

Cardio-Renal-Metabolic (CRM 2026-27)

Case Study 2 - Dr Kuldhir Johal

Group 1 (Highest risk CRM cohort) review *including response in pre-assessment questionnaire*

EMIS & SystmOne CRM Searches / Template / Care Plan - Presented by Matahir Jahn

CRM ES Clinical Searches – Presented by Tharshiya Packianathan

46 Year old M – Group 1

03-Mar-2026 08:33 Accurx Consultation JOHAL, Kuldhir (Dr)

Comment

Online questionnaire completed by patient

Pre-assessment questionnaire completed (situation) • Standing height (observable entity) 185 cm • Body weight (observable entity) 136.5 kg • Aerobic exercise once a week (finding) • Smoker (finding) • Employed (finding) • Current non-drinker of alcohol (finding) • White: English or Welsh or Scottish or Northern Irish or British - 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) • Family history of myocardial infarction in first degree relative less than 60 years (situation) • Family history: Myocardial infarct in first degree male relative less than 55 years (situation)

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

Please enter your height in metres.: 1.85

Please enter your weight in kilograms.: 21.5 stone which is 136.5 kg

How much exercise do you do each week?: Exercise once a week

What is your smoking status?: Current smoker

What is your employment status:

Employed: yes

Unemployed: no

Retired: no

Carer: no

Student: no

Part-time employment: no

Self-employed: no

What is your alcohol status?: Do not drink alcohol

What is your ethnic group?: White : English or Welsh or Scottish or Northern Irish or British

Please let us know your waist measurement (in cm - centimetres): 42inch

Please let us know your heart age - using the following calculator: 71

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



Is there a family history of any of the following?:

Family history of myocardial infarction (heart attack) in first degree relative less than 60 years (situation): yes
Family history of myocardial infarction (heart attack) in second degree relative less than 50 years (situation): no
Family history: Myocardial infarction (heart attack) at greater than 60 (situation): no
Family history: Myocardial infarction (heart attack) in first degree male relative less than 55 years (situation): yes
Family history of diabetes mellitus in first degree relative (situation): no
Family history: Hypertension (situation): no
Family history of cancer (situation): no
Family history of kidney disease (situation): no

Please kindly answer the following screening questions :

A and B Little interest or pleasure in doing things? Answer "Not at all" (Score 0) Feeling down, depressed or hopeless? Answer "Not at all" (Score 0): no
A. Little interest or pleasure in doing things? Answer "Several days" (Score 1): yes
A. Little interest or pleasure in doing things? Answer "More than half the days" (Score 2): no
A. Little interest or pleasure in doing things? Answer "Nearly every day" (Score 3): no
B. Feeling down, depressed or hopeless? Answer "Several days" (Score 1): no
B. Feeling down, depressed or hopeless? Answer "More than half the days" (Score 2): no
B. Feeling down, depressed or hopeless? Answer "Nearly every day" (Score 3): no
C. Feeling nervous anxious or on edge? Answer "Not at all" (Score 0): no
C. Feeling nervous anxious or on edge? Answer "Several days" (Score 1): no
C. Feeling nervous anxious or on edge? Answer "More than half the days" (Score 2): no
C. Feeling nervous anxious or on edge? Answer "Nearly every day" (Score 3): no
D. Not being able to stop or control worrying? Answer "Not at all" (Score 0): no
D. Not being able to stop or control worrying? Answer "Several days" (Score 1): no
D. Not being able to stop or control worrying? Answer "More than half the days" (Score 2): no
D. Not being able to stop or control worrying? Answer "Nearly every day" (Score 3): no

Health Confidence - How do you feel about caring for your health?:

A and B. I know enough about my health - Strongly agree (Score 3) I can look after my health - Strongly agree (Score 3): no
A. I know enough about my health - Agree (Score 2): no
A. I know enough about my health - Neutral (Score 1): yes
A. I know enough about my health - Disagree (Score 0): no
B. I can look after my health - Agree (Score 2): no
B. I can look after my health - Neutral (Score 1): no
B. I can look after my health - Neutral (Score 0): no
C. I can get the right help if I need it - Strongly agree (Score 3): no
C. I can get the right help if I need it - Agree (Score 2): no
C. I can get the right help if I need it - Neutral (Score 1): no
C. I can get the right help if I need it - Disagree (Score 0): no
D. I am involved in decisions about me - Strongly agree (Score 3): no
D. I am involved in decisions about me - Agree (Score 2): no

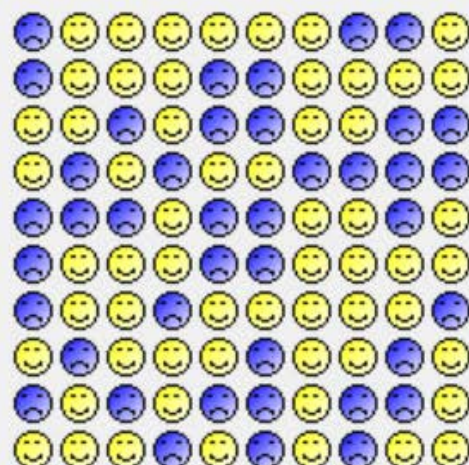
Trends





Risk of CVD in the next 10 years = 40.7%

For a 46y old Male in the UK, the average risk is 2.9%



**Risk of heart attack or
stroke**

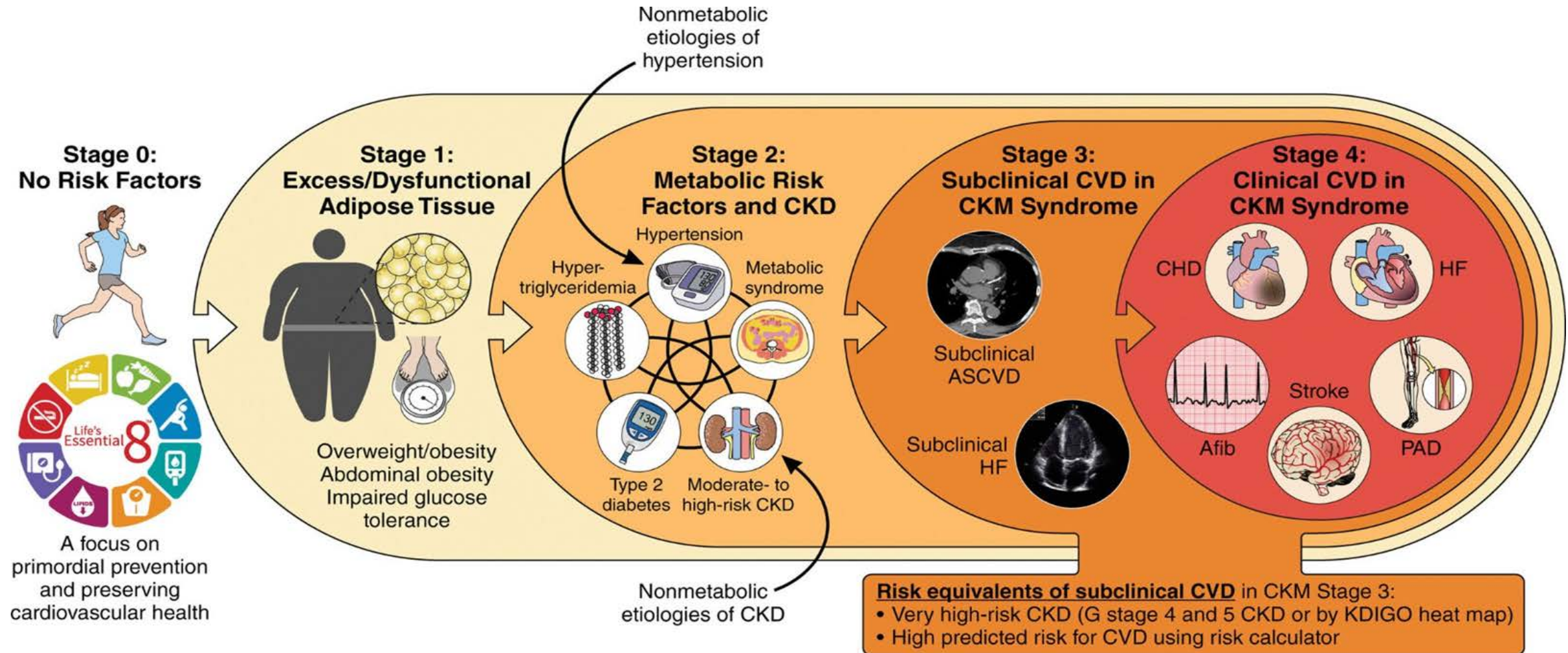
Data used to calculate the QRisk2 Score

Heart age : 83
Ethnicity : British
Smoking status : Light Smoker
Diabetes category : Type2
Systolic blood pressure : 147 mm Hg
Cholesterol / HDL ratio : 4.2 (estimated value)
BMI : 39.9 kg/m²
Postcode : UB8 3UG
Family history of CVD? : yes
Hypertensive on Rx? : yes
Atrial fibrillation? : no
Chronic kidney disease? : no
Rheumatoid arthritis? : no

Active Problems

A	Metabolic syndrome <i>(Significant)</i>	02-Mar-2026
B	Type 2 diabetes mellitus <i>(Significant)</i>	23-Jan-2026
C	Essential hypertension <i>(Significant)</i>	21-Jan-2026
D	Upper respiratory infection <i>(Minor)</i>	20-Aug-2025
E	Hypercholesterolaemia <i>(Significant)</i>	30-May-2017

CRM delivery model – Understanding the Why and How



Overview – NWL Single offer CRM element 2026 2027

- 1. Detection/Quality improvement
 - 20% - CRM01A, CRM01B, CRM01C, CRM01D, CRM01E – QOF registers
- 2. Consistency of approach across CRM interconnected/inter-related conditions
 - 20% CRM02
- 3. Clinical care optimisation – takes into account new medication guidelines for DM/CKD/Lipid/HF
 - 20% CRM03, CRM04, CRM05, CRM06
- 4. Holistic care - recognises the influence of lifestyle factors in patients lives and enabling behaviour change for both teams and patients
 - 40% CRM07, CRM08, CRM09

Combined NWL Single Offer pg 207 CRM01 – Detection (20% payment)/Quality improvement

Achievements are banded as follows:

KPI	NWL Target Thresholds	Financial Achievement
CRM01A: Identifying patients who likely have AF – screening (pulse rhythm or ECG).	62.5% ⁴¹	4%
CRM01B: Identifying patients who likely have CKD - diagnose and code appropriately.	86% ⁴²	4%
CRM01C: Identifying patients who likely have DM - diagnose and code appropriately.	80% ⁴³	4%
CRM01D: Identifying patients who likely have HTN - diagnose and code appropriately.	80% ⁴⁴	4%
CRM01E: Identifying patients who likely have NDH - diagnose and code appropriately.	80% ⁴⁵	4%

⁴¹ Current mean achievement across NWL for CRM01A is 49%, 75th centile 62.5%

⁴² Current mean achievement across NWL for CRM01B is 73%, 75th centile 86%

⁴³ Current mean achievement across NWL for CRM01C is 57%, 75th centile 67%

⁴⁴ Current mean achievement across NWL for CRM01D is 60%, 75th centile 79%

⁴⁵ Current mean achievement across NWL for CRM01E is 40%, 75th centile 41%

Key tips

- AF – Patients (all) on the whole CRM list – ensure pulse check and or ECG if clinically indicated – annual review – measure once
 - NDH/DM – check coding and annual review
 - CKD – continue with coding and review
 - HTN – check if on medications now or past/trends of BP and code – a number of these patients will be on the CRM register
- * Page 233-237 Appendix XII – PCN thresholds

Pg 208 CRM02 – Key care processes (20% payment) – consistency of approach

CRM02: % Patients on PCN registers for AF, CKD, CVD (including CVA/TIA, CHD, PAD), HF, HTN, MASLD*, NDH with completion of key care processes (BMI, BP, HbA1c, Lipids, <u>eGFR</u>, <u>uACR</u>, smoking, waist circumference) in last 15 months and FIB-4 in MASLD in last 39 months OR % Patients on PCN register for diabetes with completion of key care processes as above plus foot check and mental health <u>sc</u>) in last 15 months and retinal screening in past 27 months and FIB-4 in T2DM in last 39 months	50%	20%
---	-----	-----

CRM02 – Key points

- Eg AF etc case load 1000
- DM case load 400
- Total 1400 – target – 700
- Can be any mix from either group – leading to a total of 700
- Eg AF etc 600, DM 100
- Fib 4 – Practice data will reveal that >90% DM patients have had LFTs and AST around 10-17% - code the Fib4
- Also Fib4 - rolling over a 39 month period

Pg 208 *CRM03/CRM04/CRM05/CRM06 -

CRM03: % people on PCN registers for CKD, DM, HTN with BP ≤ 130/80 (≤ 150/90 in moderate / severe frailty and those aged >80)	52.5% ⁴⁶	5%
CRM04: % on PCN register with A) CKD, CVD (including CVA/TIA, CHD, PAD), DM, HF OR B) AF, HTN, MASLD* , NDH and QRISK > 10% on moderate/high intensity statins	60% ⁴⁷	5%
CRM05: % people on PCN CKD register with i) <u>uACR ≥ 30</u> OR ii) <u>diabetes and uACR ≥ 3</u> or <u>eGFR < 60</u> on ACEI/ARB	67% ⁴⁸	5%
CRM06: % patients on PCN register with i) <u>CKD and eGFR 20 to <45</u> OR ii) <u>CKD and uACR ≥ 22.6</u> and <u>eGFR 45-90</u> OR iii) T2DM on SGLT-2 OR iv) Heart Failure (excluding those with moderate/severe frailty or those aged >80)	50% ⁴⁹	5%

HTN – A 10mmHg reduction reduces cardiovascular risk by 20%

Statins – not just lowering cholesterol – reducing “furring of the arteries” – microvascular disease
Hence explaining “heart age”

Thresholds adjusted per practice/PCN - * localised thresholds

*Page 238-241 Appendix XII – PCN thresholds

⁴⁶ Current mean achievement across NWL for CRM03 is 51%, 75th centile 54.5%

⁴⁷ Current mean achievement across NWL for CRM04 is 56%, 75th centile 60%

⁴⁸ Current mean achievement across NWL for CRM05 is 64%, 75th centile 67%

⁴⁹ Current mean achievement across NWL for CRM05 is 36%, 75th centile 40%. There is a bigger jump on this target due to the new NICE guidelines for T2DM which recommend SGLT2 inhibitors as first line therapy for nearly all patients with T2DM.

Pg 208 CRM07, CRM08, CRM09 – personalised care recognising lifestyle factors – changing behaviours for both teams and patients

CRM07: % of Group 1 / Group 2 patients on PCN CRM register with codes for completion of holistic care plan (including six pillars of lifestyle medicine)	50%	30%
CRM08: % of Group 1 / Group 2 patients on PCN CRM register with improvement in at least one of: exercise status from inactive/moderately inactive to a more active group BMI smoking status from any smoker status to non-smoker/ex-smoker status	2.5%	5%
CRM09: % of Group 1 / Group 2 patients on PCN CRM register with pre- and post- care planning	50%	5%

CRM07 – record **once** in the year/ pre-assessment/triage/HCA

CRM08 - Improvement in **either or any** of the three of exercises status/BMI/smoking status (record **twice** in the year)

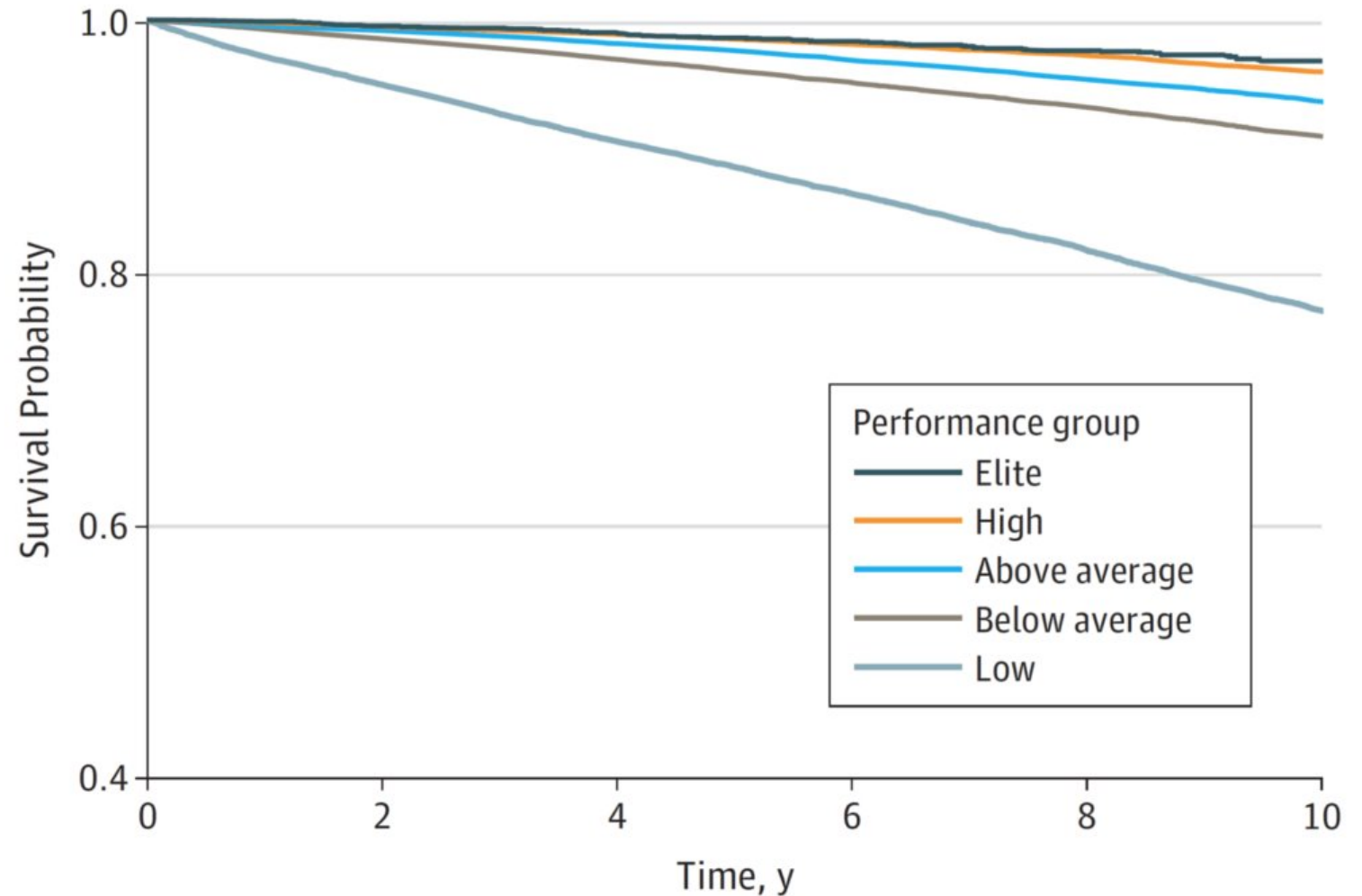
CRM09 – Record **twice** a year

CRM08

Group 1 & 2 total	Target number
100	3
200	5
300	8
400	10
500	13
600	15
700	18
800	20
900	23
1000	25

Addressing Key Risk Factors: 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 (50th-75th centile) is **equivalent risk reduction to moving from End Stage Renal Disease to normal health**



Tracking codes

- CRM00B – pg 209 – captured on S1/EMIS clinical templates
- Ensure capture as a minimum for Group 1 and 2 – *personally capture for all CRM – as enables tracking (first and follow-up – patients may move groups dependent on most recent results/readings/metrics)*

CODING USED FOR TRACKING CARE PLANNING		
Ref.	Description	SNOMED Code
CRM00B	Coding used to track first and follow-up appointments	Personalised Care and Support Plan agreed (1187911000000105) AND Review of Personalised Care and Support Plan (1187921000000104)

EMIS CRM Searches / Template / Care Plan

Presented by Matahir Jahn, Clinical Systems Developer, WNL



West and North London

EMIS CRM Lifestyle Care Plan

Create Letter > **NWL ICS CRM Lifestyle Care Plan**

- ▲ NWL EMIS Enterprise S&R
 - ▲ Cardiology
 - NWL ICS BP Home Monitoring Diary
 - NWL ICS Cardiology Referral form
 - NWL ICS CRM Lifestyle Care Plan v2.1.ewdt**
 - NWL ICS GP Ambulatory Monitor (Holter) Referral Form - Ealing Hospital CDC
 - NWL ICS GP Echocardiogram (TTE) Referral Form – Ealing Hospital CDC
 - NWL ICS Rapid Access Chest Pain Clinic Referral form

EMIS CRM Template

F12 NWL Template Launcher > Cardiovascular & Renal >
NWL ICS Custom Cardiorenal Metabolic CRM 2026/27

Multiple Choice Question
Choose the category of the template you wish to load:

- Local enhanced services (Brent)
- Local enhanced services (Harrow)
- Local enhanced services (Hillingdon)
- Cancer
- Cardiovascular & renal**
- Care Planning & Palliative Care
- Diabetes
- Medicines Management
- Mental Health
- Neurology & HCA
- Obstetrics & Gynaecology
- Pediatrics
- Respiratory
- Safeguarding
- Other

Multiple Choice Question
Click the template you wish to launch:

- NWL ICS ABPM ES 2026/27
- NWL ICS Atrial Fibrillation AF ES 2026/27
- NWL ICS Chronic Kidney Disease ES 2026/27
- NWL ICS ECG ES 2026/27
- NWL ICS Hypertension Management 2026/27
- NWL ICS Lipid Management 2026/27
- NWL ICS Custom Cardiorenal Metabolic CRM 2026/27**
- < back

EMIS CRM Searches

Population Reporting > EMIS Enterprise S&R > NWL Enhanced Services 2026 27 >

05 Cardiovascular-Renal-Metabolic (CRM)

- ▲ NWL Enhanced Services 2026 27 v1.0
 - ▶ 01 ABPM
 - ▶ 02 Access
 - ▶ 03 Anticoagulation Monitoring
 - ▶ 04 Asylum Seeker - Health Screening
 - ▲ **05 Cardiovascular-Renal-Metabolic (CRM)**
 - ▶ a) Register
 - ▶ b) Detection - PAYMENT
 - ▶ c) Key Care Processes - PAYMENT
 - ▶ d) Blood Pressure Treatment - PAYMENT
 - ▶ e) Lipid Treatment - PAYMENT
 - ▶ f) ACEI / ARB Medications - PAYMENT
 - ▶ g) SGLT2 Inhibitors - PAYMENT
 - ▶ h) Holistic Care Plan - PAYMENT
 - ▶ i) Improvement in Health Factors - PAYMENT
 - ▶ j) Health Confidence Score - PAYMENT
 - ▶ k) Diabetes - 3 Treatment Target
 - ▶ l) Diabetes - HbA1c Treatment Target
 - ▶ m) Hypertension - Black & Black British BP Target

SystemOne CRM Searches / Template / Care Plan

Presented by Matahir Jahn, Clinical Systems Developer, WNL



West and North London

SystemOne CRM Template

[Auto-consultation > 21 NWL Enhanced Services >](#)

[Custom Cardiorenal Metabolic CRM](#)

21 NWL Enhanced Services



Custom Cardiorenal Metabolic CRM

SystemOne CRM Lifestyle Care Plan

[Communications & Letters > NWL ICS CRM Lifestyle Care Plan](#)

NWL Lifestyle Care Plan CRM

SystemOne CRM Searches

[Reporting > Clinical Reporting > NW London ICB > NWL Enhanced Services 2026 27 >](#)

[05 Cardiovascular-Renal-Metabolic \(CRM\)](#)



NWL Enhanced Services 2026 27

- ♦ 01 ABPM (14)
- ♦ 02 Access (16)
- ♦ 03 Anticoagulation Monitoring (24)
- ♦ 04 Asylum Seeker Health Screening
- ♦ 05a Cardiovascular Renal Metabolic

Enhanced Services (Single Offer) Cardiovascular Renal Metabolic (CRM) Clinical Searches

Tharshiya Packianathan

Senior Information Manager (Primary Care)

Business Intelligence (Analytics)

06/05/2026



Introduction

BI Responsibilities

- SystmOne and EMIS searches for NWL Single Offer
- Reporting dashboards to monitor activity and achievement
- Supports GP Practices/PCNs on queries



Location of CRM Searches - EMIS

- Brent & Harrow GP Practices

NWL ES&R >> NWL Enhanced Services 2026 27 >> 05 Cardiovascular-Renal-Metabolic (CRM)

- Hillingdon GP Practices

Hillingdon ES&R >> NWL Enhanced Services 2026 27 >> 05 Cardiovascular-Renal-Metabolic (CRM)

The screenshot displays the EMIS system interface. On the left, a navigation tree for 'NWL Enhanced Services 2026 27 v1.1' is shown, with '05 Cardiovascular-Renal-Metabolic (CRM)' selected. The right pane shows a detailed list of sub-items under this category, including 'a) Register', 'b) Detection - PAYMENT', 'c) Key Care Processes - PAYMENT', 'd) Blood Pressure Treatment - PAYMENT', 'e) Lipid Treatment - PAYMENT', 'f) ACEI / ARB Medications - PAYMENT', 'g) SGLT2 Inhibitors - PAYMENT', 'h) Holistic Care Plan - PAYMENT', 'i) Improvement in Health Factors - PAYMENT', 'j) Health Confidence Score - PAYMENT', 'k) Diabetes - 3 Treatment Target', 'l) Diabetes - HbA1c Treatment Target', 'm) Hypertension - Black & Black British BP Target', and 'Sub'. Below this list is a table with columns: Details, Definition, Age / Sex, Trend, Population Included, and Population Excluded.

Details	Definition	Age / Sex	Trend	Population Included	Population Excluded
a) Register					
b) Detection - PAYMENT					
c) Key Care Processes - PAYMENT					
d) Blood Pressure Treatment - PAYMENT					
e) Lipid Treatment - PAYMENT					
f) ACEI / ARB Medications - PAYMENT					
g) SGLT2 Inhibitors - PAYMENT					
h) Holistic Care Plan - PAYMENT					
i) Improvement in Health Factors - PAYMENT					
j) Health Confidence Score - PAYMENT					
k) Diabetes - 3 Treatment Target					
l) Diabetes - HbA1c Treatment Target					
m) Hypertension - Black & Black British BP Target					
Sub					



Location of CRM Searches - SYSTMONE

Achievement

NW London ICB >> NWL Enhanced Services 2026 27 >> 05a Cardiovascular Renal Metabolic Payment

Data Quality

NW London ICB >> NWL Enhanced Services DQ 2026 27 >> 05 Cardiovascular Renal Metabolic

Achievement:

05a Cardiovascular Renal Metabolic PAYMENT

Name:

*RISK00: CRM RISK CLASSIFICATION

*RISKA01 | Group 1 | 14 or more risk factors

*RISKB01 | Group 2 | 10-13 risk factors

*RISKC01 | Group 3 | 0-9 Risk Factors

CRM00A: CRM COHORT

CRM00A | REGISTER | Patients on CRM Register

CRM00B: FIRST & FOLLOW UP APPT

CRM00B | LAST 15 MONTHS | ALL CRM | First and Follow Up appointments

CRM01A: ATRIAL FIBRILLATION DETECTION

CRM01AD | AF | DENOMINATOR | Age >= 55 | Patients eligible for ECG or Pulse Rhythm Check

CRM01AN | AF | ACHIEVEMENT | THIS FINANCIAL YEAR | ECG or Pulse Rhythm Check

CRM01B: CHRONIC KIDNEY DISEASE DETECTION

CRM01BD | CKD | DENOMINATOR | Patients who are likely to have CKD

CRM01BN | CKD | ACHIEVEMENT | THIS FINANCIAL YEAR | Diagnosed and coded appropriately with CKD

CRM01C: DIABETES DETECTION

CRM01CD | DM | DENOMINATOR | HbA1c >= 48 on one or more occasion

CRM01CN | DM | ACHIEVEMENT | THIS FINANCIAL YEAR | Diabetes and HbA1c >= 48

CRM01D: HYPERTENSION DETECTION

CRM01DD | HYP | DENOMINATOR | Earliest BP reading >= 140/90 OR Daytime Average BP >= 135/85

CRM01DN | HYP | ACHIEVEMENT | THIS FINANCIAL YEAR | BP >= 140/90 more than once or Daytime Average BP >= 135/85 and ...

CRM01E: NON-DIABETIC HYPERGLYCAEMIA DETECTION

CRM01ED | NDH | DENOMINATOR | HbA1c >= 42 and < 48 on one or more occasion

CRM01EN | NDH | ACHIEVEMENT | THIS FINANCIAL YEAR | NDH Diagnosis and HbA1c >= 42 & 48

CRM02: CARE PROCESSES ACHIEVEMENT

CRM02 | ALL CRM | ACHIEVEMENT | PAYMENT | Care Processes completed

CRM02a: CARE PROCESSES

CRM02Na | ALL CRM | LAST 15 MONTHS | HbA1c

CRM02Nb | ALL CRM | LAST 15 MONTHS | Blood Pressure

CRM02Nc | ALL CRM | LAST 15 MONTHS | Lipids

CRM02Nd | ALL CRM | LAST 15 MONTHS | Urine ACR

CRM02Ne | ALL CRM | LAST 15 MONTHS | eGFR

CRM02Nf | ALL CRM | LAST 15 MONTHS | BMI

CRM02Ng | ALL CRM | LAST 15 MONTHS | Waist Circumference

CRM02Nh | ALL CRM | LAST 15 MONTHS | Smoking status

CRM02Ni | All CRMs | Mental Health Review in last 15m OR No Diabetes

Data Quality:

05 Cardiovascular Renal Metabolic

Name:

*RISK00: CRM RISK CLASSIFICATION

*RISKA01 | Group 1 | 14 or more risk factors

*RISKB01 | Group 2 | 10-13 risk factors

*RISKC01 | Group 3 | 0-9 Risk Factors

CRM00A: CRM COHORT

CRM00A | REGISTER | Patients on CRM Register

CRM00B: FIRST AND FOLLOW UP APPT

CRM00Ba | LAST 15 MONTHS | MISSING First Appointment

CRM00Bb | LAST 15 MONTHS | Attended First Appt | MISSING Follow Up Appointment

CRM01A: ATRIAL FIBRILLATION DETECTION

CRM01A | AF | WORK TO DO | THIS FINANCIAL YEAR | MISSING ECG or Pulse Rhythm Check

CRM01B: CHRONIC KIDNEY DISEASE DETECTION

CRM01B | CKD | WORK TO DO | Likely to have CKD MISSING CKD Diagnosis code

CRM01C: DIABETES DETECTION

CRM01CA | DM | WORK TO DO | HbA1c >= 48 | MISSING Diabetes Diagnosis

CRM01D: HYPERTENSION DETECTION

CRM01DA | HYP | WORK TO DO | Daytime Average BP >= 135/85 OR 2ND BP >= 140/90 | MISSING Hypertension Diagnosis

CRM01DB | HYP | WORK TO DO | Earliest BP Reading (excluding daytime average) >= 140/90 | MISSING either 2nd Blood Pressu...

CRM01E: NON-DIABETIC HYPERGLYCAEMIA DETECTION

CRM01EA | NDH | WORK TO DO | HbA1c >= 42 and < 48 | MISSING NDH Diagnosis

CRM02: CARE PROCESSES ACHIEVEMENT

CRM02 | ALL CRM | WORK TO DO | Care Processes NOT Completed

CRM02a: CARE PROCESSES

CRM02a | ALL CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING HbA1c

CRM02b | ALL CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Blood Pressure

CRM02c | ALL CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Lipids

Cohort



CRM Register

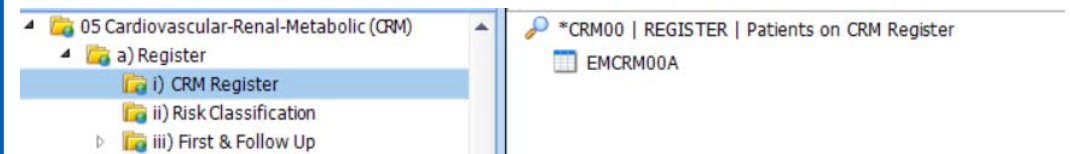
Inclusions

- Aged ≥ 17
- Atrial Fibrillation (AF)
- Coronary heart Disease (CHD)
- Peripheral arterial disease (PAD)
- Chronic Kidney Disease (CKD)
- Diabetes
- Heart failure (HF)
- Hypertension
- Metabolic dysfunction-associated steatotic disease (MASLD)
- Non-diabetic hyperglycaemia (NDH)
- Stroke/TIA

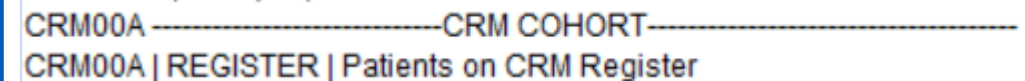
Exclusions

- Palliative Care

EMIS:



SystmOne:

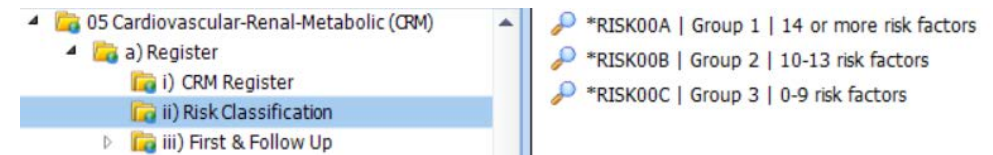




Risk Classification

- Split into 3 groups
 - Group 1 – 14 or more risk factors
 - Group 2 – 10-13 risk factors
 - Group 3 – 0-9 risk factors
- Patient will remain in a risk group when first appointment has been completed until end of financial year

EMIS:



SystemOne:



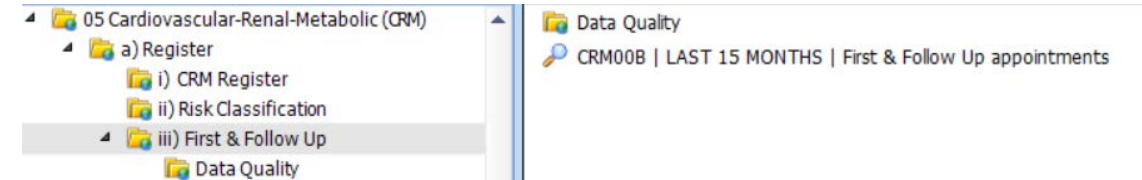
Metrics



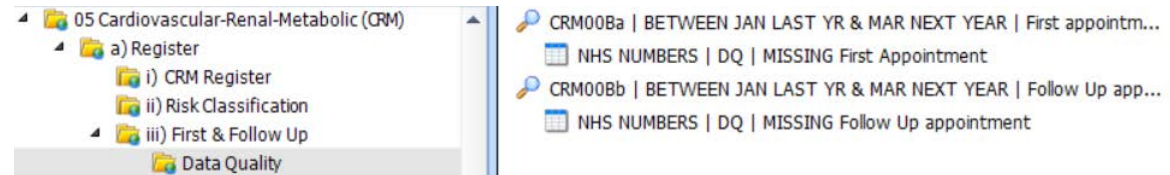
Payment and Quality Metrics

- First & Follow Up (CRM00B)
 - No longer a payment metric
 - Needed to fix patients in risk group
 - First appointment is part of holistic care plan for Groups 1 & 2
- Payment KPIs
CRM01 – CRM09
- Quality metrics (non-payment)
CRM10 – CRM12

EMIS Achievement:



EMIS Data Quality:



SystemOne Achievement:

CRM00B ----- FIRST & FOLLOW UP APPT -----
CRM00B | LAST 15 MONTHS | ALL CRM | First and Follow Up appointments

SystemOne Data Quality:

CRM00B ----- FIRST AND FOLLOW UP APPT -----
CRM00Ba | LAST 15 MONTHS | MISSING First Appointment
CRM00Bb | LAST 15 MONTHS | Attended First Appt | MISSING Follow Up Appointment

Detection Searches



CRM01 – Detection Searches

Split into 5 metrics:

a) Atrial Fibrillation

- **Cohort:** CRM patients aged ≥ 55
- **Achievement:** ECG or pulse rhythm check in financial year

b) Chronic Kidney Disease

- **Cohort:** $2 \times \text{eGFR} < 60$ or $2 \times \text{Urine ACR} > 3$
- **Achievement:** CKD diagnosis in financial year

c) Diabetes

- **Cohort:** $\text{HbA1c} \geq 48$
- **Achievement:** Diabetes diagnosis in financial year

d) Hypertension

- **Cohort:** Daytime average BP $\geq 135/85$ or BP $\geq 140/90$
- **Achievement:** Either Hypertension diagnosis OR BP $< 140/90$ or daytime average BP $< 135/85$ in financial year

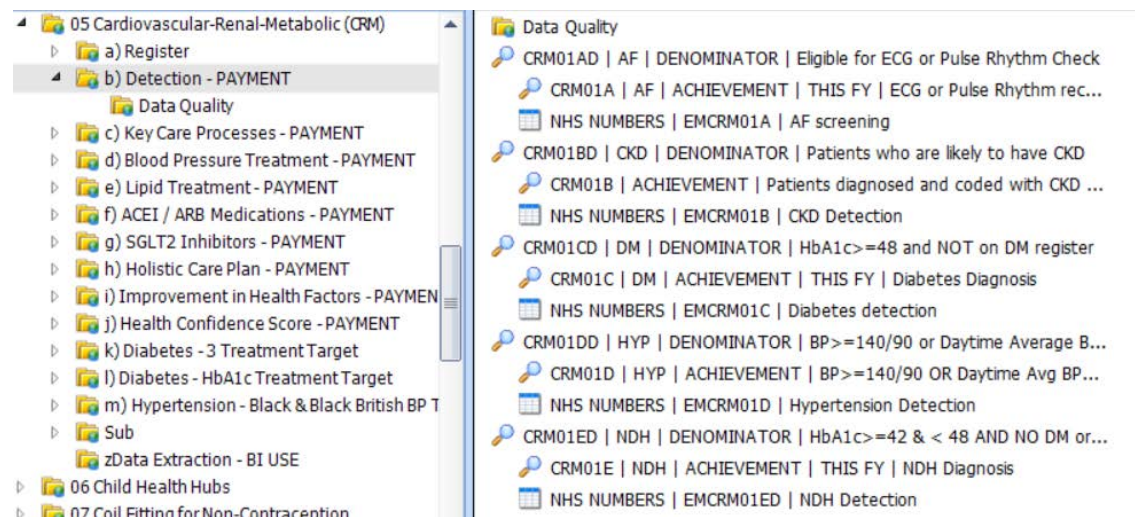
e) Non-Diabetic Hyperglycaemia

- **Cohort:** $\text{HbA1c} \geq 42$ & < 48
- **Achievement:** NDH diagnosis in financial year

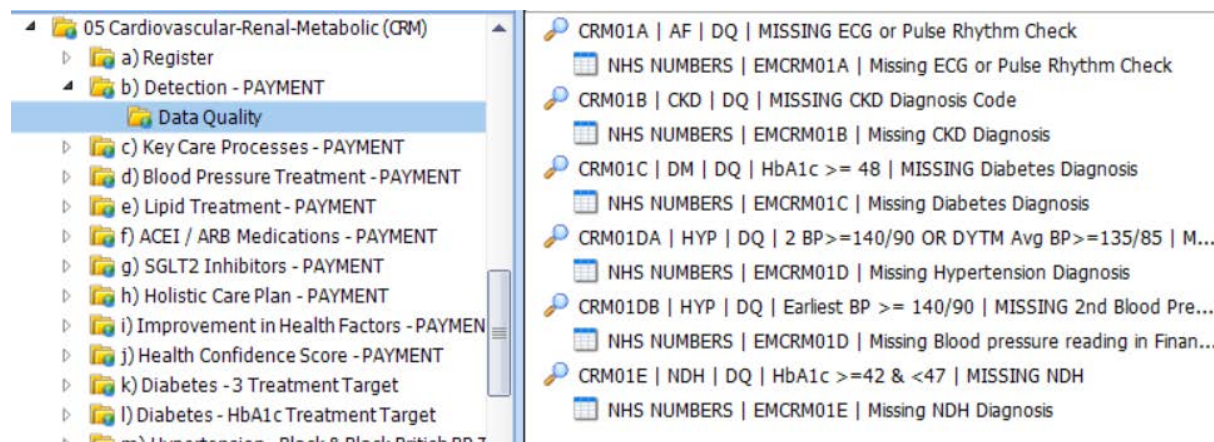


CRM01: EMIS Searches

Achievement



Data Quality





CRM01: SystmOne Searches

Achievement

CRM01A ----- ATRIAL FIBRILLATION DETECTION -----
CRM01AD | AF | DENOMINATOR | Age >= 55 | Patients eligible for ECG or Pulse Rhythm Check
CRM01AN | AF | ACHIEVEMENT | THIS FINANCIAL YEAR | ECG or Pulse Rhythm Check
CRM01B ----- CHRONIC KIDNEY DISEASE DETECTION -----
CRM01BD | CKD | DENOMINATOR | Patients who are likely to have CKD
CRM01BN | CKD | ACHIEVEMENT | THIS FINANCIAL YEAR | Diagnosed and coded appropriately with CKD
CRM01C ----- DIABETES DETECTION -----
CRM01CD | DM | DENOMINATOR | HbA1c >= 48 on one or more occasion
CRM01CN | DM | ACHIEVEMENT | THIS FINANCIAL YEAR | Diabetes and HbA1c >= 48
CRM01D ----- HYPERTENSION DETECTION -----
CRM01DD | HYP | DENOMINATOR | Earliest BP reading >= 140/90 OR Daytime Average BP >= 135/85
CRM01DN | HYP | ACHIEVEMENT | THIS FINANCIAL YEAR | BP >= 140/90 more than once or Daytime Average BP >= 135/85 and ...
CRM01E ----- NON-DIABETIC HYPERGLYCAEMIA DETECTION -----
CRM01ED | NDH | DENOMINATOR | HbA1c >= 42 and < 48 on one or more occasion
CRM01EN | NDH | ACHIEVEMENT | THIS FINANCIAL YEAR | NDH Diagnosis and HbA1c >= 42 & 48

Data Quality

CRM01A ----- ATRIAL FIBRILLATION DETECTION -----
CRM01A | AF | WORK TO DO | THIS FINANCIAL YEAR | MISSING ECG or Pulse Rhythm Check
CRM01B ----- CHRONIC KIDNEY DISEASE DETECTION -----
CRM01B | CKD | WORK TO DO | Likely to have CKD MISSING CKD Diagnosis code
CRM01C ----- DIABETES DETECTION -----
CRM01CA | DM | WORK TO DO | HbA1c >= 48 | MISSING Diabetes Diagnosis
CRM01D ----- HYPERTENSION DETECTION -----
CRM01DA | HYP | WORK TO DO | Daytime Average BP >= 135/85 OR 2ND BP >= 140/90 | MISSING Hypertension Diagnosis
CRM01DB | HYP | WORK TO DO | Earliest BP Reading (excluding daytime average) >= 140/90 | MISSING either 2nd Blood Pressu...
CRM01E ----- NON-DIABETIC HYPERGLYCAEMIA DETECTION -----
CRM01EA | NDH | WORK TO DO | HbA1c >= 42 and < 48 | MISSING NDH Diagnosis

Care Processes



CRM02 – Care Processes

- **Cohort:** All CRM patients
- **Achievement:** All care processes completed (CRM02)
- CRM02a-I – Breakdown of care processes

Note:

- Waist circumference (new metric)
- Diabetic patients only:
 - Mental health screening
 - Left & Right foot risk classification
 - Retinal screening
- Diabetic & MASLD
 - FIB-4



CRM02: EMIS Searches

Achievement

05 Cardiovascular-Renal-Metabolic (CRM)

- a) Register
- b) Detection - PAYMENT
 - Data Quality
- c) Key Care Processes - PAYMENT
- d) Blood Pressure Treatment - PAYMENT
- e) Lipid Treatment - PAYMENT
- f) ACEI / ARB Medications - PAYMENT
- g) SGLT2 Inhibitors - PAYMENT
- h) Holistic Care Plan - PAYMENT
- i) Improvement in Health Factors - PAYMENT
- j) Health Confidence Score - PAYMENT
- k) Diabetes - 3 Treatment Target
- l) Diabetes - HbA1c Treatment Target
- m) Hypertension - Black & Black British BP T
- Sub
- zData Extraction - BI USE

06 Child Health Hubs

07 Coil Fitting for Non-Contraception

08 Diabetes Level 2 MDT

09 Diabetes Early Onset Type 2

10 ECG

11 Latent TB

12 Mental Health

Data Quality

- *CRM02D | DENOMINATOR | Patients on CRM Register
- CRM02 | ACHIEVEMENT | Care Process Completed
- CRM02a | All CRM | LAST 15M | HbA1c
- CRM02b | All CRM | LAST 15M | Blood Pressure
- CRM02c | All CRM | LAST 15M | Lipids
- CRM02d | All CRM | LAST 15M | Urine ACR
- CRM02e | All CRM | LAST 15M | eGFR
- CRM02f | All CRM | LAST 15M | BMI
- CRM02g | All CRM | LAST 15M | Waist circumference
- CRM02h | All CRM | LAST 15M | Smoking Status
- CRM02i | Diabetes & Mental Health Screening in last 15m OR No Diab...
- CRM02j | Diabetes & Right & Left Feet Risk Checks in last 15m OR N...
- CRM02k | Diabetes and Retinal Screening in last 27m OR No Diabetes
- CRM02l | Diabetes or MASLD & FIB-4 in last 39m OR NO Diabetes or ...
- Diabetic Patients
 - NHS NUMBERS | CRM02 | Key Care Processes (more detailed)
- Metabolic dysfunction-associated steatotic disease patients
 - NHS NUMBERS | CRM02 | Key Care Processes (more detailed)
- NO Diabetes or Metabolic dysfunction-associated steatotic disease
 - NHS NUMBERS | CRM02 | Key Care Processes (more detailed)

Data Quality

05 Cardiovascular-Renal-Metabolic (CRM)

- a) Register
- b) Detection - PAYMENT
 - Data Quality
- c) Key Care Processes - PAYMENT
 - Data Quality
 - Sub
- d) Blood Pressure Treatment - PAYMENT
- e) Lipid Treatment - PAYMENT
- f) ACEI / ARB Medications - PAYMENT
- g) SGLT2 Inhibitors - PAYMENT
- h) Holistic Care Plan - PAYMENT
- i) Improvement in Health Factors - PAYMENT
- j) Health Confidence Score - PAYMENT
- k) Diabetes - 3 Treatment Target
- l) Diabetes - HbA1c Treatment Target
- m) Hypertension - Black & Black British BP T
- Sub
- zData Extraction - BI USE

06 Child Health Hubs

07 Coil Fitting for Non-Contraception

08 Diabetes Level 2 MDT

09 Diabetes Early Onset Type 2

10 ECG

11 Latent TB

12 Mental Health

*CRM02 | ALL CRM | DQ | Key Care Processes NOT Completed

- Diabetic Patients
 - NHS NUMBERS | CRM02 | Key Care Processes NOT Completed
 - NHS NUMBERS | CRM02 | Key Care Processes NOT Completed (...)
- Metabolic dysfunction-associated steatotic disease patients
 - NHS NUMBERS | CRM02 | Key Care Processes NOT Completed
 - NHS NUMBERS | CRM02 | Key Care Processes NOT Completed (...)
- NO Diabetes or Metabolic dysfunction-associated steatotic disease
 - NHS NUMBERS | CRM02 | Key Care Processes NOT Completed
 - NHS NUMBERS | CRM02 | Key Care Processes NOT Completed (...)
- CRM02a | ALL CRM | DQ | LAST 15M TO END OF FY | WITHOUT HbA1c
- CRM02b | ALL CRM | DQ | LAST 15M TO END OF FY | WITHOUT Blood ...
- CRM02c | ALL CRM | DQ | LAST 15M TO END OF FY | WITHOUT Lipids
- CRM02d | ALL CRM | DQ | LAST 15M TO END OF FY | WITHOUT Urine ...
- CRM02e | ALL CRM | DQ | LAST 15M TO END OF FY | WITHOUT eGFR
- CRM02f | ALL CRM | DQ | LAST 15M TO END OF FY | WITHOUT BMI
- CRM02g | ALL CRM | DQ | LAST 15M TO END OF FY | WITHOUT Waist ...
- CRM02h | ALL CRM | DQ | LAST 15M TO END OF FY | WITHOUT Smoki...
- CRM02i | DIABETES | DQ | LAST 15M TO END OF FY | WITHOUT MH S...
- CRM02j | DIABETES | DQ | LAST 15M TO END OF FY | WITHOUT Foot ...
- CRM02k | DIABETES | DQ | LAST 27M TO END OF FY | WITHOUT Reti...
- CRM02l | DIABETES OR MASLD | DQ | LAST 39M TO END OF FY | WIT...



CRM02: SystmOne Searches

Achievement

```
CRM02 -----CARE PROCESSES ACHIEVEMENT-----
CRM02 | ALL CRM | ACHIEVEMENT | PAYMENT | Care Processes completed
CRM02a -----CARE PROCESSES-----
CRM02Na | ALL CRM | LAST 15 MONTHS | HbA1c
CRM02Nb | ALL CRM | LAST 15 MONTHS | Blood Pressure
CRM02Nc | ALL CRM | LAST 15 MONTHS | Lipids
CRM02Nd | ALL CRM | LAST 15 MONTHS | Urine ACR
CRM02Ne | ALL CRM | LAST 15 MONTHS | eGFR
CRM02Nf | ALL CRM | LAST 15 MONTHS | BMI
CRM02Ng | ALL CRM | LAST 15 MONTHS | Waist Circumference
CRM02Nh | ALL CRM | LAST 15 MONTHS | Smoking status
CRM02Ni | Diabetes & Mental Health Screening in last 15m OR No Diabetes
CRM02Nj | Diabetes & Right AND Left Foot risk classification in last 15m OR No Diabetes
CRM02Nk | Diabetes & Retinal Screening in last 27m OR No Diabetes
CRM02NI | Diabetes or MASLD & FIB-4 in last 39m OR No Diabetes or MASLD
```

Data Quality

```
CRM02 -----CARE PROCESSES ACHIEVEMENT-----
CRM02 | ALL CRM | WORK TO DO | Care Processes NOT Completed
CRM02a -----CARE PROCESSES-----
CRM02a | ALL CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING HbA1c
CRM02b | ALL CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Blood Pressure
CRM02c | ALL CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Lipds
CRM02d | ALL CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Urine ACR
CRM02e | ALL CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING eGFR
CRM02f | ALL CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING BMI
CRM02g | ALL CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Waist Circumference
CRM02h | ALL CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Smoking Status
CRM02i | DIABETES | WORK TO DO | LAST 15M TO END OF FY | MISSING Mental Health Screening
CRM02j | DIABETES | WORK TO DO | LAST 15M TO END OF FY | MISSING Right and Left Foot Risk Classification
CRM02k | DIABETES | WORK TO DO | LAST 15M TO END OF FY | MISSING Retinal Screening
CRM02I | DIABETES OR MASLD | WORK TO DO | LAST 15M TO END OF FY | MISSING FIB-4
```

Blood Pressure Treatment



CRM03 – Blood Pressure Treatment

- **Cohort:** Chronic Kidney Disease, Diabetes or Hypertension
- **Achievement:** BP Targets are split into 2 categories
 - No Moderate or Severe Frailty or aged < 79 with BP target $\leq 130/80$
 - Moderate or Severe Frailty or aged ≥ 80 with BP target $\leq 150/90$



CRM03: EMIS Searches

Achievement

05 Cardiovascular-Renal-Metabolic (CRM)

- a) Register
- b) Detection - PAYMENT
 - Data Quality
- c) Key Care Processes - PAYMENT
 - Data Quality
 - Sub
- d) Blood Pressure Treatment - PAYMENT**
 - Data Quality
- e) Lipid Treatment - PAYMENT
- f) ACET / ABB Medications - PAYMENT

Data Quality

- *CRM03D | DENOMINATOR | CKD, Diabetes or Hypertension
- *CRM03 | ACHIEVEMENT | LAST 15M | Latest BP <= appropriate ta...
- CRM03A | NOT FRAIL or AGED < 80 | LAST 15M | Latest BP <= 13...
- CRM03B | FRAIL or AGED >= 80 | LAST 15M | Latest BP <= 150/90
- Patients with Moderate or Severe Frailty or aged >= 80
 - CRM03 | NHS NUMBERS | Blood Pressure Checklist
- Patients with no Moderate or Severe Frailty or aged < 80
 - CRM03 | NHS NUMBERS | Blood Pressure Checklist

Data Quality

05 Cardiovascular-Renal-Metabolic (CRM)

- a) Register
- b) Detection - PAYMENT
 - Data Quality
- c) Key Care Processes - PAYMENT
 - Data Quality
 - Sub
- d) Blood Pressure Treatment - PAYMENT**
 - Data Quality**
- e) Lipid Treatment - PAYMENT
- f) ACET / ABB Medications - PAYMENT

Sub

- CRM03A | DQ | NOT FRAIL OR AGE<79 | LAST 15M TO END OF FY | L...
- CRM03 | NHS NUMBERS | Blood Pressure > 130/80
- CRM03B | DQ | FRAIL OR AGE>=80 | LAST 15M TO END OF FY | BP>1...
- CRM03 | NHS NUMBERS | Blood Pressure > 150/90



CRM03: SystmOne Searches

Achievement

CRM03 -----BLOOD PRESSURE TREATMENT-----
CRM03D | CKD, DM, HYP | DENOMINATOR | Chronic Kidney Disease, Diabetes or Hypertension
CRM03N | CKD, DM, HYP | ACHIEVEMENT | LAST 15 MONTHS | Latest BP reading $\leq 130/80$ with no Frailty or aged < 80 or $\leq 15..$

Data Quality

CRM03 -----BLOOD PRESSURE TREATMENT-----
CRM03A | CRM WITHOUT Frailty | WORK TO DO | LAST 15 MONTHS | NOT ACHIEVED Blood pressure reading $\leq 130/80$
CRM03B | CRM WITH Frailty | WORK TO DO | LAST 15 MONTHS | NOT ACHIEVED Blood pressure reading $\leq 150/90$

Prescribing



CRM04-6 – Prescribing/Medication Metrics

- **Lipid Lowering Therapy**

- **Cohort Group 1:** CKD, Stroke/TIA, CHD, PAD, Diabetes, or HF
- **Cohort Group 2:** AF, Hypertension, MASLD, NDH and latest QRISK > 10%
- **Achievement:** Moderate or high intensity statins prescribed in last 6 months

- **ACEI/ARB Medications**

- **Cohort Group 1 :** CKD and Urine ACR ≥ 30
- **Cohort Group 2 :** Diabetes and Urine ACR ≥ 3 or eGFR < 60
- **Achievement:** ACE inhibitor or Angiotensin Receptor Blockers prescribed in last 6 months

SGLT-2 Inhibitors

- **Cohort Group 1:** CKD and latest eGFR between 20 and 45
- **Cohort Group 2:** CKD and latest eGFR between 45 and 90 and Urine ACR ≥ 22.6
- **Cohort Group 3:** Type 2 Diabetes
- **Cohort Group 4:** Heart Failure
- **Achievement:** SGLT-2 inhibitors prescribed in last 6 months



CRM04-6: EMIS Searches

Achievement

▲ e) Lipid Treatment - PAYMENT

▲ Data Quality

▲ f) ACEI / ARB Medications - PAYMENT

▲ Data Quality

▲ g) SGLT2 Inhibitors - PAYMENT

Data Quality

CRM04D | DEN | Either CKD, CVD, DM, HF or AF, HYP, MASLD NDH & Q...

CRM04 | ACHIEVEMENT | LAST 6M | Moderate or High Intensity Statin

NHS NUMBERS | CRM04 | Moderate or High Intensity statins

▲ f) ACEI / ARB Medications - PAYMENT

▲ Data Quality

▲ g) SGLT2 Inhibitors - PAYMENT

▲ Data Quality

▲ h) Holistic Care Plan - PAYMENT

Data Quality

CRM05D | CKD & uACR >= 30 OR Diabetes & uACR >= 3 or eGFR < 60

CRM05 | ACHIEVE | LAST 6M | ACE inhibitor/Angiotensin Receptor B...

NHS NUMBERS | CRM05 | ACE Inhibitor/Angiotensin Receptor Blocker

▲ e) Lipid Treatment - PAYMENT

▲ Data Quality

▲ f) ACEI / ARB Medications - PAYMENT

▲ Data Quality

▲ g) SGLT2 Inhibitors - PAYMENT

▲ Data Quality

Data Quality

CRM06D | CKD & eGFR btwn 20&45 OR CKD & uACR>=22.6 & eGFR bt...

CRM06N | ACHIEVE | LAST 6M | SGLT-2 inhibitors

NHS NUMBERS | CRM06 | SGLT-2 inhibitors

Data Quality

▲ e) Lipid Treatment - PAYMENT

▲ Data Quality

▲ f) ACEI / ARB Medications - PAYMENT

CRM04 | DQ | LAST 6M | NOT Prescribed Moderate or High Intensity St...

NHS NUMBERS | DQ | Moderate or High Intensity Statins NOT Prescr...

▲ f) ACEI / ARB Medications - PAYMENT

▲ Data Quality

CRM05 | DQ | LAST 6M | NOT Prescribed ACE inhibitor/Angiotensin Rec...

NHS NUMBERS | DQ | ACE Inhibitor/ARB NOT Prescribed

▲ g) SGLT2 Inhibitors - PAYMENT

▲ Data Quality

▲ h) Holistic Care Plan - PAYMENT

CRM06 | DQ | LAST 6M | NOT Prescribed SGLT-2 inhibitors

NHS NUMBERS | DQ | SGLT-2 inhibitors NOT Prescribed



CRM04-6: SystmOne Searches

Achievement

CRM04 ----- LIPID LOWERING THERAPY -----
CRM04D | DENOMINATOR | Either CKD, CVD, DM, HF OR AF, HYP, MASLD NDH & QRISK > 10%
CRM04N | ACHIEVEMENT | LAST 6 MONTHS | Prescribed Moderate or High Intensity Statins
CRM05 ----- ACEI / ARB MEDICATIONS -----
CRM05D | DENOMINATOR | CKD and uACR ≥ 30 OR Diabetes and uACR ≥ 3 or eGFR < 60
CRM05N | ACHIEVEMENT | LAST 6 MONTHS | Prescribed ACE inhibitor or Angiotensin Receptor Blocker
CRM06 ----- SGLT2 INHIBITORS -----
CRM06D | DENOMINATOR | Exclude Moderate or Severe Frailty | Exclude Age 80 and over | CKD and eGFR ≥ 20 & < 45 OR CKD and uACR ≥ 22.6 and
CRM06N | ACHIEVEMENT | LAST 6 MONTHS | Prescribed SGLT2 inhibitor

Data Quality

CRM04 ----- LIPID LOWERING THERAPY -----
CRM04 | CKD, CVD, DM, HF OR AF, HYP, MASLD NDH & QRISK > 10% | WORK TO DO | LAST 6 MONTHS | NOT Prescribed Moderate or High Intensity Statins
CRM05 ----- ACEI / ARB MEDICATIONS -----
CRM05 | CKD & uACR ≥ 30 OR DM & uACR ≥ 3 or eGFR < 60 | WORK TO DO | LAST 6 MONTHS | NOT Prescribed ACE inhibitor or Angiotensin Receptor Blocker
CRM06 ----- SGLT2 INHIBITORS -----
CRM06 | LAST 6 MONTHS | CKD and eGFR ≥ 20 & < 45 OR CKD and uACR ≥ 22.6 and eGFR ≥ 45 & ≤ 90 OR Type 2 Diabetes OR Heart Failure | WORK TO DO | NOT Prescribed SGLT-2 Inhibitors

Holistic Care Plan



CRM07 – Holistic Care Plan

➤ Cohort: Groups 1 & 2

- **Achievement:** All components of holistic care plan is completed (CRM07)
- CRM07Na-g: individual components of holistic care plan
- All elements to be completed in last 15 months

Note:

- CRM07Ng - Avoid harmful substances (3 items need to be completed)
 - Smoking
 - Alcohol
 - Drugs



CRM07: EMIS Searches

Achievement

- h) Holistic Care Plan - PAYMENT
 - Data Quality
 - i) Improvement in Health Factors -PAYMEN
 - j) Health Confidence Score - PAYMENT
 - k) Diabetes - 3 Treatment Target
 - l) Diabetes - HbA1c Treatment Target
 - m) Hypertension - Black & Black British BP T
 - Sub
 - zData Extraction - BI USE
 - 06 Child Health Hubs
 - 07 Coil Fitting for Non-Contraception
 - 08 Diabetes Level 2 MDT
 - 09 Diabetes Early Onset Type 2

- Data Quality
 - CRM07D | DEN | High or Moderate risk CRM Classification
 - CRM07 | ACHIEVEMENT | LAST 15M | Holistic Care Plan completed
 - CRM07a | LAST 15M | Care Plan
 - CRM07b | LAST 15M | Eat
 - CRM07c | LAST 15M | Physical Activity
 - CRM07d | LAST 15M | Sleep Pattern
 - CRM07e | LAST 15M | Relax
 - CRM07f | LAST 15M | Connect
 - CRM07g | LAST 15M | Avoid harmful substances
 - NHS NUMBERS | CRM07 | Holistic Care Plan

Data Quality

- h) Holistic Care Plan - PAYMENT
 - Data Quality
 - Sub
 - CRM07 | DQ | LAST 15M TO END OF FY | Holistic Care Plan NOT Compl...
 - NHS NUMBERS | CRM07 | Holistic Care Plan NOT Completed
 - NHS NUMBERS | CRM07 | Holistic Care Plan NOT Completed (more d...
 - i) Improvement in Health Factors -PAYMEN
 - j) Health Confidence Score -PAYMENT
 - k) Diabetes - 3 Treatment Target
 - l) Diabetes - HbA1c Treatment Target
 - m) Hypertension - Black & Black British BP T
 - Sub
 - zData Extraction - BI USE
 - 06 Child Health Hubs
 - 07 Coil Fitting for Non-Contraception
 - 08 Diabetes Level 2 MDT

- Sub
 - CRM07 | DQ | LAST 15M TO END OF FY | Holistic Care Plan NOT Compl...
 - NHS NUMBERS | CRM07 | Holistic Care Plan NOT Completed
 - NHS NUMBERS | CRM07 | Holistic Care Plan NOT Completed (more d...
 - CRM07a | DQ | LAST 15M TO END OF FY | MISSING Care Plan
 - CRM07b | DQ | LAST 15M TO END OF FY | MISSING Eat
 - CRM07c | DQ | LAST 15M TO END OF FY | MISSING Physical Activity
 - CRM07d | DQ | LAST 15M TO END OF FY | MISSING Sleep Pattern
 - CRM07e | DQ | LAST 15M TO END OF FY | MISSING Relax
 - CRM07f | DQ | LAST 15M TO END OF FY | MISSING Connect
 - CRM07g | DQ | LAST 15M TO END OF FY | MISSING Avoid harmful subs...



CRM07: SystmOne Searches

Achievement

CRM07 -----ACHIEVEMENT HOLISTIC CARE PLAN-----
CRM07 | ACHIEVEMENT | High or Moderate Risk CRM | LAST 15 MONTHS | Holistic Care Plan completed
CRM07D | DENOMINATOR | High or Moderate Risk CRM patients
CRM07N -----HOLISTIC CARE PLAN-----
CRM07Na | High or Moderate Risk CRM | LAST 15 MONTHS | Care Plan
CRM07Nb | High or Moderate Risk CRM | LAST 15 MONTHS | Eat
CRM07Nc | High or Moderate Risk CRM | LAST 15 MONTHS | Move
CRM07Nd | High or Moderate Risk CRM | LAST 15 MONTHS | Sleep
CRM07Ne | High or Moderate Risk CRM | LAST 15 MONTHS | Relax
CRM07Nf | High or Moderate Risk CRM | LAST 15 MONTHS | Connect
CRM07Ng | High or Moderate Risk CRM | LAST 15 MONTHS | Avoid harmful substances

Data Quality

CRM07 -----ACHIEVEMENT HOLISTIC CARE PLAN-----
CRM07 | High or Moderate Risk CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Holistic Care Plan
CRM07D | DENOMINATOR | High or Moderate Risk CRM patients
CRM07N -----HOLISTIC CARE PLAN-----
CRM07Na | High or Moderate Risk CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Care Plan
CRM07Nb | High or Moderate Risk CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Eat
CRM07Nc | High or Moderate Risk CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Move
CRM07Nd | High or Moderate Risk CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Sleep
CRM07Ne | High or Moderate Risk CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Relax
CRM07Nf | High or Moderate Risk CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Connect
CRM07Nga | High or Moderate Risk CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Alcohol
CRM07Ngb | High or Moderate Risk CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Smoking
CRM07Ngc | High or Moderate Risk CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Drugs

Improvement in Health Factors



CRM08 – Improvement in Health Factors

➤ Cohort: Groups 1 & 2

- Achievement: Improvement in any of exercise, BMI or smoking indicators
- E.g. Exercise
 - Cohort: earliest inactive/no exercise or moderately inactive coded between 01st Jan 26 – 31st Dec 26
 - Achievement: latest active or moderately active coded between 01st Jan 26 – 31st Mar 27 (recorded after earliest inactive/no exercise or moderately inactive code)



CRM08: EMIS Searches

Achievement

▶ i) Improvement in Health Factors -PAYMEN

▶ j) Health Confidence Score -PAYMENT

▶ k) Diabetes -3 Treatment Target

▶ l) Diabetes - HbA1c Treatment Target

▶ m) Hypertension - Black & Black British BP T

▶ Sub

zData Extraction - BI USE

06 Child Health Hubs

07 Coil Fitting for Non-Contraception

08 Diabetes Level 2 MDT

09 Diabetes Early Onset Type 2

10 ECG

Data Quality

CRM08AD | High or Moderate CRM | DEN | Earliest Inactive or moderate...

CRM08A | ACHIEVEMENT | Latest Active codes recorded after inacti...

NHS NUMBERS | CRM08A | Exercise

CRM08BD | High/Moderate CRM | DEN | Earliest BMI

CRM08B | ACHIEVEMENT | Latest BMI recorded after earliest one

NHS NUMBERS | CRM08B | BMI

CRM08CD | High or Moderate CRM | DEN | Earliest Current Smoker

CRM08C | ACHIEVEMENT | Latest Non-Smoker or Ex-Smoker

NHS NUMBERS | CRM08C | Smoking

Data Quality

▶ i) Improvement in Health Factors -PAYMEN

▶ j) Health Confidence Score -PAYMENT

▶ k) Diabetes -3 Treatment Target

▶ l) Diabetes - HbA1c Treatment Target

▶ m) Hypertension - Black & Black British BP T

▶ Sub

zData Extraction - BI USE

06 Child Health Hubs

07 Coil Fitting for Non-Contraception

08 Diabetes Level 2 MDT

09 Diabetes Early Onset Type 2

10 ECG

11 Latent TB

12 Mental Health

Data Quality

CRM08Aa | DQ | MISSING 2nd Exercise Status codes

NHS NUMBERS | CRM08A | MISSING 2nd Exercise

CRM08Ab | DQ | NO Improvement in Moderately Active or Active

NHS NUMBERS | CRM08A | No Improvement in Exercise

CRM08Ba | DQ | MISSING 2nd BMI

NHS NUMBERS | CRM08B | MISSING 2nd BMI

CRM08Bb | DQ | NO Improvement in BMI

NHS NUMBERS | CRM08B | No Improvement in BMI

CRM08Ca | DQ | MISSING 2nd Smoking Status code

NHS NUMBERS | CRM08C | MISSING 2nd Smoking Status

CRM08Cb | DQ | NO Improvement in Smoking Status

NHS NUMBERS | CRM08C | No Improvement in Smoking Status



CRM08: SystmOne Searches

Achievement

CRM08 -----IMPROVEMENT IN HEALTH FACTORS -----
CRM08AD | High or Moderate CRM | DENOMINATOR | Earliest Inactive/no exercise or moderately inactive
CRM08AN | High or Moderate CRM | ACHIEVEMENT | Latest Moderately active or active or exercise more than once a week
CRM08BD | High or Moderate CRM | DENOMINATOR | Earliest BMI
CRM08BN | High or Moderate CRM | ACHIEVEMENT | Improvement in BMI between 2 readings
CRM08CD | High or Moderate CRM | DENOMINATOR | Earliest Smoker
CRM08CN | High or Moderate CRM | ACHIEVEMENT | Latest Non-smoker or ex-smoker

Data Quality

CRM08 -----IMPROVEMENT IN HEALTH FACTORS -----
CRM08Aa | High or Moderate CRM | WORK TO DO | Exercise | MISSING Second Exercise Status
CRM08Ab | High or Moderate CRM | WORK TO DO | Exercise | NO Improvement in Exercise Status
CRM08Ba | High or Moderate CRM | WORK TO DO | BMI | MISSING Second BMI
CRM08Bb | High or Moderate CRM | WORK TO DO | BMI | NO Improvement in BMI
CRM08Ca | High or Moderate CRM | WORK TO DO | Smoking | MISSING Second Smoking Status
CRM08Cb | High or Moderate CRM | WORK TO DO | Smoking | NO Improvement in Smoking Status

Health Confidence Score



CRM09 – Health Confidence Score

➤ Cohort: **Groups 1 & 2**

- **Achievement:** 2 Health Confidence scores recorded at least 1 month apart



CRM09: EMIS Searches

Achievement

▲ j) Health Confidence Score - PAYMENT

▶ Data Quality

▶ k) Diabetes - 3 Treatment Target

▶ l) Diabetes - HbA1c Treatment Target

▶ m) Hypertension - Black & Black British BP T

▶ Sub

Folder Data Quality

Search CRM09D | DEN | High or Moderate Risk

Search CRM09 | ACHIEVEMENT | 2 Health Confidence Score recorded at lea...

Calendar NHS NUMBERS | CRM09 | 2 Health Confidence Scores

Data Quality

▲ j) Health Confidence Score - PAYMENT

▶ Data Quality

▶ k) Diabetes - 3 Treatment Target

▶ l) Diabetes - HbA1c Treatment Target

▶ m) Hypertension - Black & Black British BP T

▶ Sub

Folder Sub

Search CRM09a | DQ | LAST 15M TO END OF FY | MISSING Health Confidence ...

Calendar NHS NUMBERS | CRM09 | 2 Health Confidence Scores

Search CRM09b | DQ | LAST 15M TO END OF FY | MISSING 2 Health Confidenc...

Calendar NHS NUMBERS | CRM09 | Health Confidence Score



CRM09: SystmOne Searches

Achievement

CRM09 -----HEALTH CONFIDENCE SCORE-----
CRM09 | High or Moderate Risk CRM | ACHIEVEMENT | LAST 15 MONTHS | 2 Health Confidence Scores recorded at least 1 month apart

Data Quality

CRM09 -----HEALTH CONFIDENCE SCORE-----
CRM09Na | High or Moderate Risk CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING Health Confidence Score
CRM09Nb | High or Moderate Risk CRM | WORK TO DO | LAST 15M TO END OF FY | MISSING 2 Health Confidence Scores at least 1 month apart
