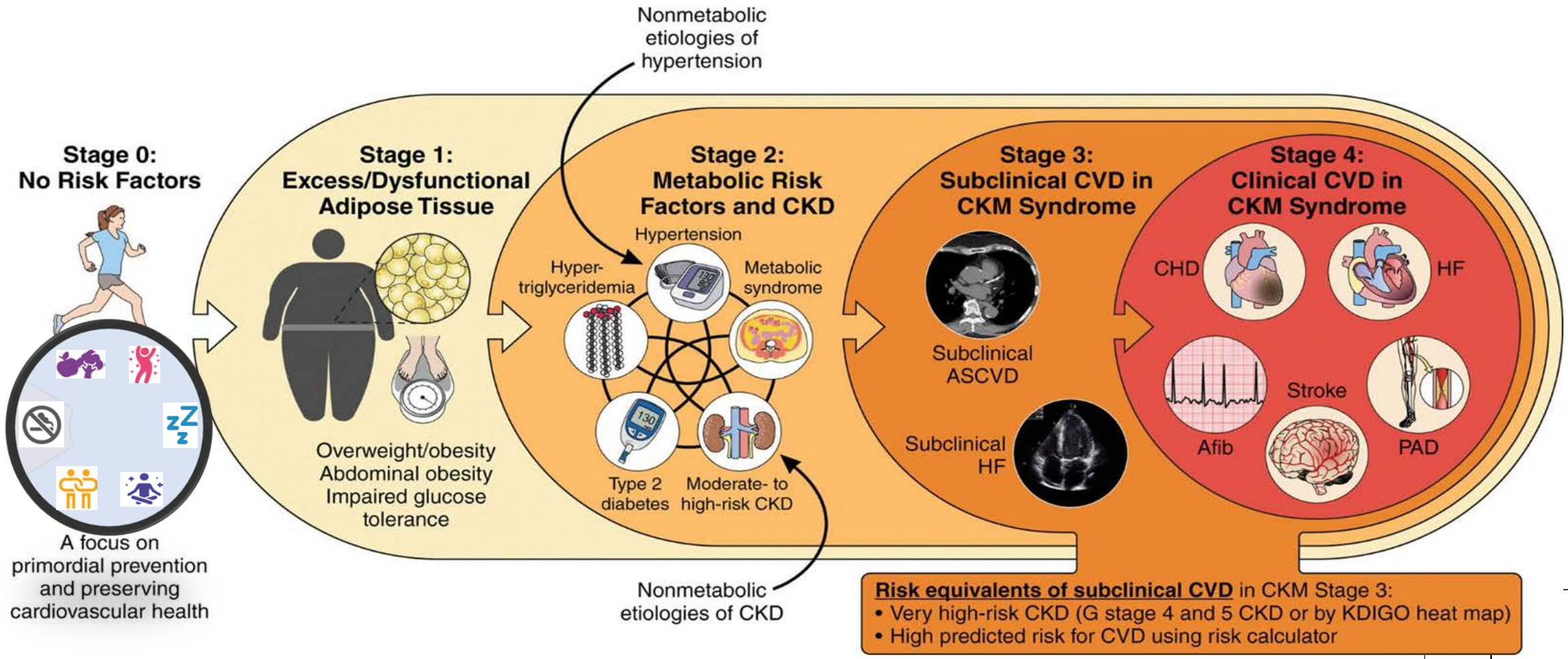
HNP HARROW NETWORK PARTNERS

GP Lifestyle Medicine/ Obesity

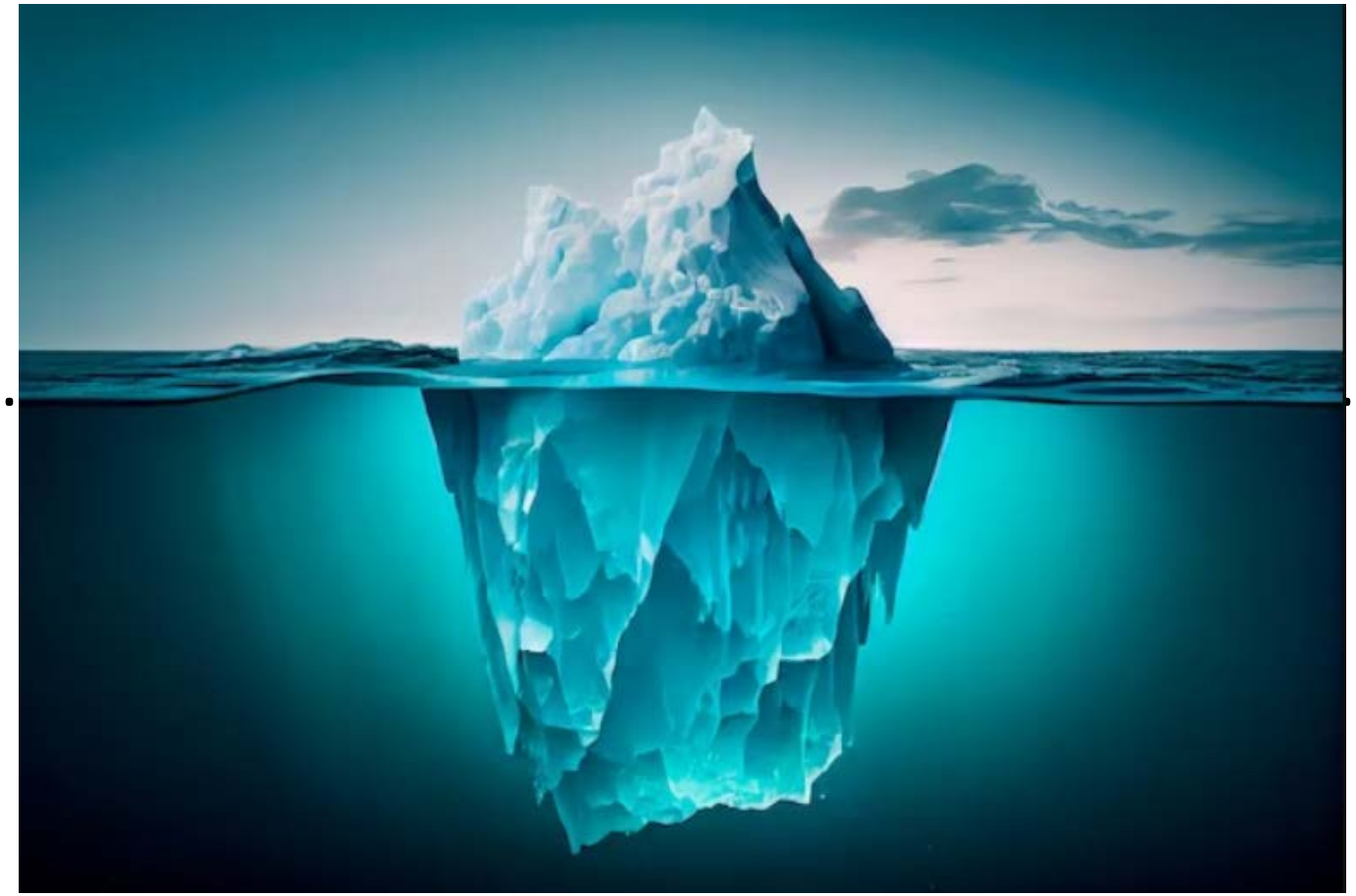
PCI Certified Health Coach


We need to stop just pulling people out of the river.
We need to go upstream and find out why they're falling in.
- Desmond
Dr Madhvi Joshi

Cardio-Renal-Metabolic spectrum - recap



What’s missing ?



What the computer tells you

What the person hasn’t told you (yet)

CRM Management:
Pillars of lifestyle medicine

Evidence-based lifestyle pillars address the root causes of CRM conditions.

Intervention points are tailored to an individual.

Select priority areas for change via health coaching techniques to build sustainable healthy habits.

Eat

Whole foods, nutrient rich, avoiding UPFs.
Cultural preference and metabolic needs.

Avoidance of Harmful Habits

Tobacco/vapes/ shisha, excess alcohol, and other addictions (social media)

Connect

Meaningful relationships & community engagement.
Group-based peer support to sustain outcomes.

Move

Cardiovascular+ strength training + flexibility.
Tailor to individual interests/capability/ resources.

Sleep

Duration & quality: sleep hygiene.
Recognise & manage sleep disorders

Relax

Reduce stress via mind-body activity & CBT.
Building resilience against chronic stress.

How to explore 6 LM Pillars effectively

"What's a normal day for you?"

CRM Pathway: Harrow Model

Patient Identification

- Inclusion: Group 1, 2 & 3 (high/medium/ low intervention) based upon lifetime risk of CVD
- NDH/ T2DM/ Hypertension/ MASLD/ CKD / HF / BMI – accounting for ethnicity and deprivation factors
- Exclusion: palliative care/ EOL

Care navigators co-ordinate patient contacts

Invitation / Preparation

- HCA check: Blood/uACR tests/ BMI/ waist circumference / BP / phys activity
- Send pre-appointment CRM questionnaire via AccuRx + QRISK/ Heart Age
- Enrol to digital platforms MyHealth London/ Know Diabetes/ NDPP

CRM Clinician: extended appointment (30 mins) Risk assessment, med review, care planning

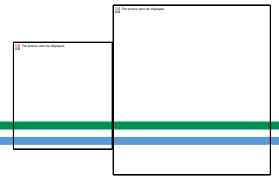
CRM clinic 1st Appointment

- Clinician review :metrics (QRISK/Heart Age/ KFRE/ Fib4) + coding
- Review & optimize medication – any barriers, side effects?
- CRM template & Lifestyle Care plan
- Referrals to IAPT / SW/ physio/ social prescribing/ VCSO / Welfare Employment

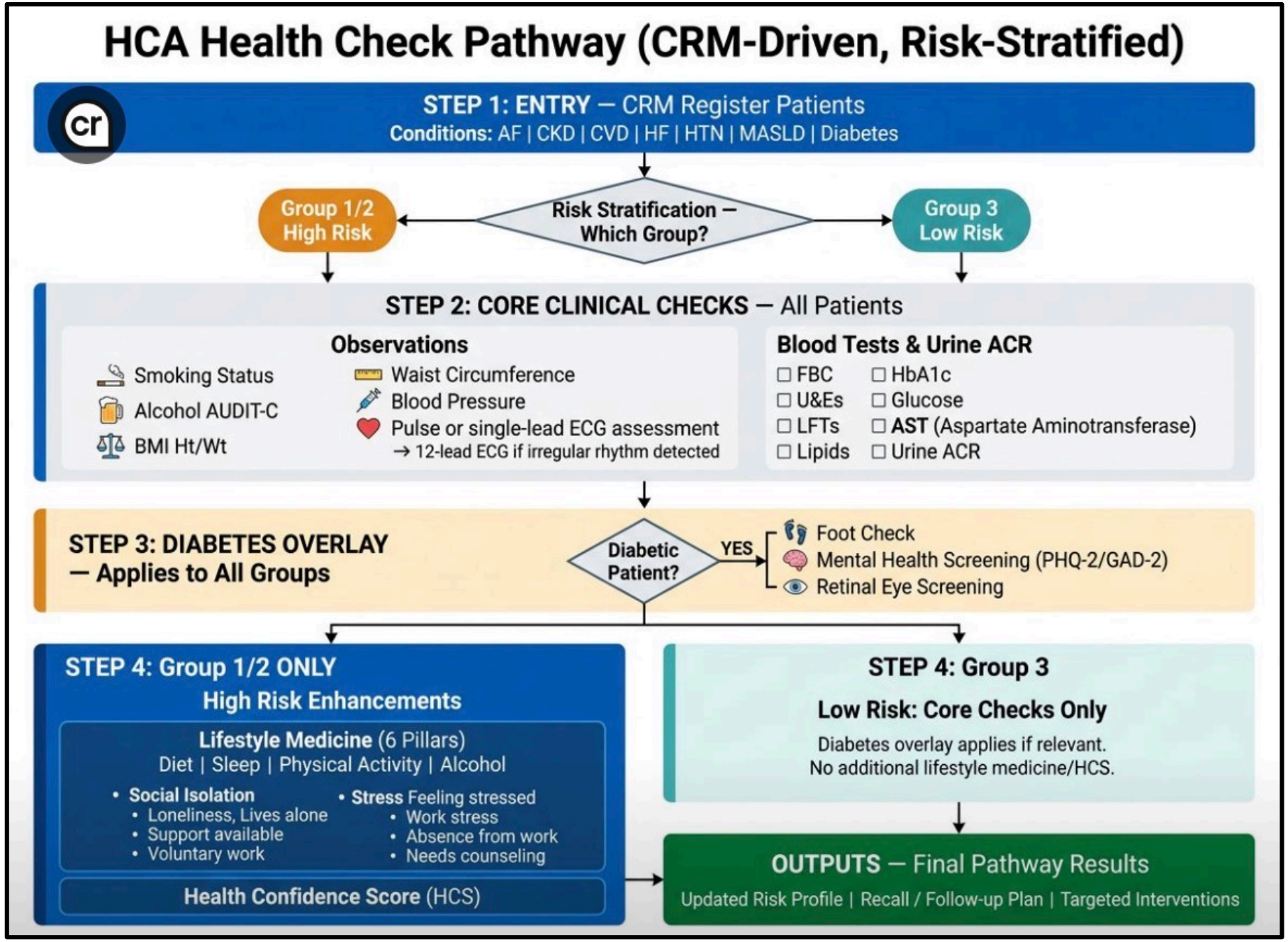
Monitoring of waist circ BP,HbA1c, lipid, and kidney function markers at 3-6 months.

Follow up 1:1 / group

- Care co-ordinator calls to check progress/ identify barriers/chase referrals
- Follow up & repeat metrics (3- 6 months) – clinician review completed



Dr Madhvi Joshi



Credit: Dr Jay Verma
Hillingdon GP

My Health Check Results: [Name]											
[Date]	Heart Age	BMI	BP	Pulse (heart rate)	Heart Rhythm	Cholesterol (TC:HDL Ratio)	HbA1c	QRISK Score	Sleep	Mood (PHQ-2)	Anxiety (GAD-2)
My Results			/			:					
Target	[age at event]	Asian, 18.5 - 22.9 All others, 18.5 – 24.9	Below 140/90 Aim for 120/80	60-100 bpm at rest	Regular	Below 5:1	Below 41	[XX]% for your age, gender and ethnicity	7-9 hours	2 or less	2 or less

For more information about your health check results, visit: https://www.nhs.uk/conditions/nhs-health-check/.

My Lifestyle Prescription

For tips and information about these lifestyle choices, visit https://www.myhealthlondon.nhs.uk/be-healthier/healthy-lifestyle

What would I like my lifestyle prescription to help me achieve? This is my goal.	

What small lifestyle change will I make to achieve my goal, feel good and improve my health?		
What will I do?	How much will I do? When will I do it? Which days will I do it?	What might stop me? How can I prepare for this?

I will use the following services to help me achieve my goal. Visit: www.healthyharrow.org.uk/lifestyleprescription for more services and support.

☐ Harrow Health Walks ☐ Street Tag ☐ Shape-Up Harrow ☐ Exercise on Referral ☐ Smoking Support ☐ Drug or Alcohol support

☐ Living a healthy life with a long-term condition ☐ Other: _____

LONDON BOROUGH OF HARROW · HEALTHY HARROW · MyHealth London · NHS North West London

Dr Madhvi Joshi

☐ Alcoholic fatty liver 01-Apr-2025 No previous entry

Dr Madhvi Joshi

Person-centered Care

~~What's the matter with you?~~

"What matters to you most?"

Seeing people as a **whole**

This means the person:

- can **take control** of their own care & build knowledge to **engage** meaningfully
- has **hope and confidence** that the process /plan will deliver **what matters most to them**
- is **central** in developing their personalised care plan
- is seen within the **context of their whole life**, valuing their skills, strengths, **experience** and important relationships
- is an **active participant** in conversations and **decisions** about their health and well being.

Equal Partners

Person's Input

- What matters to them
- Experience of symptoms
- Risk appetite
- Personal preferences
- Experience of how the wider determinants of health affect them

Practitioner's Input

- How symptoms affect systems
- Lifestyle interventions that could help
- Outcome probabilities
- Other treatment options
- Diagnosis
- Prognosis

Engagement

↓

Agenda Setting

↓

Shared Decision Making

"Equal in importance, different in strengths, effective together"

BMJ April 2026 Prof THHG Koh - Queensland

Pause for Self reflection

"What would help you achieve better health?"

"What gets in the way?"

"How might you manage that?"

"Who/ what else might help?"

Health Coaching skills

Connection & active listening

Positive affirmation/ reflective language

Partnership / co design care plan

3 As Motivational interviewing
Ask-advise-Ask

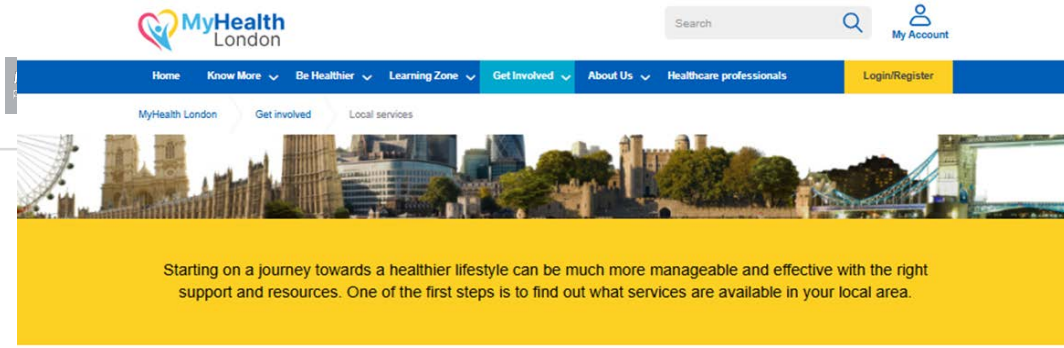
- GROW model:

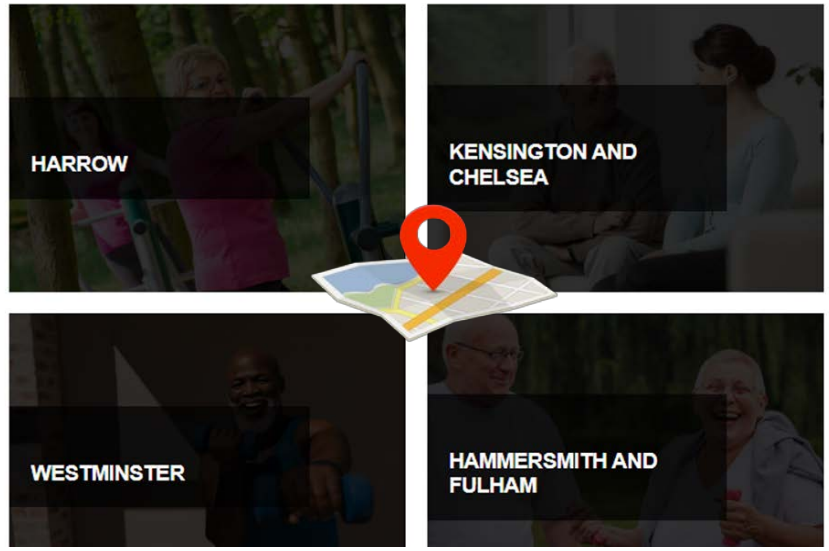
Goal setting - SMART
Right now/ reality…
Options
What will you now do?

- Conversation with your future self


People will forget what you said,
people will forget what you did,
but people will never forget
how you made them feel.
Maya Angelou

3 Things I learnt from CRM





1. Prepare ahead – helps you & patient

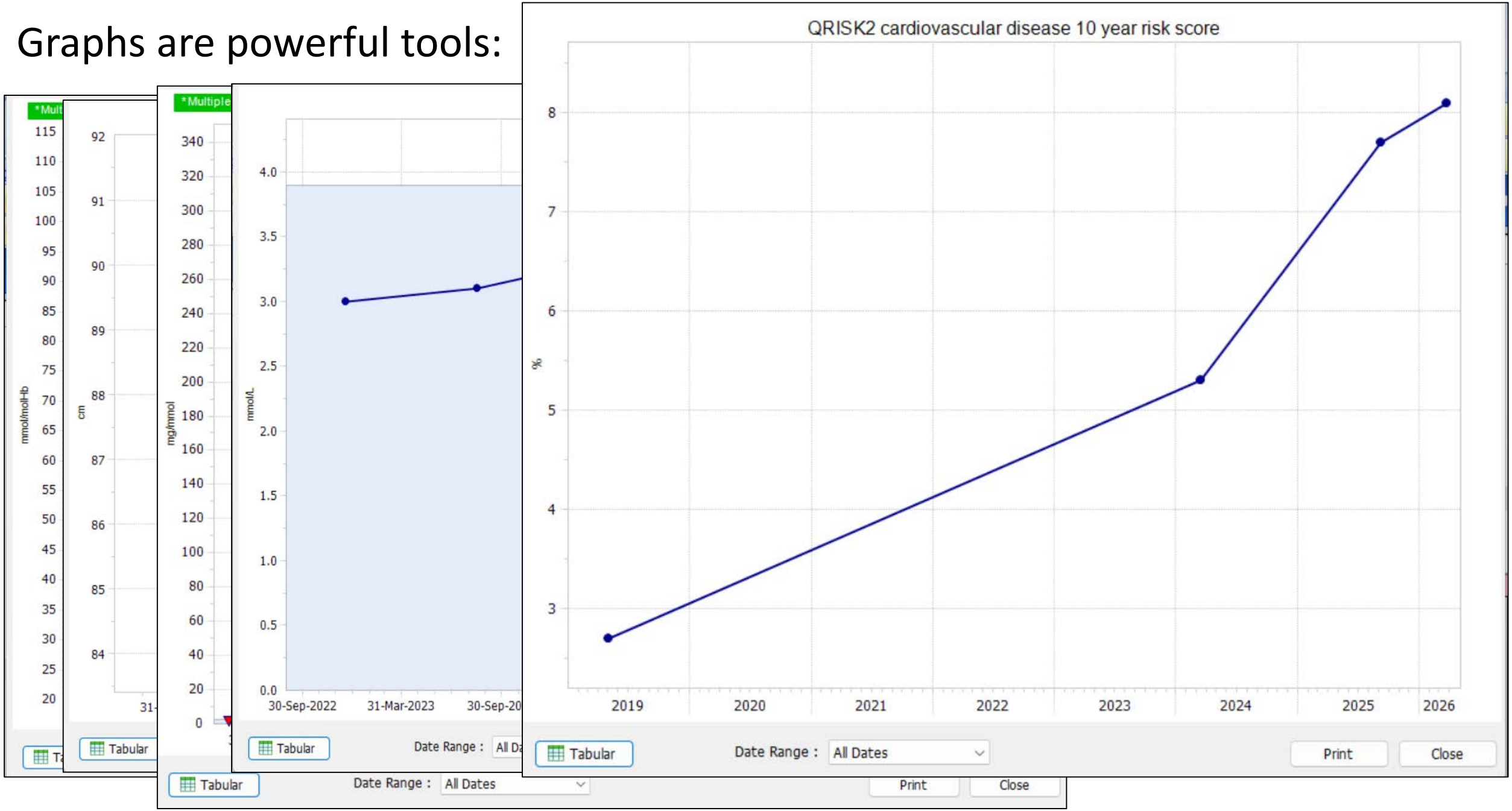
(QRISK/Heart Age, KFRE, Fib4, HCS, use graphs)

2. Talk less - listen++ (curiosity & compassion)

(Max impact with F2F. Language matters. AI Scribe/ Notes later)

3. Know your neighbourhood – local knowledge/ resources

Graphs are powerful tools:



Top Tips

- Patient preparation: invitation, check/ test, send pre assessment Q's, motivation
- Doing the homework & preparing ahead:
- QRISK/ Heart Age / KFRE/ Fib4/ Health Confidence Score
- Build an adaptable Menu of resources: connect with local VCSE/public health

Key Messages

- CRM: a “whole system” one- stop approach

- Add non-drug interventions to your toolbox
(lifestyle medicine, peer groups, voluntary/ community support).

- Good partnerships = successful outcomes
- Further learning: Coaching for health, PLM, For Kidneys Sake

CRM Diagnosis Date Timeline

November 2024 – 1st practice goes live

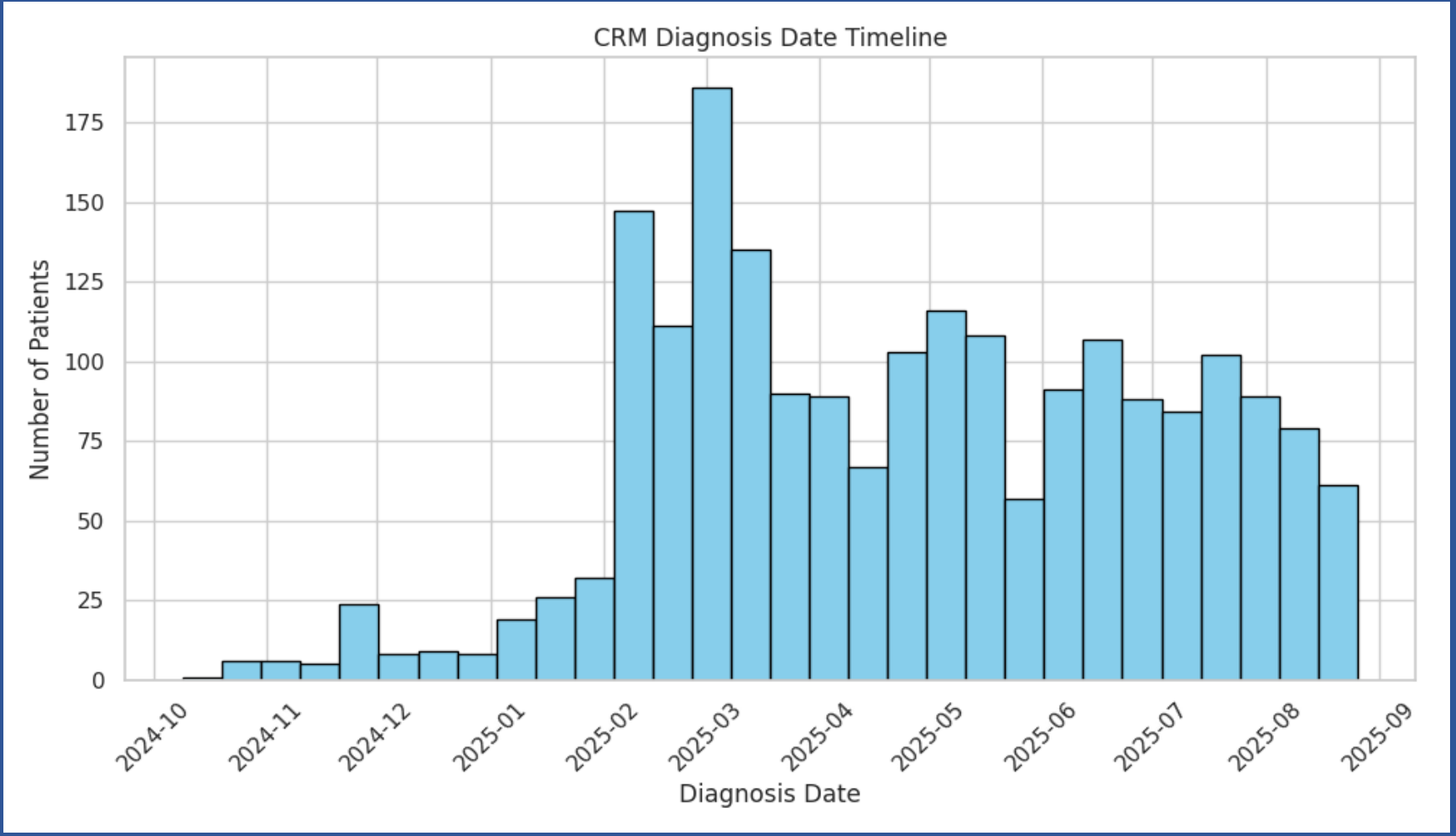
Dec – 2 PCNs

Jan – 1 PCN

By April 2025 – All 5 PCNs – live

Dec 2025/Jan 2026 – last few follow-ups completed….

First appointment – 30 minutes – F2F - key

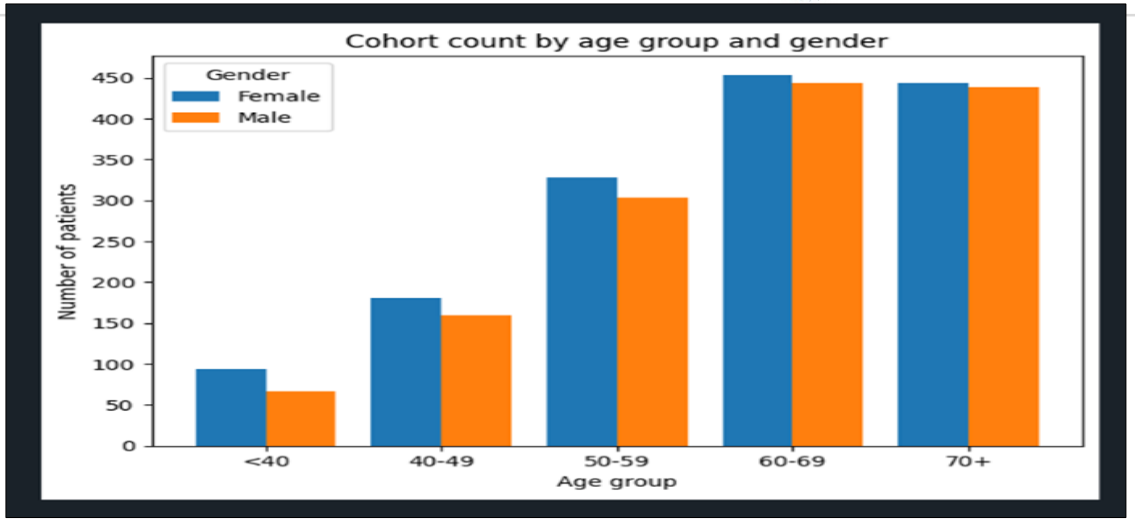


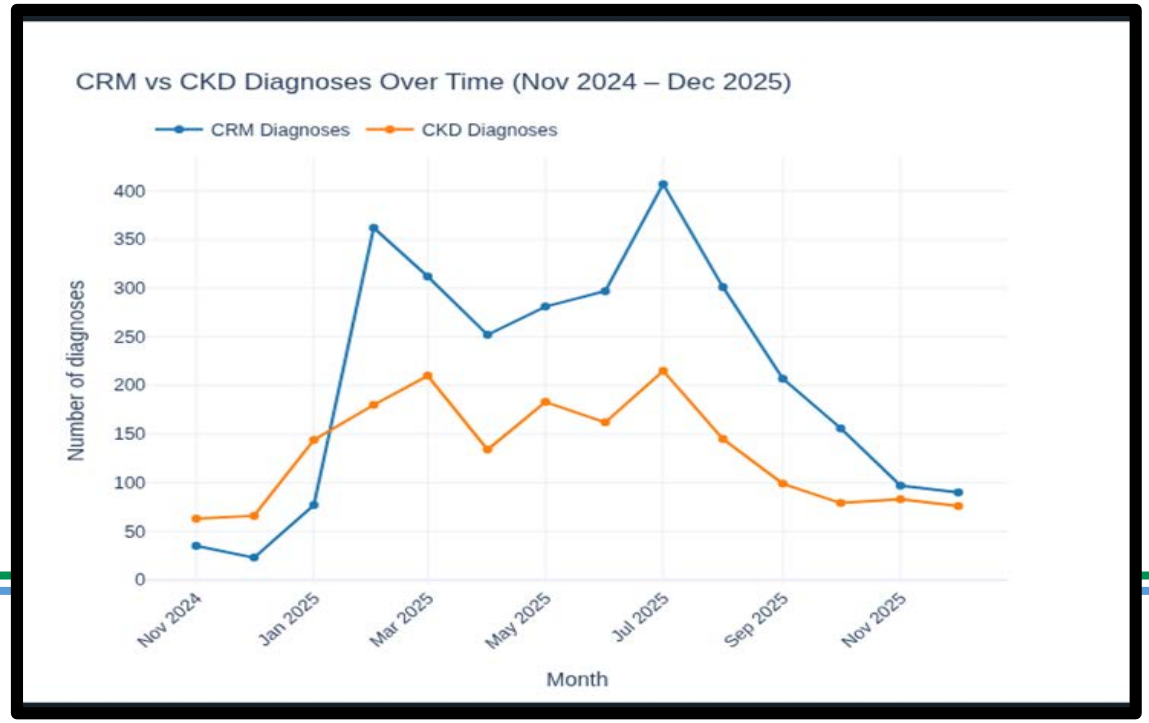
Update on data to Dec 2025

CRM/CKD diagnosis:-

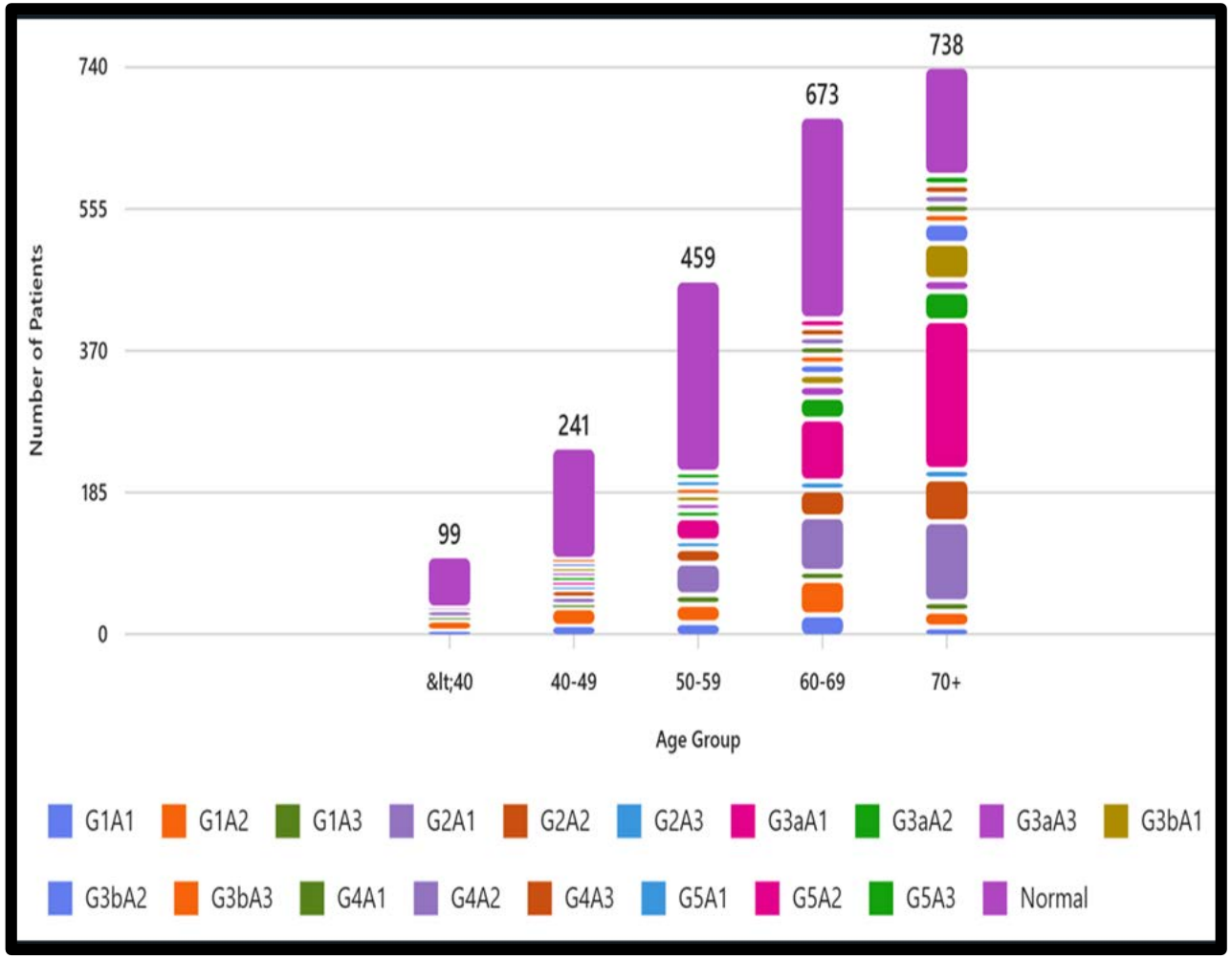
- **Total number of patients: 2,914**
- **Average age: 61.56 years**
- **Gender distribution:**
- **Female: 1,501**
- **Male: 1,413**
- **CKD status recorded in around 75% of this cohort**

AGE GROUP	FEMALE (%)	MALE (%)
<40	58.4%	41.6%
40-49	53.1%	46.9%
50-59	52.0%	48.0%
60-69	50.6%	49.4%
70+	50.3%	49.7%





CKD status in 75% of the cohort (including normal status)



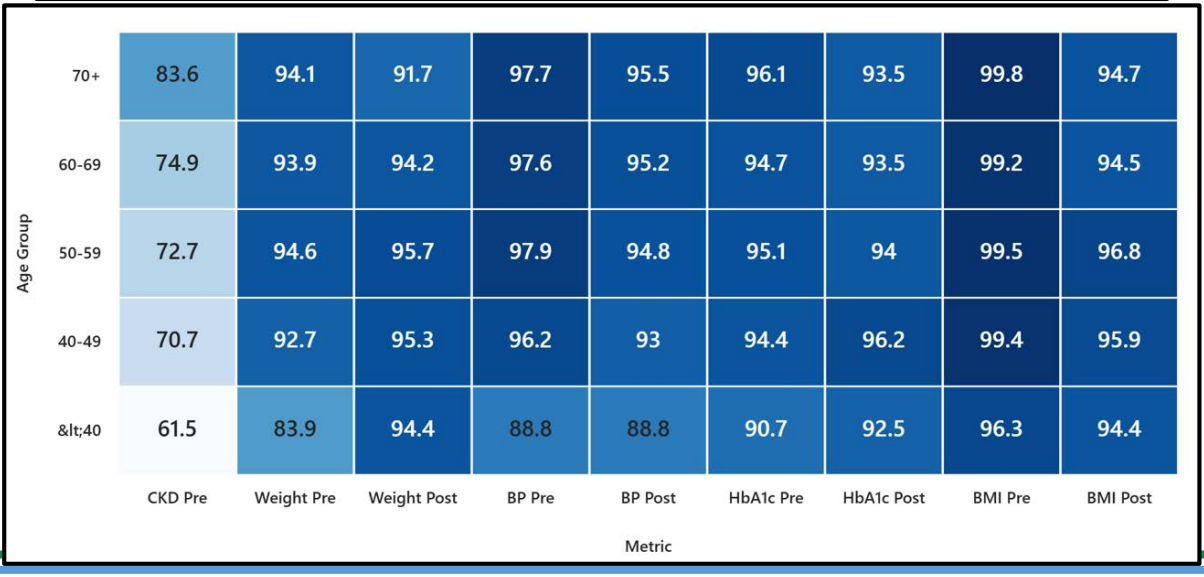
CKD status	<40	40-49	50-59	60-69	70+
Normal	77	180	308	315	162
G5A3	0	0	1	0	5
G5A2	0	0	0	1	0
G5A1	0	0	1	0	0
G4A3	0	0	0	2	7
G4A2	0	0	0	1	5
G4A1	0	0	0	2	1
G3bA3	0	1	3	6	6
G3bA2	0	1	0	9	24
G3bA1	0	2	2	10	49
G3aA3	1	1	2	11	11
G3aA2	0	3	4	27	38
G3aA1	0	2	30	91	224
G2A3	0	1	3	3	5
G2A2	0	6	16	35	59
G2A1	5	6	44	79	117
G1A3	2	3	8	7	3
G1A2	10	23	22	47	17
G1A1	4	12	15	27	5

Age Group

*Data completeness

Completeness summary (overall)

Measure	Pre complete (n, %)	Post complete (n, %)
CKD status	2,210 (75.8%)	— *(not captured)*
Weight	2,722 (93.4%)	2,737 (93.9%)
BP	2,828 (97.0%)	2,756 (94.6%)
HbA1c	2,767 (95.0%)	2,736 (93.9%)
BMI	2,894 (99.3%)	2,775 (95.2%)

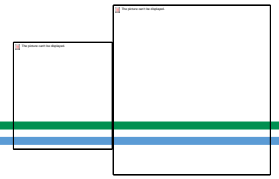


Overall Cohort (N = 2,914)

Measure	Paired Complete (n)	Paired Complete (%)
Weight	2,571	88.2%
BP	2,687	92.2%
HbA1c	2,633	90.4%
BMI	2,772	95.1%
CKD Baseline	2,210	75.8% *(baseline only)*

- **Waist measurement completeness (overall)**
- **Pre complete: 2,093 / 2,914 (71.8%)**
- **Post complete: 2,290 / 2,914 (78.6%)**
- **Paired complete (pre & post): 1,831 / 2,914 (62.8%)**

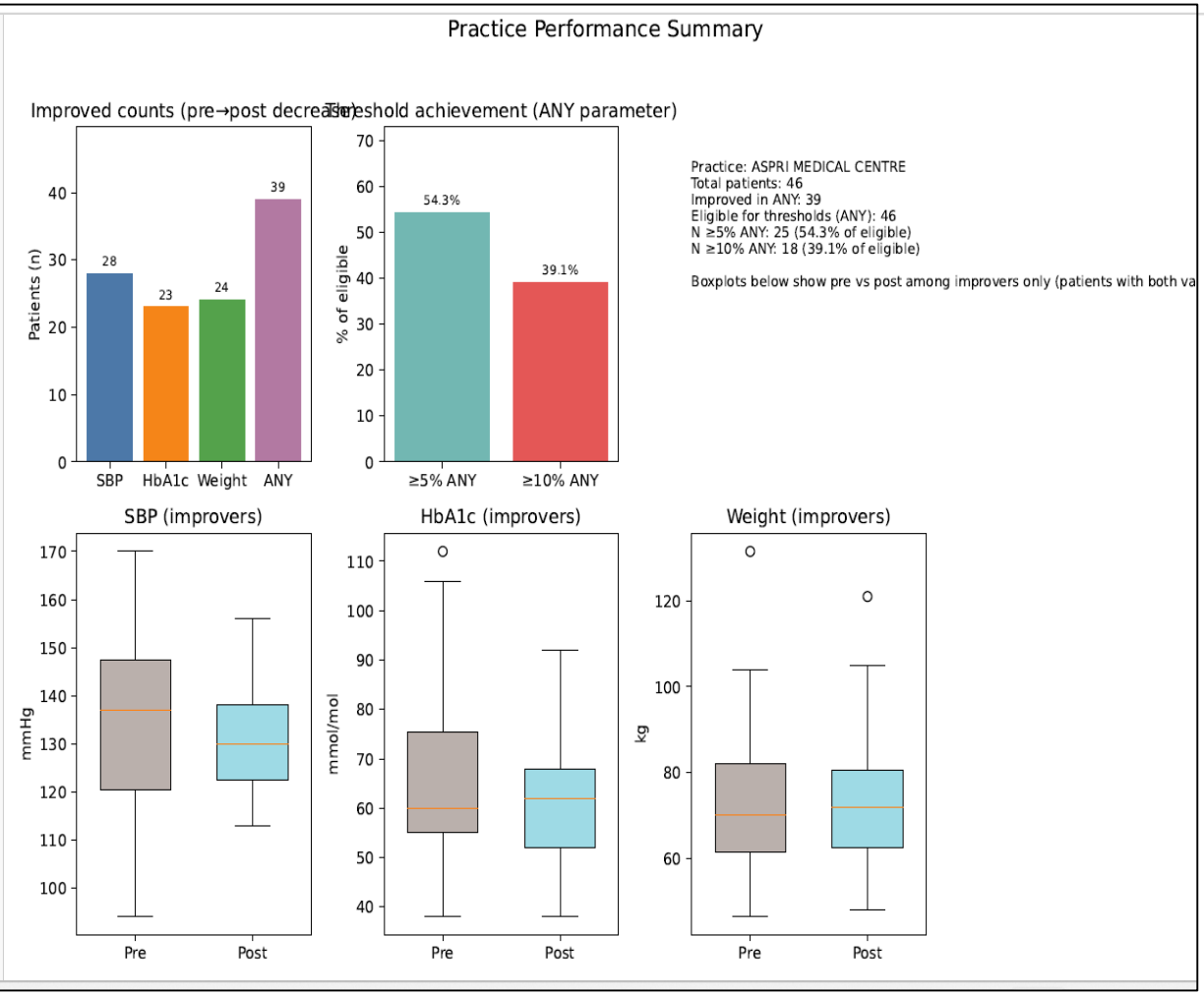
Measure *Whole-cohort results (paired samples only)	N paired	Mean pre	Mean post	Mean change (post−pre)	95% CI	p-value	Sig.
BP	2,687	132.11	128.92	**−3.18**	−3.77 to −2.60	4.71×10^{-26}	***
Weight (kg)	2,571	84.98	83.95	**−1.03 kg**	−1.22 to −0.84	5.04×10^{-26}	***
HbA1c (mmol/mol)	2,633	51.51	50.30	**−1.21**	−1.57 to −0.84	1.36×10^{-10}	***
BMI (kg/m²)	2,772	31.39	31.17	−0.22	−0.71 to 0.27	0.381	ns

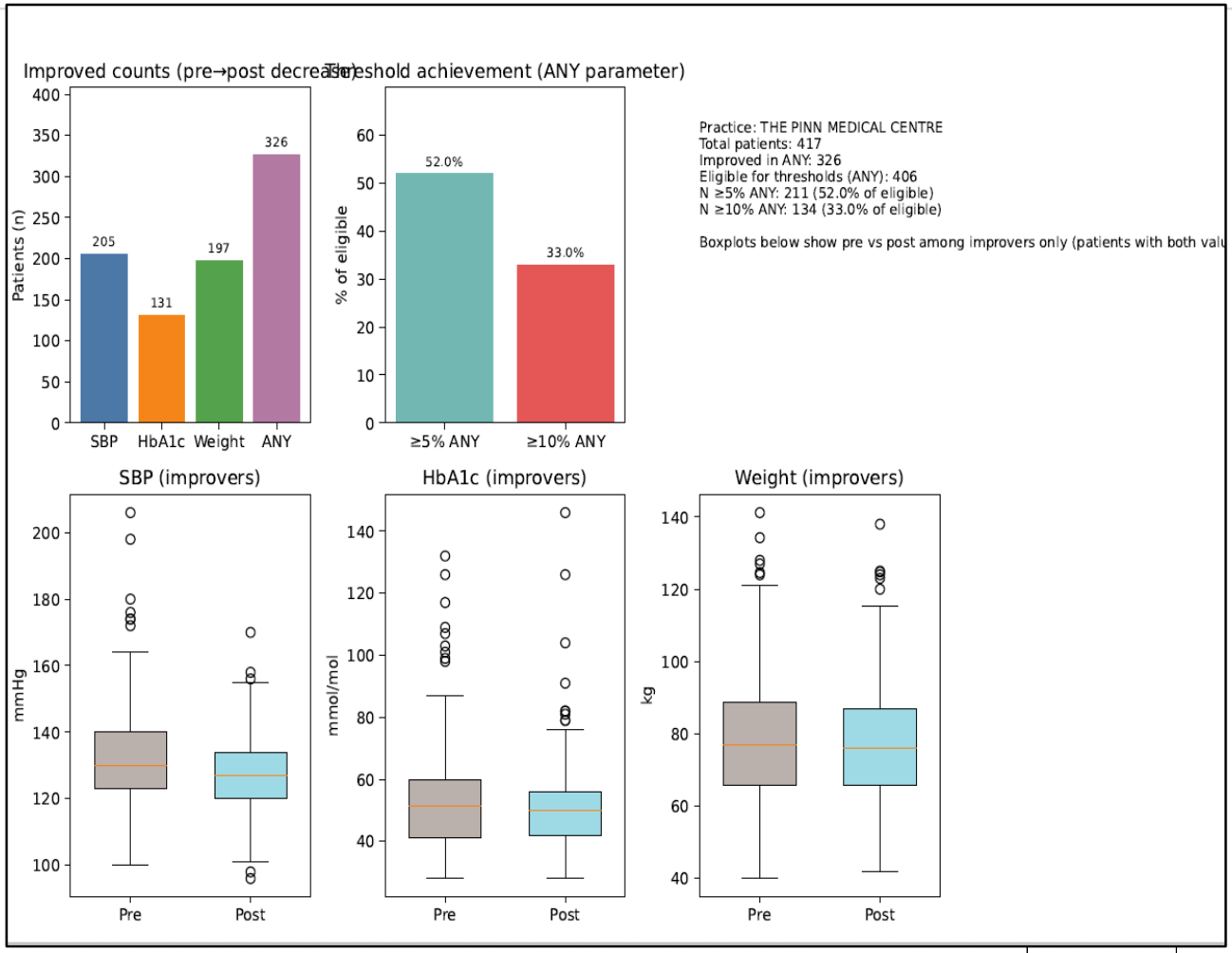


Practice	N pts	gible ANY (pre+po	Pct ≥10% ANY	Pct ≥5% ANY	N ≥10% ANY	N ≥5% ANY	SBP mean (improve	HbA1c mean (improve	Weight mean kg (improve
Enderley Road Medical Centre	98	97	45.4%	63.9%	44	62	-9.56	-7.61	-2.10
First Choice Medical Care	9	9	44.4%	77.8%	4	7	-0.11	-3.00	-1.14
Kenton Bridge Medical Centre Dr Abu	63	61	44.3%	60.7%	27	37	-8.09	-4.68	-2.34
Simpson House Medical Centre	69	67	41.8%	61.2%	28	41	-10.38	-0.56	-0.33
HONEYPOT MEDICAL CENTRE	156	153	41.2%	61.4%	63	94	-8.45	-2.27	-1.64
BACON LANE SURGERY	131	129	39.5%	58.1%	51	75	-8.22	-1.32	-1.72
ASPRI MEDICAL CENTRE	46	46	39.1%	54.3%	18	25	-3.82	-5.57	-1.28
The Northwick Surgery	74	73	38.4%	58.9%	28	43	-3.82	-5.25	-1.60
GP Direct	77	77	37.7%	53.2%	29	41	-2.41	-3.79	-1.83
Mollison Way Surgery	80	80	37.5%	72.5%	30	58	-4.74	-3.08	-1.04
Kenton Bridge Medical Centre Dr Raja & D	58	57	35.1%	63.2%	20	36	-3.96	-2.00	-2.89
HEADSTONE LANE MEDICAL CENTRE	101	98	34.7%	54.1%	34	53	-12.18	0.39	-1.18
PINNER VIEW MEDICAL CENTRE	122	121	33.9%	49.6%	41	60	-4.65	-1.14	-1.85
The Ridgeway Surgery - Harrow	65	65	33.8%	49.2%	22	32	-10.22	-2.12	-0.86
Elliott Hall Medical Centre	114	113	33.6%	60.2%	38	68	-4.63	-2.16	-2.54
THE PINN MEDICAL CENTRE	417	406	33.0%	52.0%	134	211	-4.79	-3.12	-1.45
THE CIRCLE PRACTICE	55	54	31.5%	50.0%	17	27	-2.27	-1.26	-4.45
THE PINNER ROAD SURGERY	30	29	31.0%	51.7%	9	15	-11.60	0.26	-1.23
ZAIN MEDICAL CENTRE	78	70	30.0%	47.1%	21	33	-6.69	-1.21	-0.97
HEADSTONE ROAD SURGERY	171	163	28.8%	49.1%	47	80	-5.16	-2.18	-1.82
Belmont Health Centre	169	165	27.3%	55.2%	45	91	-7.87	-0.33	-1.70
The Stanmore Medical Centre	114	111	26.1%	47.7%	29	53	-8.00	-0.45	-1.73
THE STREATFIELD MEDICAL CENTRE	67	66	25.8%	50.0%	17	33	-4.40	-1.05	-0.02
ST. PETER'S MEDICAL CENTRE	79						-3.35	-1.00	-2.12
THE SHAFTESBURY MEDICAL CENTRE	114						-7.86	-1.03	-1.12
Streatfield Health Centre	91						-1.39	-1.27	-2.10
ROXBOURNE MEDICAL CENTRE	62						-3.77	-1.05	-2.47
THE CIVIC MEDICAL CENTRE	13						3.50	-4.30	-2.50
Kings Road Medical Centre	88						-4.10	-1.89	-1.30
HATCH END MEDICAL CENTRE	16						-1.67	0.83	-2.38
KENTON CLINIC	87						-7.37	0.51	-0.71

Every practice – demonstrated improvements for patients – each practice looked at different patient cohorts – RAG only related to >10% improvement in any one parameter – for "sorting the column"

Example Practice level report

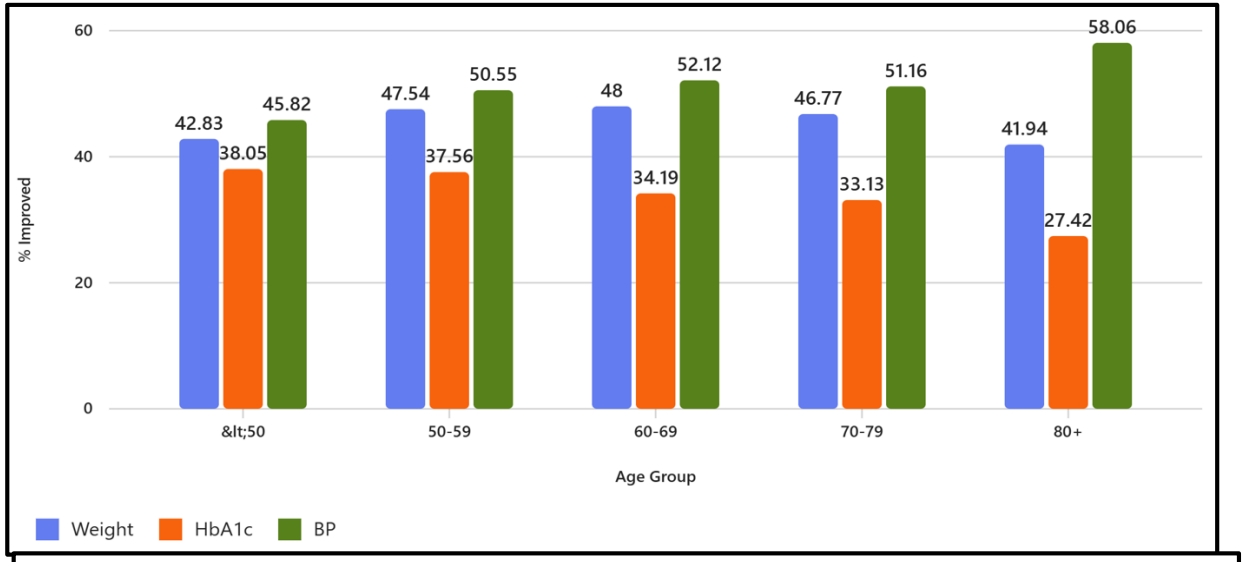


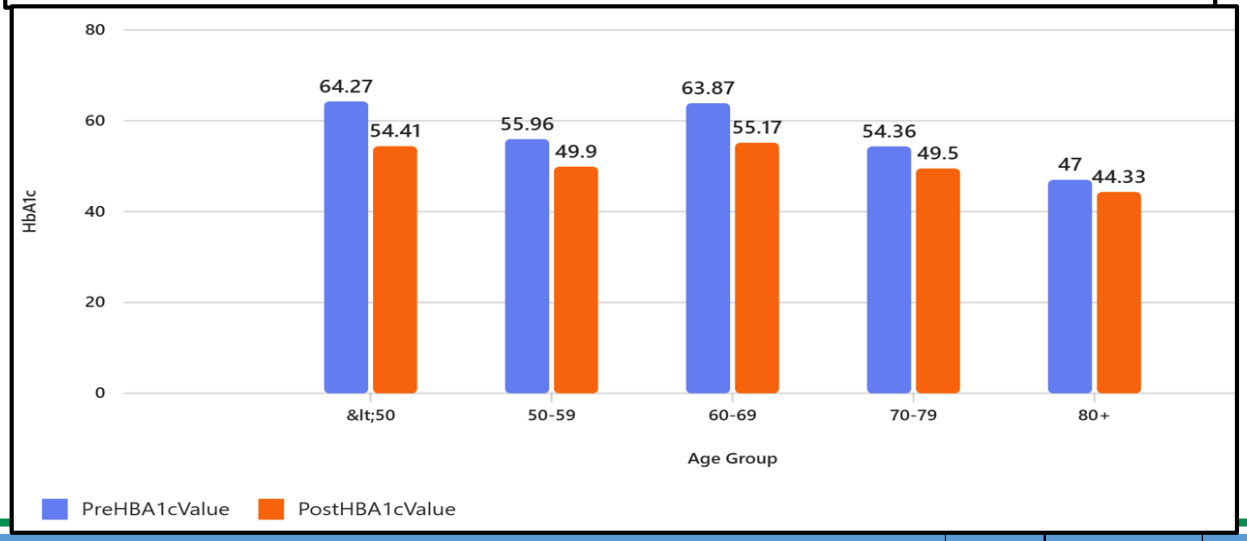


Improvement in at least one parameter of BP, weight, HbA1c, BP, BMI or waist measurement by age, size of improvement

Age Group	Cohort Size	Patients Improved in ≥1 Parameter	% Improved
<40	161	132	82.0%
40–49	341	285	83.6%
50–59	631	535	84.8%
60–69	898	746	83.1%
70+	883	714	80.8%

Reduction band (by max % across any metric)	Patients (n)
No improvement	467
0–5%	812
>5–10%	655
>10%	980

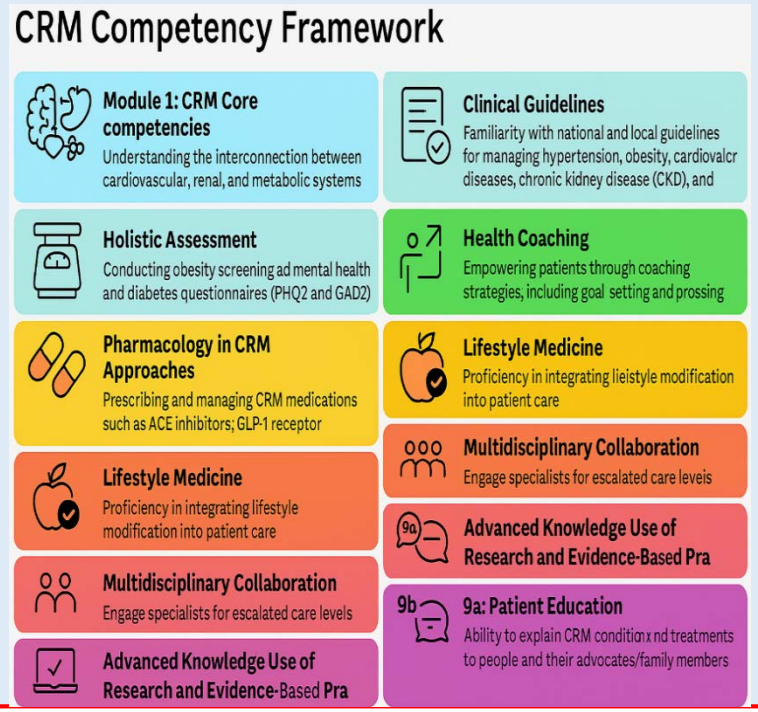




*Over four-fifths of the cohort showed improvement in at least one key cardio metabolic measure

Total patients with improvement in at least one parameter:

- **2,271 out of 2,914 (~77.9%)**



Cohort summary — “any of the three metrics” – BP, Weight or HbA1C:

- **Any improvement >0%: 2,389 / 2,914 (81.98%)**
- **Any improvement ≥5%: 1,500 / 2,914 (51.5%)**
- **Any improvement ≥10%: 920 / 2,914 (31.5%)**

Additional insights…

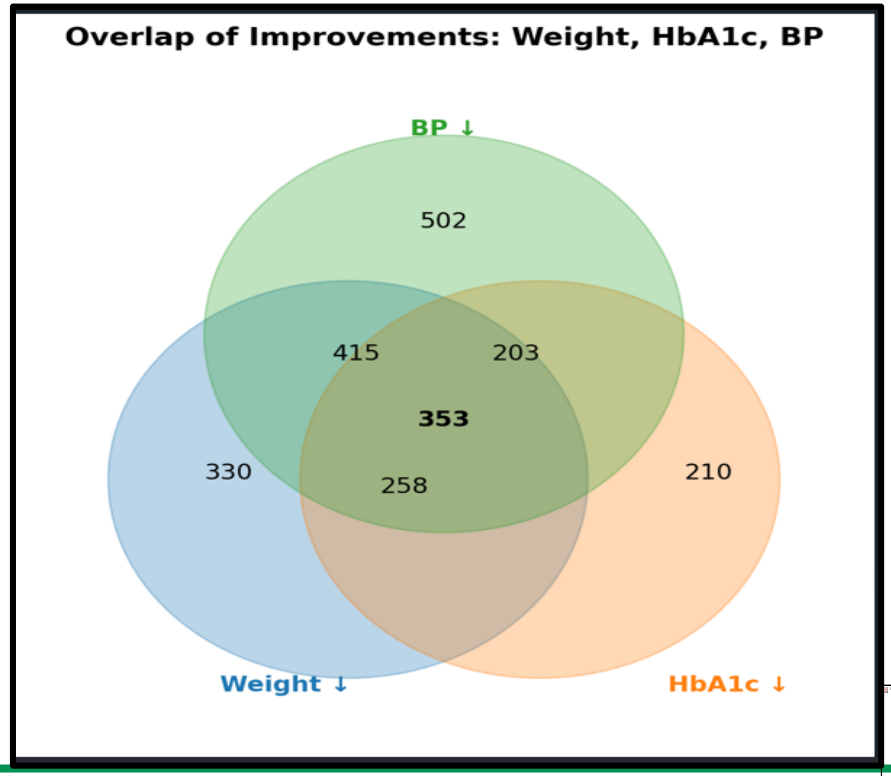
≥5% threshold

- **Exactly 1 metric: 1,068 patients**
- **Exactly 2 metrics: 348 patients**
- **All 3 metrics: 84 patients**

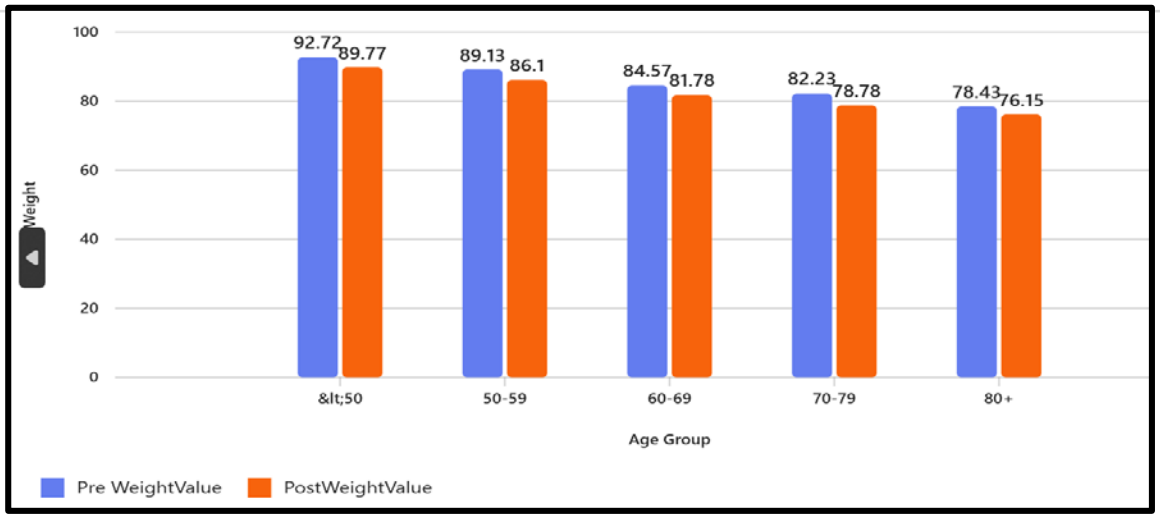
≥10% threshold

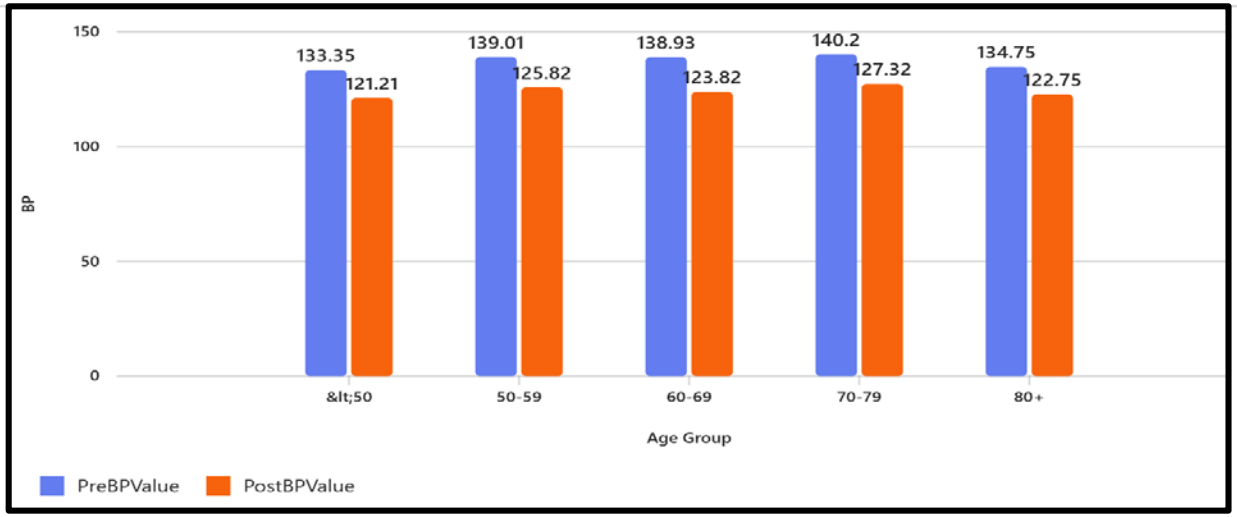
- **Exactly 1 metric: 779 patients**
- **Exactly 2 metrics: 117 patients**
- **All 3 metrics: 24 patients**

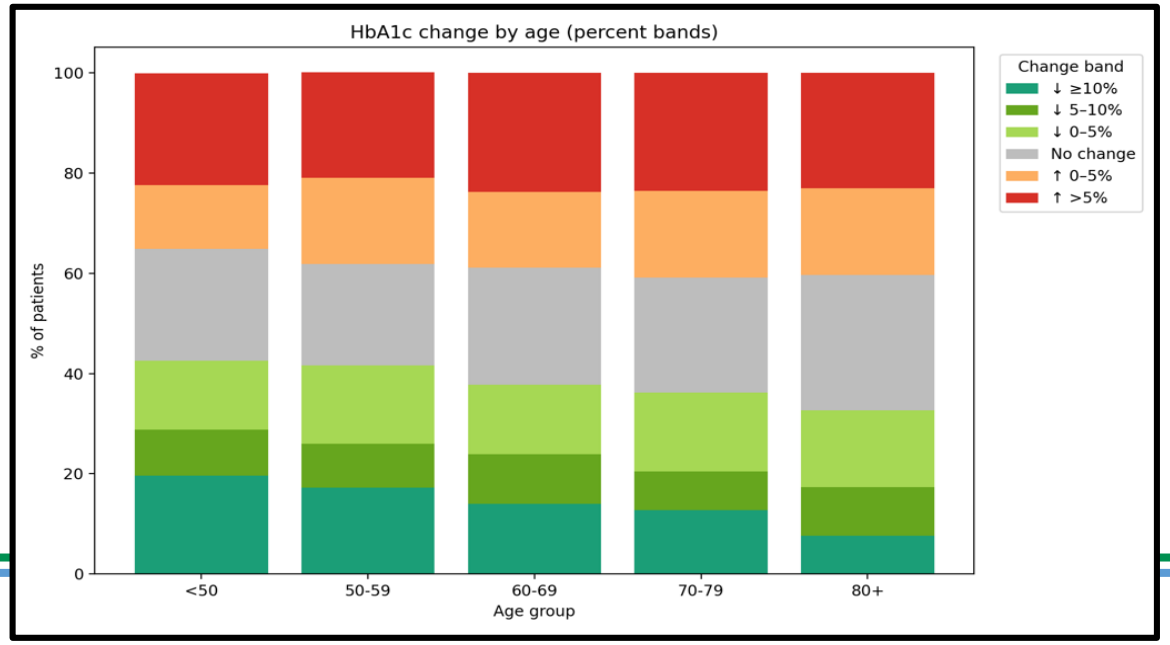
- Statistically significant improvements were noted in patients with CKD status
- Improvements across all age groups

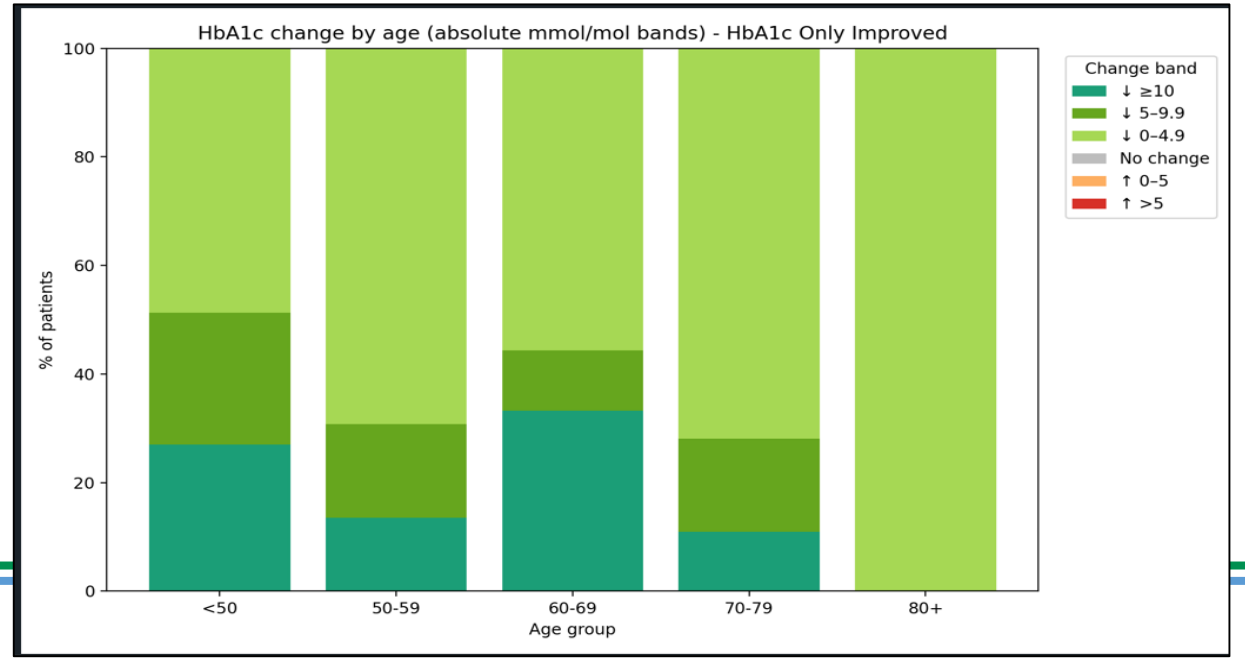


Additional information…









Further insights…

For HbA1c-only improvers:

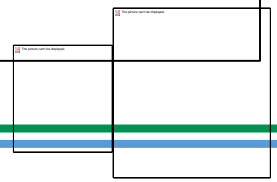
<50 age group:

- **Mean reduction ≈ 9.9 mmol/mol (12%) → clinically significant, likely high ROI**
- **60–69 age group: Mean reduction ≈ 8.7 mmol/mol (11.5%) → strong ROI**
- **80+ age group: Mean reduction ≈ 2.7 mmol/mol (5.9%) → modest ROI, but still beneficial for reducing acute complications**

Patients with:-

- **Pre HbA1c > 48 and Post HbA1c < 48: 143**
- **Patients with Pre HbA1c > 41 and Post HbA1c < 41: 68**

Remember the cohorts of patients was wide with differing degrees of CKD – all practices indicated patients with improvements



Project Outputs and Outcomes - Achievements to date (Dec 25)

Outputs:

- ✓ Alignment to the proposed NWL "Single Offer" – CRM specification and business case.
- ✓ Structured programme on personalised care – increased awareness re Motivational Interviewing Training Programme
- ✓ Alignment to NHS Healthchecks
- ✓ Alignment to Make Every Contact Count (MECC)
- ✓ Detailed alignment to national GMS/QOF/ Enhanced services – patient is seen once for a detailed appointment
- ✓ Positive staff and Patient feedback
- ✓ Discussion opportunities for complex patients in MDT meetings – ongoing shared learning

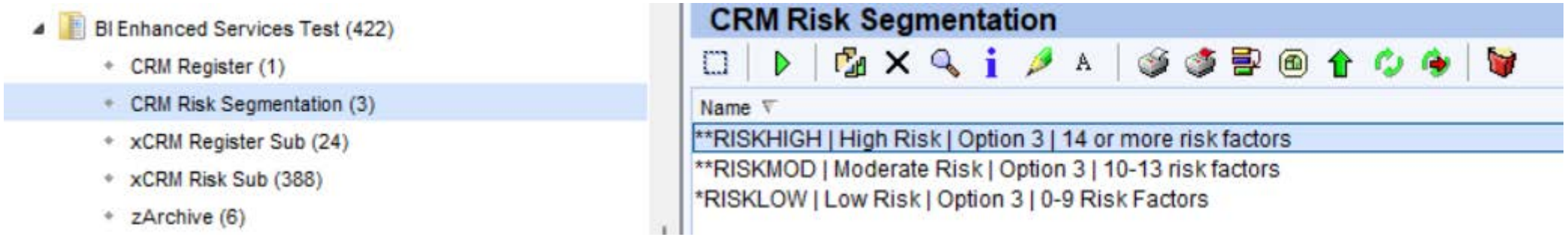
Desired outcomes/benefits:

- ✓ 80% patients had an improvement in either BP, weight or HbA1c
- ✓ Improved CKD screening and initiate earlier interventions
- ✓ Improved screening and early identification of early liver disease
- ✓ over 95 % of the suggested cohort of patients have been seen and reviewed by Month 12 of the programme
- ✓ Increased referrals to aligned services eg weight management – but also enhanced support to those who have declined - motivated

Searches – NWL CRM Cohort

SystmOne Practices

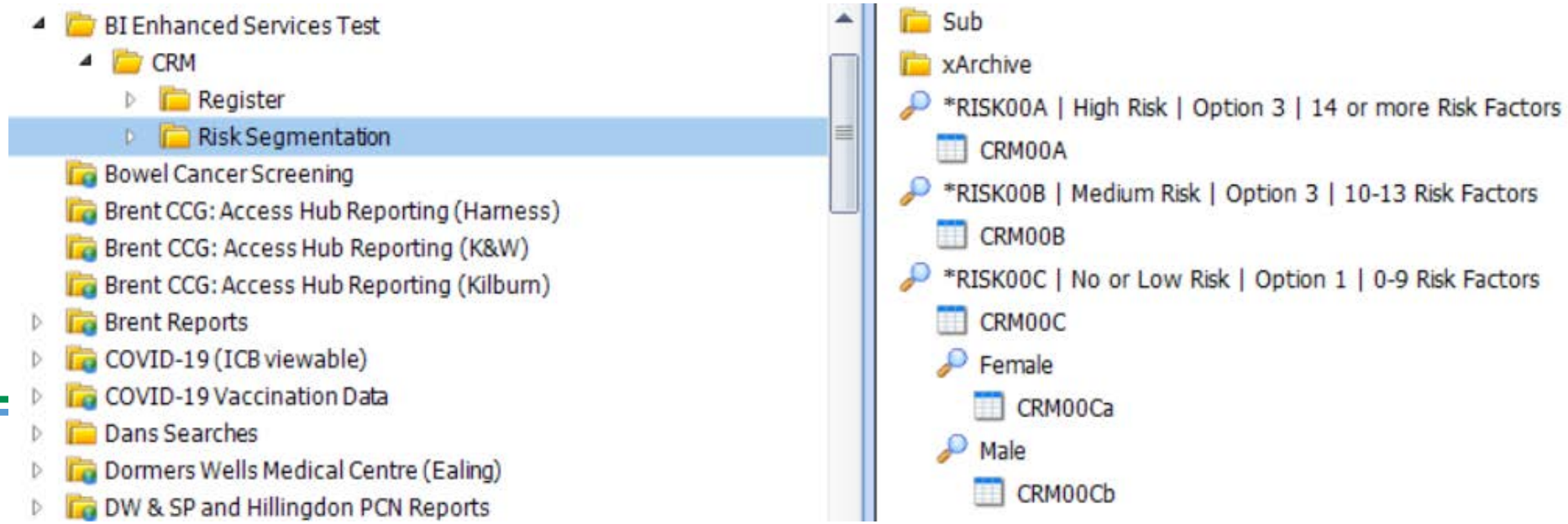
NW London ICB >> BI Enhanced Service Test >> CRM Risk Segmentation



EMIS Practices

Brent & Harrow: **NWL ES&R >> BI Enhanced Services Test >> CRM >> Risk Segmentation**

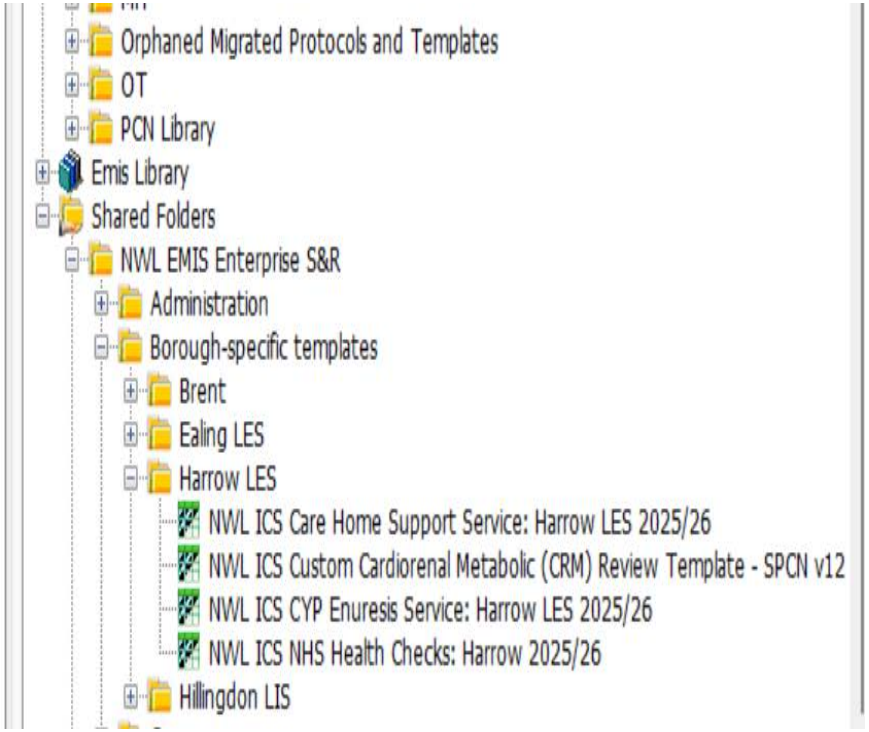
Hillingdon: **Hillingdon ES&R >> BI Enhanced Services Test >> CRM >> Risk Segmentation**



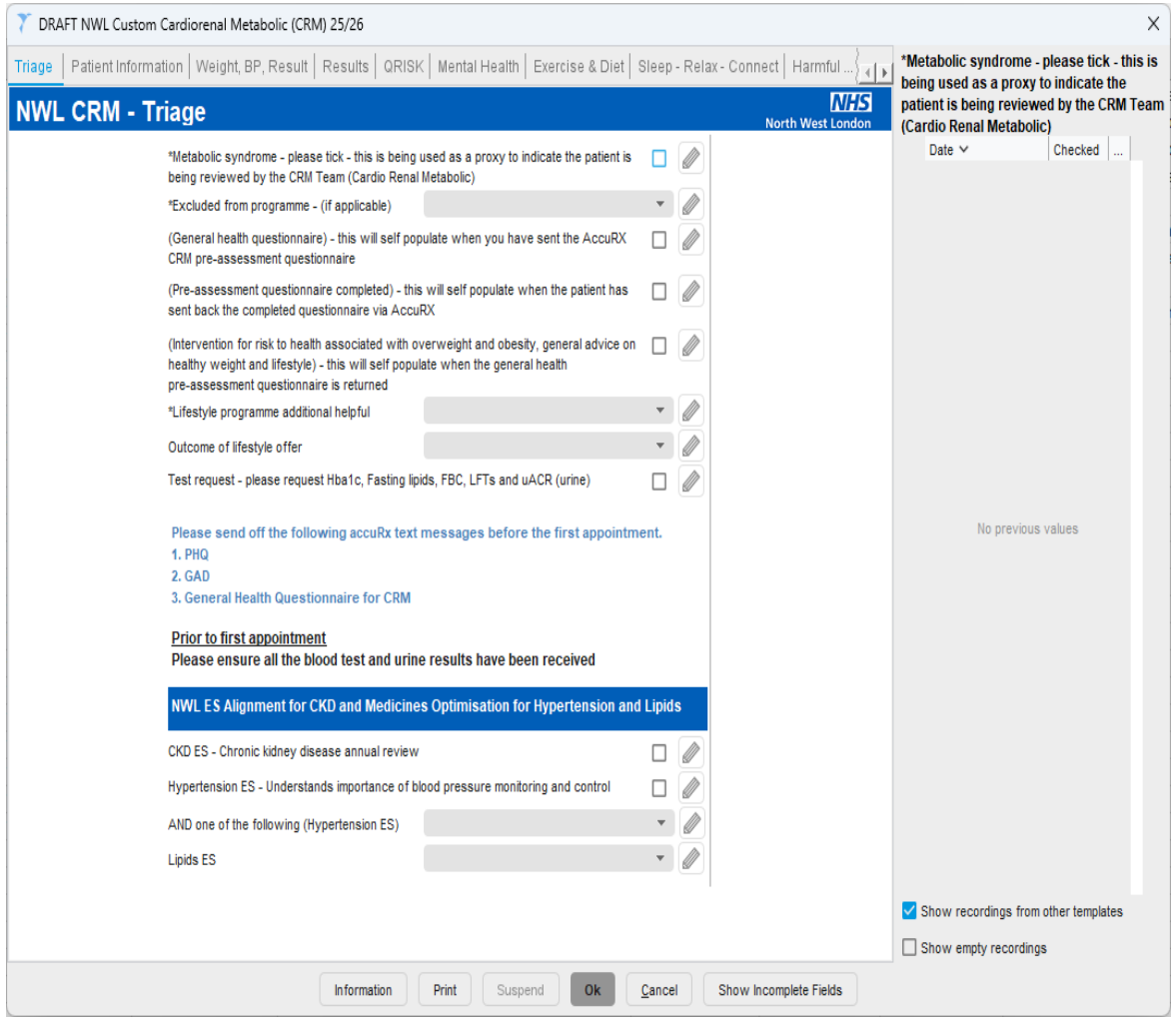
Clinical Template

Draft versions - *already live*

EMIS – Version 12 – Sharefolders – NWL EMIS Enterprise S&R – Borough-specific templates – Harrow LES –NWL ICS Custom Cardiorenal Metabolic (CRM) Review Template v12



S1 – Version 11 - The template can be found under Autoconsultations > z NWL Testing > DRAFT NWL Custom Cardiorenal Metabolic (CRM) 25/26



1. 30 minute face to face consultation
2. Personalised holistic care
3. Data – from the fingertips of the patient
to the fingertips of the integrated primary care team
to the fingertips of public health
and strategic planning - empowering and enbling but also funding.
Keep it short and simple – BP, Sugar control, cholesterol control, healthy weight
So what is your heart age?

Thank You for listening from Harrow Network Partners

Sharing our learning…..

- **LKN – Educational framework/LKN/MHM**
- Hammersmith and Fulham
- 3 Educational events - Dr Kyla Cranmer/Dr James Tomlinson/Dr Yin Yin Lee/Dr Kuldhir Johal/Matt Ayres/Dr Alasdair Macrae/Jessica Mathews/Eve Costello – Hammersmith &Fulham Training Hub
- Hillingdon – Hypertension Steering Group – Masterclass and CDs – Kim Rice/Sasha Nelson/Dr Sabby Kant/Dr Diviash Thakrar/Dr Kuldhir Johal/Dr Ritu Prasad Hillingdon Confederation Training Hub
- Harrow – CRM Steering Group and CD/PCN Manager meetings – Dr Madhvi Joshi/Steven Buck/Rashida Rahman/Shaban Siddik/Dr Ashok Kelshiker/Dr Hannah Bundock/Dr Mathi Woodhouse/Dr Dimple Shah/Dr Andrew Frankel/Victoria Brookman – Harrow Training Hub
- Brent – Dr Madhvi Joshi/Rashida Rahman/Dr Kuldhir Johal/Dr Andrew Frankel/Sheik Auladin/Dr Mo Ali
- CLEAR Programme – sharing lessons learnt with 6 PCNs as a part of the MHM programme – Rashida Rahman/Dr Kuldhir Johal
- NWL Renal CRG – 3Ps programme – Governance
- March 2026 UKKW – 3 Poster presentations and speaker attendance
- September 2026 BSLM Speaker presentations by Dr Madhvi Joshi and Dr Kuldhir Johal

Stage 1: Logic Model

A logic model was developed based on project team inputs from collaborative workshop in 2024 and built upon via 1:1 stakeholder interviews – to be signed-off by the CRM project Steering Group.

Inputs	Activities	Outputs	Outcomes**	Impact
National 3P funding	Staff training sessions & self-directed learning	# staff trained to deliver CRM consultations / care	Reduction in cardio-renal-metabolic risk amongst cohort	Onset and progression of additional LTCs prevented for patients with a diagnosis of 1 condition
Integrate Care Team support	Case-finding and risk assessment, incl EMIS searches	# patients treated through CRM pathway & discharged	Improved population health in Harrow	ICHD demand does not outweigh capacity in 15-20 years
Workforce across 5 PCNs*	Proactive contact / invitation to selected patients	# CRM consultations delivered	Patients feel more knowledgeable about their health and empowered to manage it	Prevention of heart attacks and strokes
CRM clinic design & pathway	Longer, holistic consultations using health coaching & personalised care techniques	# patients active on MyHealth London platform	Staff feel confident and able to deliver holistic lifestyle medicine using a CRM lens	Staff deliver holistic, integrated care as BAU
EMIS consultation template	Referrals to community resources and services		Improved system integration	ROI and implementation learnings / blueprint allow for spread and scale of model across NW London, with any adaptations
EMIS search logic for 2 defined patient cohorts	Patient education & self-management		Positive return on investment	
Staff training & materials via education framework	Complete EMIS templates		Improved coding of CKD	
Pt educational resources	Monitoring & follow-up appointments		**Balance measure**: increase in system activity/referrals due to proactive care	
SOP for CRM clinics				
Project steering & working group				
PCN MOUs				
Harrow Network Partners				
NW London Renal leadership				
London Kidney Network				
National 3P programme				

Summary – NWL Current position

- People with CRM conditions are 20% of NWL population and constitute 70% of NWL admissions, with huge impact on premature mortality, illness and disability
- Includes: Hypertension, CVD, Heart Failure, AF, NDH, DM, CKD (with clinical obesity as a risk factor)
- A common set of risk factors involved in most of these disorders (excluding T1DM) and a common set of care processes, pathways and opportunities for self-management
- Good evidence that optimal care has an impact – evidence for this particularly with DM in NWL (admissions correlate with HbA1c and BP, independent of age, frailty, etc)
- To-date most of the focus has been on care processes and medicines optimisation, but medical care only accounts for 20% of outcomes
- Growing understanding of the value of collaborative care planning, lifestyle medicine, support for behavioural change – Harrow CRM hub pilot demonstrating some encouraging outcomes
- Need to address health inequalities – close association between deprivation and obesity/CRM conditions as well as non-white ethnicity
- Challenge – how to use the funding most effectively?

Proposed NWL CRM Service Specification – Overview – 2026/2027

Population to include:

- **Cardiovascular Disease** (**CVD** - including Ischaemic Heart Disease [IHD], Stroke, TIA, Peripheral Vascular Disease [PVD], Heart Failure [HF]), **Hypertension (HTN)**, **Type 2 Diabetes**, **NDH**, **Chronic Kidney Disease (CKD) Non-alcoholic fatty liver disease (NAFLD), and Atrial Fibrillation (AF).**
- **Specification to incentivise 5 elements:**
- **Case finding** e.g. data quality will increase prevalence – hypertension, AF, DM
- **Completion of processes** (e.g. BMI, uACR, eGFR, waist circumference, FIB-4 as standard parts of care in DM/Liver disease)
- **Achievement of targets** (e.g. % achieving BP targets, % of CKD patients on SGLT-2, statins and ACEI/ARB)
- **Holistic care** – including care planning and lifestyle outcomes, Health Confidence
- **Reduction in end-point outcomes** (e.g. admissions for CVD, progression to T2DM from NDH, progression to ESRF) – ***Maybe not initially in the primary care contract – this would be the focus of a neighbourhood health model***

Adopting a Combined CRM Service Specification will allow us to simplify the contracting, clinical management and reporting, removing overlapping or redundant KPIs and harmonise those which remain.

Dr Tony Willis, Dr Mohammad Haidar NWL ICB

Patient and Staff feedback…

Early staff insights – training and upskilling

Training and upskilling

- Elements emerging a
  impactful for staff:
  - Shadowing clini
    playing with exp
    colleagues, hea
  - YouTube video
    Willis
- Framework experienc
  sometimes difficult to
  links/registration), cor
  feasible to complete i
  available.
- Perceived relevance
  varies by staff role – f
  it felt like a recap of w
  already, whereas for
  content was newer.

Early staff insights – consultations

Consultations

- Strong support for 3(
  required in order to c
  approach
- However, still difficul
  medicines optimisati
- There is variation in
  between medical vs
  buy-in and interest in
  - Example views
    long time; (2) c
    Mounjaro – an
    access to it
- Some practices may
  add'l f2f visit before
- Critical for making in
  change – e.g. goal s
- Unclear when 'disch

Early patient insights – contact about CRM appointment

Contact

- Patients gener
  proactively cont
- Because this is
  having the initia
  for clarifying the
  chance to ask
- Offering flexibili
  is appreciated -
  longer than typi
- Having access
  can help prepa
  conversation
- Giving patients
  advance – e.g.
  urine sample –

Early patient insights – activation and motivation

Activation & motivation

- Motivated by seeing da
  blood sugar levels via
  seeing visuals on scre
  consultation
- Eager to play a more a
  healthcare
- Regular review periods
  able to try out changes
- Having/building a regul
  their care professional
- Importance of family in
  motivation and as acco
  (staff also noted benefi
  involved where possibl
- Not many using digital
  their condition – but wo

Early patient insights – care plans and advice

Care planning and advice

- Broad support for this more proactive, preventative approach
- For most, this is the first appointment of this type that they have had. Several have had diabetes check-ins but noted these are shorter and less comprehensive
- Most keen to implement changes, but some more unsure about whether they would; having small, tailored goals to work towards helps
- Important for the information being shared to be culturally appropriate, especially around diet
- Having relevant links shared post-appointment is helpful, but better to receive just one email rather than several

*"What I would be more inclined to say is that **preventative care is more important than care that you'll receive later on** in remission or to come out of it. And if I had more preventative care, knowing that I had a high BMI, knowing I had high-risk, I wasn't given… it was just advice and then I got to the stage where I obviously became a bit diabetic and then I had to do something, but preventative care would have been more helpful for me."*

*"I think the biggest change out of the consultation was that **it changed my perspective and made me feel confident there are things that I can really integrate** or that I can do on a daily basis which can play a big role."*

*"When it comes to talking about heart conditions my view is 'if it happens it happens'. **If I really get ill that's my fault for not listening**, but I feel healthy and I was given a list of walks."*

*"If you gave me tips for eating British food that is falling in the allowed food list, it might have been a bit difficult for me because **that's not my everyday food**"*

*"There was also a lot of emails with the content that we discussed, which was good to go through after. But I think there were **too many emails**, maybe four or five of them, one consolidated with everything would have been easier"*

Victoria Brookman ICHP
Sept 2025

My Health Check Results: [Name]											
[Date]	**Heart Age**	**BMI**	**BP**	**Pulse** (heart rate)	**Heart Rhythm**	**Cholesterol** (TC:HDL Ratio)	**HbA1c**	**QRISK Score**	**Sleep**	**Mood** (PHQ-2)	**Anxiety** (GAD-2)
My Results			/			:					
Target	[age at event]	Asian,18.5 - 22.9 All others, 18.5 – 24.9	Below 140/90 Aim for 120/80	60-100 bpm at rest	Regular	Below 5:1	Below 41	[XX]% for your age, gender and ethnicity	7-9 hours	2 or less	2 or less

For more information about your health check results, visit: https://www.nhs.uk/conditions/nhs-health-check/.

My Lifestyle Prescription

					
MOVE	**EAT**	**SLEEP**	**RELAX**	**CONNECT**	**AVOID HARMFUL SUBSTANCES**

For tips and information about these lifestyle choices, visit https://www.myhealthlondon.nhs.uk/be-healthier/healthy-lifestyle

What would I like my lifestyle prescription to help me achieve? This is my goal.	

What small lifestyle change will I make to achieve my goal, feel good and improve my health?				
What will I do?	**How much will I do?**	**When will I do it?**	**Which days will I do it?**	**What might stop me? How can I prepare for this?**

I will use the following services to help me achieve my goal. Visit: www.healthyharrow.org.uk/lifestyleprescription for more services and support.

☐ Harrow Health Walks ☐ Street Tag ☐ Shape-Up Harrow ☐ Exercise on Referral ☐ Smoking Support ☐ Drug or Alcohol support

☐ Living a healthy life with a long-term condition ☐ Other: _____

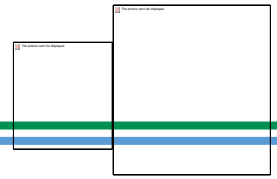
LONDON BOROUGH OF HARROW HEALTHY HARROW MyHealth London NHS North West London

Improving patient coding in PRIMARY CARE

DL101-KPI-DEN-Patients on Diabetes QOF Register	5805	8%	29-Jul-2025
9KCP complete (MISSING URINE ACR)	141	2%	29-Jul-2025
DL102a-KPI-NUM-Patients WITH BMI recorded (Jan 24 - Mar 25)	3215	55%	29-Jul-2025
DL102b-KPI-NUM-Patients WITH HbA1c recorded (Jan 24 - Mar 25)	2804	48%	29-Jul-2025
DL102c-KPI-NUM-Patients WITH Blood Pressure recorded (Jan 24 - Mar 25)	3511	60%	29-Jul-2025
DL102d-KPI-NUM-Patients WITH Lipids recorded (Jan 24 - Mar 25)	3102	53%	29-Jul-2025
DL102e-KPI-NUM-Patients WITH Urine ACR recorded (Jan 24 - Mar 25)	3350	58%	29-Jul-2025
DL102e-KPI-NUM-Patients WITHOUT Urine ACR recorded (Jan 24 - Mar 25)	2455	42%	29-Jul-2025
DL102f-KPI-NUM-Patients WITH eGFR recorded (Jan 24 - Mar 25)	2867	49%	29-Jul-2025
DL102g-KPI-NUM-Patients WITH Retinal Screening recorded (Jan 23 - Mar 25)	3770	65%	29-Jul-2025
DL102h-KPI-NUM-Patients WITH Right & Left Feet Risk recorded(Jan 24 - Mar 25)	3534	61%	29-Jul-2025
DL102i-KPI-NUM-Patients WITH Smoking Status recorded (Jan 24 - Mar 25)	3398	59%	29-Jul-2025

DL101-KPI-DEN-Patients on Diabetes QOF Regis and CRM	350	1%	15-Oct-2025
9KCP complete (MISSING URINE ACR)	1	1%	15-Oct-2025
DL102a-KPI-NUM-Patients WITH BMI recorded (Jan 24 - Mar 25)	35	10%	15-Oct-2025
DL102b-KPI-NUM-Patients WITH HbA1c recorded (Jan 24 - Mar 25)	29	8%	15-Oct-2025
DL102c-KPI-NUM-Patients WITH Blood Pressure recorded (Jan 24 - Mar 25)	122	35%	15-Oct-2025
DL102d-KPI-NUM-Patients WITH Lipids recorded (Jan 24 - Mar 25)	41	12%	15-Oct-2025
DL102e-KPI-NUM-Patients WITH Urine ACR recorded (Jan 24 - Mar 25)	133	38%	15-Oct-2025
DL102e-KPI-NUM-Patients WITHOUT Urine ACR recorded (Jan 24 - Mar 25)	217	62%	15-Oct-2025
DL102f-KPI-NUM-Patients WITH eGFR recorded (Jan 24 - Mar 25)	44	13%	15-Oct-2025
DL102g-KPI-NUM-Patients WITH Retinal Screening recorded (Jan 23 - Mar 25)	190	54%	15-Oct-2025
DL102h-KPI-NUM-Patients WITH Right & Left Feet Risk recorded(Jan 24 - Mar 25)	100	29%	15-Oct-2025

DL101-KPI-DEN-Patients on Diabetes QOF Register and CRM 2025 2026	350	1%	15-Oct-2025
9KCP complete (MISSING URINE ACR)	36	10%	15-Oct-2025
DL102a-KPI-NUM-Patients WITH BMI recorded (Jan 25 - Mar 26)	337	96%	15-Oct-2025
DL102b-KPI-NUM-Patients WITH HbA1c recorded (Jan 25 - Mar 26)	343	98%	15-Oct-2025
DL102c-KPI-NUM-Patients WITH Blood Pressure recorded (Jan 25 - Mar 26)	319	91%	15-Oct-2025
DL102d-KPI-NUM-Patients WITH Lipids recorded (Jan 25 - Mar 26)	335	96%	15-Oct-2025
DL102e-KPI-NUM-Patients WITH Urine ACR recorded (Jan 25 - Mar 26)	248	71%	15-Oct-2025
DL102e-KPI-NUM-Patients WITHOUT Urine ACR recorded (Jan 25 - Mar 26)	102	29%	15-Oct-2025
DL102f-KPI-NUM-Patients WITH eGFR recorded (Jan 25 - Mar 26)	328	94%	15-Oct-2025
DL102g-KPI-NUM-Patients WITH Retinal Screening recorded (Jan 24 - Mar 26)	316	90%	15-Oct-2025
DL102h-KPI-NUM-Patients WITH Right & Left Feet Risk recorded(Jan 25 - Mar 26)	258	74%	15-Oct-2025
DL102i-KPI-NUM-Patients WITH Smoking Status recorded (Jan 25 - Mar 26)	324	93%	15-Oct-2025

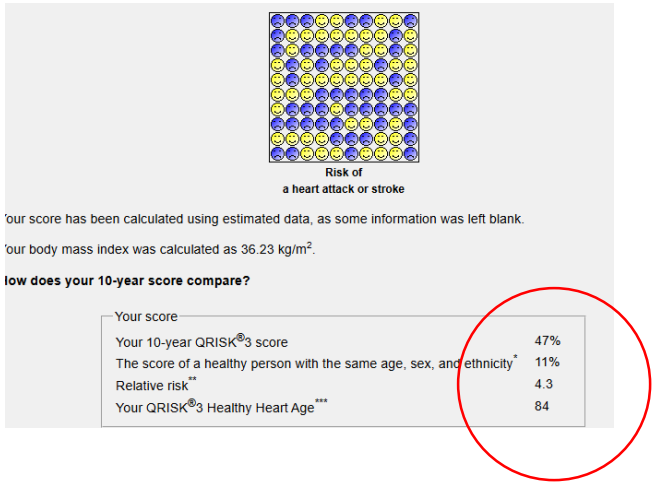


“Excitement and Inspiration”…

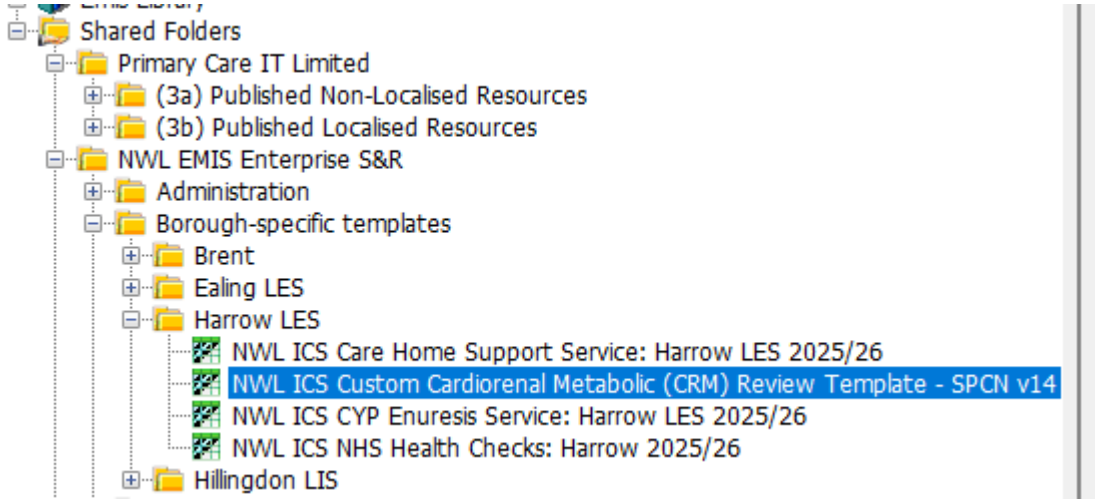
- **Light bulb moment** – “paradigm shift” – more one patient - one series of interlinked and interrelated conditions.
- **Stream line** – using tools in place – but compliment and empower – alignment of digital enablers (SMS/Email), signposting/clinical and quality audits (monthly/bimonthly)
- **Saves time** – Empowers patients to know where to look and how to use the information for themselves.
- **Treat early** – quality improvement on clinical care, increased prevalence of CKD, Hypertension, CRM, Early liver disease, QRISK, dyslipidaemia, medication optimisation (20%) as well as personalised care (50%).
- **Sustainability** – Continued evolution of looking at incorporating as a single offer for Primary care in NWL – *so here we are*

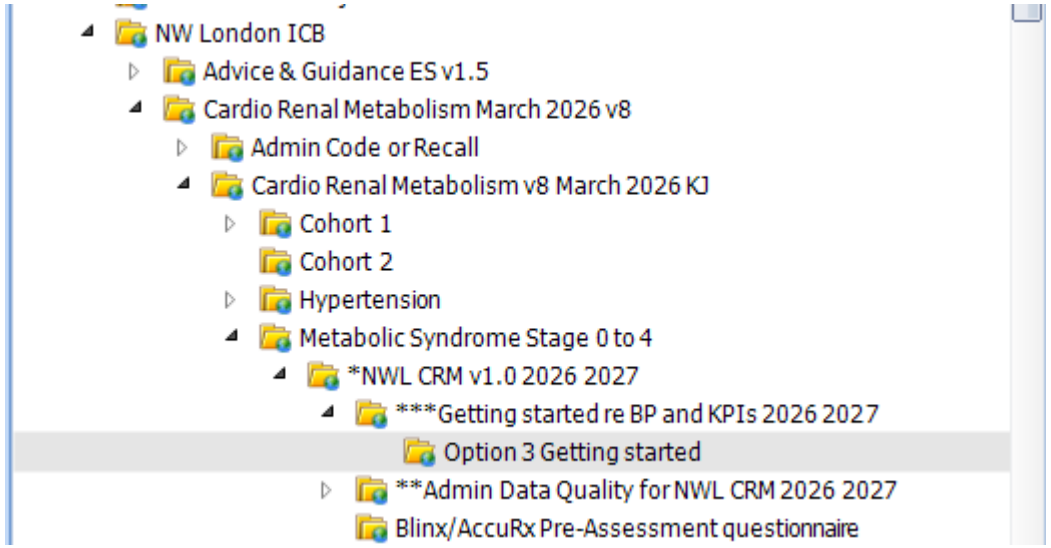
Getting Started….. More next time

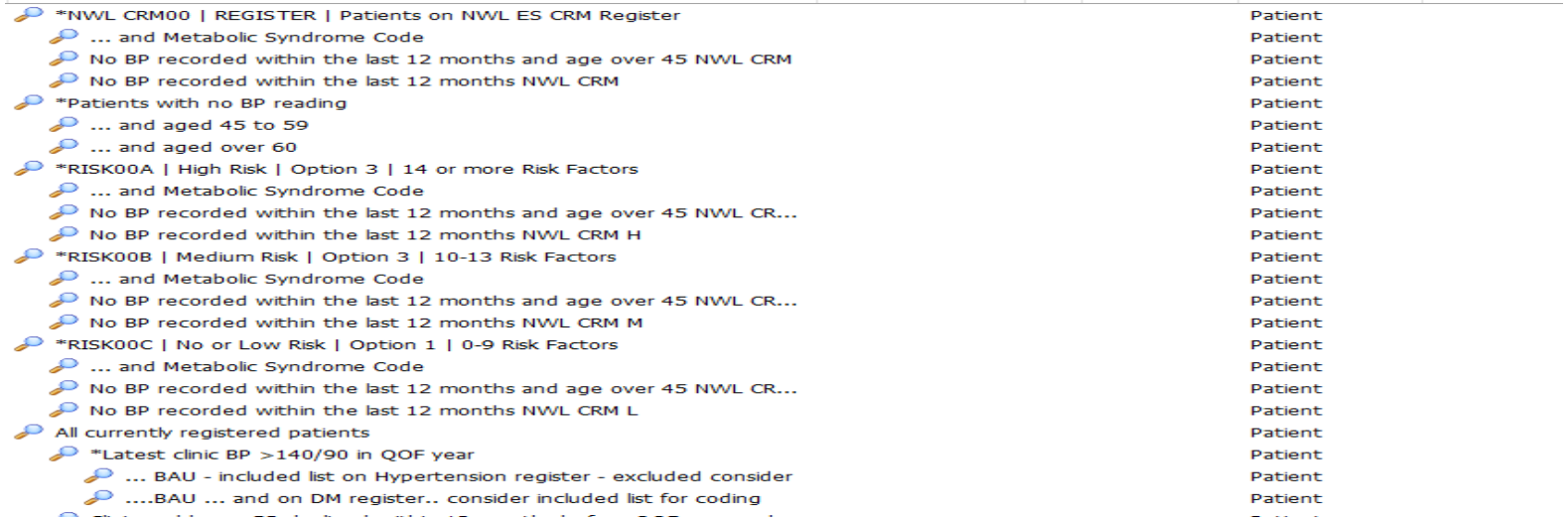
- 1. Decide who in your practice….
- 2. Motivational Interviewing
- 3. Appointments High – 30 minutes, Medium - 30 minutes, Low – 20 minutes
- 4. EMIS training sessions
- 5. The following slides are for you to keep on your desk top
- 6. Heart age calculator a) [Calculate your heart age – NHS]
- b) QRISK3 c) In EMIS QRISK2 View
-

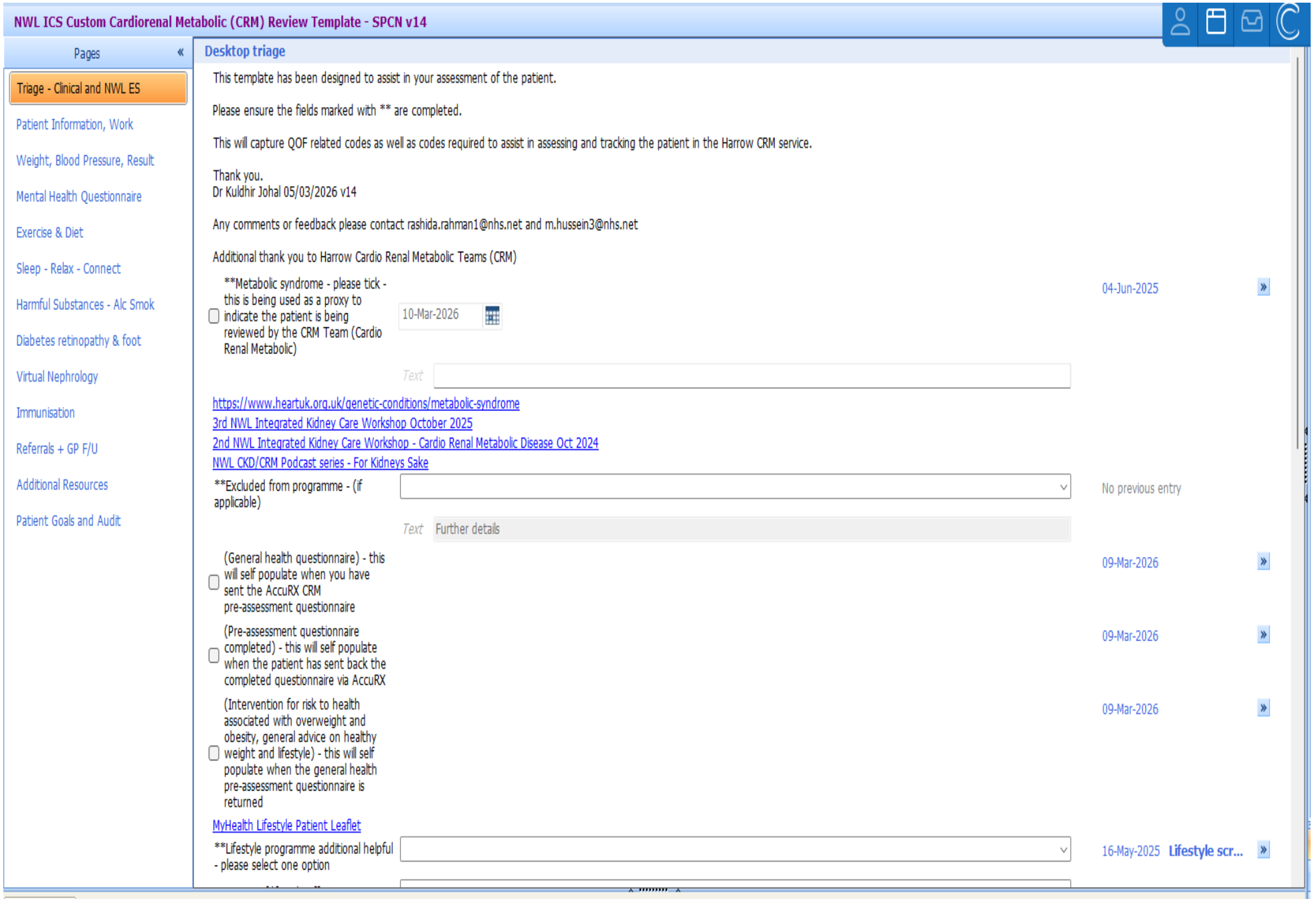


CRM V14 Template and Searches








NWL ICS Custom Cardiorenal Metabolic (CRM) Review Template - SPCN v14
Pages
Triage - Clinical and NWL ES
Patient Information, Work
Weight, Blood Pressure, Result
Mental Health Questionnaire
Exercise & Diet
Sleep - Relax - Connect
Harmful Substances - Alc Smok
Diabetes retinopathy & foot
Virtual Nephrology
Immunisation
Referrals + GP F/U
Additional Resources
Patient Goals and Audit
Desktop triage
This template has been designed to assist in your assessment of the patient.
Please ensure the fields marked with ** are completed.
This will capture QOF related codes as well as codes required to assist in assessing and tracking the patient in the Harrow CRM service.
Thank you.
Dr Kuldhir Johal 05/03/2026 v14
Any comments or feedback please contact rashida.rahman1@nhs.net and m.hussein3@nhs.net
Additional thank you to Harrow Cardio Renal Metabolic Teams (CRM)
**Metabolic syndrome - please tick - this is being used as a proxy to indicate the patient is being reviewed by the CRM Team (Cardio Renal Metabolic)
10-Mar-2026
04-Jun-2025
Text
https://www.heartuk.org.uk/genetic-conditions/metabolic-syndrome
3rd NWL Integrated Kidney Care Workshop October 2025
2nd NWL Integrated Kidney Care Workshop - Cardio Renal Metabolic Disease Oct 2024
NWL CKD/CRM Podcast series - For Kidneys Sake
**Excluded from programme - (if applicable)
No previous entry
Text
Further details
(General health questionnaire) - this will self populate when you have sent the AccuRX CRM pre-assessment questionnaire
09-Mar-2026
(Pre-assessment questionnaire completed) - this will self populate when the patient has sent back the completed questionnaire via AccuRX
09-Mar-2026
(Intervention for risk to health associated with overweight and obesity, general advice on healthy weight and lifestyle) - this will self populate when the general health pre-assessment questionnaire is returned
09-Mar-2026
MyHealth Lifestyle Patient Leaflet
**Lifestyle programme additional helpful - please select one option
16-May-2025
Lifestyle scr...

NWL ICS Custom Cardiorenal Metabolic (CRM) Review Template - SPCN v14

Pages «

- Triage - Clinical and NWL ES
- Patient Information, Work
- Weight, Blood Pressure, Result
- Mental Health Questionnaire
- Exercise & Diet
- Sleep - Relax - Connect
- Harmful Substances - Alc Smok
- Diabetes retinopathy & foot
- Virtual Nephrology
- Immunisation
- Referrals + GP F/U
- Additional Resources
- Patient Goals and Audit

Additional Resources

CKD health check: look after your kidneys and keep yourself well [PDF]
Know your Kidneys
Medication sick day guidance
What is CKD?
Urine ACR testing explained

AccuRx – Pre-assessment questionnaire - Link if you wish to import

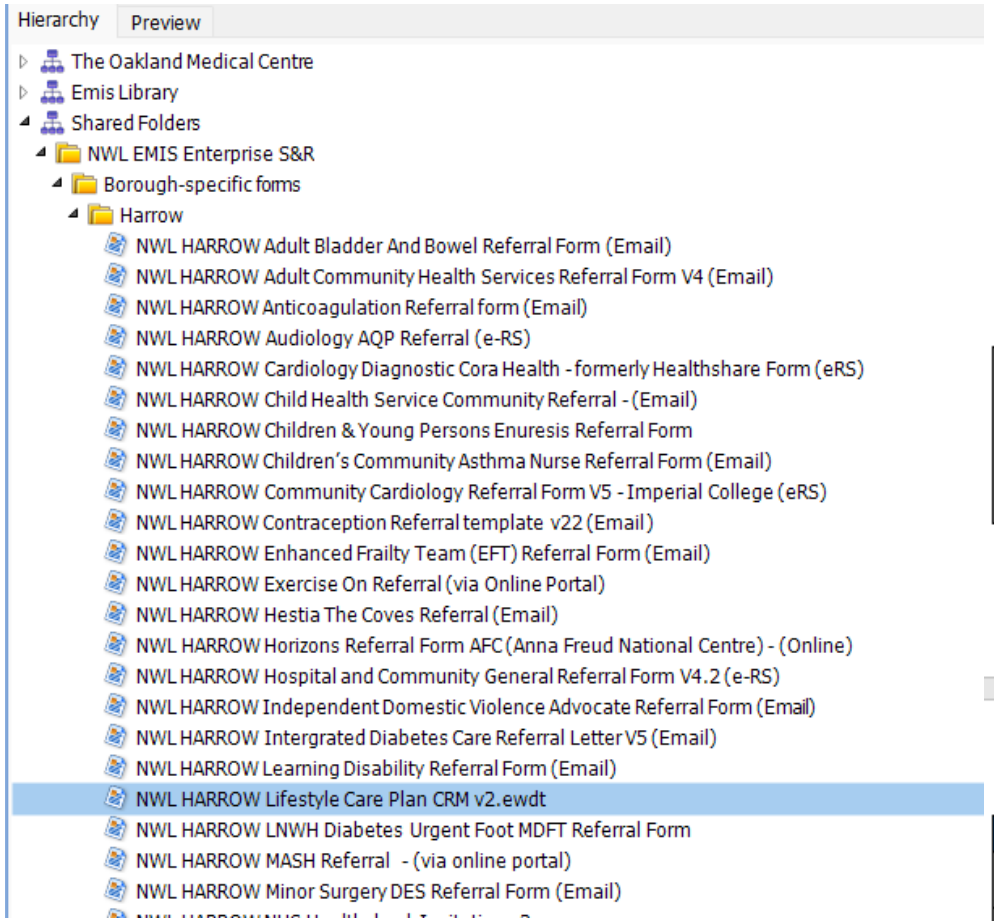
Assessment for Obstructive Sleep Apnoea

ESS (Epworth Sleepiness Scale) score _____ /24 10-Mar-2026 No previc

Text _____

Epworth Sleepiness Scale Calculator

Care Plan



TEST, Margaret (Mrs)

10-Mar-2026	BMI	BP	Pulse (heart rate)	Heart Rhythm	Cholesterol Total	Cholesterol Non HDL	HbA1c	QRISK Score	Heart Age	Sleep	Mood (PHQ-2)	Anxiety (GAD-2)
My Results	03-Mar-2026 : 23	21-May-2025 : 145/70	17-Apr-2025 : 98	No events found.	No events found.	No events found.	No events found.	No events found.	04-Jun-2025 : 95 -	0	03-Mar-2026 : 0	03-Mar-2026 : 0
Target	Asian,18.5 - 22.9 All others, 18.5 – 24.9	Below 135/85 at home Aim for 120/80	60-100 bpm at rest	Regular	Below 5:1 (Total) Aim for less than 2.0 (LDL)	Aim for less than 2.0 (LDL) Less than 2.6 (non HDL)	Below 41	[XX]% for your age, gender and ethnicity	Your age today 95y	7-9 hours	2 or less	2 or less

For more information about your health check results, visit: https://www.nhs.uk/conditions/nhs-health-check/.

My Lifestyle Prescription	MOVE	EAT	SLEEP	RELAX	CONNECT	AVOID HARMFUL SUBSTANCES

For tips and information about these lifestyle choices, visit https://www.myhealthlondon.nhs.uk/be-healthier/healthy-lifestyle

What would I like my lifestyle prescription to help me achieve? This is my goal.	0

What small lifestyle change will I make to achieve my goal, feel good and improve my health?

What will I do?	How much will I do?	When will I do it?	Which days will I do it?	What might stop me? How can I prepare for this?
0	0	0	0	0

Importance of Risk Factors – reduce BP, Cholesterol, HbA1C and inter-relation with weight/health

Weight

- 0-5% weight loss can reverse hypertension and NDH.
- 5-10% weight loss can prevent T2DM and reverse Non-Alcoholic Fatty Liver Disease (NAFLD) and dyslipidaemia.
- 10-15% weight loss can reverse Non-Alcoholic Steato-Hepatitis (NASH) and prevent Cardiovascular Disease progression.
- >15% weight loss can support remission from T2DM, reduce CVD mortality and reverse Heart Failure with preserved Ejection Fraction (HFpEF).
- Weight loss can also reduce proteinuria and support sustained improvements in eGFR.

Physical Activity

- Moving out of bottom 25% of fitness level reduces 10-year mortality relative risk by 80% and actual risk by about 20%
- Moving from low to above average fitness is equivalent risk reduction to moving from End Stage Renal Disease to normal health

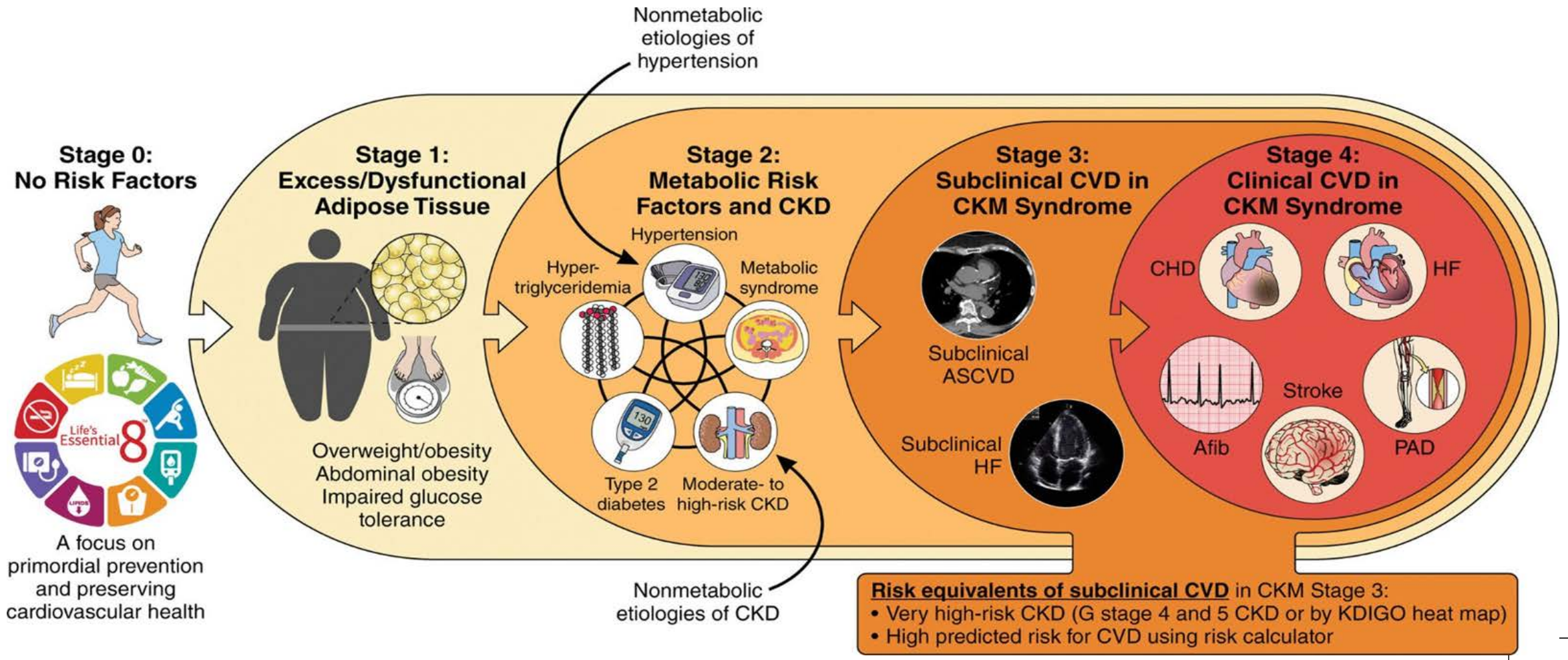
Smoking

- Risk of MI halves within a year of stopping smoking
- After 15 years, risk of CHD is close to that of a non-smoker

Blood Pressure

A reduction of **10mmHg** reduces major cardiovascular risk by **20%**

CRM delivery model



CRM Competency Framework

Module 1: CRM Core competencies
Understanding the interconnection between cardiovascular, renal, and metabolic systems

Clinical Guidelines
Familiarity with national and local guidelines for managing hypertension, obesity, cardiovalcr diseases, chronic kidney disease (CKD), and

Holistic Assessment
Conducting obesity screening ad mental health and diabetes questionnaires (PHQ2 and GAD2)

Health Coaching
Empowering patients through coaching strategies; including goal setting and prossing

Pharmacology in CRM Approaches
Prescribing and managing CRM medications such as ACE inhibitors; GLP-1 receptor

Lifestyle Medicine
Proficiency in integrating lieistyle modification into patient care

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Proficiency in integrating lifestyle modification into patient care

Multidisciplinary Collaboration
Engage specialists for escalated care leveis

Multidisciplinary Collaboration
Engage specialists for escalated care levels

Advanced Knowledge Use of Research and Evidence-Based Pra
9a

Advanced Knowledge Use of Research and Evidence-Based Pra

9a: Patient Education
9b
Ability to explain CRM conditicnx nd treatments to people and their advocates/family members

CRM PATHWAY OVERVIEW

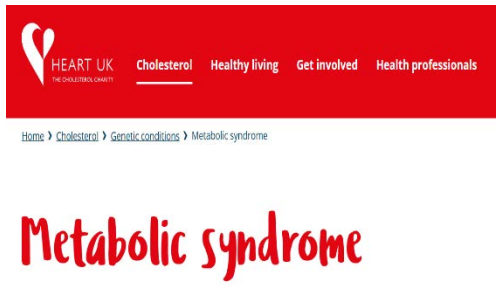
PATIENT IDENTIFICATION
- Patients identifjed via bespoke EMIS/S1 searches that go beyond existing search tools to identify có hort with muitiple risk factors at early stage of CRM risk
- Care coordinators use new patient script to invite pts – explaining CRM health and wellbeing appointment offer and conveyfeits

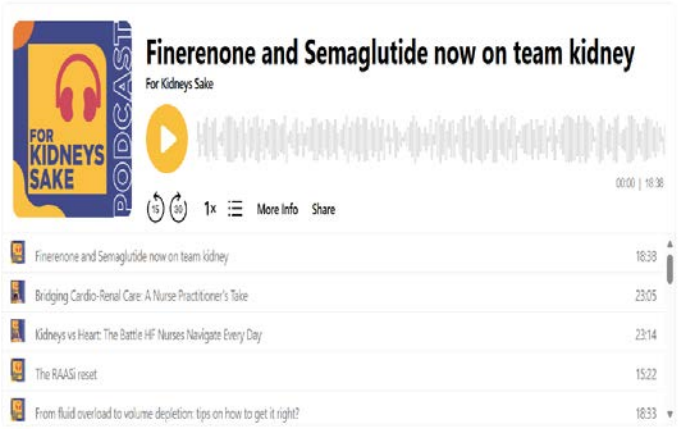
PRE–APPOINTMENT PREPARATION
- Pre-appointment questionnaires sent
- Bloods/urine collected to maximise time in consultation for personalised care approach

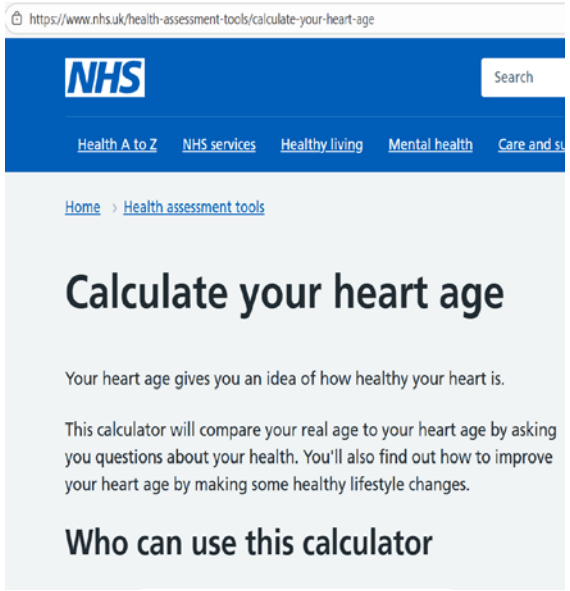
FIRST CRM APPOINTMENT
- Clinician discusses overall health and wellbeing goals with patient, recent metrics, and risks
- Holistic education and care of related CRM conditions in one appointment
- Lifestyle medicine incorporated into care approach in addition to usual appropriate pharmacological interventions

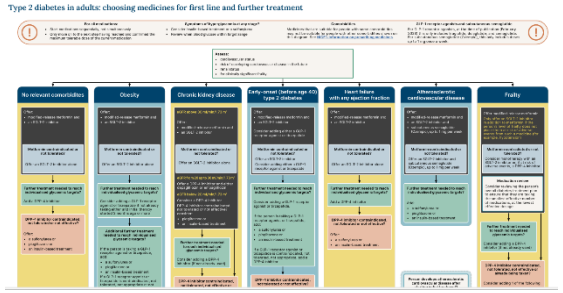
REVIEW CRM APPOINTMENT (3–6 MONTHS)
- Bloods/urine repeated prior to review
- Clinician and patient assess changes in health metrics, discuss progress/challenges, care ajdjusted
- Patient experience and motivation captured via AccuRx

Additional Links already in pre-assessment questionnaire and clinical templates









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- Patient experience and motivation captured via AccuRx

Rashida Rahman HNP Feb 2026 contributing to the London Kidney Network on the CRM Competency Framework

Health Confidence Score

The four items are as follows:

- I know enough about my health (short term: knowledge).
- I can look after my health (short term: self-management).
- I can get the right help if I need it (short term: access).
- I am involved in decisions about me (short term: shared decision-making).

Reference
Development and initial testing of a Health Confidence Score (HCS) | BMJ Open Quality

Development of an Educational Tool to Support Training in Cardiorenal Metabolic Care within Harrow Primary Care Networks

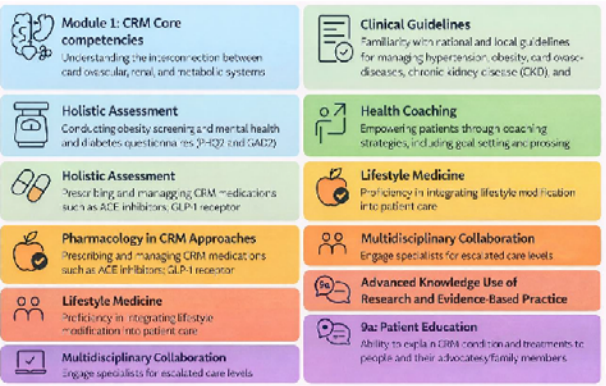
Imperial College London
IMPERIAL COLLEGE HEALTH PARTNERS
HARROW COLLABORATIVE NHS
healthsense primary care network NHS
A H Frankel, R Dattani, X Ooi, R Rahman ,S Siddik ,V Brookman, A Kelshiker , J Shah, M Joshi, K Johal. Corresponding Author: rakesh.Dattani@nhs.net

Introduction

- Cardiorenal metabolic (CRM) disease represents a convergence of obesity, diabetes, chronic kidney disease and cardiovascular disease, driving high morbidity and premature mortality.
- The Harrow CRM Programme utilised a personalised care approach in a bid to improve personal well being with the aim to instil change in individuals and the local community and reduce the future risk of advanced kidney disease.
- Addressing these conditions requires workforce development to enable holistic, preventative care across primary and secondary care.
- Cardio-Renal Metabolic Hub Training Framework aims to ensure that clinicians working with CRM syndrome possess a holistic, interdisciplinary, and patient-centred skill set to address the complexity of this overlapping triad of diseases.

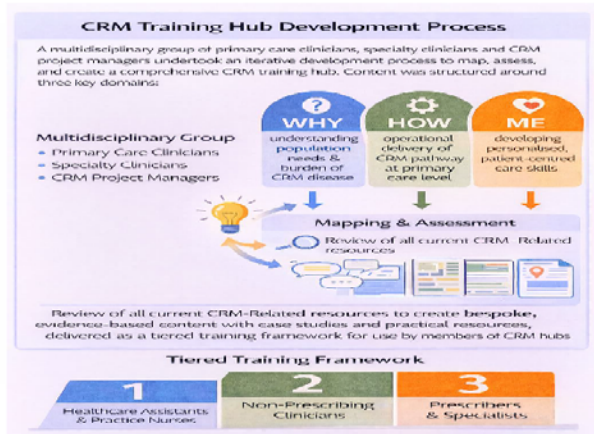
Cardio-Renal-Metabolic (CRM) Care Pathway

CRM Competency Framework



CRM Training Hub Development Process

A multidisciplinary group of primary care clinicians, specialty clinicians and CRM project managers undertook an iterative development process to map, assess, and create a comprehensive CRM training hub. Content was structured around three key domains:



Discussion

- Healthcare professionals are assessed against defined CRM competencies across Tier 1, Tier 2, and Tier 3, with evaluation used to identify training needs and support progression between tiers.
- At PCN level, CRM Lead training is mandatory, with a minimum of one trained clinician per PCN responsible for delivering CRM clinics and providing local clinical leadership.
- The CRM Steering Group provides governance and oversight, including guidance on minimum training hours and competency standards required for each tier.
- Ongoing collaboration with local and national CRM whole-system partners supports the development of a consistent and universal CRM training and competency framework.

CardioRenal Metabolic Diseases: Using a Personalised Care Approach to Improve Well-being and Reduce Future Risk of Advanced Kidney Disease – Patient and clinician perspective.

Imperial College London
IMPERIAL COLLEGE HEALTH PARTNERS
HARROW COLLABORATIVE NHS
healthsense primary care network NHS
V Brookman, R Dattani, R Rahman , S Siddik, A Kelshiker , J Shah , A H Frankel, M Joshi, K Johal.
Corresponding Author: rakesh.Dattani@nhs.net

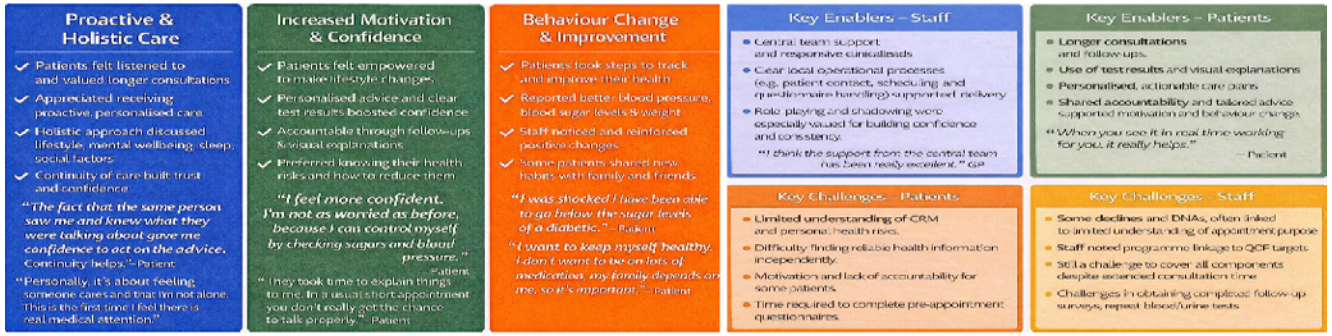
Introduction

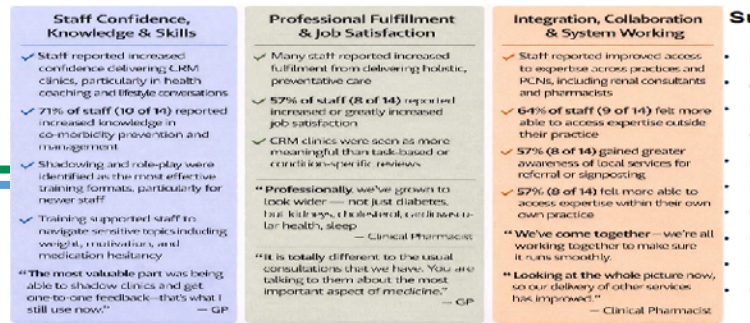
- Cardiorenal Metabolic (CRM) diseases include obesity, diabetes, dyslipidaemia, and cardiovascular disease
- CRM diseases contribute significantly to chronic kidney disease (CKD) and cardiovascular morbidity.
- They are interconnected through systemic inflammation and insulin resistance
- In Harrow, diabetes prevalence = 8.3% (national average = 6.2%), hypertension prevalence = 13.5% (national average = 17.9 %) and obesity prevalence= 10.6%) : likely under-diagnosed or under-recorded.
- **Up to 30% risk reduction is possible through early intervention and personalised care.**
- The Harrow CRM Programme utilised a personalised care approach in a bid to improve personal well being with the aim to instil change in individuals and the local community and reduce the future risk of advanced kidney disease.

- **Between November 2024 and September 2025, 2,641 patients were reviewed, with 2,300 included in paired analysis. Results 3-6 months post 1st CRM Hub appointment show:**

Patient and clinician Perspective of Harrow CRM Pathway

Findings below from semi-structured interviews with 18 patients, 22 staff members (GPs, pharmacists, physician associates, nurses, care coordinators, receptionists) thematically analysed using Nvivo software, as well as from 14 staff responses to brief online survey.





Summary

- Patients had a positive experience of care.
- Appointments felt different from usual care.
- Patients valued more time, wider wellbeing discussion, and clear advice.
- Patients felt more confident, supported and looked after.
- Behaviour change was reported by patients and clinicians.
- Clinicians felt confident running CRM clinics.
- Clinicians reported improved knowledge and skills.
- Shadowing and role-play were helpful for learning.
- CRM clinics were valued by both patients and clinicians.

Imperial College London

CardioRenalMetabolic Diseases: Using a personalised care approach to improve well-being and reduce future risk of advanced kidney disease:

Results from the Harrow CRM Project

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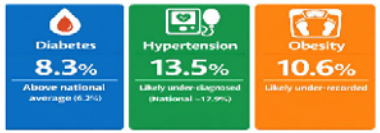
Introduction

- Cardio-renal-metabolic (CRM) syndrome is anlentity that reflects the interaction between metabolic risk factors, chronic kidney disease, and cardiovascular disorders. Elements of the disorder include obesity, diabetes, dyslipidaemia, and cardiovascular disease.
- CRM disease develops progressively, with individuals transitioning over time from no identifiable CRM pathology to increasingly advanced disease states
- CRM diseases contribute significantly to chronic kidney disease (CKD) and cardiovascular morbidity.
- They are interconnected through a common pathway which includes insulin resistance and systemic inflammation

Cardio Renal Metabolic Disease in Harrow



- Up to 30% risk reduction is possible through early intervention and personalised care.

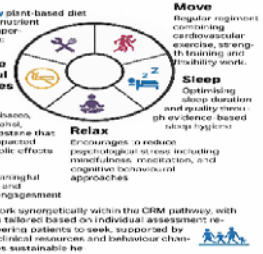
CRM Intervention in Harrow – Using a personalised care approach to improve well being and reduce future risk of advanced kidney disease – Clinical Pathway

Personalised Care:
A way of 'seeing people' as a whole person, so as an individual the person:

- can take control of their care & build knowledge to engage meaningfully
- has hope and confidence that the process /plan will deliver what matters most to them
- is central in developing their personalised care and support is seen within the context of their whole life, valuing their skills, strengths, experience and important relationships
- is an active participant in conversations and decisions about their health and well-being.

CRM pathway – Management: Pillars of lifestyle medicine

The core Management approach are evidence-based lifestyle interventions that form the foundation of comprehensive lifestyle medicine strategy.



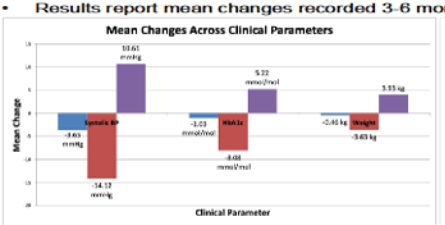
The pillars work synergistically within the CRM pathway, with interventions tailored based on individual assessment results. Empowering patients to seek, supported by appropriate clinical resources and behaviour change techniques sustainable he

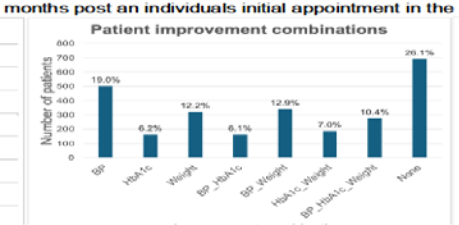
Cardio-Renal-Metabolic (CRM) Care Pathway

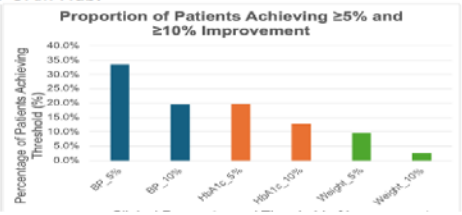
Results

Between November 2024 and September 2025:

- 2,641 patients were reviewed within the CRM Hub
- The cohort of 2,641 patients was roughly evenly split by gender (51.2% female, 48.8% male) with a mean age of 60.5 years for women and 60.3 years for men.
- 2300 were included in the analysis after exclusion of outliers at the time of writing.
- Results report mean changes recorded 3-6 months post an individuals initial appointment in the CRM Hub.







Discussion and Conclusion

- When social determinants of health are addressed, and patients are motivated with self-care with co-created care plans that address lifestyle factors, we can enhance the effectiveness of therapeutic outcomes.
- Extended length appointments enable deeper exploration of the reasons why treatment pathways may not achieve desired outcomes e.g. health literacy, digital / food poverty, social and financial barriers, lack of support networks, mental health status.
- A personalised, multidisciplinary CRM model embedded within primary care was associated with statistically and clinically significant improvements in blood pressure, glycaemic control, and weight in a large, ethnically diverse population.
- The approach combining structured identification, extended consultations and co-produced care plans demonstrates a scalable, sustainable pathway

Numerous presentations to colleagues in Harrow – practice/PCNs

Hearing/listening/adapting – enabling a learning organisation to enable ownership at the frontline

Presentations to NWL ICB Colleagues, Planned care board, Primary Care Exec, Primary Care webinars, Health Equity, Place based teams in Harrow

Presentations to neighbourhood teams across NWL – key discussion with the LMC - communication/collaboration/understanding

Data – aligned to real time at practice level, PHM – Stage 0-4 – Insights have informed the NWL CRM Single offer as well as the business case

Currently in the process of the evaluation with ICHP – Independent and looking at population comparators and ROI Modelling

Key is Conversation and communication and collaboration