

The Power of Personalised Care

Helping people achieve better health outcomes



CRM Training _ H&F

Dr Madhvi Joshi



GP Lifestyle Medicine/ Obesity

PCI Certified Health Coach

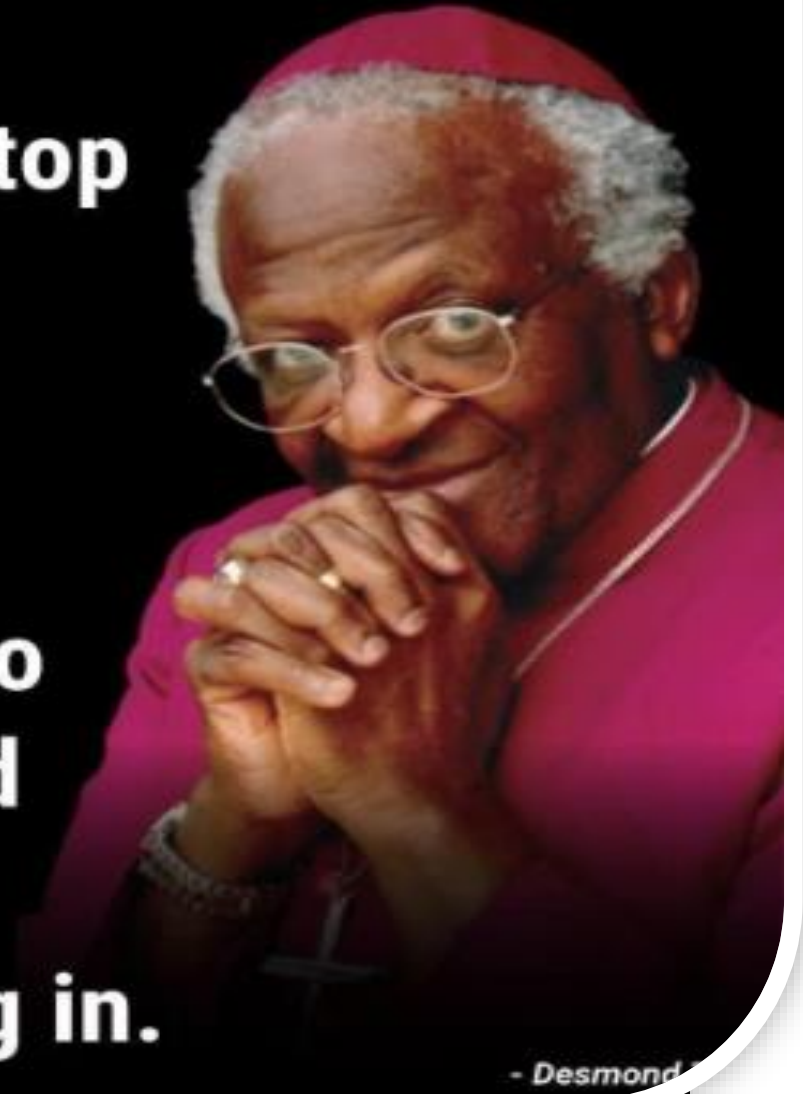


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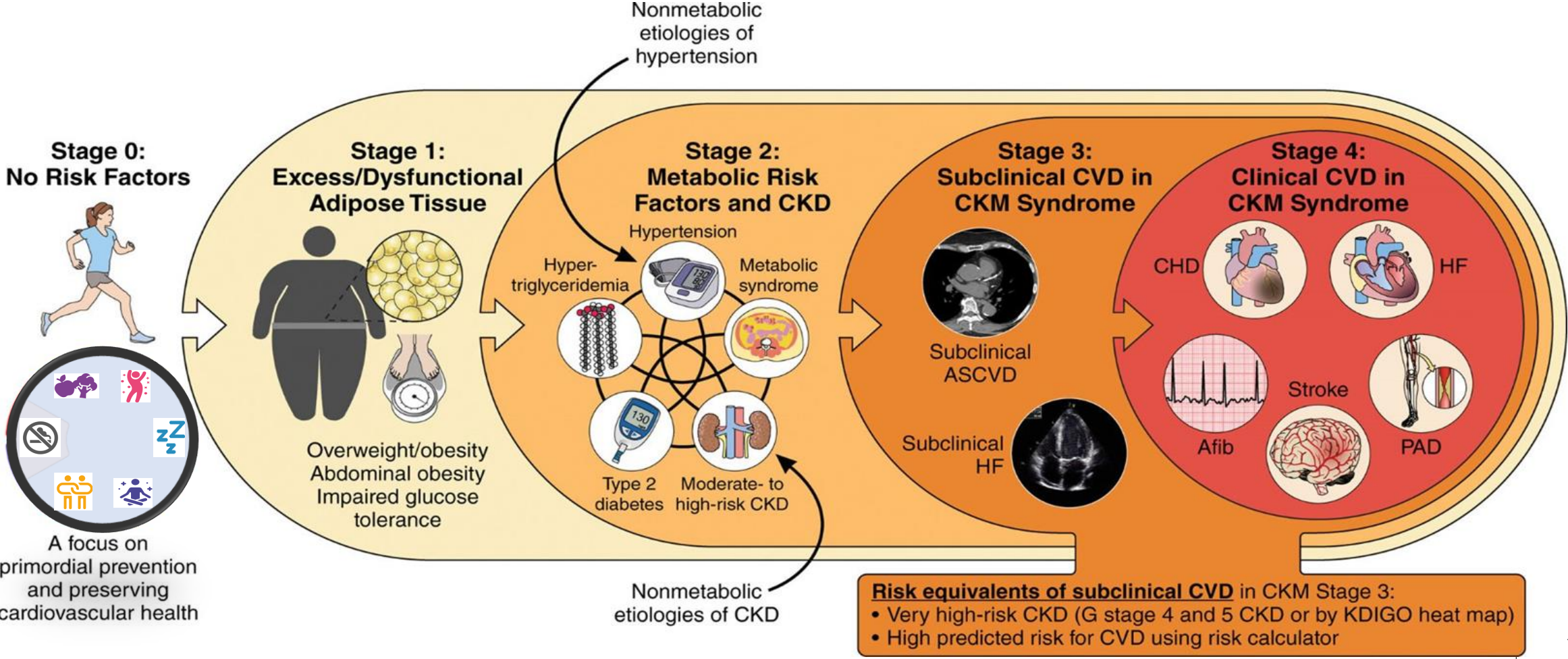
**We need to stop
just pulling
people out
of the river.**

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



- Desmond

Cardio-Renal-Metabolic spectrum - recap



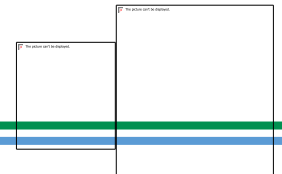
What's missing ?



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

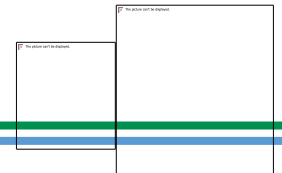


Duration & quality: sleep hygiene.
Recognise & manage sleep disorders

Relax



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



Turn & Talk: table activity

5 mins

"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

All patients benefit from care navigators to co-ordinate across different settings.

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

Patients offered an extended length appointment 20-30 mins with CRM clinician + Personalised Care Plan

CRM clinic 1st Appointment

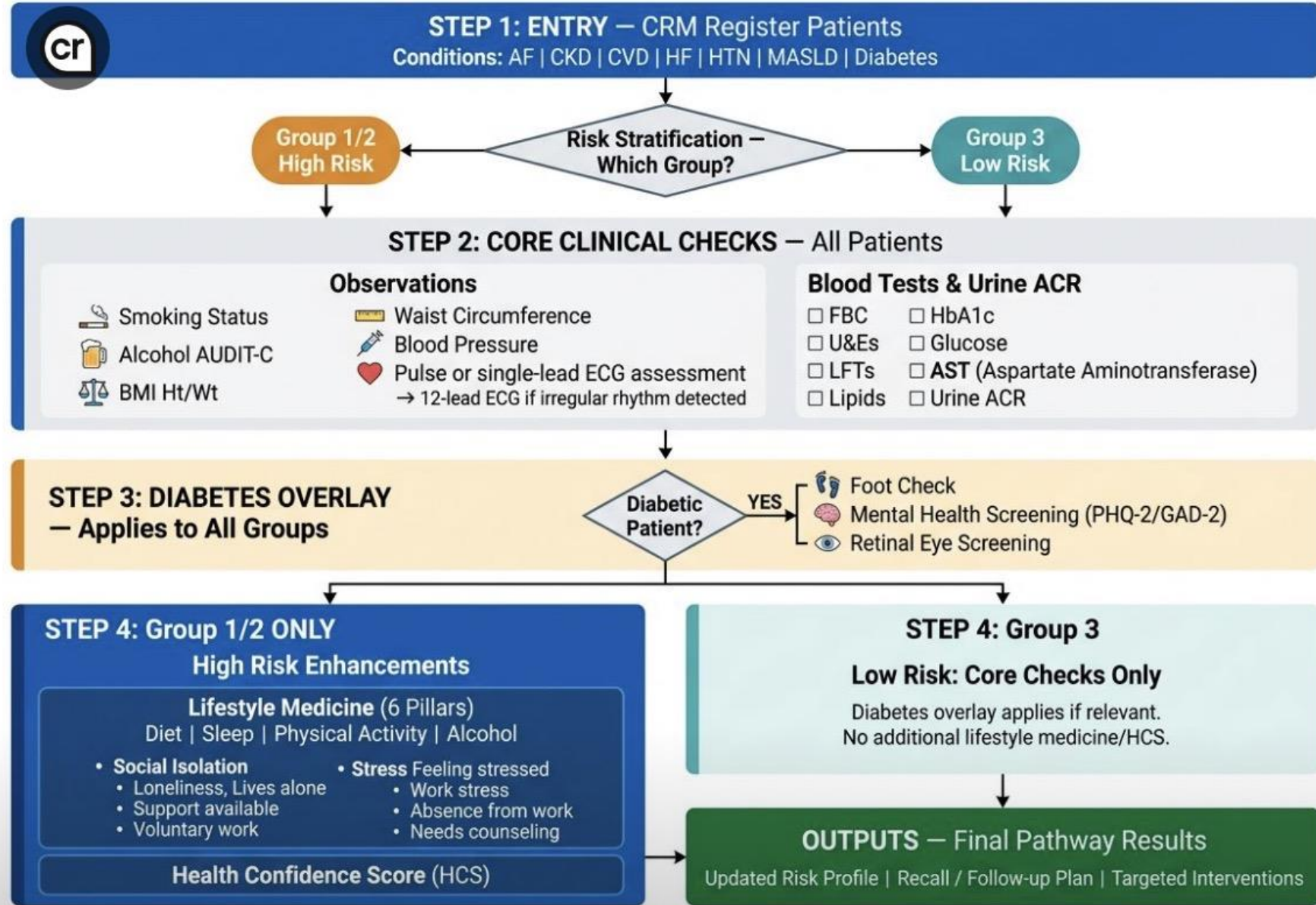
- Clinician review :metrics (QRISK/Heart Age/ KFRE/ Fib4) + coding
- Review & optimize medication – any barriers, side effects?
- CRM template & Lifestyle Care plan
- Referrals to IAPT / SW/ physio/ social prescribing/ VCSO / Welfare Employment

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
- 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.	
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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: _____



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Alcohol; fatty liver

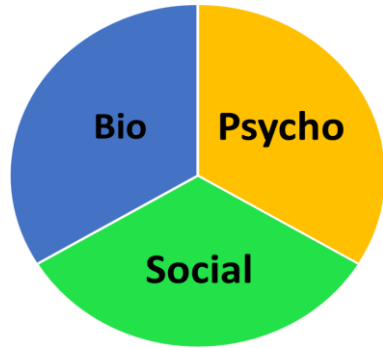
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Person-centered Care

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

“What matters to you most?”



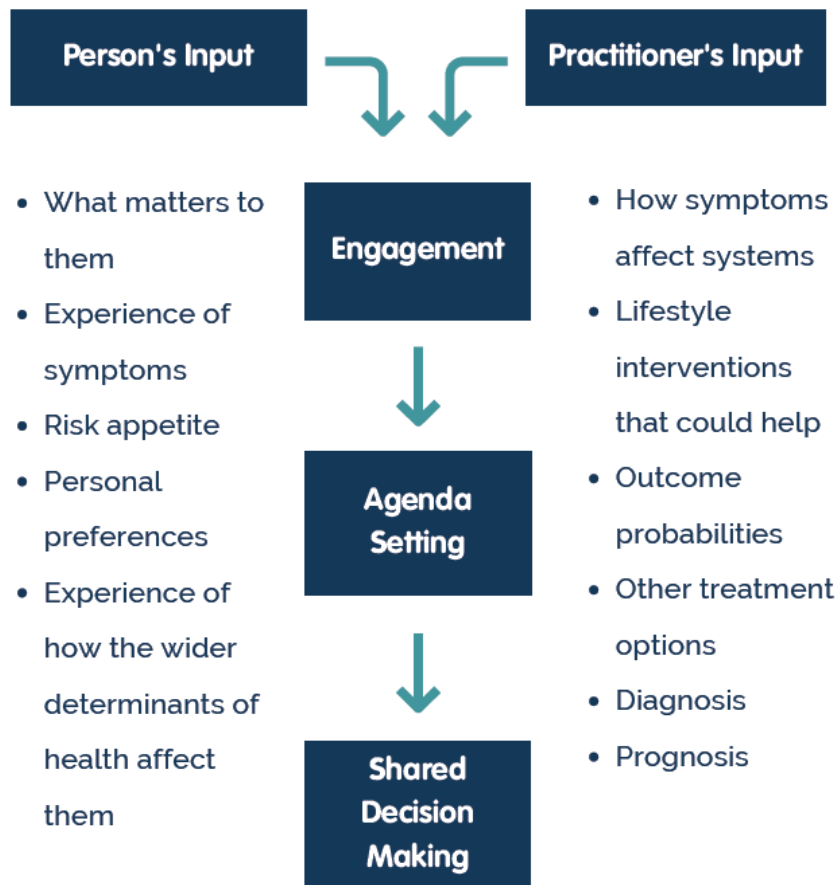
Seeing people as a **whole**

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



“Equal in importance, different in strengths, powerful together”

BMJ April 2026 Prof THHG Koh - Queensland

Write- Pair- Share – 5 mins

**“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 empowerment

Partnership working
Language matters !!!

- 5 A's :
ask, assess, advise, assist, arrange
- GROW model:
Goal setting
Right now/ reality...
Options
What will you now do?
- Conversation with your future self

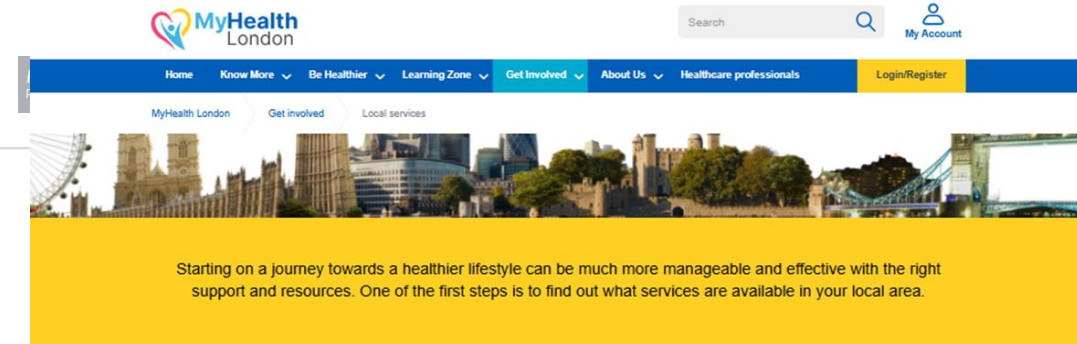


*People will forget what you said,
people will forget what you did,
but people will never forget*



how you made them feel.

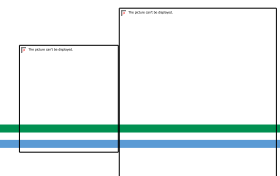
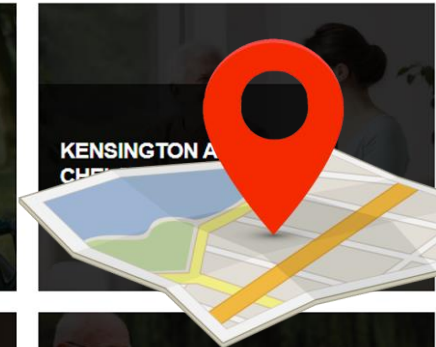
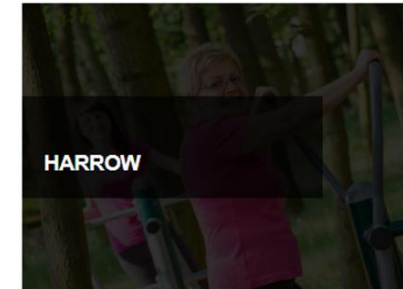
3 Things I learnt from CRM



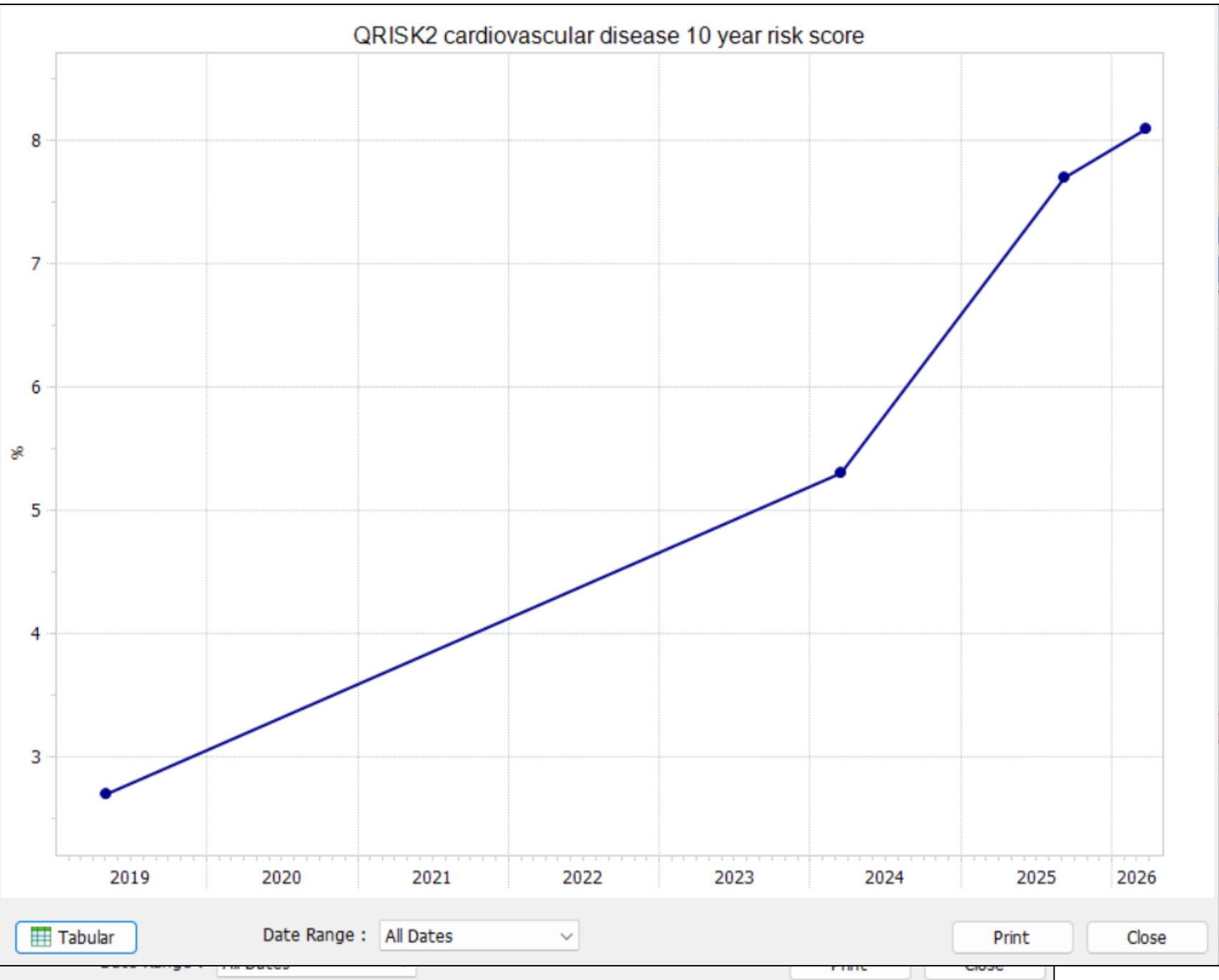
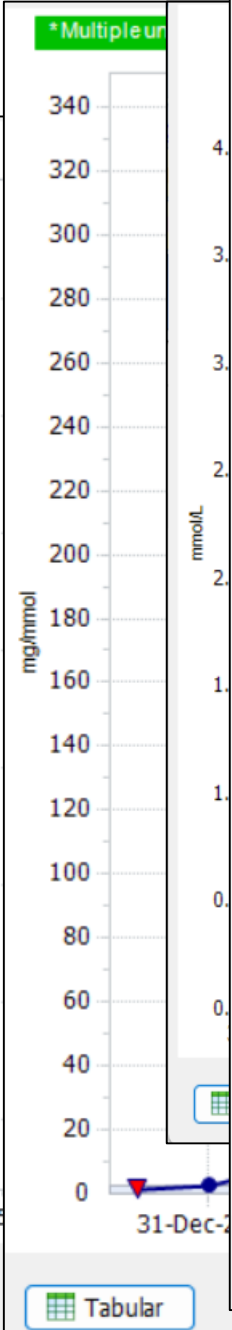
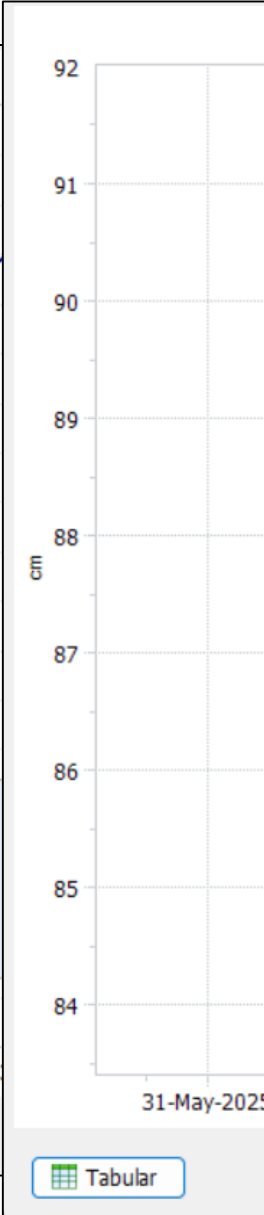
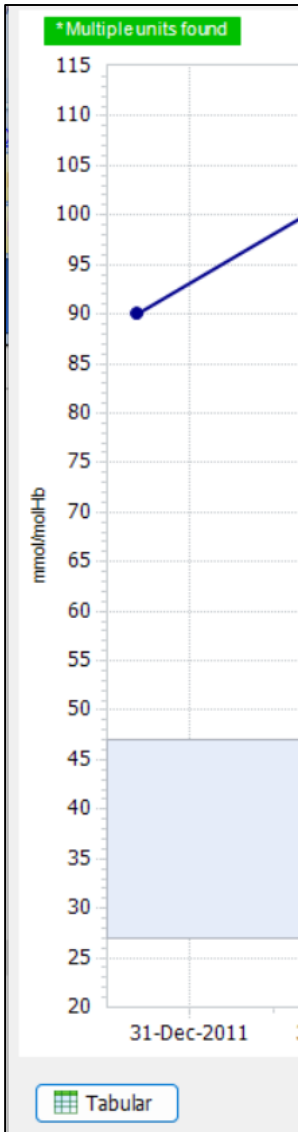
1. Prepare ahead – helps you & patient
(QRISK/Heart Age, KFRE, Fib4, HCS, use graphs !)

2. Talk less - listen++ (curiosity & compassion)
(Max impact with F2F. Language matters. File notes at end)

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: QRISK/ Heart Age / KFRE/ Fib4/ HCS



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

Thank you- do share your ideas!



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