Harrow Network Partners Ltd

NWL 3Ps Event

London Kidney Network

Harrow Cardio-Renal-Metabolic (CRM) Hammersmith and Fulham Event

Dr Kuldhir Johal

Dr Madhvi Joshi

Rashida Rahman

Wednesday 11th February 2026

Slides will be shared

Harrow CRM – London Renal 3Ps Transformation Programme

▪ Our Delivery model	▪ Dr Kuldhir Johal
▪ Eligibility criteria, e.g. Patient cohorts	▪ Dr Kuldhir Johal
▪ CRM Pathway…	▪ Dr Kuldhir Johal
▪ Personalised Care Approach	▪ Dr Madhvi Joshi
▪ The Evidence…	▪ Dr Madhvi Joshi
▪ CRM Learning and Sharing	▪ Dr Madhvi Joshi
▪ CRM Data Metrics	▪ Dr Kuldhir Johal
▪ Impact evaluation…	▪ Dr Kuldhir Johal
▪ “Excitement and Inspiration”	▪ Dr Kuldhir Johal

Harrow CRM Model

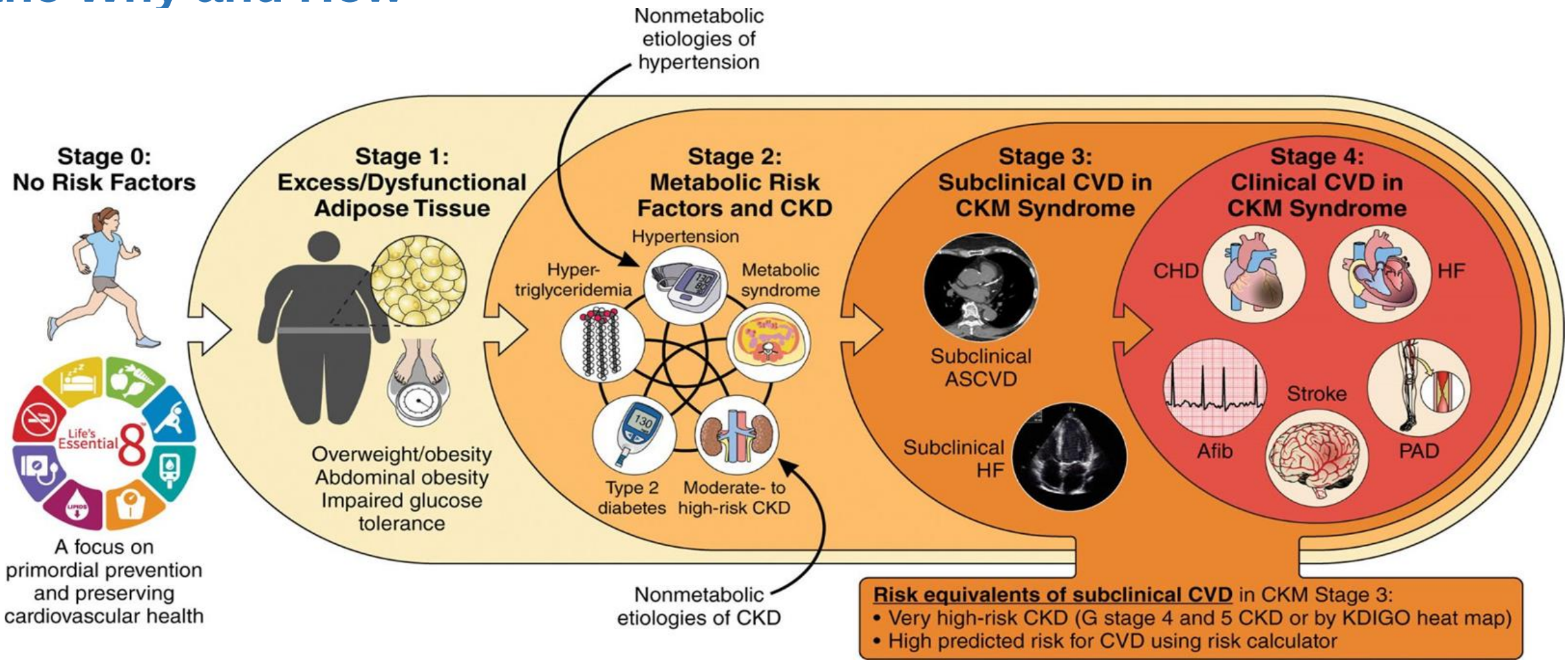
Aims of the programme:

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

Metrics:

- 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.

CRM delivery model – Understanding the Why and How



Getting started …

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
- Understanding the data currently available
- 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-assessement template, clinical template, patient lifestyle leaflet, systems quality searches and alignment to CVD prevent/LKN CKD parameters

Impact evaluation…

The Harrow CRM Pilot is establishing:-

- ✓ **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.

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				

Eligibility criteria:- CRM Patient Cohorts in Detail

CRM Patient Identification
Clinical metrics
Asset Map

EMIS CRM Population Report

Harrow Population Age: 20-80 207,660

Patient COHORT 1: Obesity 50212

Ethnic Min.	65932 32%
OBESITY (BMI 27.5)	25556 39%

- HTN 8020 31% → NO DM & CVD 4452 56%
- HTN 8020 31% → NO DM 4728 59% → HC 924 20%
- HTN 8020 31% → NO DM 4728 59% → No HC 3804 80%
- NDH 5516 22%
- CKD 1-5 840 3%

Ethnic Other	141724 68%
OBESITY (BMI 30)	24656 17%

- CKD 1-5 764 3%
- NDH 2960 12% → NO DM 3364 62% → No HC 2976 88%
- NDH 2960 12% → NO DM 3364 62% → HC 388 12%
- HTN 5448 22% → NO DM & CVD 3568 65%

OBESITY (BMI 27.5-30) | HTN | NO DM | NO HC | 6780

Harrow Population Age: 20-80 207,660

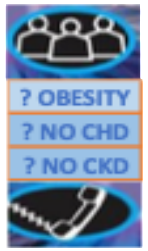
3%

14%

OBESITY (BMI 27.5-30)

Patient COHORT 2: Diabetes 24,642

- DM / CVD 3208 14% → NO CKD 3196 99.6%
- DM / CKD 1-5 108 0.5% → NO CHD 92 0.4%
- DM / OBESITY 8776 39% → YES CHD 1008 11% → YES CKD 712 9%
- DM / OBESITY 8776 39% → YES CHD 1008 11% → NO CKD 7056 91%
- DM / OBESITY 8776 39% → NO CHD 7768 89%



- ES Diabetes Level 1 QOF Diabetes
- ES Diabetes (NDH) QOF NDH
- ES Diabetes (EOT2D)
- ES Diabetes (MDT)
- ES Hypertension QOF Hypertension
- ES Ambulatory Blood Pressure Monitoring (ABPM)
- ES Atrial Fibrilation (AF) QOF Atrial Fibrilation (AF)
- ES ECG @ GP Practice
- QOF Secondary prevention of coronary heart disease (CHD)
- QOF Stroke and TIA (STIA)
- QOF Cholesterol control and lipid management (CHOL)
- ES Chronic Kidney Disease (CKD) QOF Chronic Kidney Disease
- NHS Health Checks
- NHS Weight Management
- Effective Resource Management (ERM) INT*

Harrow CRM Pathway

Patient Identification

- Find pts to invite to CRM using the CRM folder searches for Cohort 1 or 2.
- (Cohort 1 have Obesity & either NDH/ hypertension/ CKD. Cohort 2 have Obesity + Diabetes).
- 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

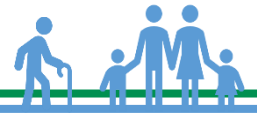
- Prescribing clinician to review health & recent metrics (QRISK/Heart Age/ KFRE/ Fib4 if relevant)
- Review/ optimize medications – explore barriers/ side effects.
- Apply NWL ICS CRM template & co-create Lifestyle Care plan with patient
- Signpost to sign up to MyHealth London/ Know Diabetes/ NDPP
- Consider referral to IAPT / Slimming World/ 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, send CRM post-clinic questionnaire and seek feedback via AccuRx.
- Follow up appointment with HCA to repeat metrics and then follow up in CRM clinic with clinician.

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



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	
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 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

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 - Alc Smok
- Referrals + GP F/U
- Patient Goals and Audit

Lifestyle Care Plan

WEBDUM

11-May-2025	
My Results	
Target	Asia All o

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
... NDH register	112	16%	23-Jun-2025	Patient	
... Obesity register					
... recorded BMI					
... recorded BP					
... statin					
... on RAASi					
... recorded Heart age					
... recorded QRISK 2/3 Score					

... recorded BMI

Details | Definition | Age / Sex | Trend | Population Included | Population Excluded

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

Warning: The results are now out of date as the parent results have chan

Organisation	NPC	Population Count	Parent
Elliott Hall Medical Centre	E84061	83	83
GP Direct	E84058	68	68
HATCH END MEDICAL CENTRE	E84053	13	13
ST. PETER'S MEDICAL CENTRE	E84693	60	60
Streatfield Health Centre	E84018	67	67
The Northwick Surgery	E84044	55	55
Sphere Primary Care Network	Y07626	321	342

Name	Population Count	%	Last Run	Search Type	Schedule
... recorded BP	401	58%	23-Jun-2025	Patient	

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

Details | Definition | Age / Sex | Trend | Population Included | Population Excluded

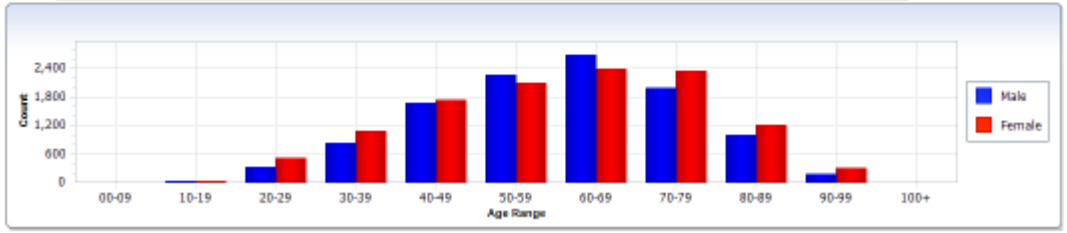
Last Run 24-Jun-2025 09:16 Relative Date 24-Jun-2025 09:11

Organisation	NPC	Population Count	Parent	%	Excluded	Status
Elliott Hall Medical Centre	E84061	4210	9218	46%	5008	Completed
GP Direct	E84058	8041	20189	40%	12148	Completed
HATCH END MEDICAL CENTRE	E84053	1249	2755	45%	1506	Completed
Sphere Primary Care Network	Y07626	538	7028	8%	6490	Completed
ST. PETER'S MEDICAL CENTRE	E84693	2471	7837	32%	5366	Completed
Streatfield Health Centre	E84018	2983	6376	47%	3393	Completed
The Northwick Surgery	E84044	3137	9101	34%	5964	Completed
Total		**22629**	**62504**	**36%**	39875	

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)



Personalised Care

"What matters to you most?"

"What would help you achieve better health?

"What gets in the way?"

"What's a normal day like for you?"

- A way of '**seeing people**' as **whole person**

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 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 Management:
Pillars of lifestyle medicine

At the core of the CRM Management approach are evidence-based lifestyle interventions that address the root causes of cardiometabolic conditions.
These six interconnected pillars form the foundation of our comprehensive lifestyle medicine strategy.

These pillars work synergistically within the CRM pathway, with interventions tailored based on individual assessment results. Patients are empowered to select priority areas for change, supported by appropriate clinical resources and behaviour change techniques to build sustainable healthy habits.

Eat

Predominantly whole food, plant-based diet emphasising nutrient density and appropriate caloric intake. Personalized nutritional plans consider cultural preferences and specific metabolic needs.

Avoidance of Harmful Substances

Support for reducing or eliminating tobacco, excessive alcohol, and other substances with negative cardiometabolic effects.

Connect

Fostering meaningful relationships and community engagement. Group-based interventions and peer support to enhance treatment adherence and outcomes.

Move

Regular movement combining cardiovascular exercise, strength training, and flexibility work. Tailored to individual capability and gradually increased to meet recommended guidelines.

Sleep

Optimising sleep duration and quality through evidence-based sleep hygiene practices. Addressing sleep disorders that impact cardiometabolic health.

Relax

Techniques to reduce psychological stress including mindfulness, meditation, and cognitive behavioral approaches. Focus on building resilience against chronic stressors.

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

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."*

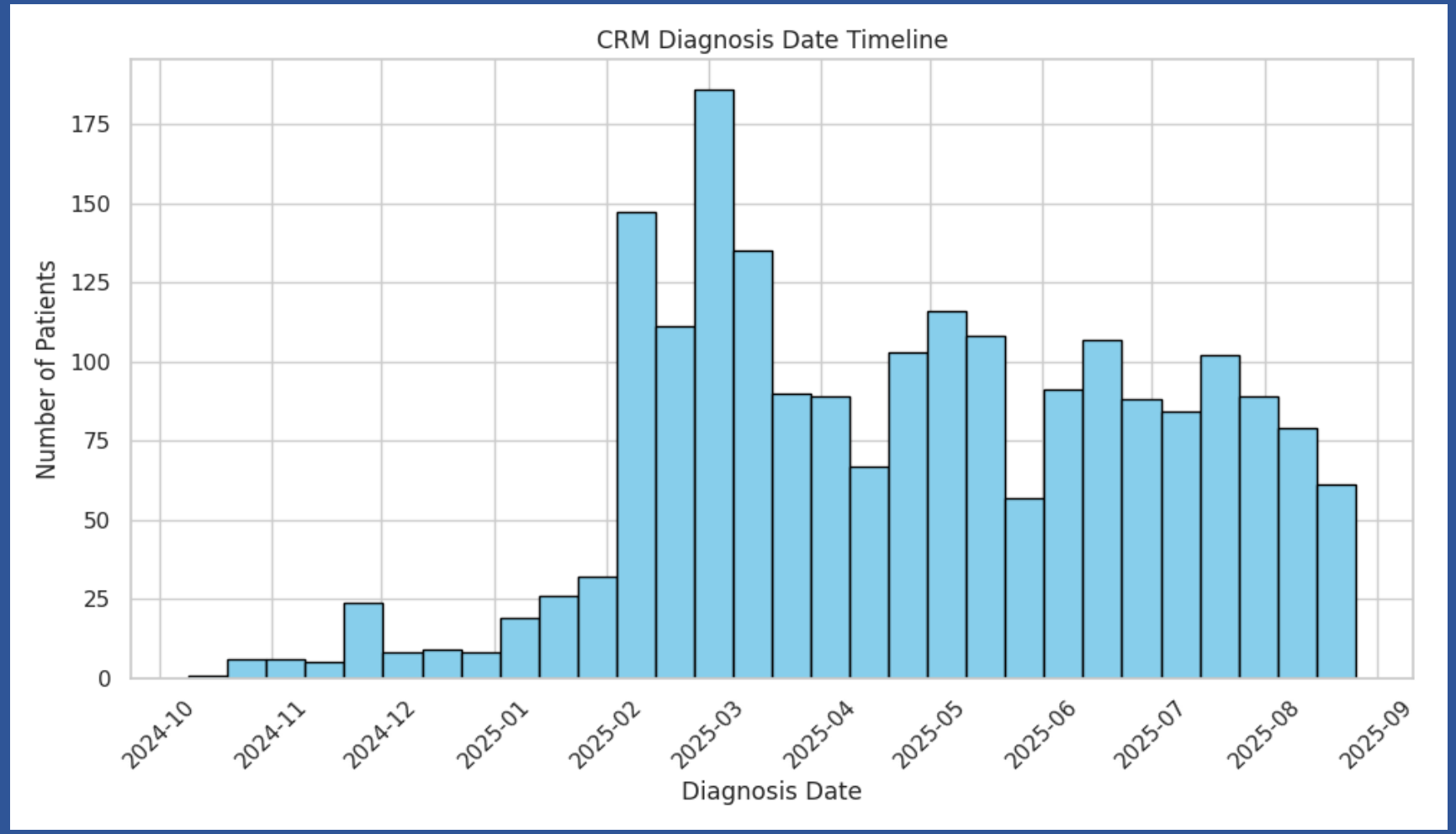
*"When it comes to talking about heart conditions my view is 'if it happens it happens'. **If I really get ill that's my fault for not listening**, but I feel healthy and I was given a list of walks."*

*"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"*

CRM Diagnosis Date Timeline

DRAFT

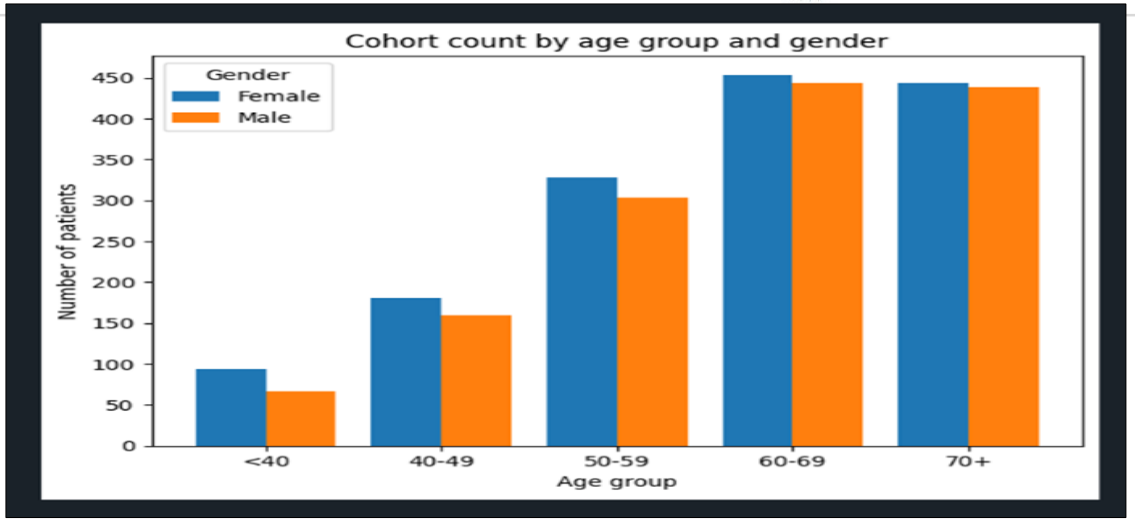


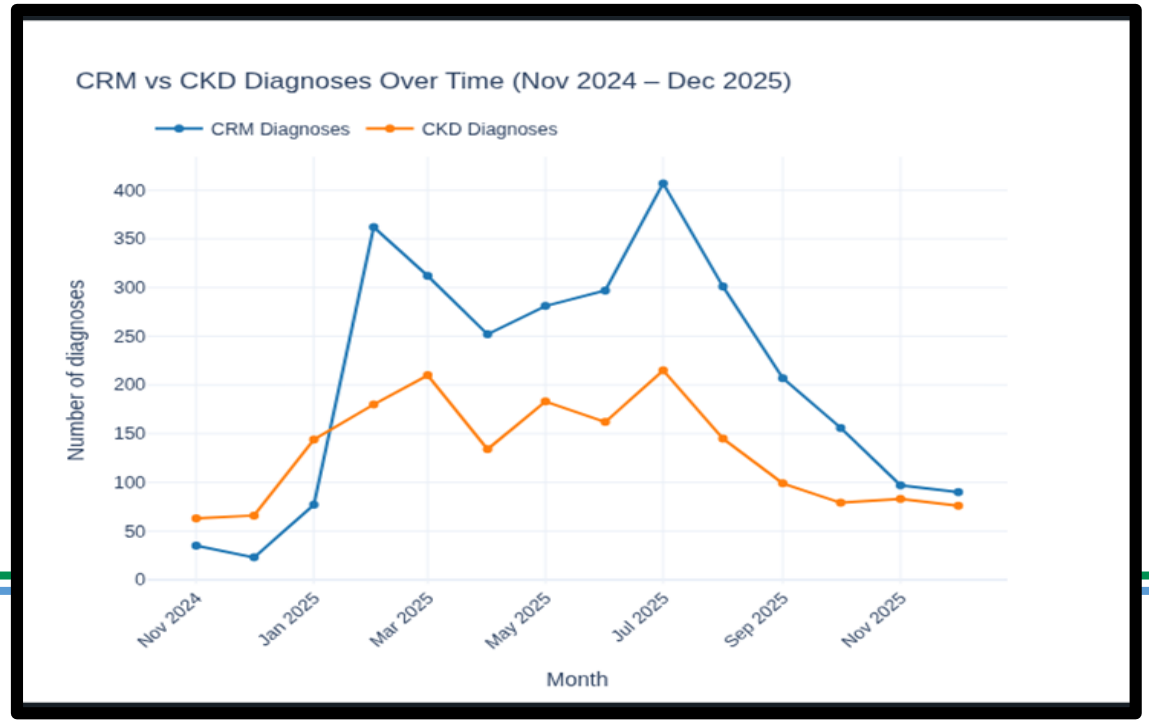
Update on data to Dec 2025

CRM/CKD diagnosis:-

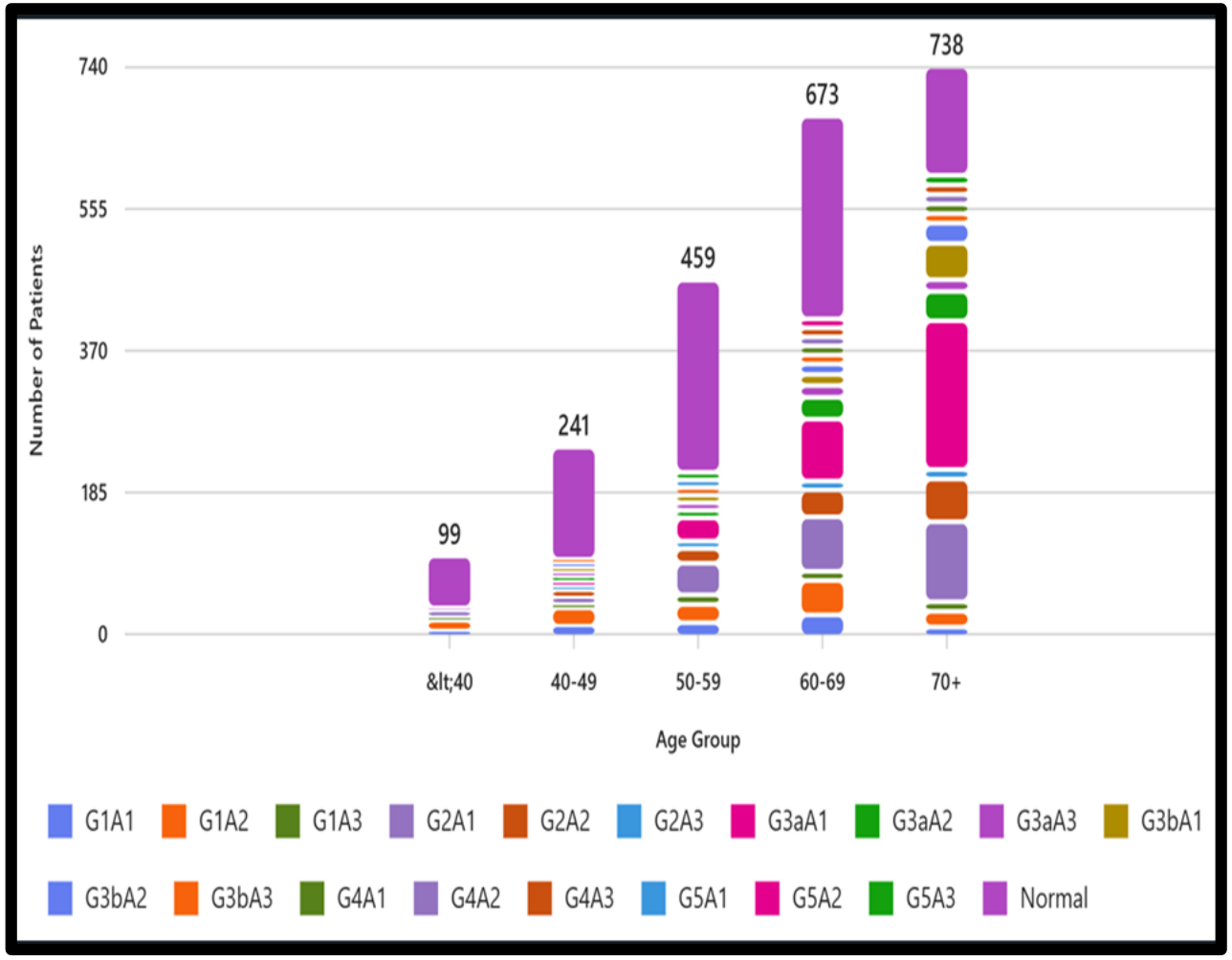
- **Total number of patients: 2,914**
- **Average age: 61.56 years**
- **Gender distribution:**
- **Female: 1,501**
- **Male: 1,413**
- **CKD status recorded in around 75% of this cohort**

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)



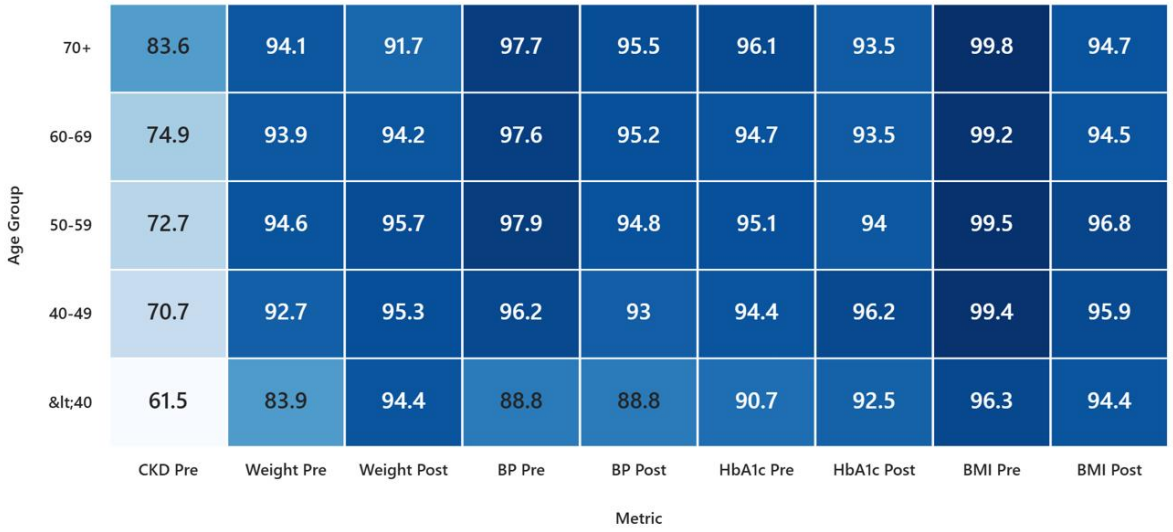
CKD status	<40	40-49	50-59	60-69	70+
Normal	77	180	308	315	162
G5A3	0	0	1	0	5
G5A2	0	0	0	1	0
G5A1	0	0	1	0	0
G4A3	0	0	0	2	7
G4A2	0	0	0	1	5
G4A1	0	0	0	2	1
G3bA3	0	1	3	6	6
G3bA2	0	1	0	9	24
G3bA1	0	2	2	10	49
G3aA3	1	1	2	11	11
G3aA2	0	3	4	27	38
G3aA1	0	2	30	91	224
G2A3	0	1	3	3	5
G2A2	0	6	16	35	59
G2A1	5	6	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%)**

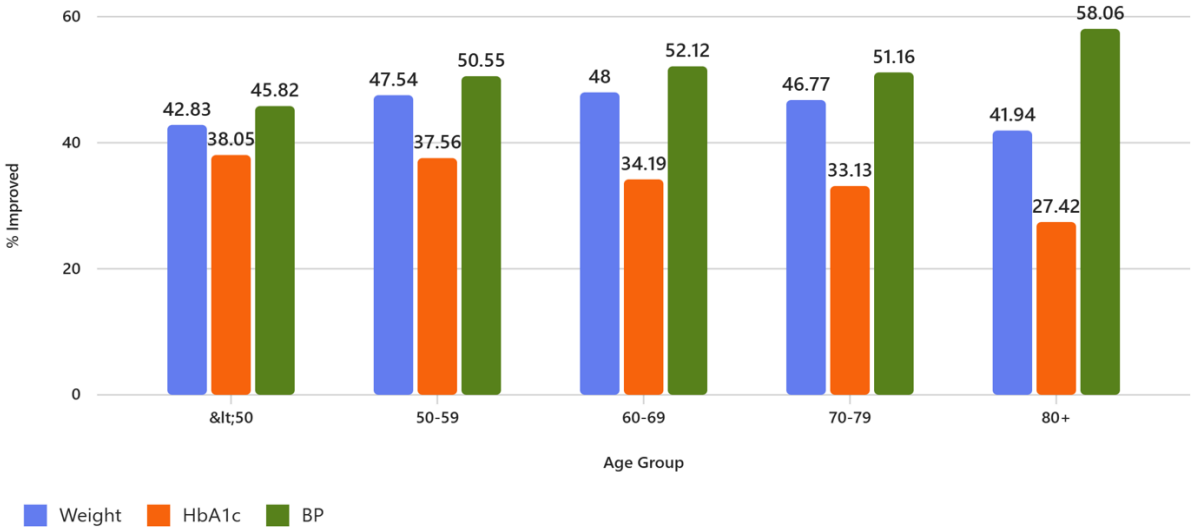
Measure *Whole-cohort results (paired samples only)	**N paired**	**Mean pre**	**Mean post**	**Mean change (post−pre)**	**95% CI**	**p-value**	**Sig.**
BP	2,687	132.11	128.92	**−3.18**	−3.77 to −2.60	4.71×10^{-26}	***
Weight (kg)	2,571	84.98	83.95	**−1.03 kg**	−1.22 to −0.84	5.04×10^{-26}	***
HbA1c (mmol/mol)	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

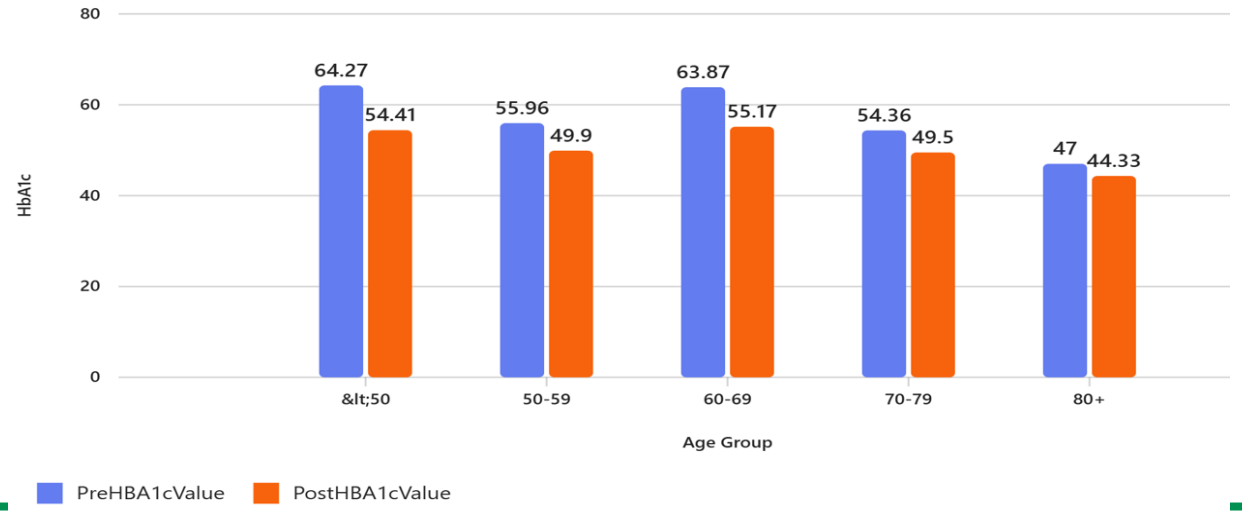
Practice	N pts	gible ANY (pre+po	Pct ≥10% ANY	Pct ≥5% ANY	N ≥10% ANY	N ≥5% ANY	SBP mean (improve	HbA1c mean (improve	Weight mean kg (improve
Enderley Road Medical Centre	98	97	45.4%	63.9%	44	62	-9.56	-7.61	-2.10
First Choice Medical Care	9	9	44.4%	77.8%	4	7	-0.11	-3.00	-1.14
Kenton Bridge Medical Centre 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	78	25.6%	48.7%	20	38	-3.35	-1.00	-2.12
THE SHAFTESBURY MEDICAL CENTRE	114	108	25.0%	44.4%	27	48	-7.86	-1.03	-1.12
Streatfield Health Centre	91	90	24.4%	35.6%	22	32	-1.39	-1.27	-2.10
ROXBOURNE MEDICAL CENTRE	62	62	24.2%	35.5%	15	22	-3.77	-1.05	-2.47
THE CIVIC MEDICAL CENTRE	13	13	23.1%	69.2%	3	9	3.50	-4.30	-2.50
Kings Road Medical Centre	88	85	21.2%	41.2%	18	35	-4.10	-1.89	-1.30
HATCH END MEDICAL CENTRE	16	15	20.0%	33.3%	3	5	-1.67	0.83	-2.38
KENTON CLINIC	87	87	18.4%	41.4%	16	36	-7.37	0.51	-0.71

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 cardiometabolic measure – check slide

Total patients with improvement in at least one parameter:

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

Breakdown by parameter (individual improvements):

- **Weight: ~2126 patients improved**
- **HbA1c: ~2132 patients improved**
- **BP: ~2179 patients improved**

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…

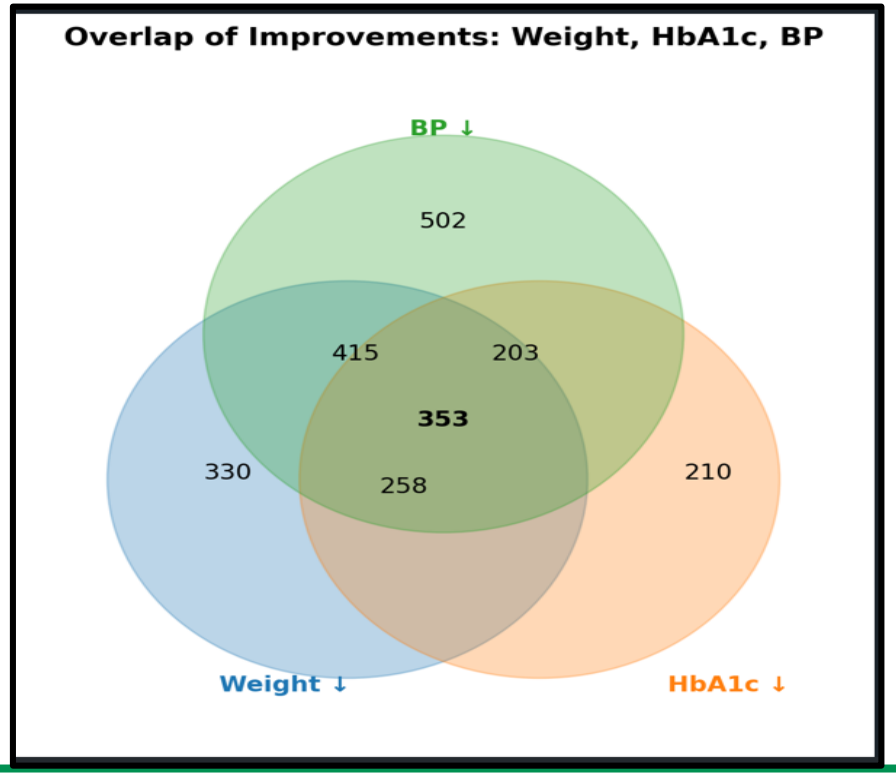
≥5% threshold

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

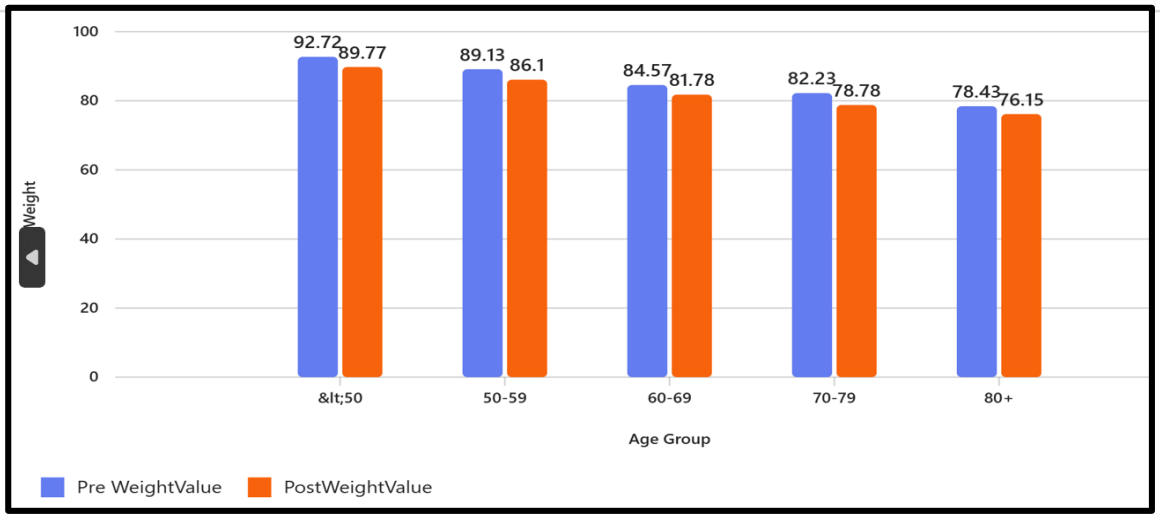
≥10% threshold

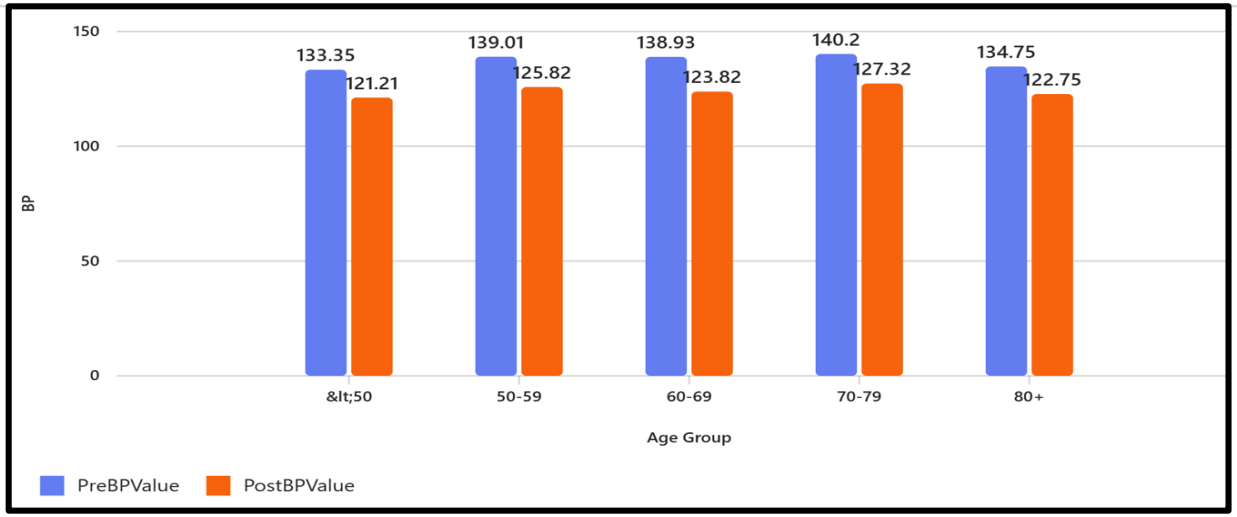
- **Exactly 1 metric: 779 patients**
- **Exactly 2 metrics: 117 patients**
- **All 3 metrics: 24 patients**

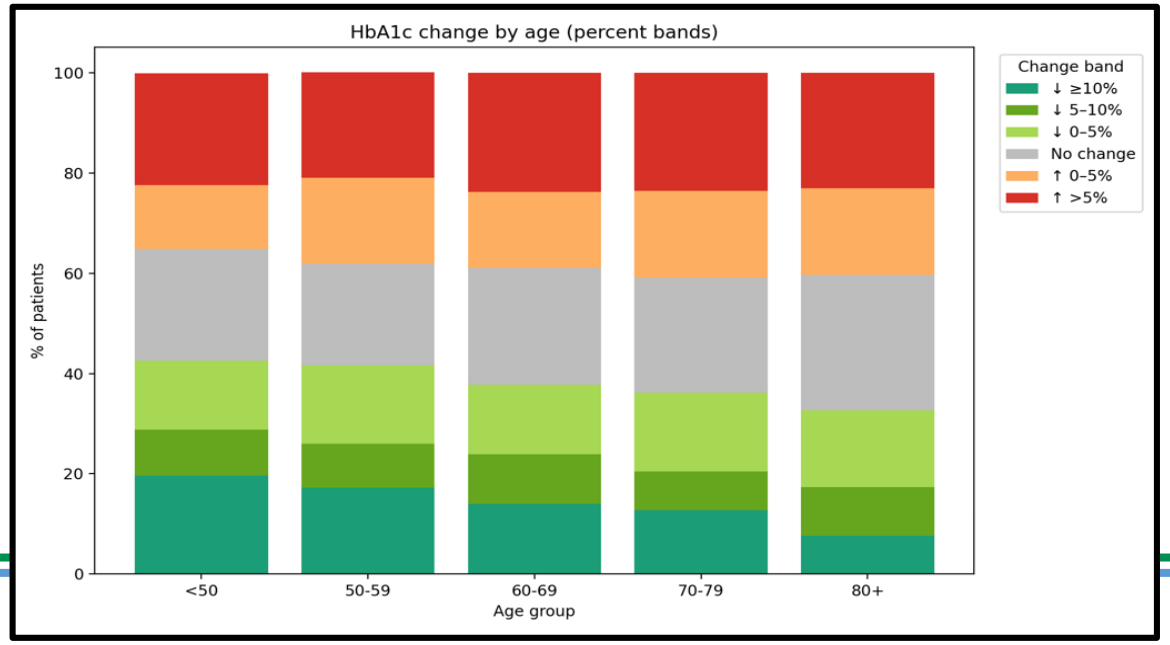
- Statistically significant improvements were noted in patients with CKD status
- Improvements across all age groups

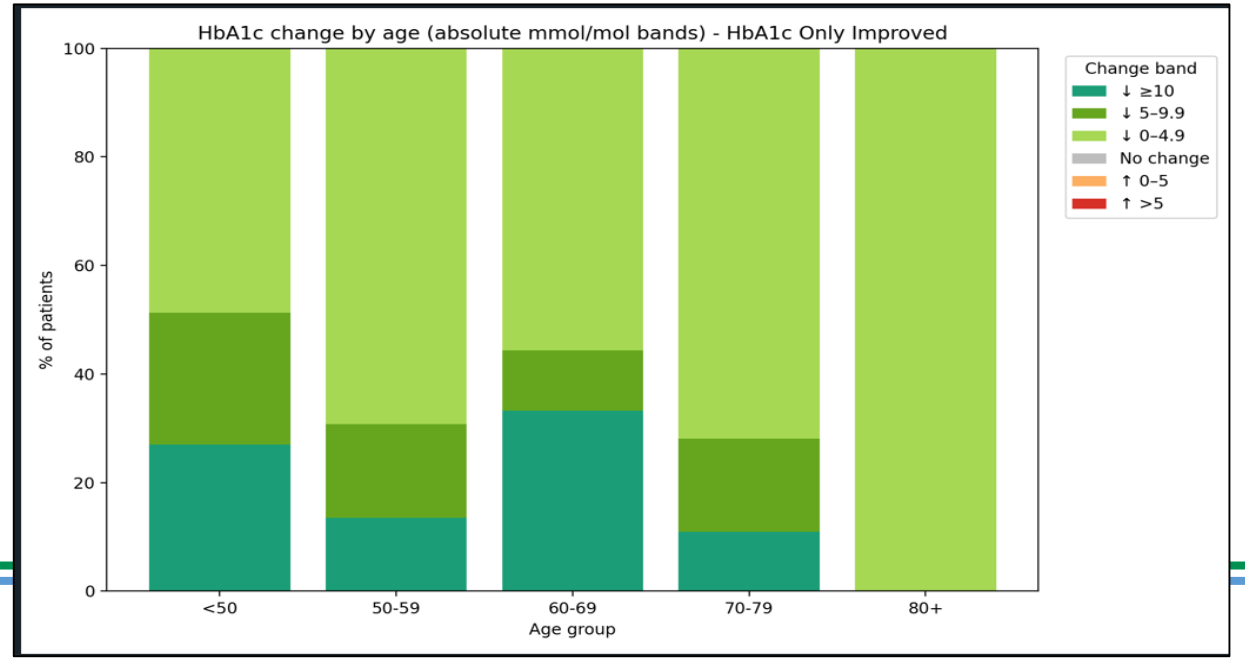


Additional information…









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

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

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

Outputs:

- ✓ Structured educational framework on CRM
- ✓ Structured programme on personalised care
- ✓ 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:

- ✓ Enhanced understanding of CKD stage 0-4
- ✓ Improved CKD screening and initiate earlier interventions
- ✓ Improved screening and early identification of early liver disease
- ✓ over 70% of the suggested cohort of patients have been seen by Month 3 of the programme
- ✓ Increased referrals to aligned services eg weight management – but also enhanced support to those who have declined

“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
- **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 as well as personalised care.
- **Sustainability** – Continued evolution of looking at incorporating as a single offer for Primary care in NWL

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 80% 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?

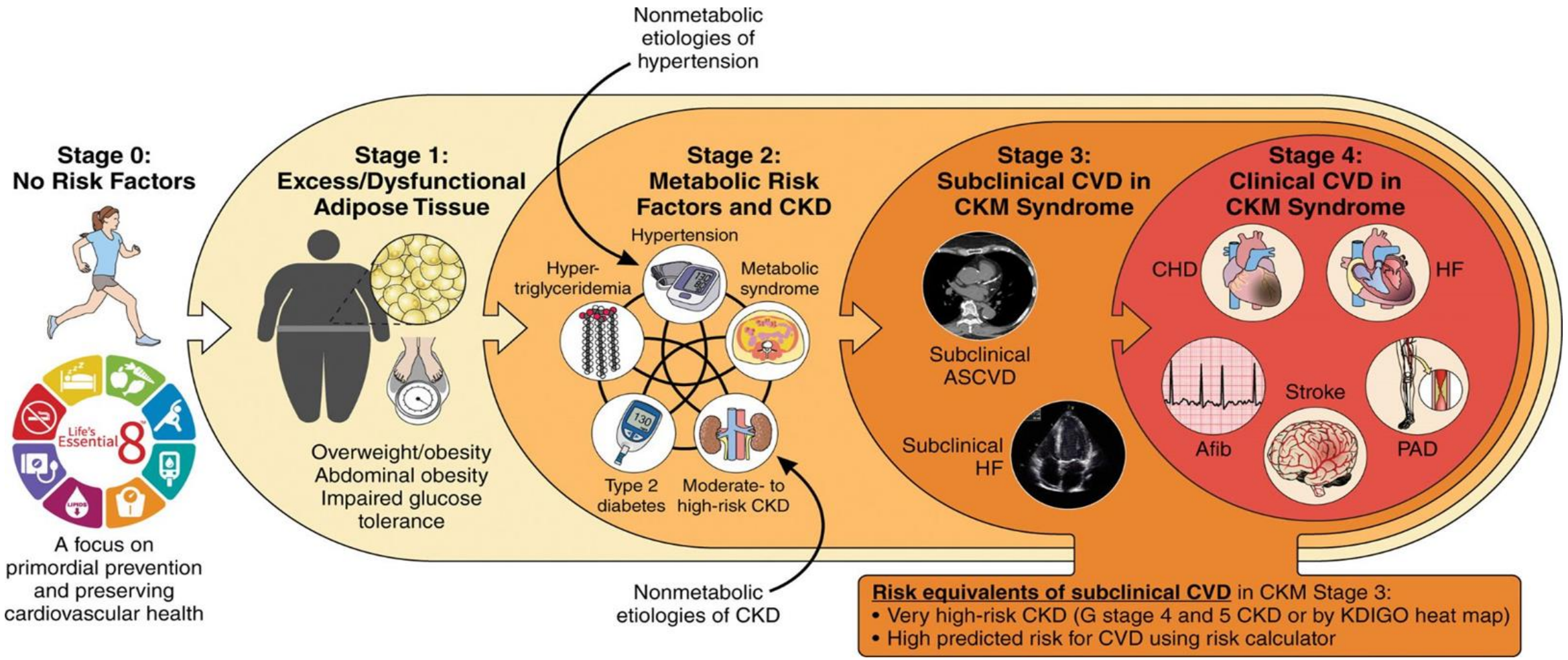
Proposed CRM Service Specification – Overview – 2026/2027

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
- **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.

CRM delivery model



Importance of Risk Factors – reduce BP, Cholest, 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

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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Multidisciplinary Collaboration
Engage specialists for escalated care leveis

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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

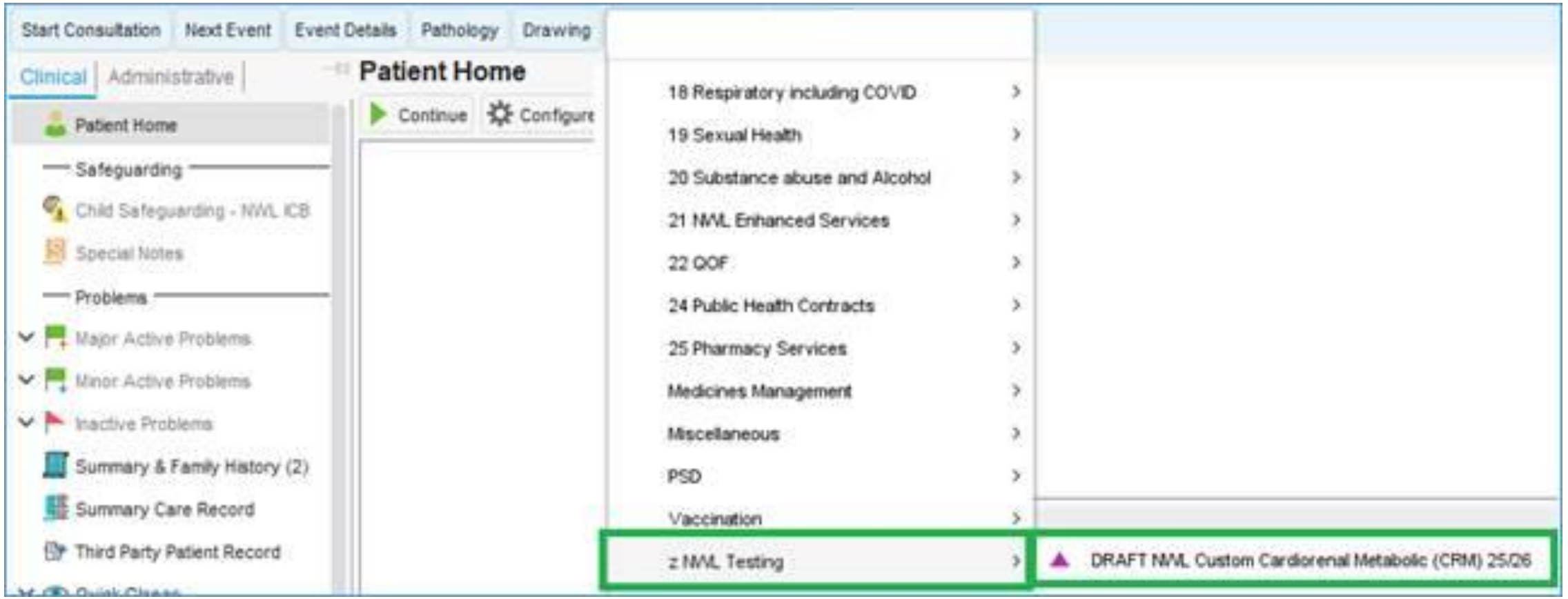
PATIENT IDENTIFICATION
- Patients identifjed via bespoke EMIS/S1 searches that go beyond existing search tools to identify có hort with muitiple risk factors at early stage of CRM risk
- Care coordinators use new patient script to invite pts – explaining CRM health and wellbeing appointment offer and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

Take away slides - S1 Clinical Template location



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

Case 1 Mr X 61 M Indian

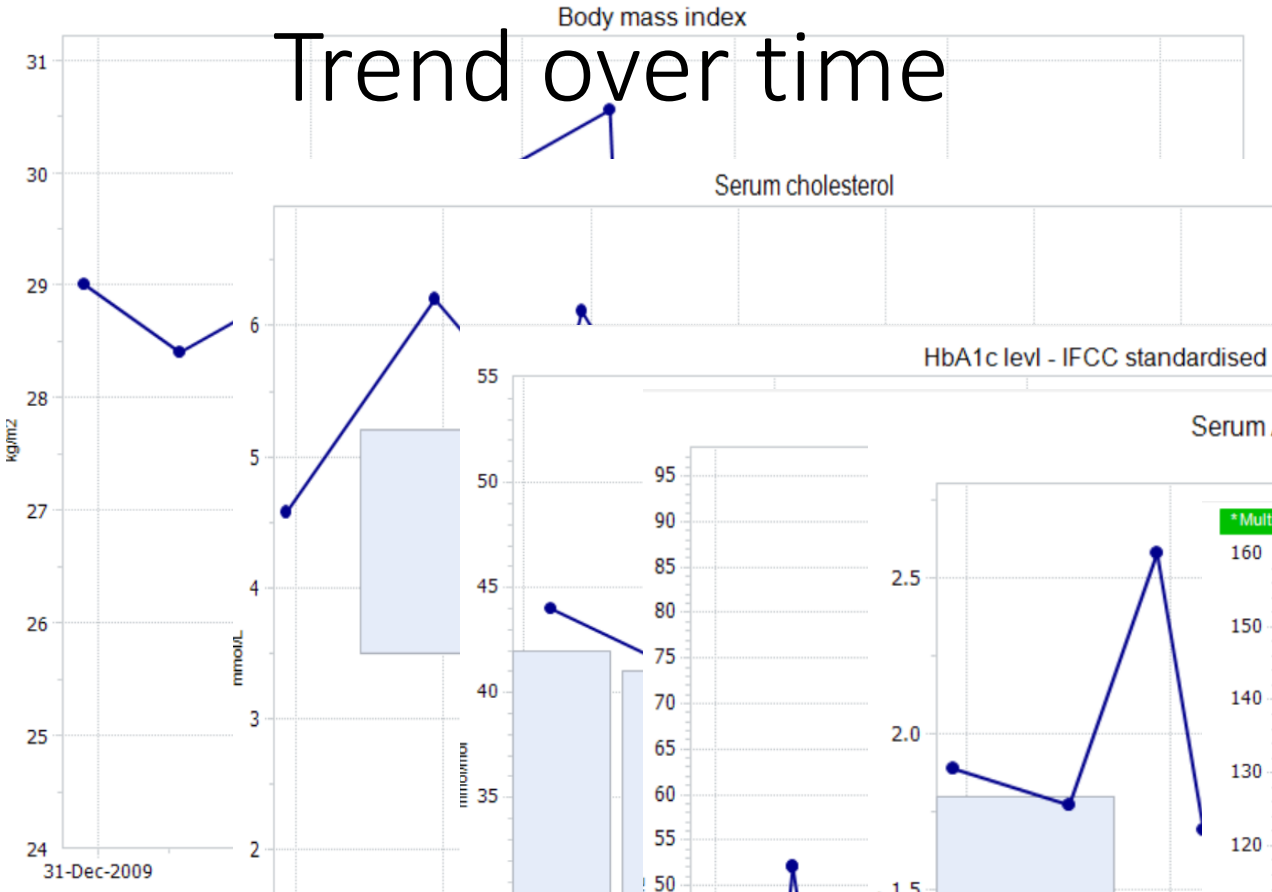
July 2025

- US – Fibrosis stage 3
- 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 Stage 0 – 4 – all interrelated and influence each other
- Went from being NDH to T2DM

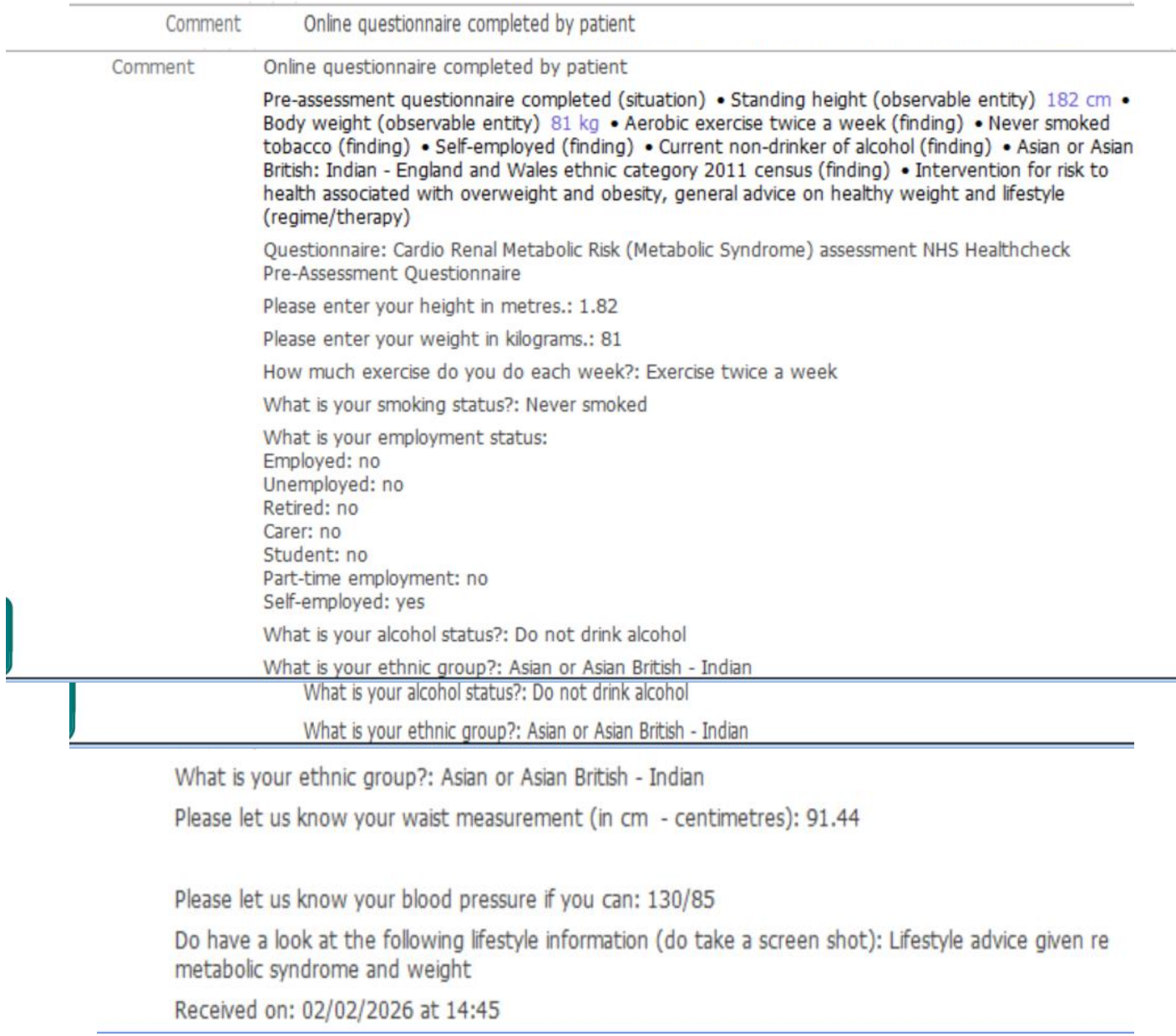
Trend over time



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



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

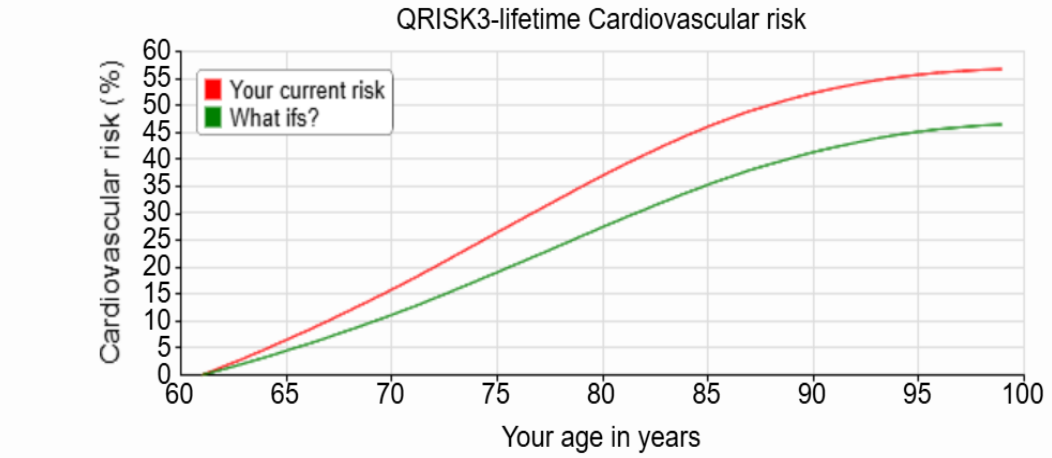
Received on: 02/02/2026 at 14:45

Qrisk Lifetime – has reduced risk by 14%

Where he was starting from….

Your QRISK3-lifetime score

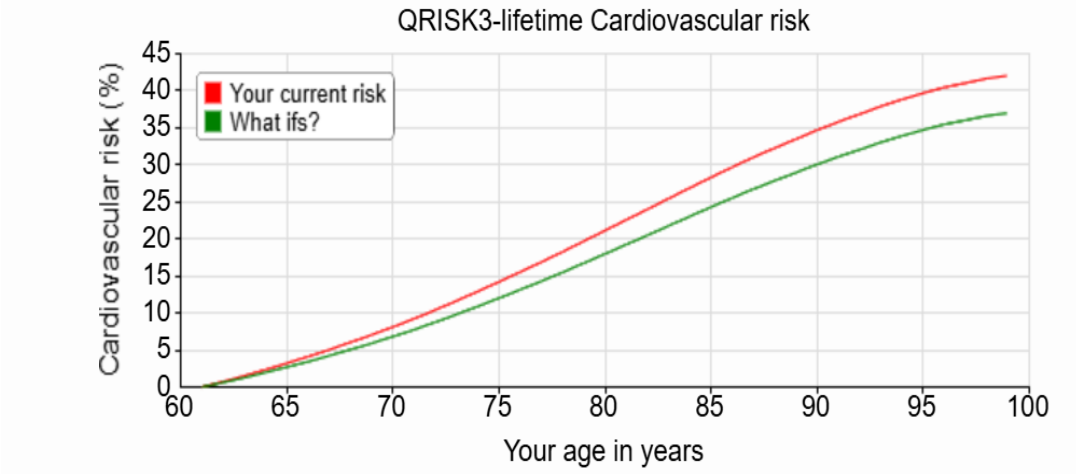
	Current	What if?
Your lifetime risk (i.e. by the time you are 99)	56.7%	46.5%



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

Your QRISK3-lifetime score

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



Case 2 – Mrs Z 85 F White look back over time

	1990	1995	2000	2005	2010	2015	2020	2025	2026
Diagnosis	Hypertension		T2DM	CKD3	CKD3aA2 (Bendrofluazide)			AF, HF	
Medication	Amlodipine		Atorvastatin, ACEI		Losartan			Insulin, Digoxin, Apixaban, Frusemide, Bisoprolol, Empa	
Stage	2	2	2	3	3	3	3	4	4
Age	50	55	60	65	70	75	80	85	86
BP Systolic			145	159	147	190	134	135	123
BP Diastolic			95	98	85	98	67	85	61
BMI			36.4	38.6	37.5	40.4	41.6	42.1	33
Weight			99	109	103	110	108	91	84
Height	159	159	159	159	159	159	159	159	
FH IHD<60	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
HbA1C					49.7	90	64	85	
eGFR							50	40	43
uACR					26.8	50.7	26.6	66	15.1
Total Chol			6.34	7.15	5.5	4.86	3.79	4	
Triglycerides			2.92	2.76	1.57	2.23	2.16	2.1	
LDL			3.64	2.53	3.2	2.5	2.1	2.1	
HDL			1.37	1.23	1	1.24	1.18	1.1	
QRISK2						46%	57.80%		
Smoker	Yes	Yes	Yes	Yes	Yes	No	No	No	No
Heart age - NHS calculator			95	95	95	95	95	95	
Age to which they live without heart attack or stroke			72	70	74	79	83	87	
Difference - years			12	5	4	4	3	2	
QRISK3			30.90%	48.20%	35.80%	48.80%	40.20%	61.30%	
QRISK3HeartAge			83						

Thank You