

# 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:

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- Council Member of London Clinical Senate
- GP Educator, Brunel Medical School, Brunel University, London
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**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		<b>Balance measure:</b> 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

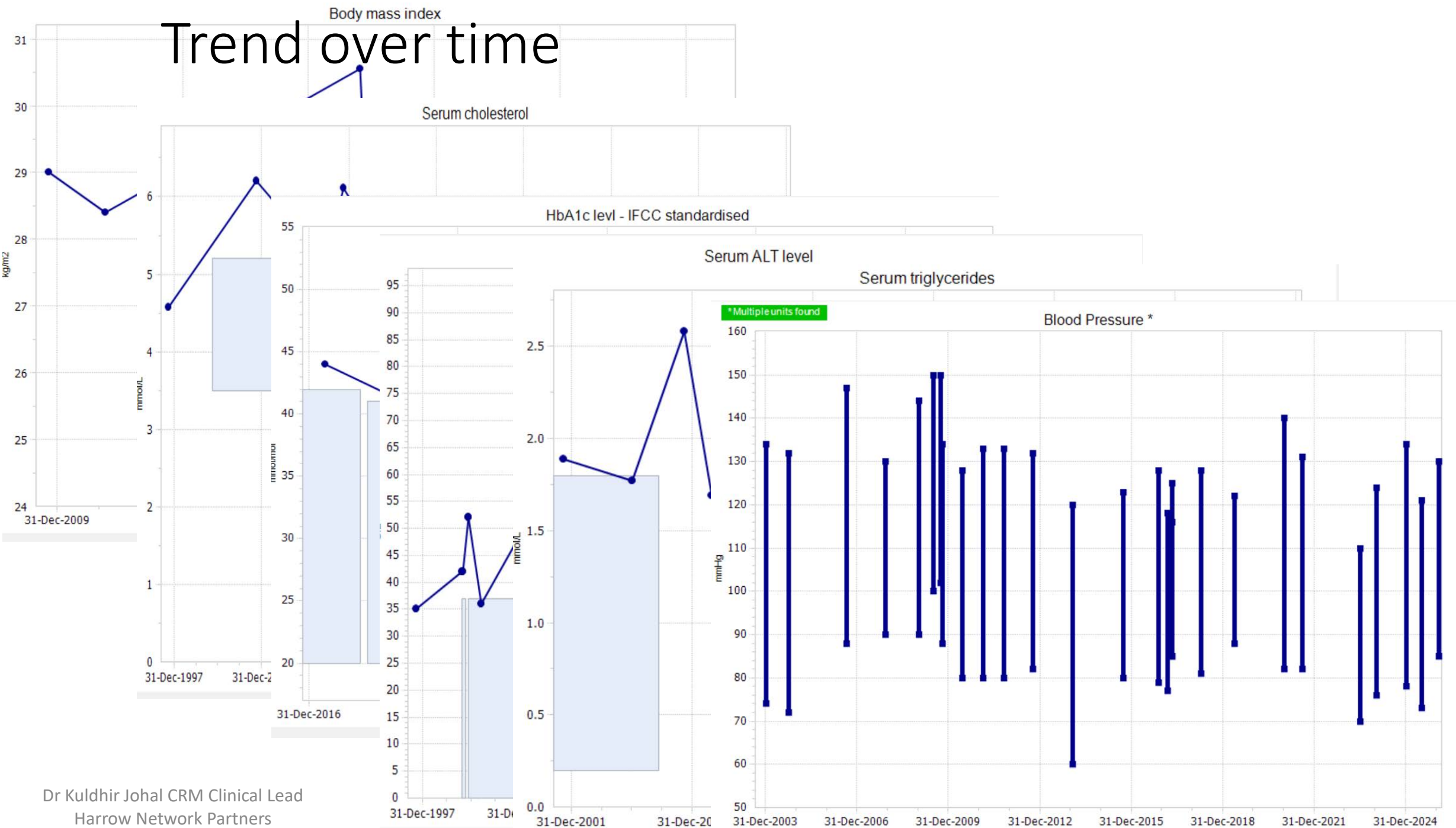


- **July 2025**
- Ultrasound – Fibrosis stage 3 of the liver
- Shortness of breath – chest pain – awaiting cardiac investigations
- Unsure re statin – had stopped
- Unsure re BP medication – Ramipril 2.5mg – had stopped
- Q – “Do I really need to take these?”
- **Interested in self care alone**
- **“wait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

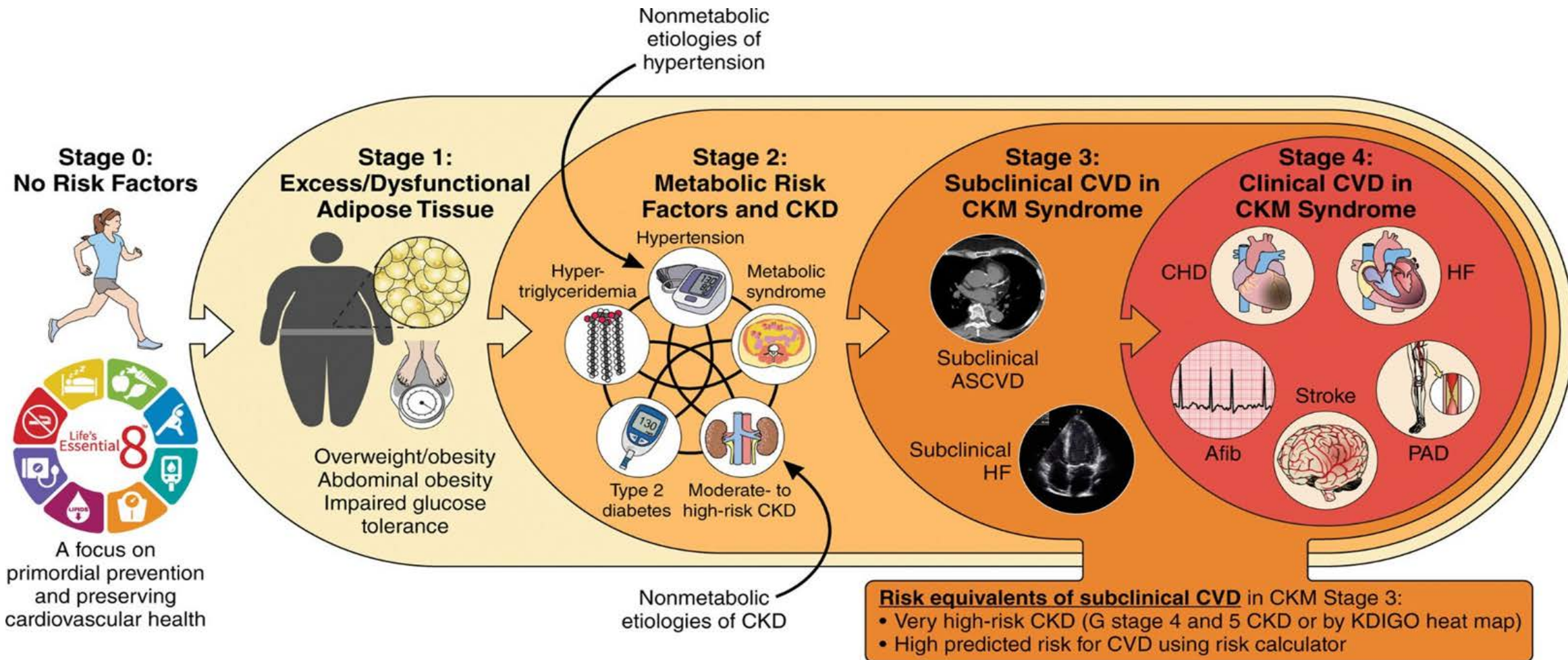
## • “What mattered to him?”

- **“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



## Jan 2026 – 6 months - later

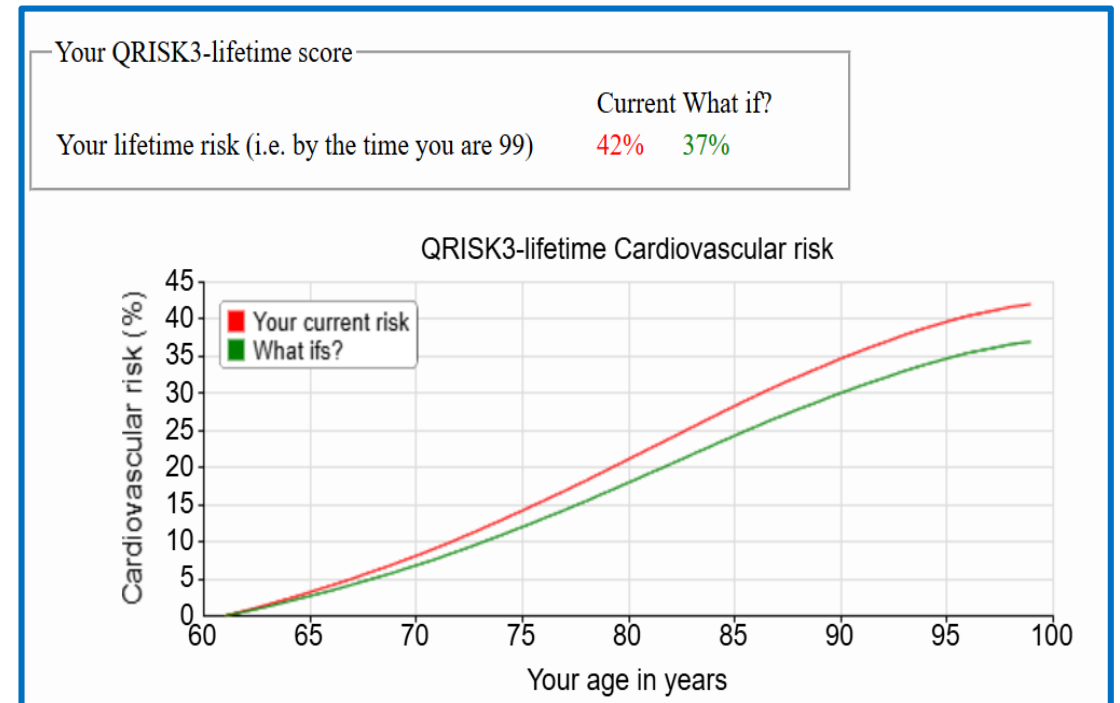
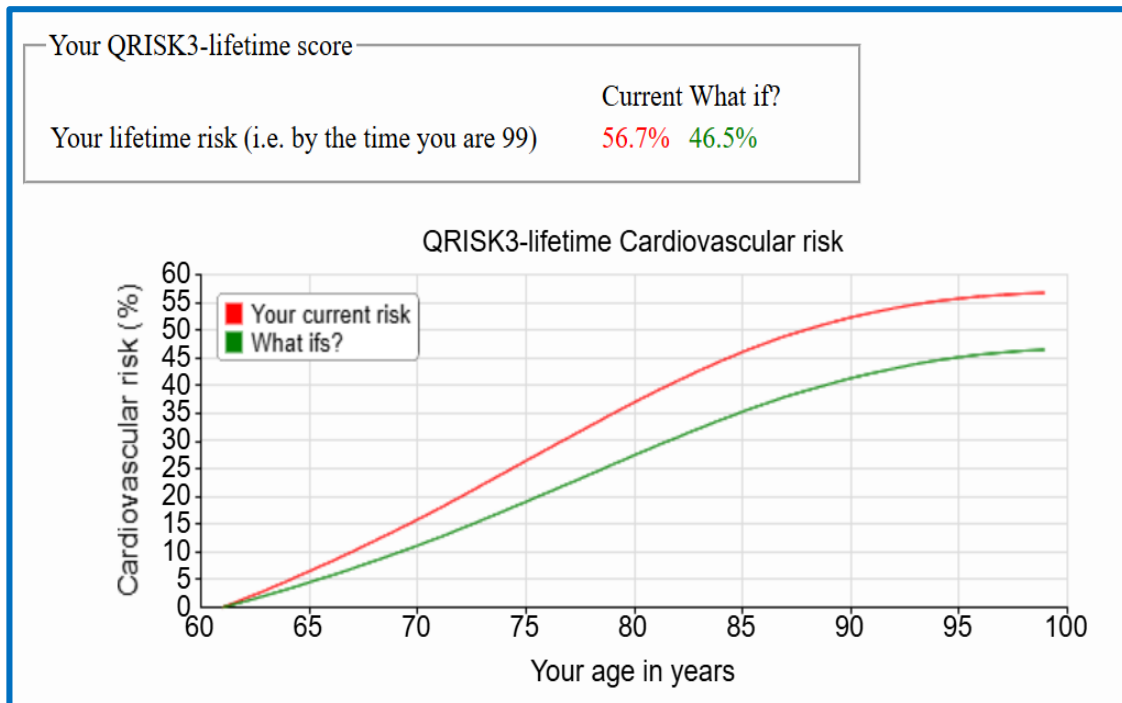
- Fibroscan – reported as “normal”
- MASH  MAFLD
- Weight 89  81
- BMI 25.74  24.5
- HbA1c 52  44
- BP 121/73 , 130/83
- Waist cm 114  91
  
- Ramipril 2.5mg OD
- Atorvastatin 20mg
- Lost 18 kg Since Oct 2023
- Regular walking – stopped alcohol, reduced sugar
- Heart age 66 live to 81 without an event
- **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
	What is your alcohol status?: Do not drink alcohol
	What is your ethnic group?: Asian or Asian British - Indian
	What is your ethnic group?: Asian or Asian British - Indian
	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....

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

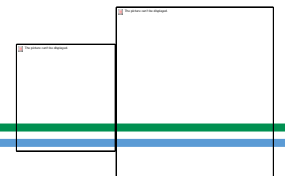


## Aims of the programme:

- 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 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

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

- 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.

## CRM clinic 1st Appointment

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

- 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)

## Follow up 1:1 / group

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

- 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.

# Using digital tools as "enablers" from AccuRx to EMIS

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

Date	Consultation Text	Status
01-Apr-2025 09:14	AccuRx Consultation	JOHAL, Kuldir (Dr)

Comment: Online questionnaire completed by patient

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 gr  
Northern Irish or Britis  
Please let us know yo  
Please let us know yo  
Please let us know yo  
Do have a look at the  
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

Data trans

NWL ICS Custom Cardiorenal Me

- Pages
- Triage - Clinical
- Patient Information, Work**
- Weight, Blood Pressure, Result
- Mental Health Questionnaire
- Exercise & Diet
- Sleep - Relax - Connect
- Harmful Substances - Alk Smok
- Referrals + GP F/U
- Patient Goals and Audit

### Lifestyle Care Plan

#### WEBDUM

11-May-2025	
My Results	
Target	Asial All or

For more information

#### My Lifestyle Prescription

For tips and informat

What would I like m  
to help me achieve?

#### What will I do?

Eat more fibre (bean  
berries, wholegrains)

Name	Population Count	%	Last Run	Search Type	Sch
... NIH register	112	16%	23-Jun-2025	Patient	
... Obesity register					
... recorded BNC					
... recorded BP					
... statin					
... on RAASi					
... recorded heart age					
... recorded QRISK 2/3 Score					
... recorded BMI					

Details Definition Age / Sex Trend Population Included Population Excluded  
BMI, BMI (UK) Last modified: 22-08-2017

Last Run: 23-Jun-2025 12:21 Relative Date: 23-Jun-2025 1

**Warning: The results are now out of date as the patient results have ch**

Organisation	NPC	Population Count	Patient
Elkott Hall Medical Centre	EB4061	63	63
GP Direct	EB4058	68	68
HATCH END MEDICAL CENTRE	EB4053	13	13
ST. PETER'S MEDICAL CENTRE	EB4063	60	60
Streetfield Health Centre	EB4018	67	67
The Northwick Surgery	EB4044	55	55
Sphere Primary Care Network	Y07626	321	342

#### Total CRM Stage 1 to Stage 4 of patients over the age of 18

Details Definition Age / Sex Trend Population Included Population Excluded

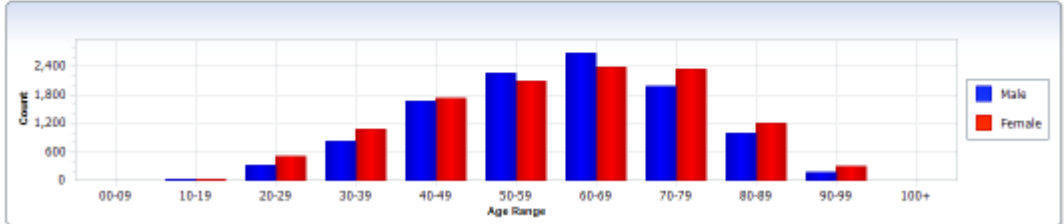
Last Run: 24-Jun-2025 09:16 Relative Date: 24-Jun-2025 09:11

Organisation	NPC	Population Count	Patient	%	Excluded	Status
Elkott Hall Medical Centre	EB4061	4210	9218	46%	5008	Completed
GP Direct	EB4058	8041	20189	40%	12148	Completed
HATCH END MEDICAL CENTRE	EB4053	1249	2755	45%	1506	Completed
Sphere Primary Care Network	Y07626	538	7028	8%	6490	Completed
ST. PETER'S MEDICAL CENTRE	EB4063	2471	7837	32%	5366	Completed
Streetfield Health Centre	EB4018	2963	6376	47%	3393	Completed
The Northwick Surgery	EB4044	3137	9101	34%	5964	Completed
<b>Total</b>		<b>22629</b>	<b>62504</b>	<b>36%</b>	<b>39875</b>	

#### Total CRM Stage 1 to Stage 4 of patients over the age of 18

Details Definition Age / Sex Trend Population Included Population Excluded

Bands: 10 yearly bands Graphical Tabular



# The Power of Personalised Care

## Helping people achieve better health outcomes



CRM Training

Dr Madhvi Joshi



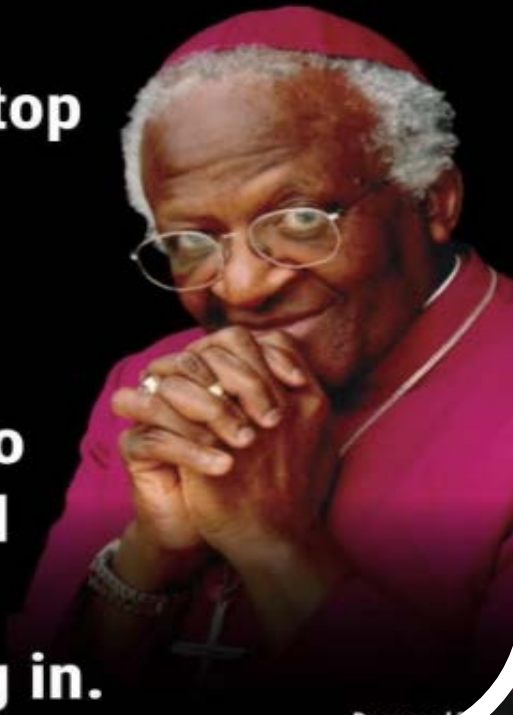
GP Lifestyle Medicine/ Obesity

PCI Certified Health Coach



**We need to stop  
just pulling  
people out  
of the river.**

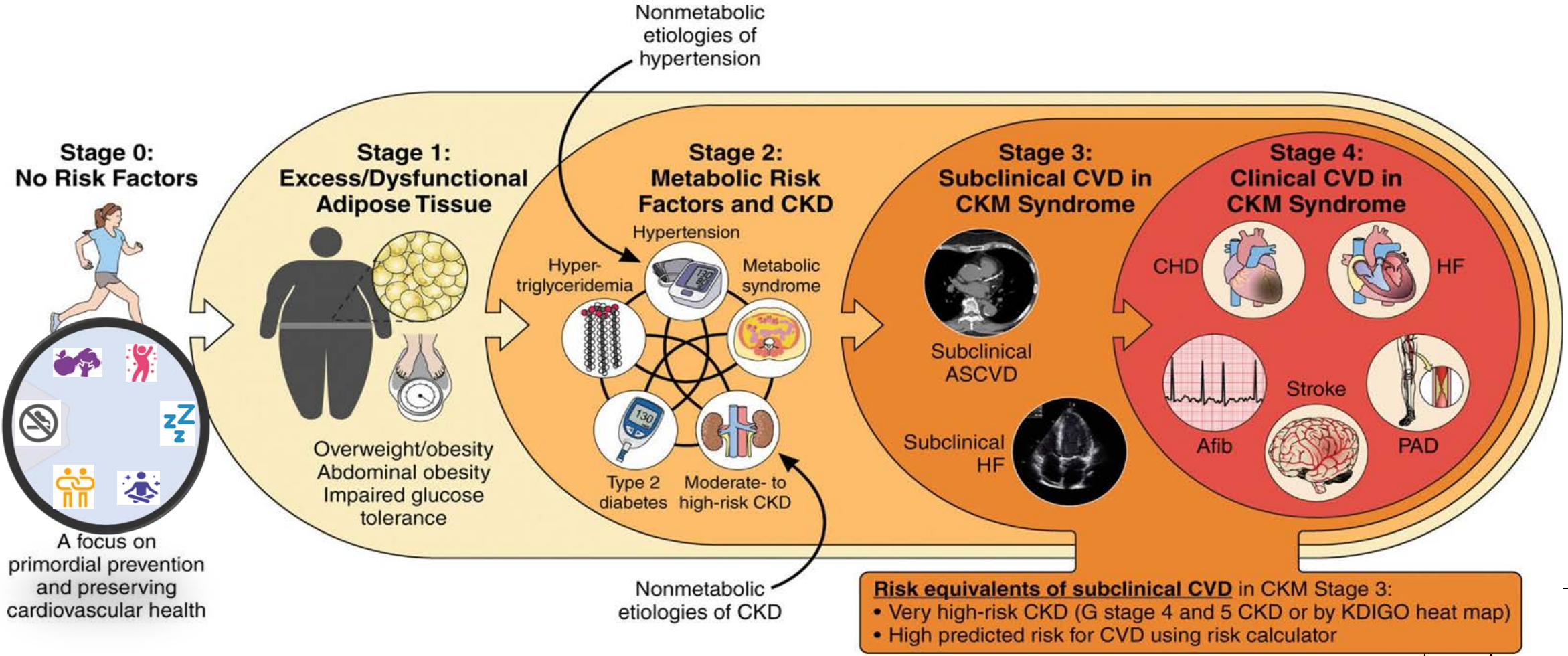
**We need to go  
upstream and  
find out why  
they're falling in.**



*- Desmond*



# 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.



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

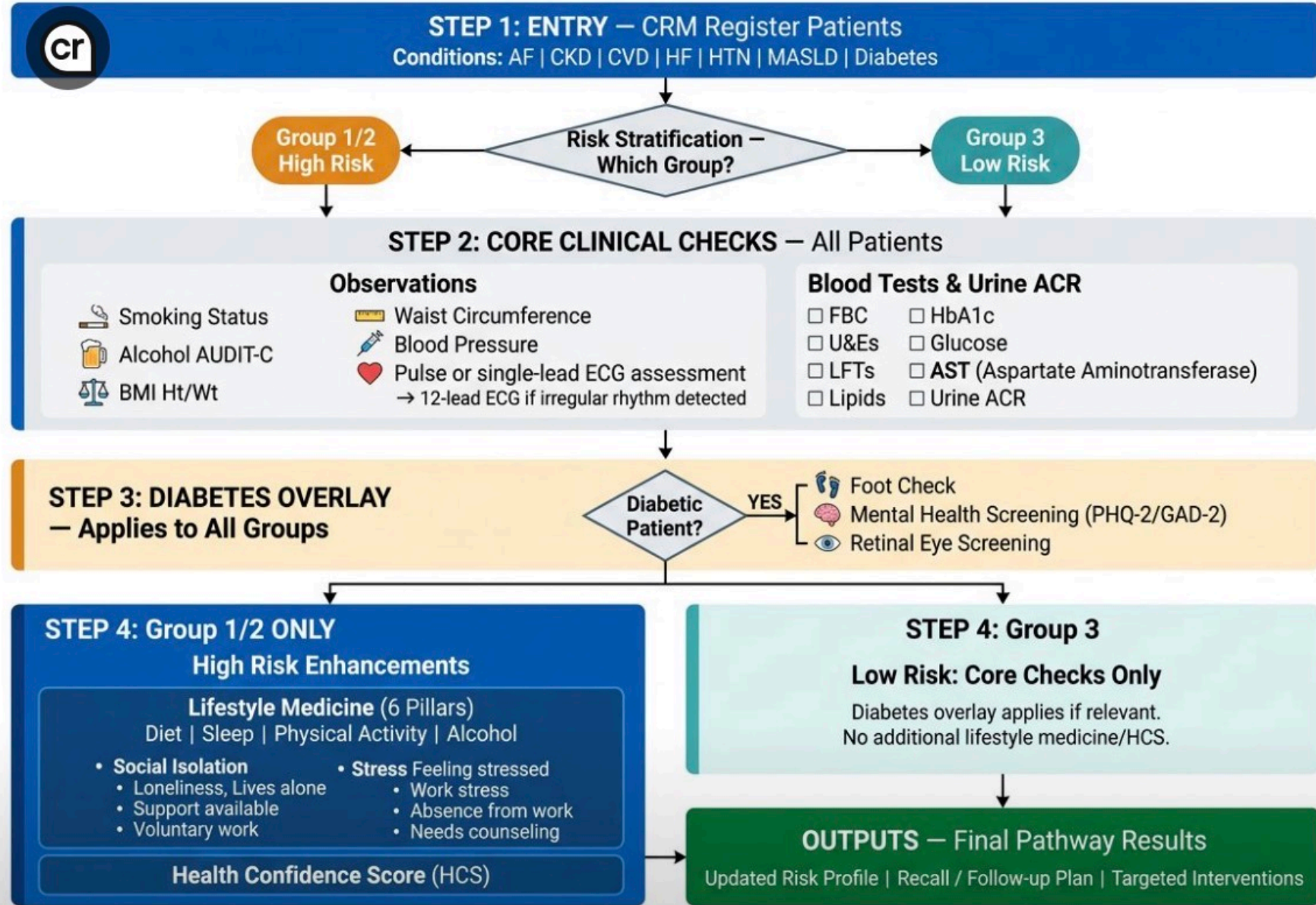
- Clinician review :metrics (QRISK/Heart Age/ KFRE/ Fib4) + coding
- Review & optimize medication – any barriers, side effects?
- CRM template & Lifestyle Care plan
- Referrals to IAPT / SW/ physio/ social prescribing/ VCSO / Welfare Employment

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

# HCA Health Check Pathway (CRM-Driven, Risk-Stratified)



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



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](http://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: \_\_\_\_\_



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

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“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?”

“Who/ what else  
might help?”

“What gets in the  
way?”

“How might you manage  
that?”

# 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?

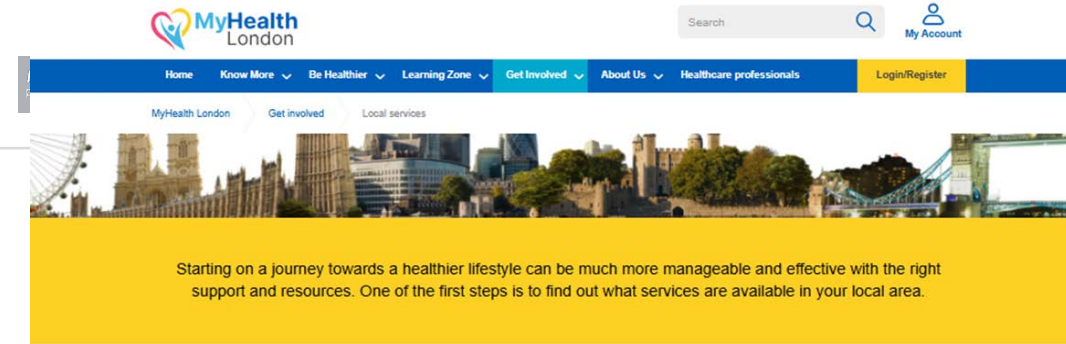
- Conversation with your future self



*People will forget what you said,  
people will forget what you did,  
but people will never forget*

*how you made them feel.*

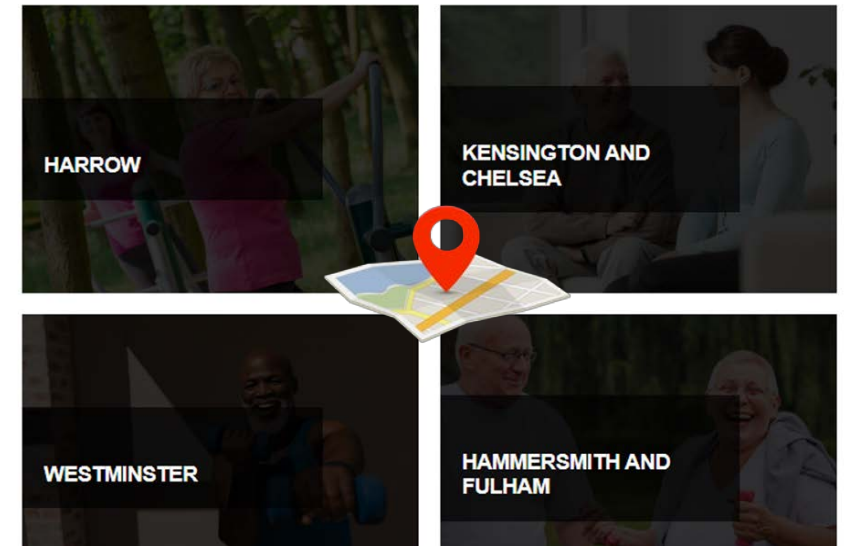
# 3 Things I learnt from CRM



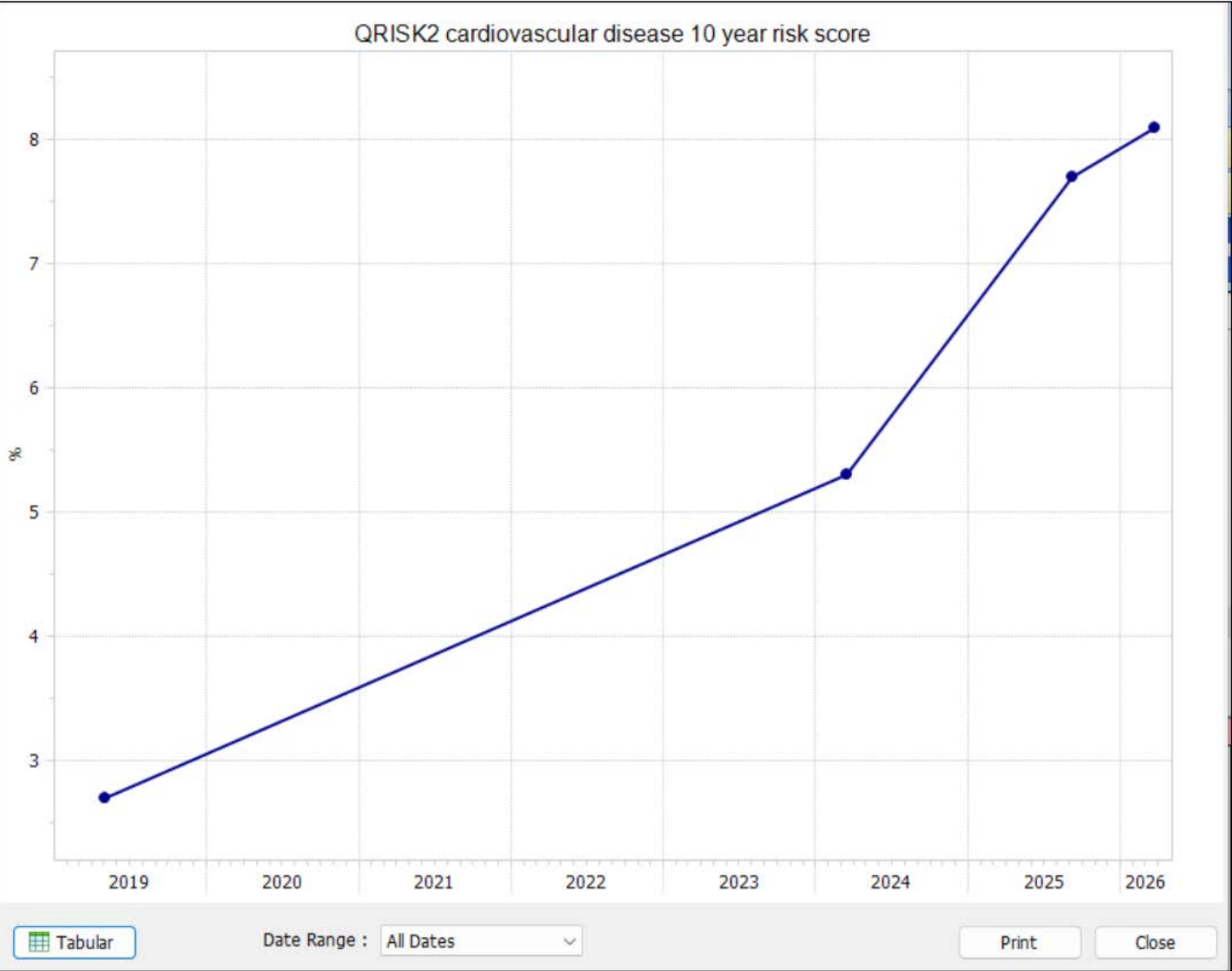
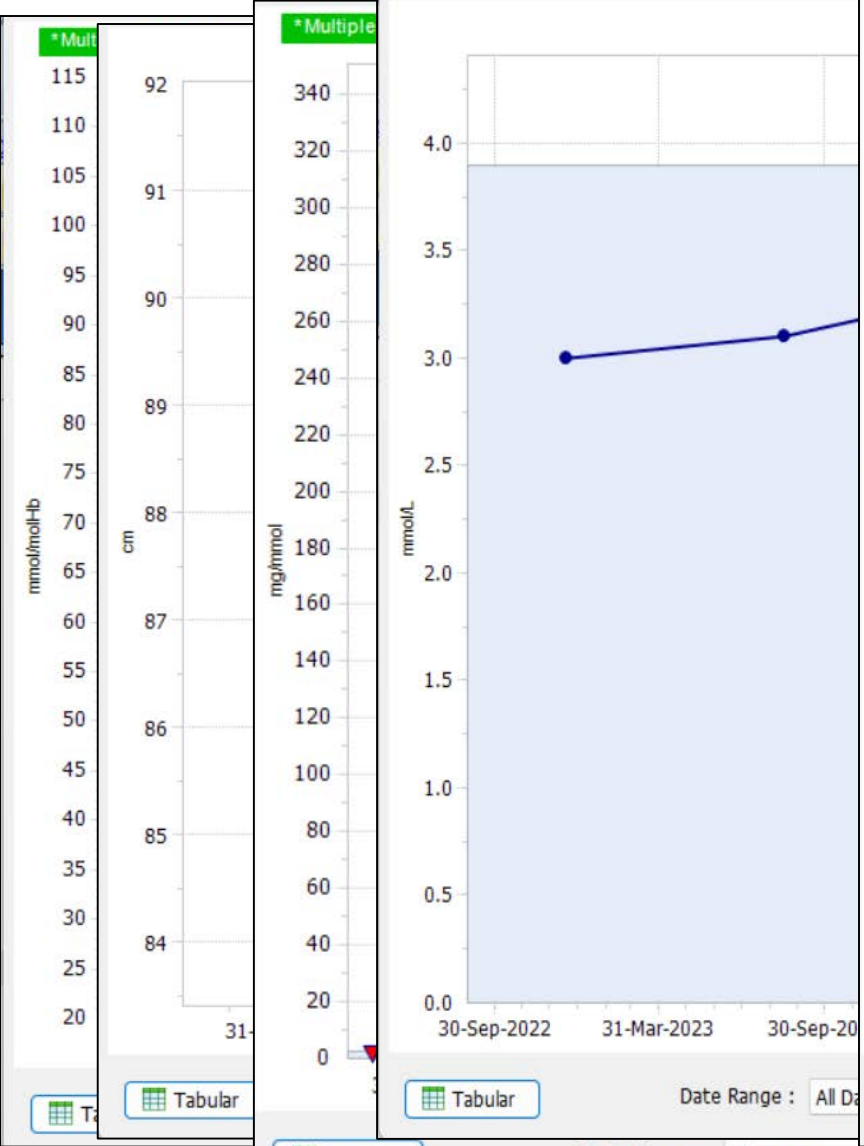
1. Prepare ahead – helps you & patient  
(QRISK/Heart Age, KFRE, Fib4, HCS, use graphs )

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 – 1<sup>st</sup> practice goes live

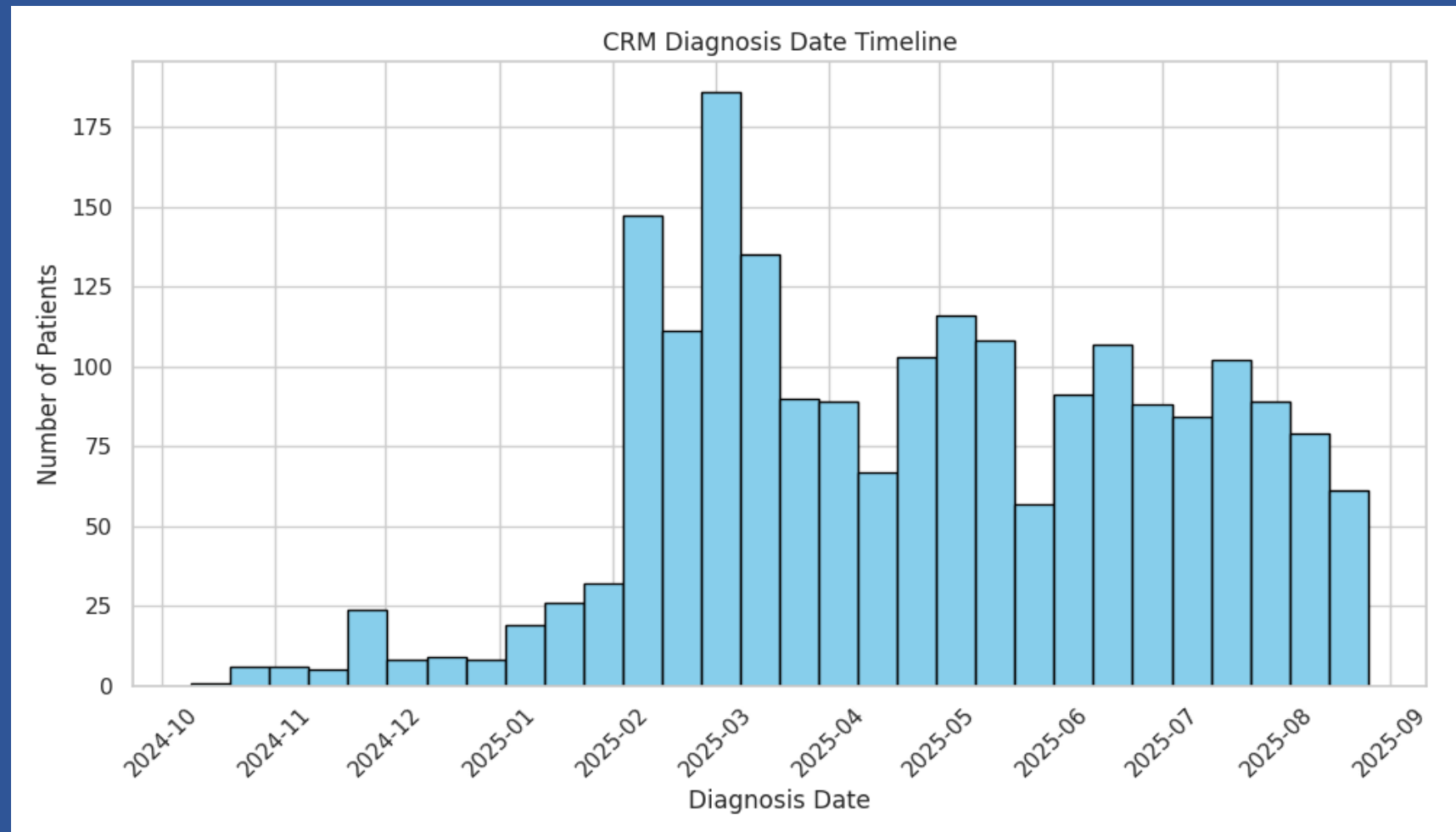
Dec – 2 PCNs

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

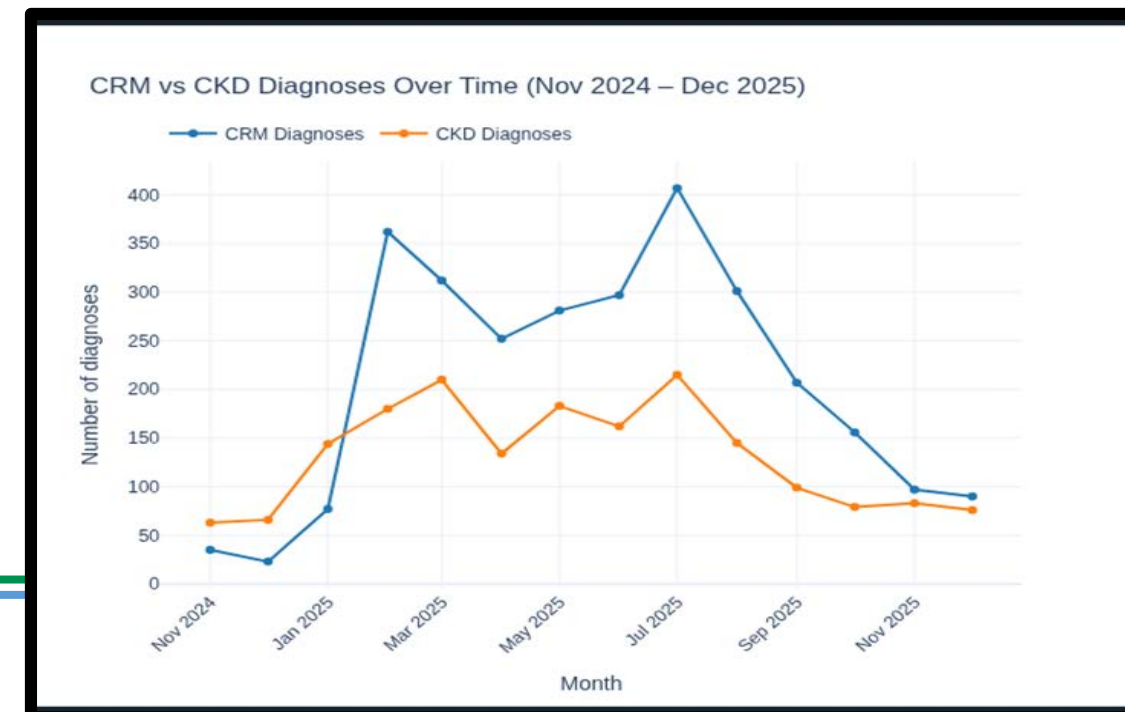
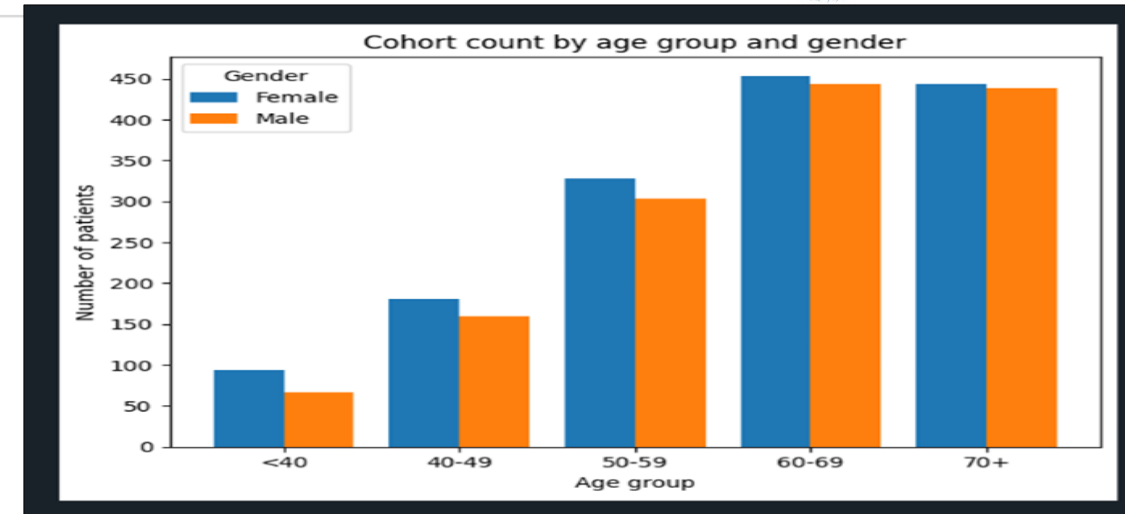


# Update on data to Dec 2025

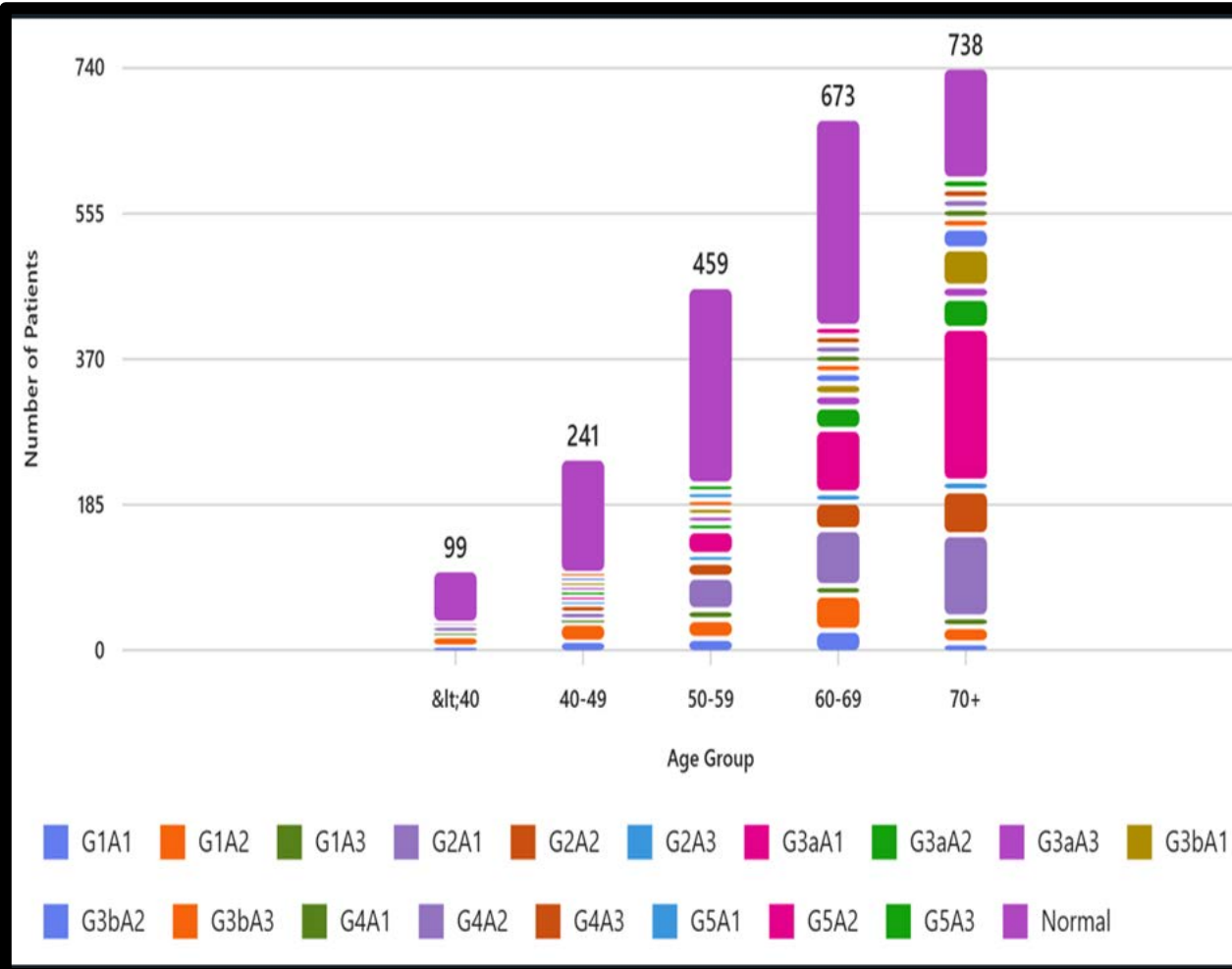
## CRM/CKD diagnosis:-

- 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%	46.8%
50-59	52.0%	48.0%
60-69	50.8%	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)

Age Group	CKD Pre	Weight Pre	Weight Post	BP Pre	BP Post	HbA1c Pre	HbA1c Post	BMI Pre	BMI Post
70+	83.6	94.1	91.7	97.7	95.5	96.1	93.5	99.8	94.7
60-69	74.9	93.9	94.2	97.6	95.2	94.7	93.5	99.2	94.5
50-59	72.7	94.6	95.7	97.9	94.8	95.1	94	99.5	96.8
40-49	70.7	92.7	95.3	96.2	93	94.4	96.2	99.4	95.9
&lt;40	61.5	83.9	94.4	88.8	88.8	90.7	92.5	96.3	94.4

Metric

- **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%)**

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



Practice	N pts	eligible ANY (pre+post)	Pct ≥10% ANY	Pct ≥5% ANY	N ≥10% ANY	N ≥5% ANY	SBP mean (improvement)	HbA1c mean (improvement)	Weight mean kg (improvement)
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	78	● 25.6%	48.7%	20	38	-3.35	-1.00	-2.12
THE SHAFTESBURY MEDICAL CENTRE	114	113	● 25.6%	48.7%	20	38	-7.86	-1.03	-1.12
Streatfield Health Centre	91	90	● 25.3%	48.3%	20	37	-1.39	-1.27	-2.10
ROXBOURNE MEDICAL CENTRE	62	61	● 24.3%	46.8%	16	27	-3.77	-1.05	-2.47
THE CIVIC MEDICAL CENTRE	13	12	● 23.1%	45.4%	3	5	3.50	-4.30	-2.50
Kings Road Medical Centre	88	87	● 22.7%	45.1%	20	45	-4.10	-1.89	-1.30
HATCH END MEDICAL CENTRE	16	15	● 21.9%	44.7%	4	9	-1.67	0.83	-2.38
KENTON CLINIC	87	86	● 21.8%	44.7%	20	45	-7.37	0.51	-0.71

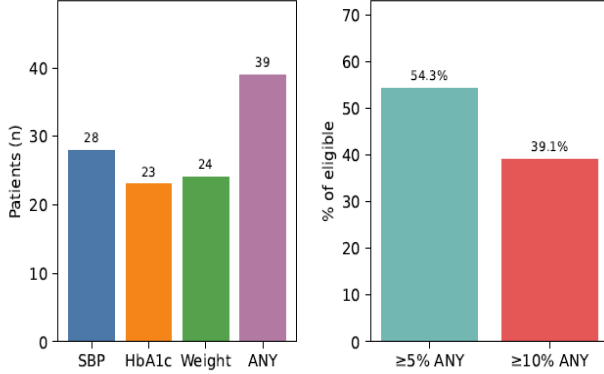
Every practice – demonstrated improvements for patients – each practice looked at different patient cohorts – RAG only related to >10% improvement in any one parameter – for “sorting the column”

# Example Practice level report



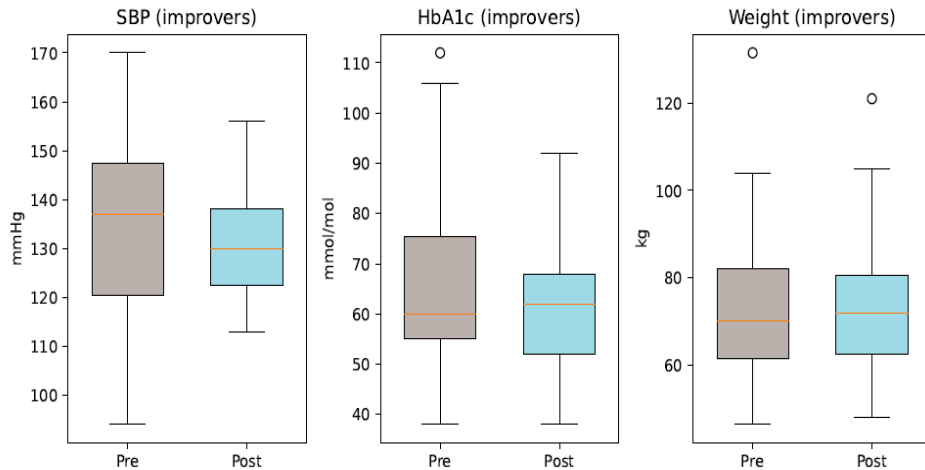
## Practice Performance Summary

### Improved counts (pre→post decrease) Threshold achievement (ANY parameter)

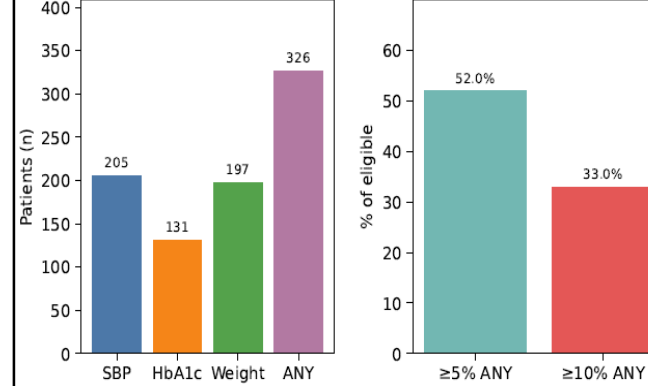


Practice: ASPRI MEDICAL CENTRE  
 Total patients: 46  
 Improved in ANY: 39  
 Eligible for thresholds (ANY): 46  
 N ≥5% ANY: 25 (54.3% of eligible)  
 N ≥10% ANY: 18 (39.1% of eligible)

Boxplots below show pre vs post among improvers only (patients with both values)

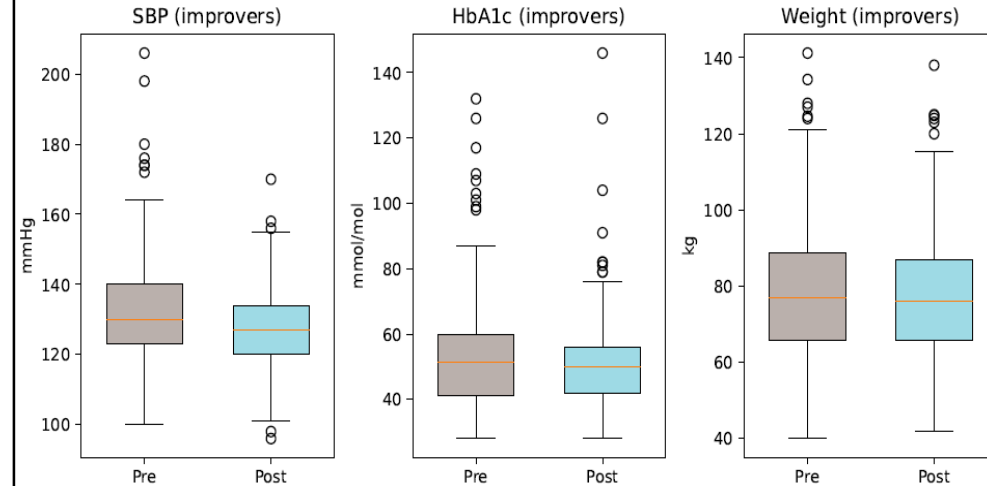


### Improved counts (pre→post decrease) Threshold achievement (ANY parameter)



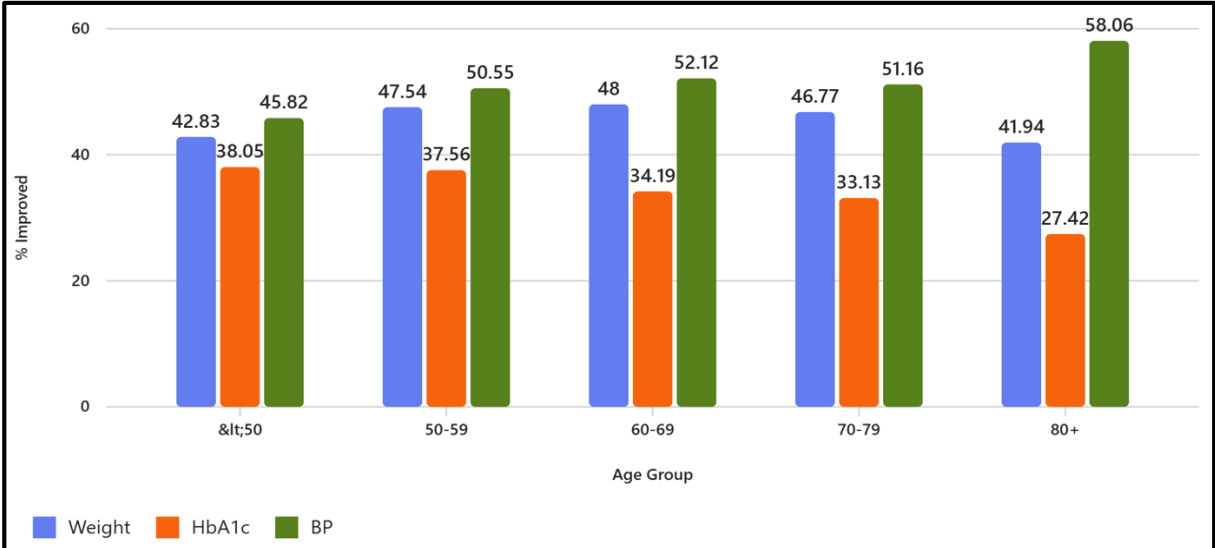
Practice: THE PINN MEDICAL CENTRE  
 Total patients: 417  
 Improved in ANY: 326  
 Eligible for thresholds (ANY): 406  
 N ≥5% ANY: 211 (52.0% of eligible)  
 N ≥10% ANY: 134 (33.0% of eligible)

Boxplots below show pre vs post among improvers only (patients with both values)

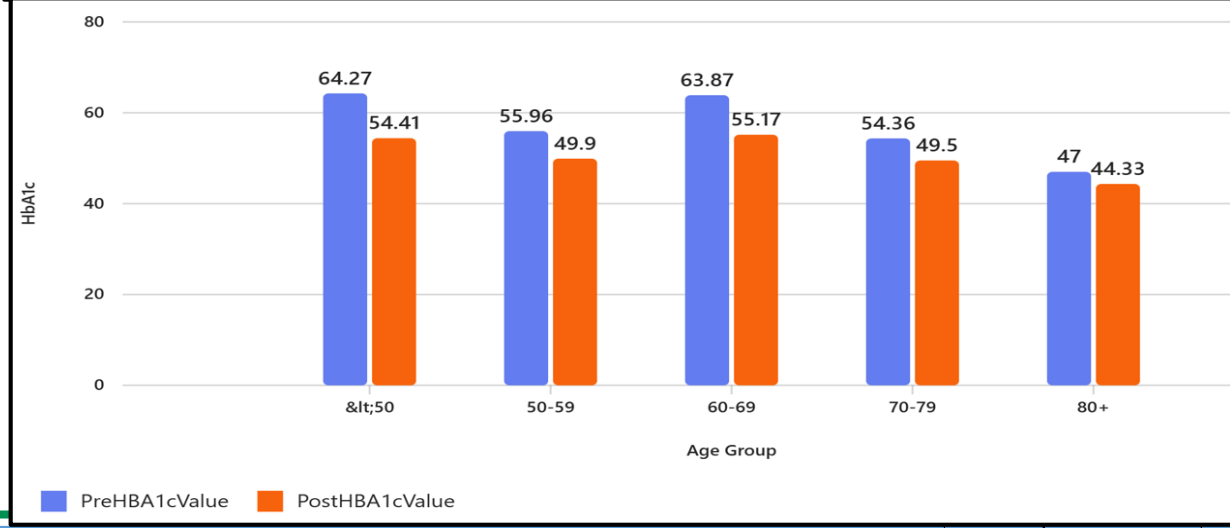


# Improvement in at least one parameter of BP, weight, HbA1c, BP, BMI or waist measurement by age, size of improvement

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%)**

## CRM Competency Framework

 <b>Module 1: CRM Core competencies</b> Understanding the interconnection between cardiovascular, renal, and metabolic systems	 <b>Clinical Guidelines</b> Familiarity with national and local guidelines for managing hypertension, obesity, cardiovascular diseases, chronic kidney disease (CKD), and
 <b>Holistic Assessment</b> Conducting obesity screening and mental health and diabetes questionnaires (PHQ2 and GAD2)	 <b>Health Coaching</b> Empowering patients through coaching strategies, including goal setting and crossing
 <b>Pharmacology in CRM Approaches</b> Prescribing and managing CRM medications such as ACE inhibitors, GLP-1 receptor	 <b>Lifestyle Medicine</b> Proficiency in integrating lifestyle modification into patient care
 <b>Lifestyle Medicine</b> Proficiency in integrating lifestyle modification into patient care	 <b>Multidisciplinary Collaboration</b> Engage specialists for escalated care levels
 <b>Multidisciplinary Collaboration</b> Engage specialists for escalated care levels	 <b>Advanced Knowledge Use of Research and Evidence-Based Pra</b>
 <b>Advanced Knowledge Use of Research and Evidence-Based Pra</b>	 <b>9a: Patient Education</b> Ability to explain CRM condition and treatments to people and their advocates/family members

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...

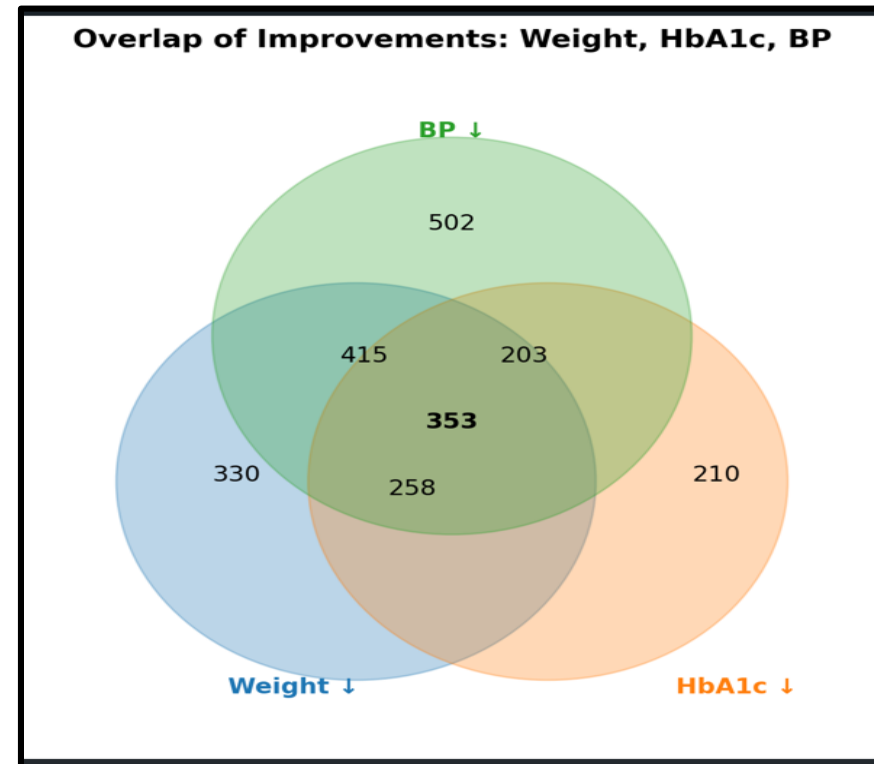
≥5% threshold

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

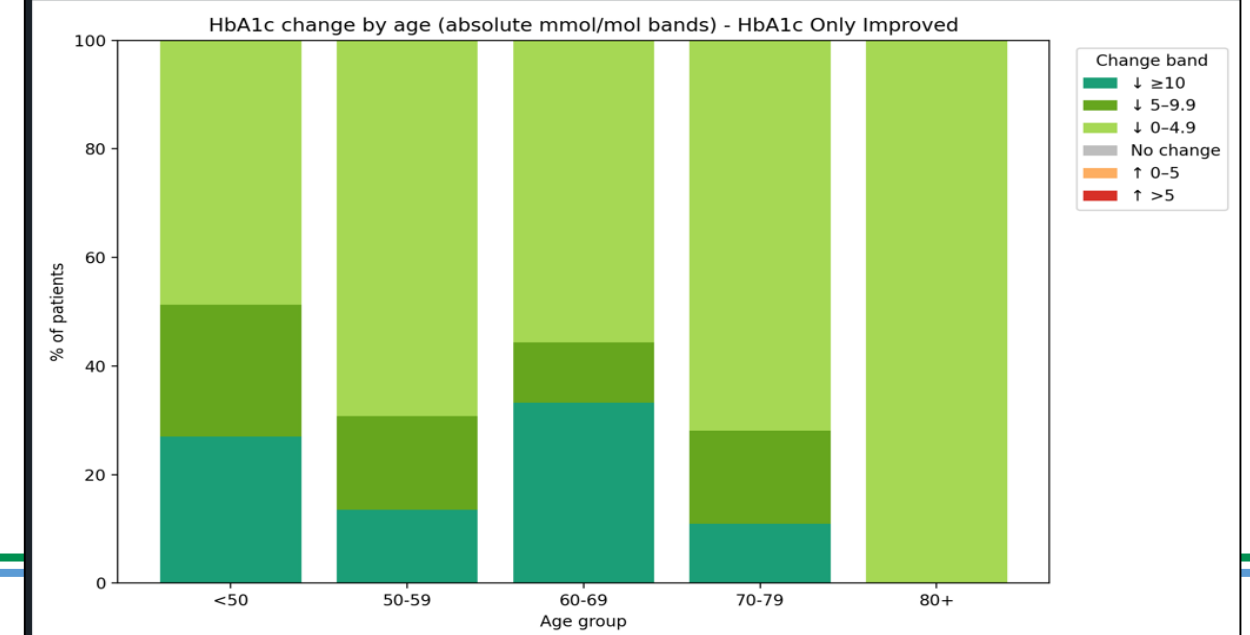
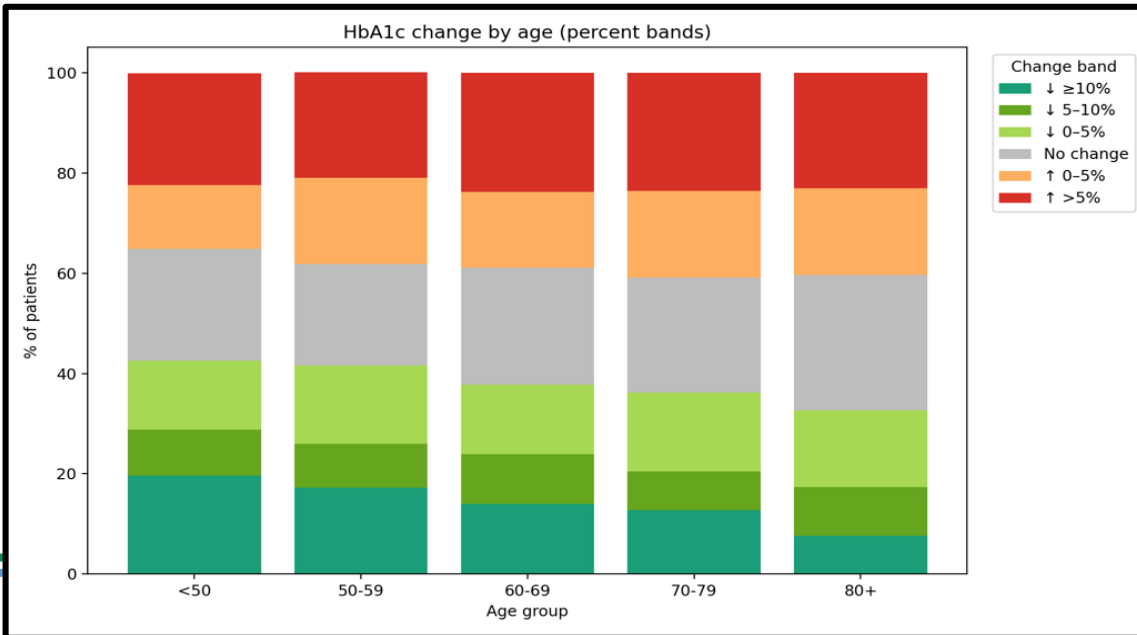
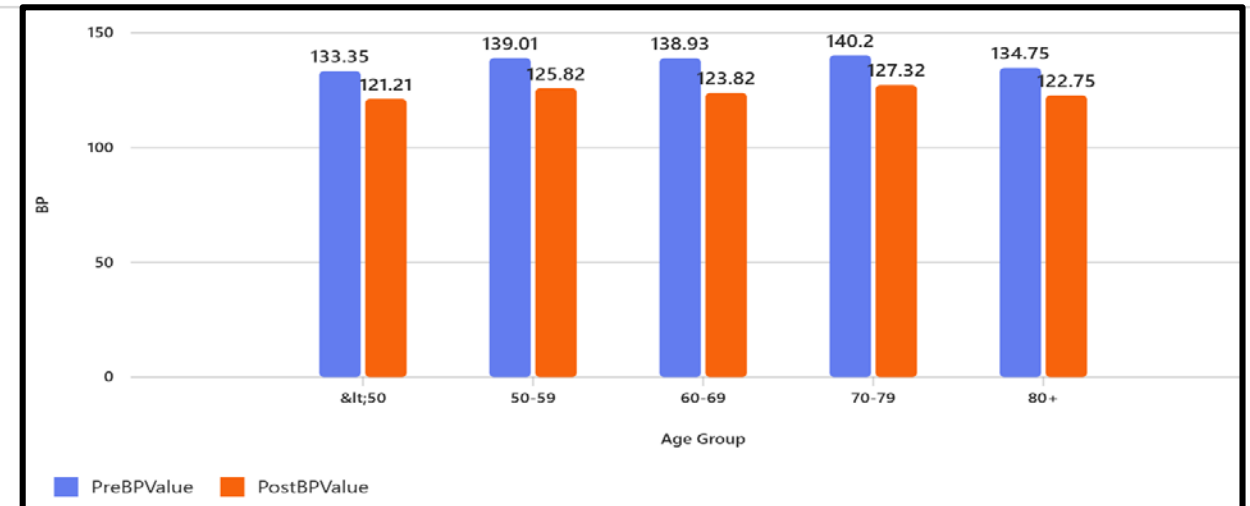
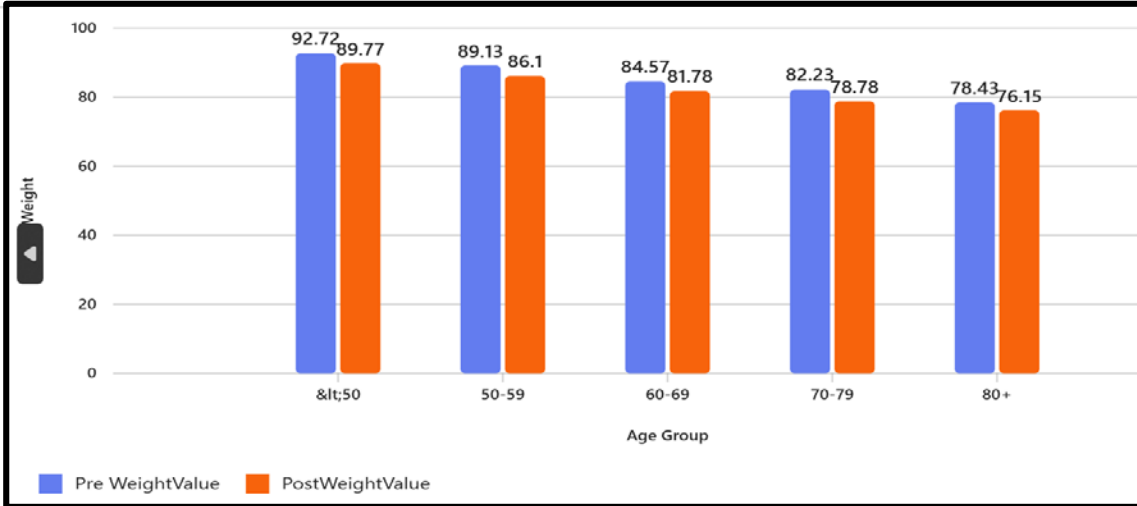
≥10% threshold

- 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  $\approx$  9.9 mmol/mol (12%)  
→ clinically significant, likely high ROI
- **60–69 age group:** Mean reduction  $\approx$  8.7 mmol/mol (11.5%) → strong ROI
- **80+ age group:** Mean reduction  $\approx$  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

## SystemOne Practices

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

- BI Enhanced Services Test (422)
  - CRM Register (1)
  - CRM Risk Segmentation (3)
  - xCRM Register Sub (24)
  - xCRM Risk Sub (388)
  - zArchive (6)

**CRM Risk Segmentation**

Name ▾

- \*\*RISKHIGH | High Risk | Option 3 | 14 or more risk factors
- \*\*RISKMOD | Moderate Risk | Option 3 | 10-13 risk factors
- \*RISKLOW | Low Risk | Option 3 | 0-9 Risk Factors

## 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

- BI Enhanced Services Test
  - CRM
    - Register
    - Risk Segmentation
  - Bowel Cancer Screening
  - Brent CCG: Access Hub Reporting (Harness)
  - Brent CCG: Access Hub Reporting (K&W)
  - Brent CCG: Access Hub Reporting (Kilburn)
  - Brent Reports
  - COVID-19 (ICB viewable)
  - COVID-19 Vaccination Data
  - Dans Searches
  - Dormers Wells Medical Centre (Ealing)
  - DW & SP and Hillingdon PCN Reports

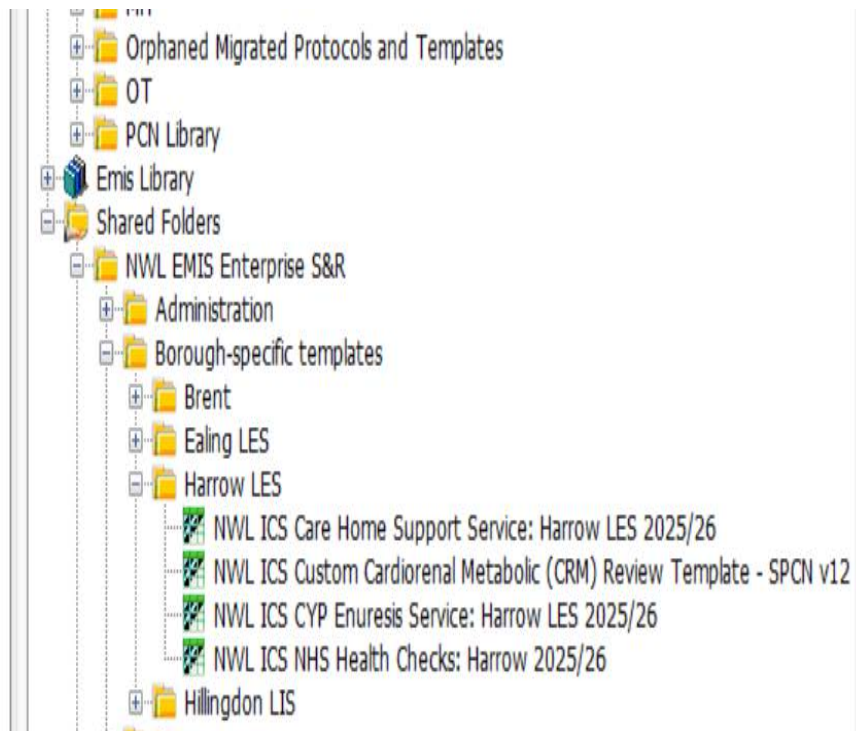
- Sub
- xArchive
- \*RISK00A | High Risk | Option 3 | 14 or more Risk Factors
- CRM00A
- \*RISK00B | Medium Risk | Option 3 | 10-13 Risk Factors
- CRM00B
- \*RISK00C | No or Low Risk | Option 1 | 0-9 Risk Factors
- CRM00C
- Female
- CRM00Ca
- Male
- CRM00Cb



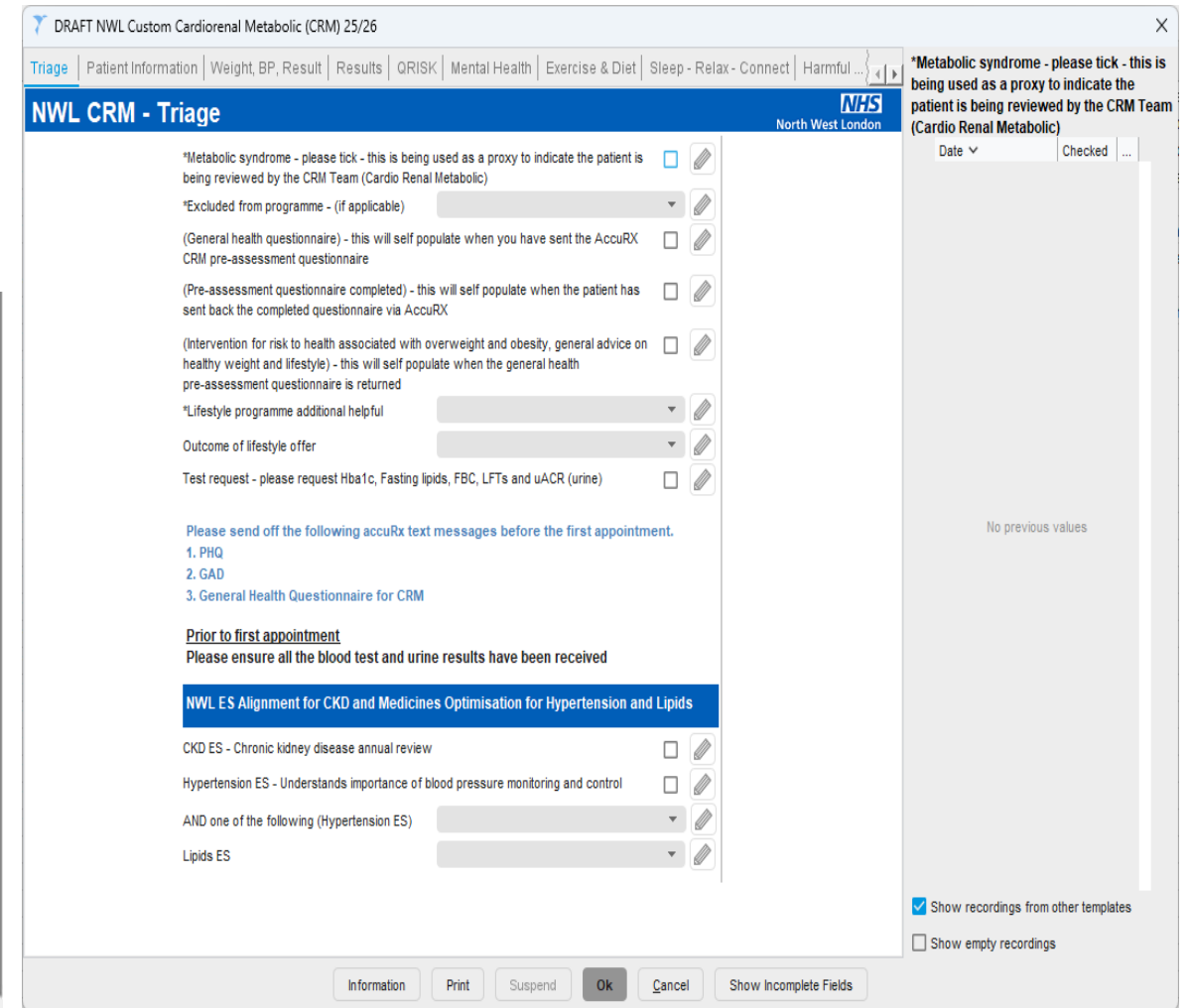
# Clinical Template

## 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**



DRAFT NWL Custom Cardiorenal Metabolic (CRM) 25/26

Triage | Patient Information | Weight, BP, Result | Results | QRISK | Mental Health | Exercise & Diet | Sleep - Relax - Connect | Harmful ...

### NWL CRM - Triage

North West London

\*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)  [edit]

\*Excluded from programme - (if applicable) [dropdown] [edit]

(General health questionnaire) - this will self populate when you have sent the AccuRX CRM pre-assessment questionnaire  [edit]

(Pre-assessment questionnaire completed) - this will self populate when the patient has sent back the completed questionnaire via AccuRX  [edit]

(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  [edit]

\*Lifestyle programme additional helpful [dropdown] [edit]

Outcome of lifestyle offer [dropdown] [edit]

Test request - please request Hba1c, Fasting lipids, FBC, LFTs and uACR (urine)  [edit]

Please send off the following accuRx text messages before the first appointment.

- PHQ
- GAD
- General Health Questionnaire for CRM

**Prior to first appointment**  
Please ensure all the blood test and urine results have been received

**NWL ES Alignment for CKD and Medicines Optimisation for Hypertension and Lipids**

CKD ES - Chronic kidney disease annual review  [edit]

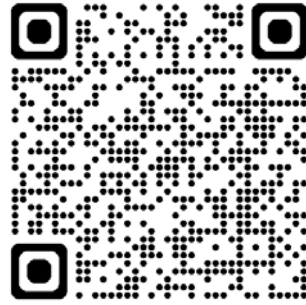
Hypertension ES - Understands importance of blood pressure monitoring and control  [edit]

AND one of the following (Hypertension ES) [dropdown] [edit]

Lipids ES [dropdown] [edit]

Show recordings from other templates  
 Show empty recordings

Information | Print | Suspend | **Ok** | Cancel | Show Incomplete Fields



- 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 enabling 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.....

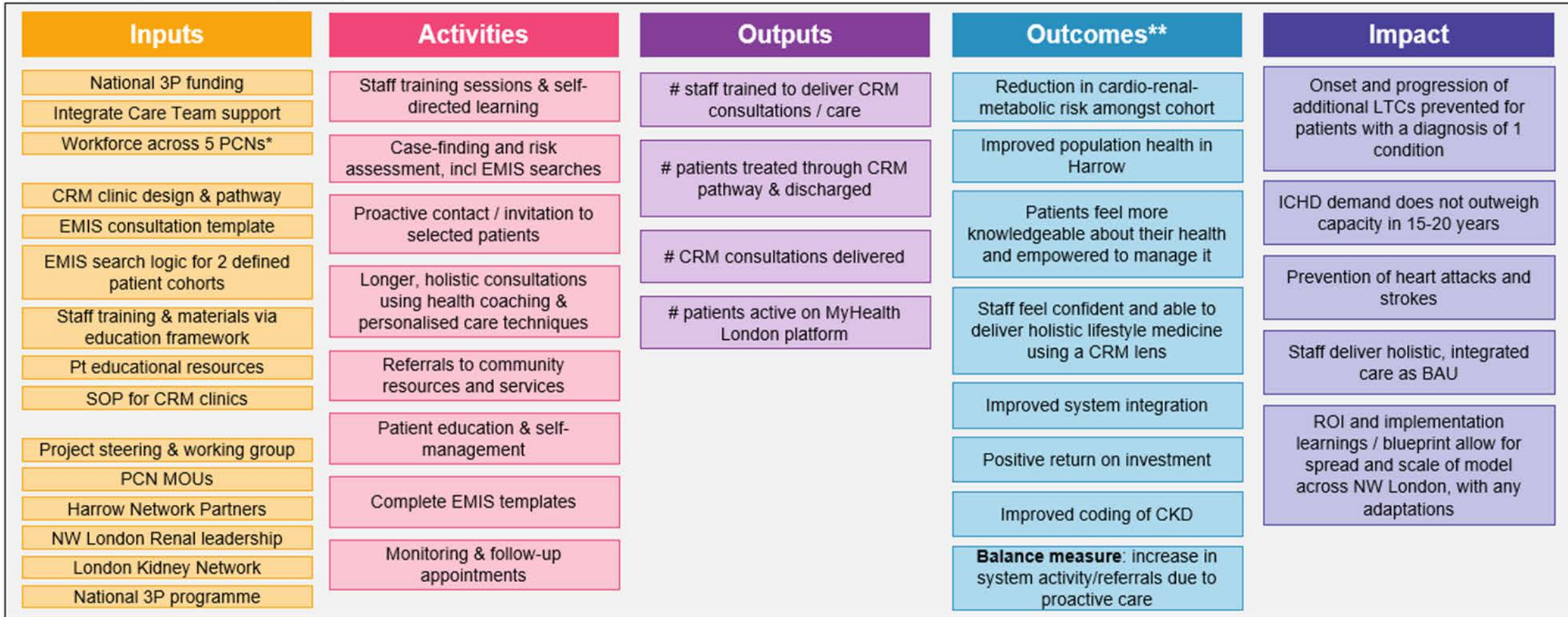


- **LKN – Educational framework/LKN/MHM**
- **Hammersmith and Fulham**
- 3 Educational events - Dr Kyla Cranmer/Dr James Tomlinson/Dr Yin Yin Lee/Dr Kuldhir Johal/Matt Ayres/Dr Alasdair Macrae/Jessica Mathews/Eve Costello – Hammersmith & Fulham Training Hub
- **Hillingdon** – Hypertension Steering Group – 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.



## 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 as impactful for staff:
  - Shadowing clinical colleagues, hearing feedback
  - YouTube video on Willis
- Framework experienced sometimes difficult to complete (links/registration), not always feasible to complete if not available.
- Perceived relevance varies by staff role – felt like a recap of what was already known, whereas for some content was newer.

## Early staff insights – consultations

### Consultations

- Strong support for 30 minutes required in order to do a consultation approach
- However, still difficult to optimise medicines optimisation
- There is variation in buy-in and interest in consultations
  - Example views: (1) long time; (2) cost of Mounjaro – an access to it
- Some practices may add 15 minutes before
- Critical for making in change – e.g. goal setting
- Unclear when 'discharge' is needed

## Early patient insights – contact about CRM appointment

### Contact

- Patients generally proactively contact
- Because this is having the initial chance to ask questions
- Offering flexibility is appreciated - longer than typical
- Having access can help prepare conversation
- Giving patients advance – e.g. urine sample –

## Early patient insights – activation and motivation

### Activation & motivation

- Motivated by seeing data on blood sugar levels via seeing visuals on screen during consultation
- Eager to play a more active role in healthcare
- Regular review periods able to try out changes
- Having/building a regular relationship with their care professional
- Importance of family involvement and as a result (staff also noted benefit involved where possible)
- Not many using digital resources for their condition – but would like to

## 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"*

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)
<b>My Results</b>			/			:					
<b>Target</b>	[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/>.

<b>My Lifestyle Prescription</b>						
	<b>MOVE</b>	<b>EAT</b>	<b>SLEEP</b>	<b>RELAX</b>	<b>CONNECT</b>	<b>AVOID HARMFUL SUBSTANCES</b>

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

<b>What would I like my lifestyle prescription to help me achieve? This is my goal.</b>	
---	--

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](http://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: \_\_\_\_\_

# 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 Register 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” ...

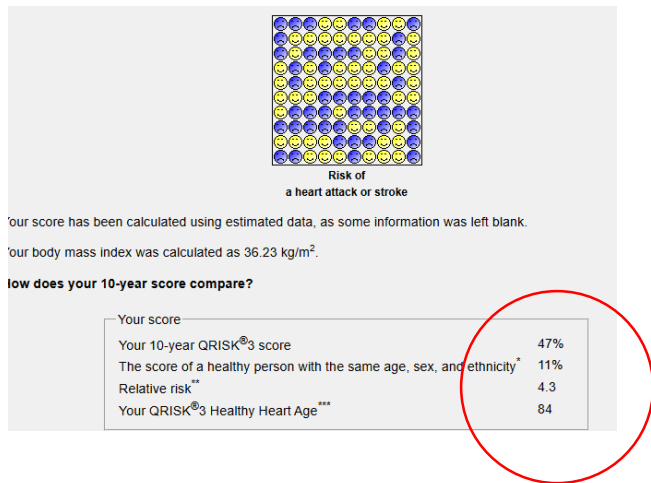


- **Light bulb moment** – “paradigm shift” – more one patient - one series of interlinked and interrelated conditions.
- **Stream line** – using tools in place – but compliment and empower – alignment of digital enablers (SMS/Email), signposting/clinical and quality audits (monthly/bimonthly)
- **Saves 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



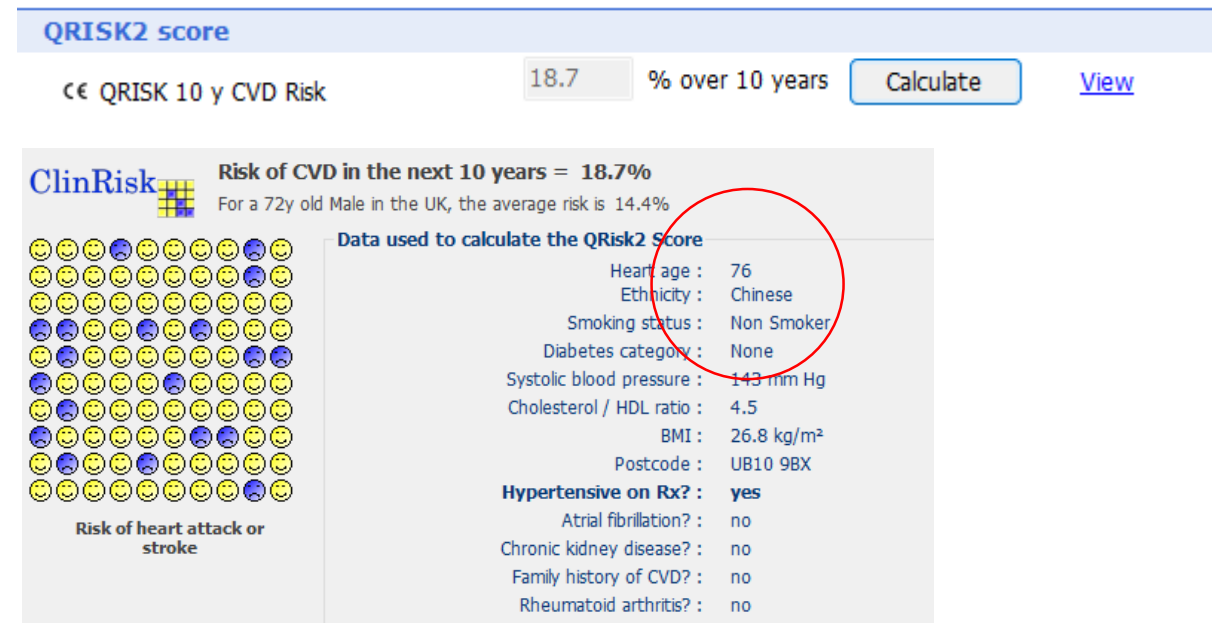
Risk of a heart attack or stroke

Your score has been calculated using estimated data, as some information was left blank.

Your body mass index was calculated as 36.23 kg/m<sup>2</sup>.

**How does your 10-year score compare?**

Your score	47%
Your 10-year QRISK <sup>®</sup> 3 score	11%
The score of a healthy person with the same age, sex, and ethnicity*	4.3
Relative risk**	84
Your QRISK <sup>®</sup> 3 Healthy Heart Age***	



**QRISK2 score**

€ QRISK 10 y CVD Risk **18.7** % over 10 years **Calculate** [View](#)

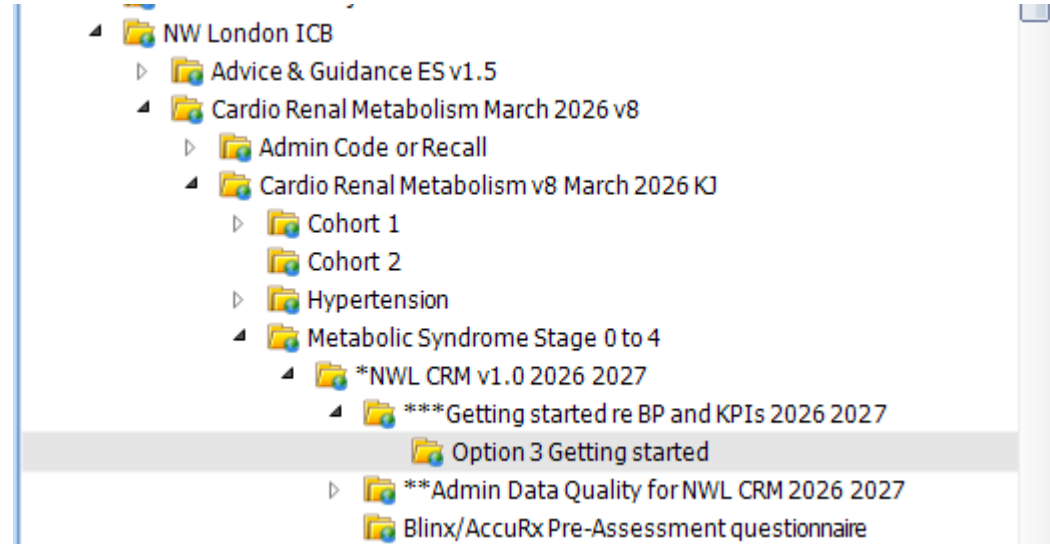
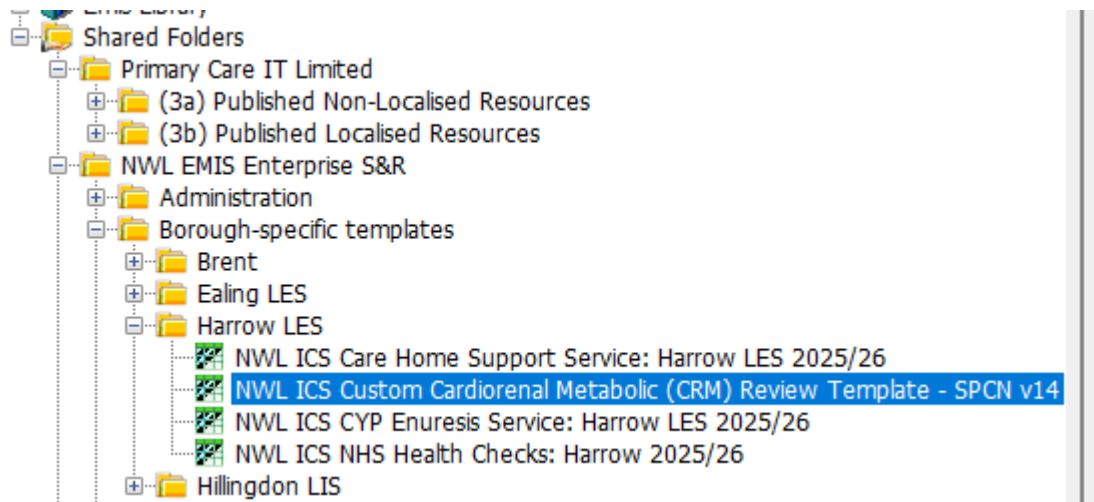
**ClinRisk** Risk of CVD in the next 10 years = **18.7%**  
For a 72y old Male in the UK, the average risk is 14.4%

**Data used to calculate the QRisk2 Score**

Heart age :	76
Ethnicity :	Chinese
Smoking status :	Non Smoker
Diabetes category :	None
Systolic blood pressure :	143 mm Hg
Cholesterol / HDL ratio :	4.5
BMI :	26.8 kg/m <sup>2</sup>
Postcode :	UB10 9BX
<b>Hypertensive on Rx? :</b>	<b>yes</b>
Atrial fibrillation? :	no
Chronic kidney disease? :	no
Family history of CVD? :	no
Rheumatoid arthritis? :	no

Risk of heart attack or stroke

# CRM V14 Template and Searches



*NWL CRM00   REGISTER   Patients on NWL ES CRM Register	Patient
... and Metabolic Syndrome Code	Patient
No BP recorded within the last 12 months and age over 45 NWL CRM	Patient
No BP recorded within the last 12 months NWL CRM	Patient
*Patients with no BP reading	Patient
... and aged 45 to 59	Patient
... and aged over 60	Patient
*RISK00A   High Risk   Option 3   14 or more Risk Factors	Patient
... and Metabolic Syndrome Code	Patient
No BP recorded within the last 12 months and age over 45 NWL CR...	Patient
No BP recorded within the last 12 months NWL CRM H	Patient
*RISK00B   Medium Risk   Option 3   10-13 Risk Factors	Patient
... and Metabolic Syndrome Code	Patient
No BP recorded within the last 12 months and age over 45 NWL CR...	Patient
No BP recorded within the last 12 months NWL CRM M	Patient
*RISK00C   No or Low Risk   Option 1   0-9 Risk Factors	Patient
... and Metabolic Syndrome Code	Patient
No BP recorded within the last 12 months and age over 45 NWL CR...	Patient
No BP recorded within the last 12 months NWL CRM L	Patient
All currently registered patients	Patient
*Latest clinic BP >140/90 in QOF year	Patient
... BAU - included list on Hypertension register - excluded consider	Patient
....BAU ... and on DM register.. consider included list for coding	Patient

Pages

Desktop triage

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

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

Text

04-Jun-2025



<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

(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...



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

Hierarchy Preview

- ▶ The Oakland Medical Centre
- ▶ Emis Library
- ▶ Shared Folders
  - ▶ NWL EMIS Enterprise S&R
    - ▶ Borough-specific forms
      - ▶ Harrow
        - NWL HARROW Adult Bladder And Bowel Referral Form (Email)
        - NWL HARROW Adult Community Health Services Referral Form V4 (Email)
        - NWL HARROW Anticoagulation Referral form (Email)
        - NWL HARROW Audiology AQP Referral (e-RS)
        - NWL HARROW Cardiology Diagnostic Cora Health - formerly Healthshare Form (eRS)
        - NWL HARROW Child Health Service Community Referral - (Email)
        - NWL HARROW Children & Young Persons Enuresis Referral Form
        - NWL HARROW Children's Community Asthma Nurse Referral Form (Email)
        - NWL HARROW Community Cardiology Referral Form V5 - Imperial College (eRS)
        - NWL HARROW Contraception Referral template v22 (Email)
        - NWL HARROW Enhanced Frailty Team (EFT) Referral Form (Email)
        - NWL HARROW Exercise On Referral (via Online Portal)
        - NWL HARROW Hestia The Coves Referral (Email)
        - NWL HARROW Horizons Referral Form AFC (Anna Freud National Centre) - (Online)
        - NWL HARROW Hospital and Community General Referral Form V4.2 (e-RS)
        - NWL HARROW Independent Domestic Violence Advocate Referral Form (Email)
        - NWL HARROW Intergrated Diabetes Care Referral Letter V5 (Email)
        - NWL HARROW Learning Disability Referral Form (Email)
        - NWL HARROW Lifestyle Care Plan CRM v2.edwt
        - NWL HARROW LNWH Diabetes Urgent Foot MDFT Referral Form
        - NWL HARROW MASH Referral - (via online portal)
        - NWL HARROW Minor Surgery DES Referral Form (Email)

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>

<p><b>What would I like my lifestyle prescription to help me achieve? This is my goal.</b></p>	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

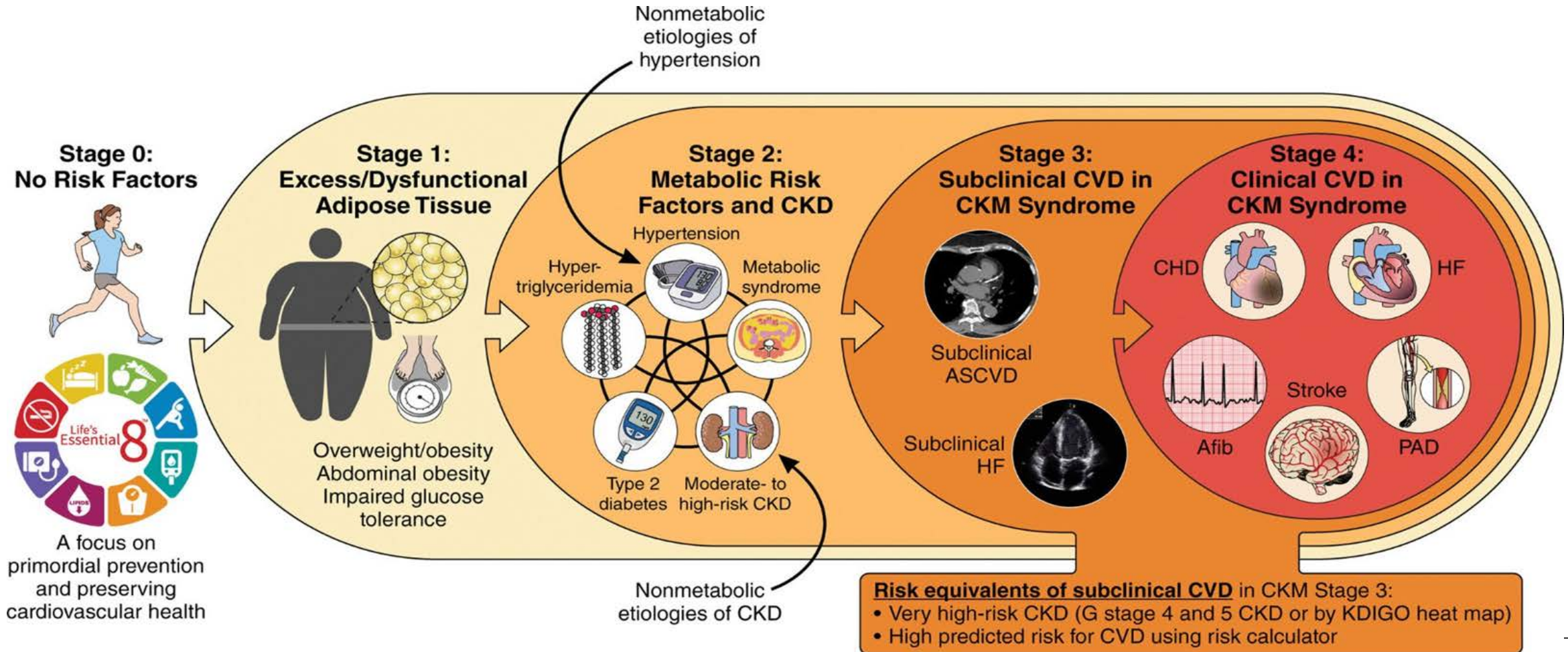
## Smoking

- 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, cardiovascular diseases, chronic kidney disease (CKD), and



## Holistic Assessment

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



## Health Coaching

Empowering patients through coaching strategies; including goal setting and crossing



## Pharmacology in CRM Approaches

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



## Lifestyle Medicine

Proficiency in integrating lifestyle modification into patient care



## Lifestyle Medicine

Proficiency in integrating lifestyle modification into patient care



## Multidisciplinary Collaboration

Engage specialists for escalated care levels



## Multidisciplinary Collaboration

Engage specialists for escalated care levels



## Advanced Knowledge Use of Research and Evidence-Based Practice



## Advanced Knowledge Use of Research and Evidence-Based Practice



## 9a: Patient Education

Ability to explain CRM conditions and treatments to people and their advocates/family members

# CRM PATHWAY OVERVIEW



## PATIENT IDENTIFICATION

- Patients identified via bespoke EMIS/S1 searches that go beyond existing search tools to identify cohort with multiple 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 conveyers



## 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 adjusted
- Patient experience and motivation captured via AccuRx

# Additional Links already in pre-assessment questionnaire and clinical templates



Home > Cholesterol > Genetic conditions > Metabolic syndrome

## Metabolic syndrome



**Finerenone and Semaglutide now on team kidney**  
For Kidneys Sake

00:00 | 18:38

- Finerenone and Semaglutide now on team kidney 18:39
- Bridging Cardio-Renal Care: A Nurse Practitioner's Take 23:05
- Kidneys vs Heart: The Battle HF Nurses Navigate Every Day 23:14
- The RAASi reset 15:22
- From fluid overload to volume depletion: tips on how to get it right? 18:33

https://www.nhs.uk/health-assessment-tools/calculate-your-heart-age

### Calculate your heart age

Your heart age gives you an idea of how healthy your heart is.

This calculator will compare your real age to your heart age by asking you questions about your health. You'll also find out how to improve your heart age by making some healthy lifestyle changes.

#### Who can use this calculator

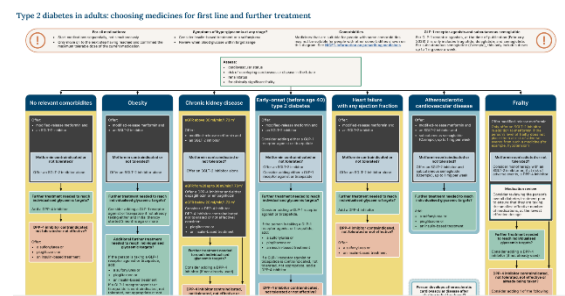
### 5 steps to a happier, healthier you

Changing your lifestyle to improve your health and wellbeing is easier than you think. Start with these small steps towards feeling good and living longer:

- Move** more to feel good and less tired:
  - Aim for 150 minutes of physical activity spread across the week - a brisk walk, jog, dancing, gardening or anything else that feels good. Try splitting it up into just 30 mins a day.
  - Get up and move every 30 minutes or so - don't sit for a long time without moving.
  - Do simple strengthening exercises with weights, yoga or even carrying your shopping home.
- Eat** well to feel good:
  - Eat a more plant-based diet with things like vegetables, beans, pulses, herbs and spices to satisfy your appetite and help your mood.
  - Eat a rainbow of different coloured vegetables to help you get the different nutrients you need.
  - Reduce sugar and refined starchy food like white rice, pasta and bread to lose weight and reduce blood sugar.
  - Avoid ultra processed foods like ready meals, crisps, processed meats and biscuits which are linked to obesity, diabetes, heart disease, cancer and depression.
  - Intermittent fasting can help reduce risk of obesity, memory problems and some types of cancer.
- Sleep** 7 to 9 hours a night:
  - Prioritise getting a good night's rest to reduce risk of stroke, heart disease and depression by at least 30%.
  - It will help your concentration, regulate your appetite and maintain your physical and mental health.

**MY HEALTHY PLATE**

30% more to feel good and less tired



WorkWell in North West London



# CRM Competency Framework



## Module 1: CRM Core competencies

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Engage specialists for escalated care levels



## Advanced Knowledge Use of Research and Evidence-Based Practice



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- Patient experience and motivation captured via AccuRx

# Health Confidence Score

## Health Confidence

How do you feel about caring for your health?

How much do you agree?

Strongly agree   Agree   Neutral   Disagree

I know enough about my health



I can look after my health



I can get the right help if I need it



I am involved in decisions about me

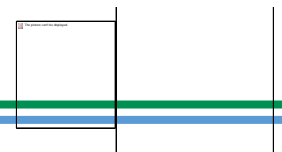


The four items are as follows:

- 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](#)



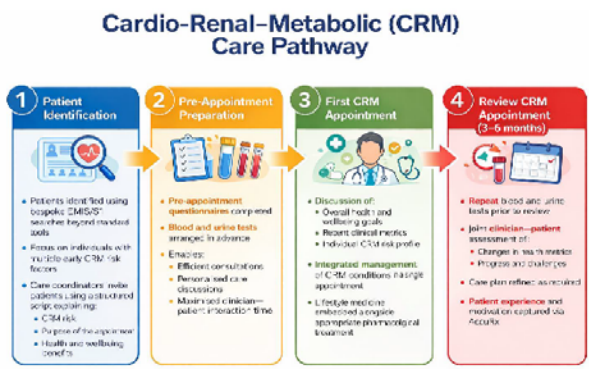
# Imperial College London

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

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.



### CRM Competency Framework

<b>Module 1: CRM Core competencies</b> Understanding the interconnection between cardiovascular, renal, and metabolic systems	<b>Clinical Guidelines</b> Familiarity with national and local guidelines for managing hypertension, obesity, cardiovascular diseases, chronic kidney disease (CKD), and
<b>Holistic Assessment</b> Conducting obesity screening and mental health and diabetes questionnaires (9-HQ2 and GAD2)	<b>Health Coaching</b> Empowering patients through coaching strategies, including goal setting and progress
<b>Holistic Assessment</b> Prescribing and managing CRM medications such as ACE inhibitors, GLP-1 receptor	<b>Lifestyle Medicine</b> Proficiency in integrating lifestyle modification into patient care
<b>Pharmacology in CRM Approaches</b> Prescribing and managing CRM medications such as ACE inhibitors, GLP-1 receptor	<b>Multidisciplinary Collaboration</b> Engage specialists for escalated care levels
<b>Lifestyle Medicine</b> Proficiency in integrating lifestyle modification into patient care	<b>Advanced Knowledge Use of Research and Evidence-Based Practice</b>
<b>Multidisciplinary Collaboration</b> Engage specialists for escalated care levels	<b>9a: Patient Education</b> Ability to explain a CRM condition and treatments to people and their advocacy family members

### 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.

# Imperial College London

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

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.



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.

<h4>Proactive &amp; Holistic Care</h4> <ul style="list-style-type: none"> <li>Patients felt listened to and valued longer consultations</li> <li>Appreciated receiving proactive, personalised care</li> <li>Holistic approach discussed lifestyle, mental wellbeing, sleep, social factors</li> <li>Continuity of care built trust and confidence</li> </ul> <p><i>"The fact that the same person saw me and knew what they were talking about gave me confidence to act on the advice. Continuity helps."</i> - Patient</p> <p><i>"Personally, it's about feeling someone cares and that I'm not alone. This is the first time I feel there is real medical attention."</i> - Patient</p>	<h4>Increased Motivation &amp; Confidence</h4> <ul style="list-style-type: none"> <li>Patients felt empowered to make lifestyle changes</li> <li>Personalised advice and clear test results boosted confidence</li> <li>Accountable through follow-ups &amp; visual explanations</li> <li>Preferred knowing their health risks and how to reduce them</li> </ul> <p><i>"I feel more confident. I'm not as worried as before, because I can control myself by checking sugars and blood pressure."</i> - Patient</p> <p><i>"I had to take time to explain things to me. In a usual short appointment you don't really get the chance to talk properly."</i> - Patient</p>	<h4>Behaviour Change &amp; Improvement</h4> <ul style="list-style-type: none"> <li>Patients took steps to track and improve their health</li> <li>Reported better blood pressure, blood sugar levels &amp; weight</li> <li>Staff noticed and reinforced positive changes</li> <li>Some patients shared new habits with family and friends</li> </ul> <p><i>"I was shocked I have been able to go below the sugar levels of a diabetic."</i> - Patient</p> <p><i>"I want to keep myself healthy. I don't want to be on lots of medication, my family depends on me, so it's important."</i> - Patient</p>	<h4>Key Enablers – Staff</h4> <ul style="list-style-type: none"> <li>Central team support and responsive clinicians</li> <li>Clear local operational processes (e.g. patient contact, scheduling and medication handling) supported delivery</li> <li>Role playing and shadowing were especially valued for building confidence and consistency</li> </ul> <p><i>"I think the support from the central team has been really excellent."</i> - GP</p>	<h4>Key Enablers – Patients</h4> <ul style="list-style-type: none"> <li>Longer consultations and follow-ups</li> <li>Use of test results and visual explanations (e.g. patient contact, scheduling and medication handling) supported delivery</li> <li>Personalised, actionable care plans</li> <li>Shared accountability and tailored advice supported motivation and behaviour change</li> </ul> <p><i>"When you see it in real time working for you, it really helps."</i> - Patient</p>
<h4>Staff Confidence, Knowledge &amp; Skills</h4> <ul style="list-style-type: none"> <li>Staff reported increased confidence delivering CRM clinics, particularly in health coaching and lifestyle conversations</li> <li>71% of staff (10 of 14) reported increased knowledge in co-morbidity prevention and management</li> <li>Shadowing and roleplay were identified as the most effective training formats, particularly for newer staff</li> <li>Training supported staff to navigate sensitive topics including weight, motivation, and medication hesitancy</li> </ul> <p><i>"The most valuable part was being able to shadow clinics and get one-to-one feedback - that's what I still use now."</i> - GP</p>	<h4>Professional Fulfillment &amp; Job Satisfaction</h4> <ul style="list-style-type: none"> <li>Many staff reported increased fulfillment from delivering holistic, preventative care</li> <li>57% of staff (8 of 14) reported increased or greatly increased job satisfaction</li> <li>CRM clinics were seen as more meaningful than task-based or generalist-specific reviews</li> </ul> <p><i>"Professionally, we've grown to look wider - not just diabetes, but kidney, cholesterol, cardiovascular health, sleep"</i> - Clinical Pharmacist</p> <p><i>"It is totally different to the usual consultations that we have. You are talking to them about the most important aspect of medicine."</i> - GP</p>	<h4>Integration, Collaboration &amp; System Working</h4> <ul style="list-style-type: none"> <li>Staff reported improved access to expertise across practices and PCNs, including renal consultants and pharmacists</li> <li>64% of staff (9 of 14) felt more able to access expertise outside their practice</li> <li>57% (8 of 14) gained greater awareness of local services for referral or signposting</li> <li>57% (8 of 14) felt more able to access expertise within their own practice</li> </ul> <p><i>"We've come together - we're all working together to make sure it runs smoothly"</i> - Clinical Pharmacist</p> <p><i>"Looking at the whole picture now, so our delivery of other services has improved."</i> - Clinical Pharmacist</p>	<h4>Key Challenges – Patients</h4> <ul style="list-style-type: none"> <li>Limited understanding of CRM and personal health risks</li> <li>Difficulty finding reliable health information independently</li> <li>Motivation and lack of accountability for some patients</li> <li>Time required to complete pre-appointment questionnaires</li> </ul>	<h4>Key Challenges – Staff</h4> <ul style="list-style-type: none"> <li>Some declines and DNAs, often linked to limited understanding of appointment purpose</li> <li>Staff noted underpinning links to QOF targets</li> <li>Still a challenge to cover all components despite advanced consultation time</li> <li>Challenges in obtaining completed follow-up surveys, repeat blood/urine tests</li> </ul>
<h3>Summary</h3> <ul style="list-style-type: none"> <li>Patients had a positive experience of care.</li> <li>Appointments felt different from usual care.</li> <li>Patients valued more time, wider wellbeing discussion, and clear advice.</li> <li>Patients felt more confident, supported and looked after.</li> <li>Behaviour change was reported by patients and clinicians.</li> <li>Clinicians felt confident running CRM clinics.</li> <li>Clinicians reported improved knowledge and skills.</li> <li>Shadowing and role-play were helpful for learning.</li> <li>CRM clinics were valued by both patients and clinicians.</li> </ul>				

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

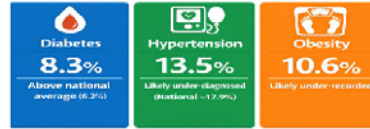
## Results from the Harrow CRM Project

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### Introduction

- Cardio-renal-metabolic (CRM) syndrome is a entity 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.

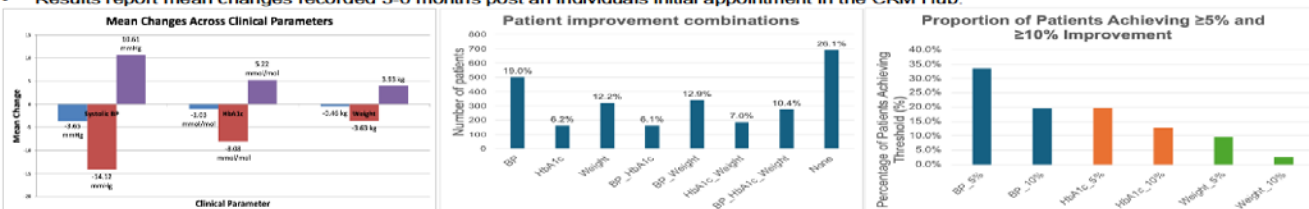


#### Cardio-Renal-Metabolic (CRM) Care Pathway



### 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**