

CRM Training Programme — Summary

Cardiac · Renal · Metabolic · Liver | MASLD · NDH · T2DM · CKD · Heart Failure

Proactive & Prevention	Follow-up & Continuity	Personalised Care	Integrated Neighbourhood	Patient Empowerment
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What this programme covers

This training equips HCAs, practice nurses, and allied health professionals to deliver proactive, personalised, integrated CRM care — identifying risk early, empowering patients to own their health, and working as part of the neighbourhood team.

- Cardiac, renal, metabolic and liver disease — managed together
- MASLD (Metabolic dysfunction-associated steatotic liver disease)
- Non-Diabetic Hyperglycaemia (NDH / pre-diabetes) and prevention of T2DM
- Personalised care planning co-produced with the patient
- Motivational interviewing and patient empowerment
- Blood test interpretation including LFTs and FIB-4 scoring
- UACR and eGFR kidney function — staging and action
- Rebuilding trust and the neighbourhood relational model
- Social prescribing, NHS DPP, and community connection
- Coaching, team development, and CPD for all roles

For:
 HCAs · Practice Nurses · Dietitians
 Physiotherapists · Podiatrists · OTs
 Paramedics · Pharmacists · PAs · MH practitioners

The five guiding principles

Proactive & Prevention
 Identify risk early. Act before crises. Recall, screen, and intervene proactively. In liver disease, early changes are reversible — but only if found.

Follow-up & Continuity
 Long-term conditions need long-term relationships. Follow up every result, referral, and agreed goal. Named clinician. Consistent face.

Personalised Care
 The patient's goals—in their own words — drive the care plan. Co-produced, taken home, and revisited at every contact.

Integrated Neighbourhood
 Work as part of the neighbourhood team: GP, nurse, HCA, AHPs, SPLW, care coordinator, pharmacist, voluntary sector — all connected around the patient.

Patient Empowerment
 Build knowledge, confidence, and self-efficacy. An empowered patient manages better, attends less urgently, and lives better.

The four pillars of CRM

<p>Cardiac Heart failure · IHD · AF Hypertension Manage BP, lipids, and cardiac medications. Co-exists with CKD, T2DM, and liver disease.</p>	<p>Renal CKD stages 1–5 · AKI risk eGFR + UACR annual review ACEi/ARB in proteinuria. Drug dose review in CKD. Monitor potassium.</p>	<p>Metabolic T2DM · NDH · Obesity Dyslipidaemia NDH: NDPP referral. T2DM: HbA1c 53–58 target. Lifestyle first.</p>	<p>Liver / Hepatic MASLD · MASH · Fibrosis ALD · Cirrhosis LFTs + FIB-4 at every CRM review in at-risk patients. Lifestyle reverses early disease.</p>
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CRM Training Programme — At a Glance | Cardiac · Renal · Metabolic · Liver | HCAs, Nurses & Allied Health Professionals

The 9 modules — what each one covers

<p>M1 Foundations</p> <ul style="list-style-type: none"> • 4 pillars: cardiac, renal, metabolic, liver • HCA, nurse & AHP competency tables • Proactive vs reactive model • The CRM interconnected web 	<p>M2 CarePlanning</p> <ul style="list-style-type: none"> • 'What matters to you?' conversation • 3-part care planning model • SMART goals co-produced with patient • Continuity at every contact point 	<p>M3 MotivationalInterviewing</p> <ul style="list-style-type: none"> • 4 MI processes: engage, focus, evoke, plan • OARS skills in practice • Scripts for clinical scenarios • Empowerment as a 12-month journey
<p>M4 BloodTests</p> <ul style="list-style-type: none"> • Full CRM panel inc. LFTs • HbA1c: NDH range 42–47 mmol/mol • FIB-4 formula and thresholds • Proactive follow-up by result type 	<p>M5 Liver&MASLD</p> <ul style="list-style-type: none"> • Liver's 8 metabolic functions • MASLD, MASH, ALD — full spectrum • NDH, pre-diabetes and liver risk • FIB-4 + NDPP referral • Treatment: lifestyle, GLP-1, SGLT2i 	<p>M6 UACR&eGFR</p> <ul style="list-style-type: none"> • CKD G1–G5 staging and actions • UACR categories A1–A3 • Liver-kidney connection in CRM • UACR sample collection guidance
<p>M7 RebuildingTrust</p> <ul style="list-style-type: none"> • Why trust was lost • Neighbourhood relational model • Transactional vs relational care • Equity, culture, and inclusion 	<p>M8 SocialPrescribing</p> <ul style="list-style-type: none"> • Warm referral 4-step pathway • Full integrated neighbourhood team • NHS Diabetes Prevention Programme • Community asset directory 	<p>M9 Coaching&CPD</p> <ul style="list-style-type: none"> • GROW framework for all roles • Multi-professional team debrief • AHP-specific CPD resources • Clinician wellbeing support

Key clinical thresholds at a glance

<p>HbA1c < 42 mmol/mol Normal 42–47 mmol/mol NDPP ≥ 48 mmol/mol Target in T2DM</p>	<p>FIB-4 (liver fibrosis risk) < 1.30 Low risk—recheck in 1–3 yrs 1.30–2.67 Indeterminate — enhanced assessment > 2.67 High risk — hepatology referral Formula Age × AST ÷ (Platelets × √ALT)</p>	<p>eGFR & UACR eGFR G3a < 60 Optimise BP, glucose, meds eGFR G4 < 30 Nephrology referral UACR A2: 3–30 ACEi/ARB; recheck 3–6 mths UACR A3: > 30 Intensify; consider referral</p>
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The patient is the most important member of the care team. We work with people — not on them. Every interaction is an opportunity to build trust, share knowledge, and help someone take ownership of their own health.

