HNP HARROW NETWORK PARTNERS

Harrow Primary Care Networks

West & North London ICB CRM Training Session 3

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 infarct (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

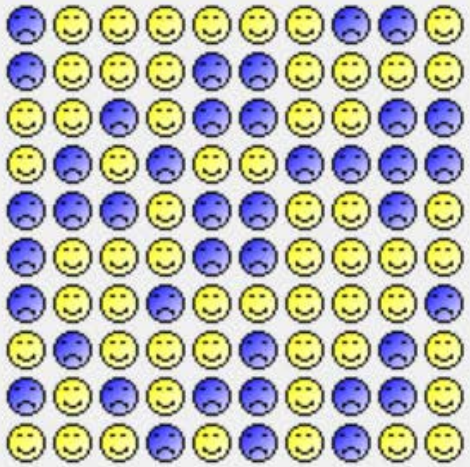
Trends


Body mass index
kg/m2
Body weight (observable entity)
kg
HbA1c level - IFCC standardised
mmol/mol
Waist circumference
cm
Serum ALT level
U/L
*Multiple units found
Blood Pressure *
mmHg
Blood Pressure *
31-Dec-2011
31-Dec-2013
31-Dec-2015
31-Dec-2017
31-Dec-2019
31-Dec-2021
31-Dec-2023
31-Dec-2025

ClinRisk

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

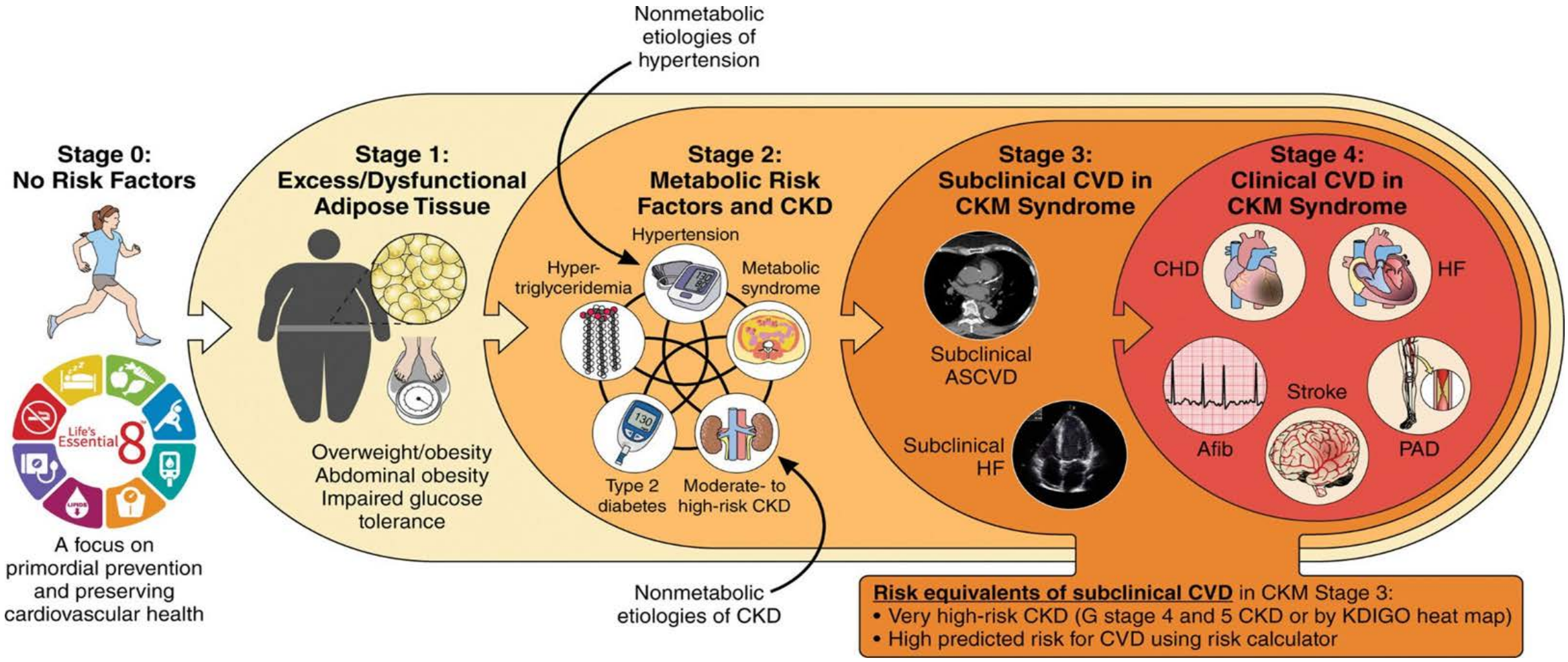
Data used to calculate the QRisk2 Score

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** *(Significant)*	02-Mar-2026
B	**Type 2 diabetes mellitus** *(Significant)*	23-Jan-2026
C	**Essential hypertension** *(Significant)*	21-Jan-2026
D	**Upper respiratory infection** *(Minor)*	20-Aug-2025
E	**Hypercholesterolaemia** *(Significant)*	30-May-2017

CRM delivery model – Understanding the Why and How



AHA 2023

Overview – NWL Single offer CRM element 2026 2027

- 1. Detection/Quality improvement
- 2. Consistency of approach across CRM interconnected/inter-related conditions
- 3. Clinical care optimisation – takes into account new medication guidelines for DM/CKD/Lipid/HF
- 4. Holistic care - recognises the influence of lifestyle factors in patients lives and enabling behaviour change for both teams and patients

- 20% - CRM01A, CRM01B, CRMO1C, CRMO1D, CRM01E – QOF registers
- 20% CRMO2
- 20% CRM03, CRM04, CRM05, CRM06
- 40% CRM07, CRM08, CRM09

Combined NWL Single Offer pg 207 CRMO1 – 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, eGFR, uACR, 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 sc**) 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) uACR ≥ 30 OR ii) diabetes and uACR ≥ 3 or eGFR < 60 **on ACEI/ARB**	67%[48]	5%
CRM06: % patients on PCN register with i) **CKD** and eGFR 20 to <45 **OR** ii) **CKD** and uACR ≥ 22.6 and eGFR 45-90 **OR** iii) **T2DM** on **SGLT-2 OR** iv) **Heart Failure** (excluding those with moderate/severe frailty or those aged >80)	50%[49]	5%

[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.

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

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%

CRMO7 – 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)

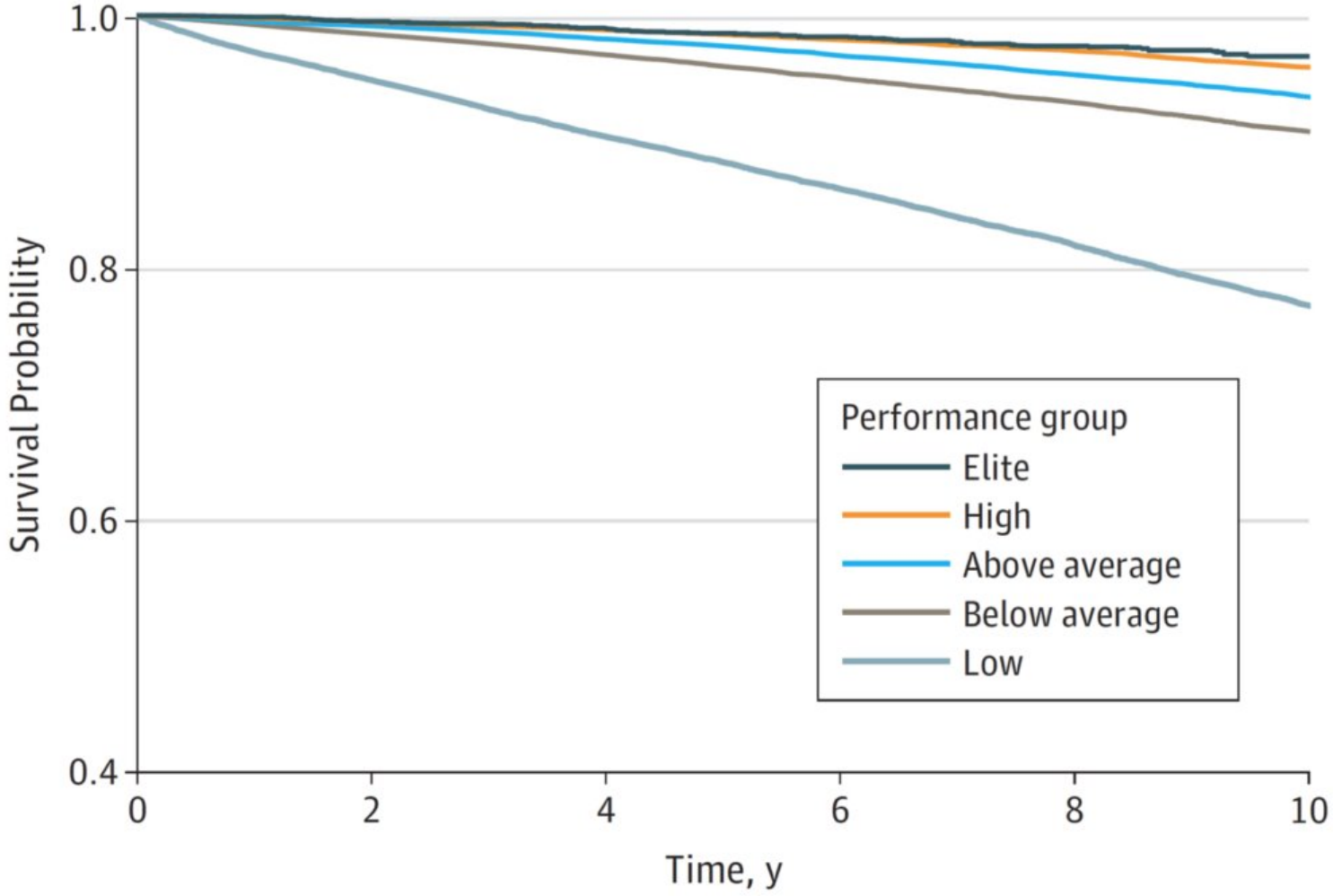
CRM09 – Record twice a year

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

- CRM0B – 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**)

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EMIS CRM Searches / Template / Care Plan

Presented by Matahir Jahn, Clinical Systems Developer, WNL

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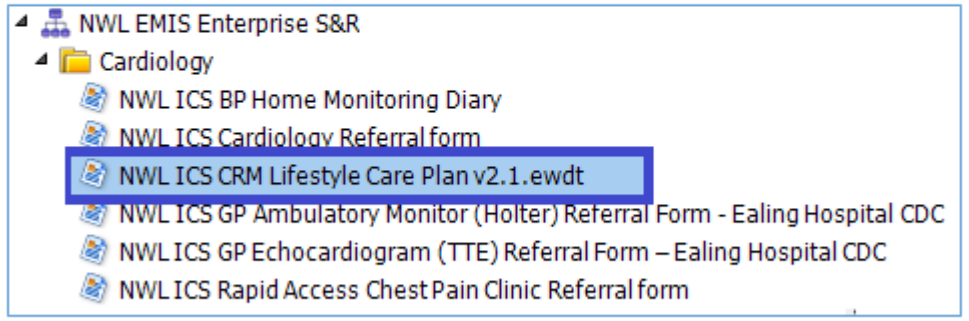
EMIS CRM Lifestyle Care Plan

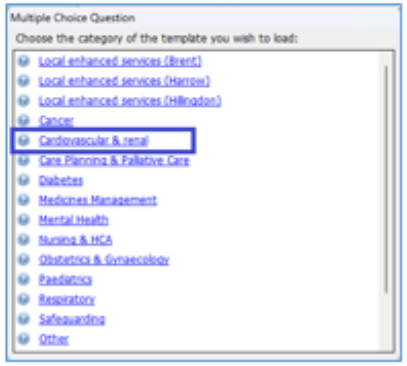
Create Letter > **NWL ICS CRM Lifestyle Care Plan**

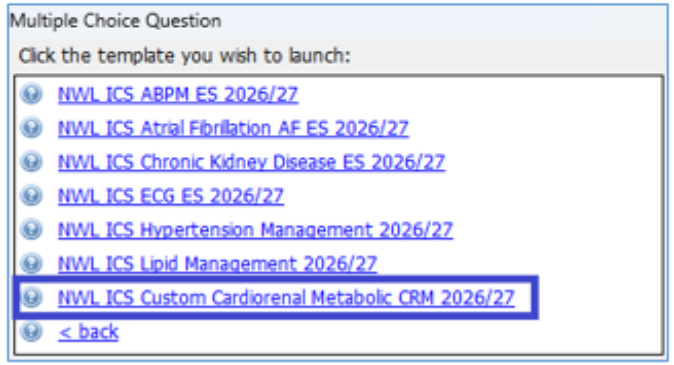


EMIS CRM Template

F12 NWL Template Launcher > Cardiovascular & Renal >

NWL ICS Custom Cardiorenal Metabolic CRM 2026/27

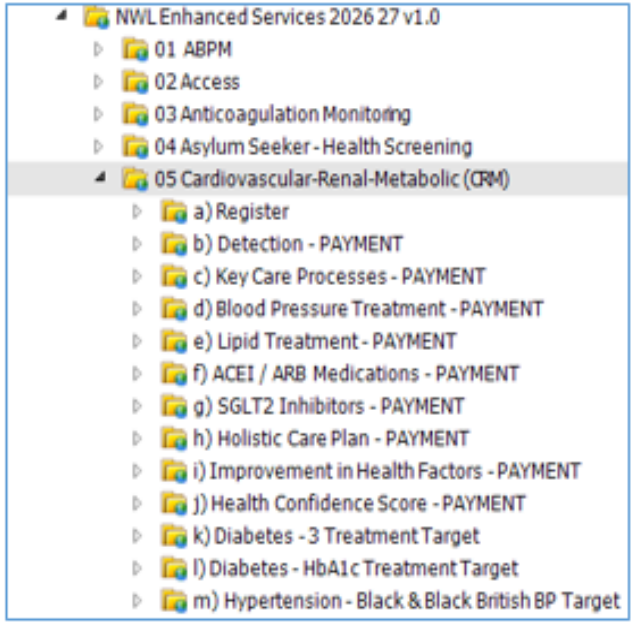




EMIS CRM Searches

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

05 Cardiovascular-Renal-Metabolic (CRM)



SystemOne CRM Searches / Template / Care Plan

Presented by Matahir Jahn, Clinical Systems Developer, WNL

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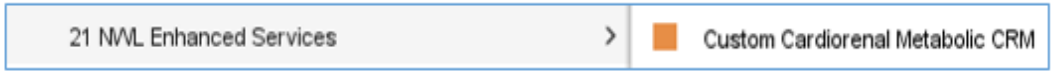
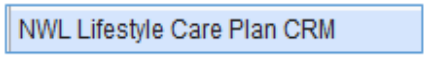
SystmOne CRM Template

Auto-consultation > 21 NWL Enhanced Services >
Custom Cardiorenal Metabolic CRM



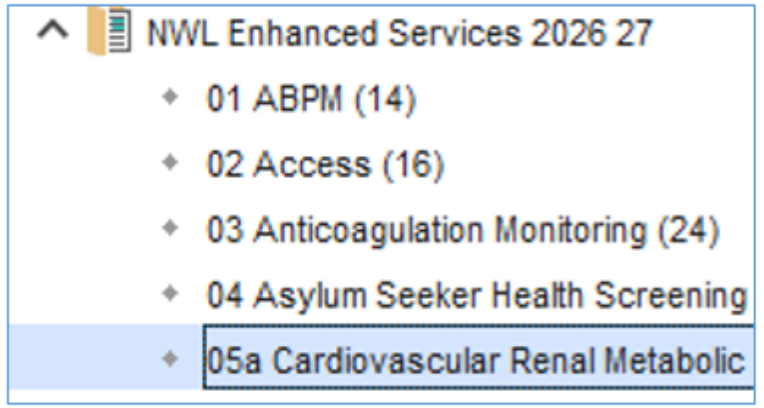
SystmOne CRM Lifestyle Care Plan

Communications & Letters > **NWL ICS CRM Lifestyle Care Plan**



SystmOne CRM Searches

Reporting > Clinical Reporting > NW London ICB > NWL Enhanced Services 2026 27 >
05 Cardiovascular-Renal-Metabolic (CRM)



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

Tharshiya Packianathan

Senior Information Manager (Primary Care)

Business Intelligence (Analytics)

06/05/2026

Introduction

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BI Responsibilities

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

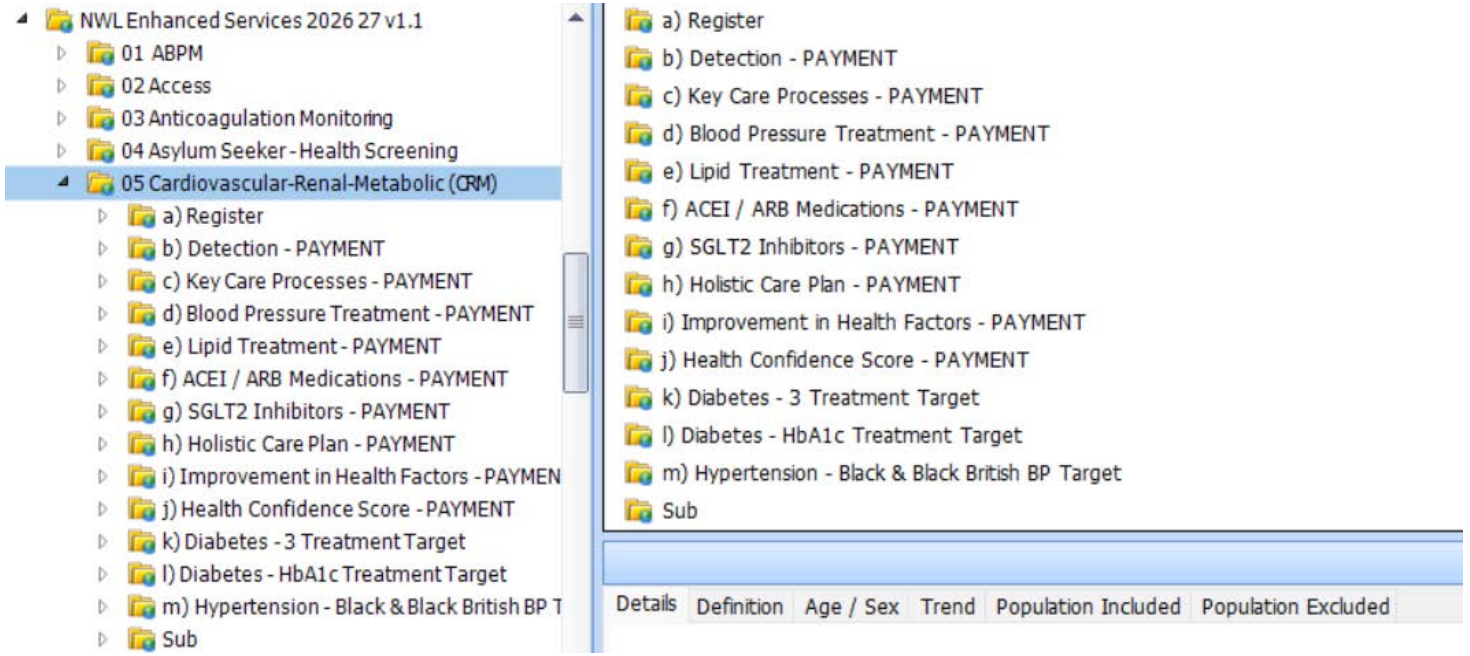
Location of CRM Searches - EMIS

- 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)



Location of CRM Searches - SYSTMONE

West and North London

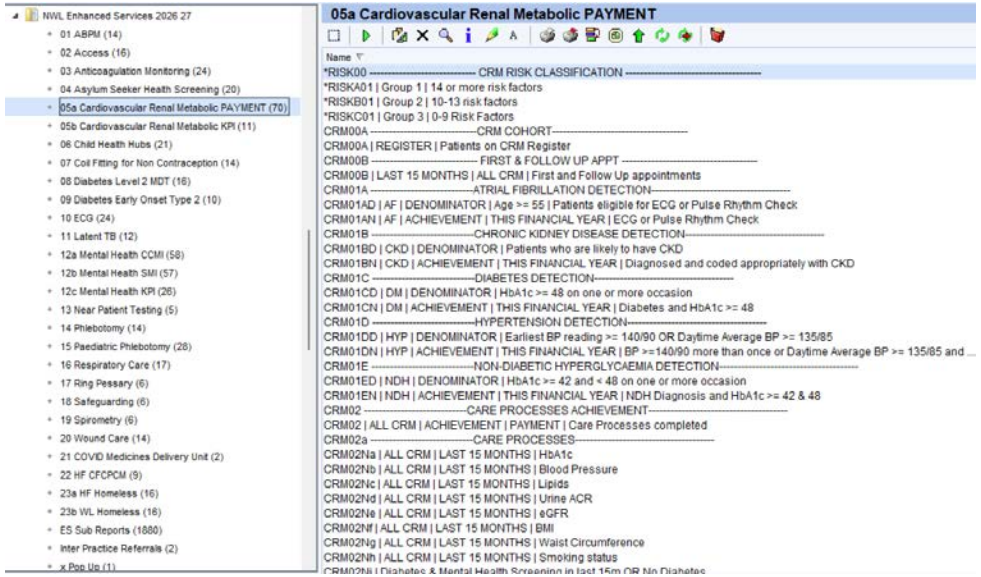
Achievement

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

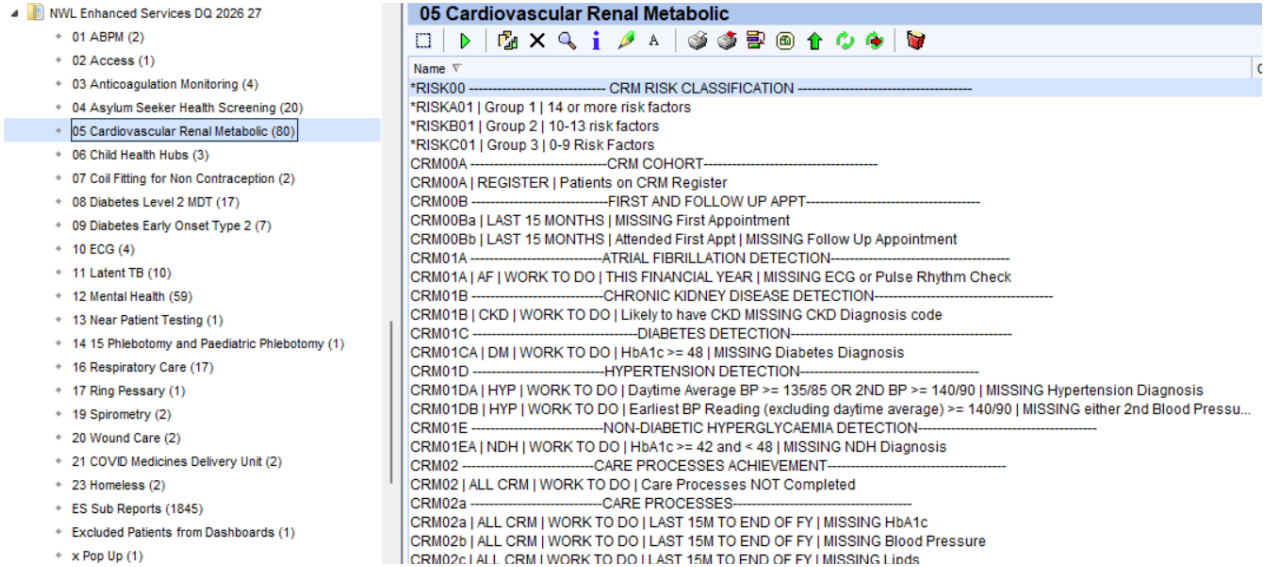
Data Quality

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

Achievement:



Data Quality:



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Cohort

CRM Register

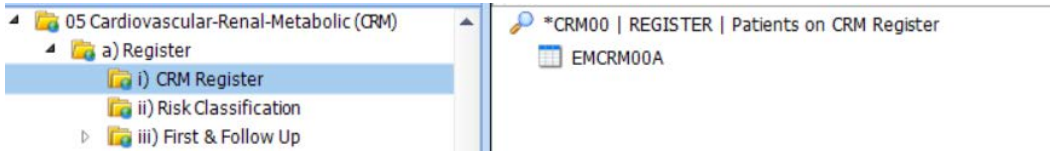
Inclusions

- 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

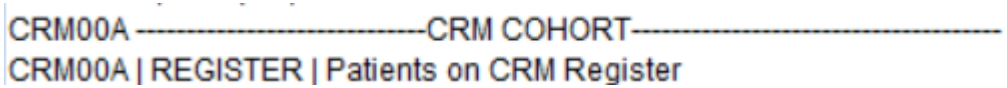
Exclusions

- Palliative Care

EMIS:



SystmOne:

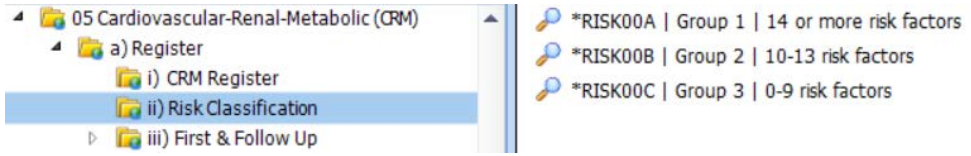


Risk Classification

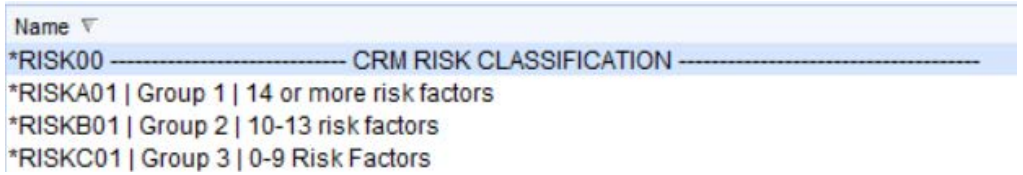
- Split into 3 groups
  - Group 1 – 14 or more risk factors
  - Group 2 – 10-13 risk factors
  - Group 3 – 0-9 risk factors

- Patient will remain in a risk group when first appointment has been completed until end of financial year

EMIS:



SystmOne:



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Metrics

Payment and Quality Metrics

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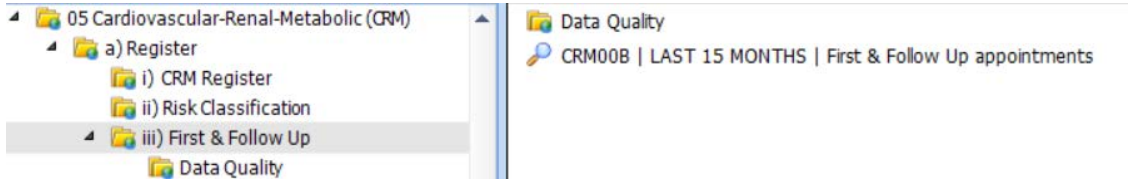
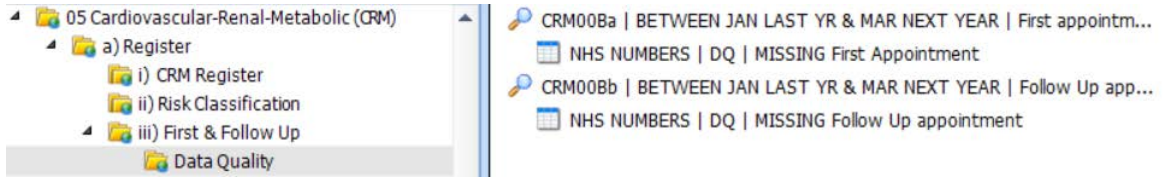
- First & Follow Up (CRM00B)
  - ➢ No longer a payment metric
  - ➢ Needed to fix patients in risk group
  - ➢ First appointment is part of holistic care plan for Groups 1 & 2

- Payment KPIs
  CRM01 – CRM09
- Quality metrics (non-payment)
  CRM10 – CRM12

EMIS Achievement:



EMIS Data Quality:



SystmOne Achievement:

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

SystmOne 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

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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*eGFR < 60 or 2*Urine ACR > 3
- Achievement: CKD diagnosis in financial year

c) Diabetes

- Cohort**:** HbA1c ≥ 48
- Achievement: Diabetes diagnosis in financial year

d) Hypertension

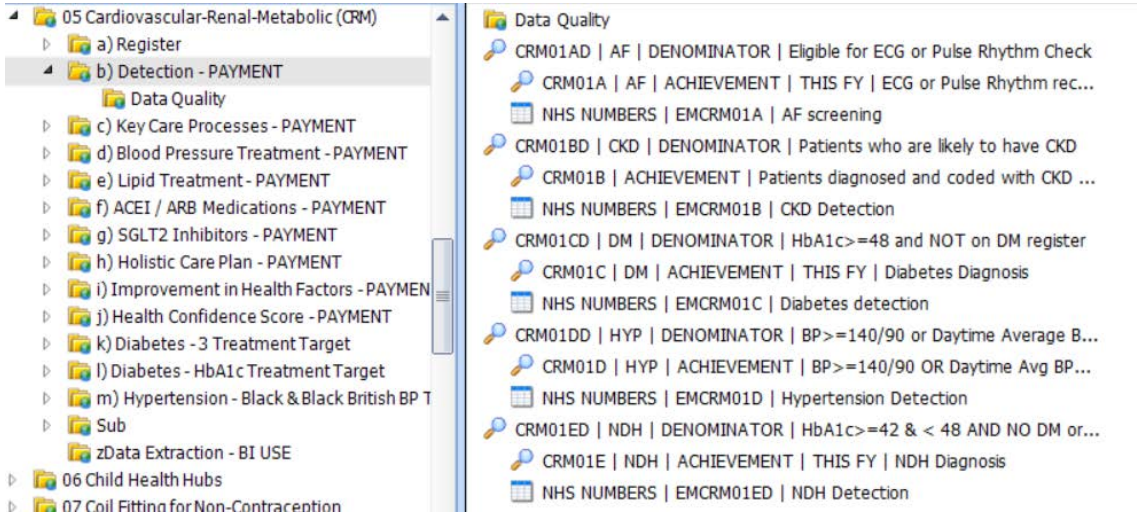
- Cohort**:** Daytime average BP ≥ 135/85 or BP ≥ 140/90
- Achievement: Either Hypertension diagnosis OR BP < 140/90 or daytime average BP < 135/85 in financial year

e) Non-Diabetic Hyperglycaemia

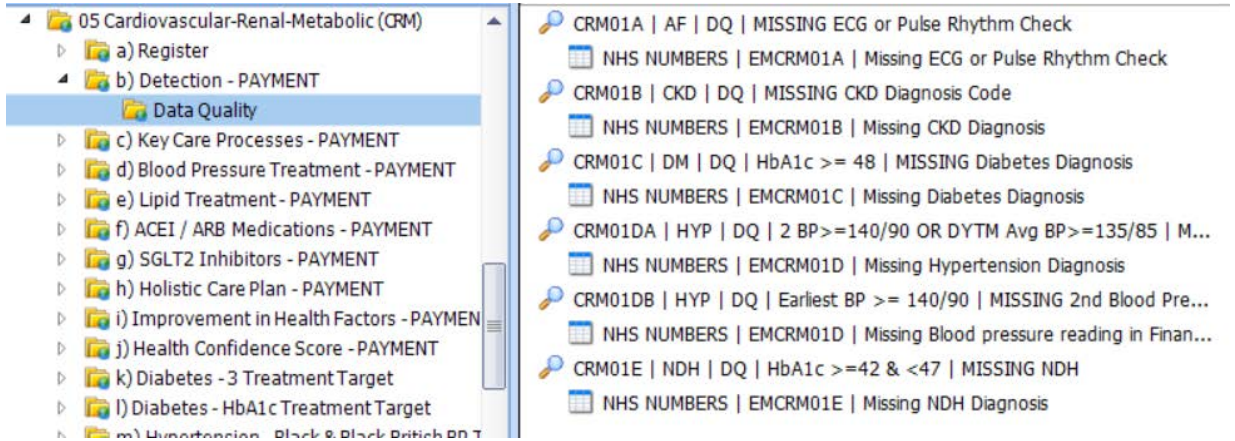
- Cohort**:** HbA1c ≥ 42 & < 48
- Achievement: NDH diagnosis in financial year

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

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Care Processes

CRM02 – Care Processes

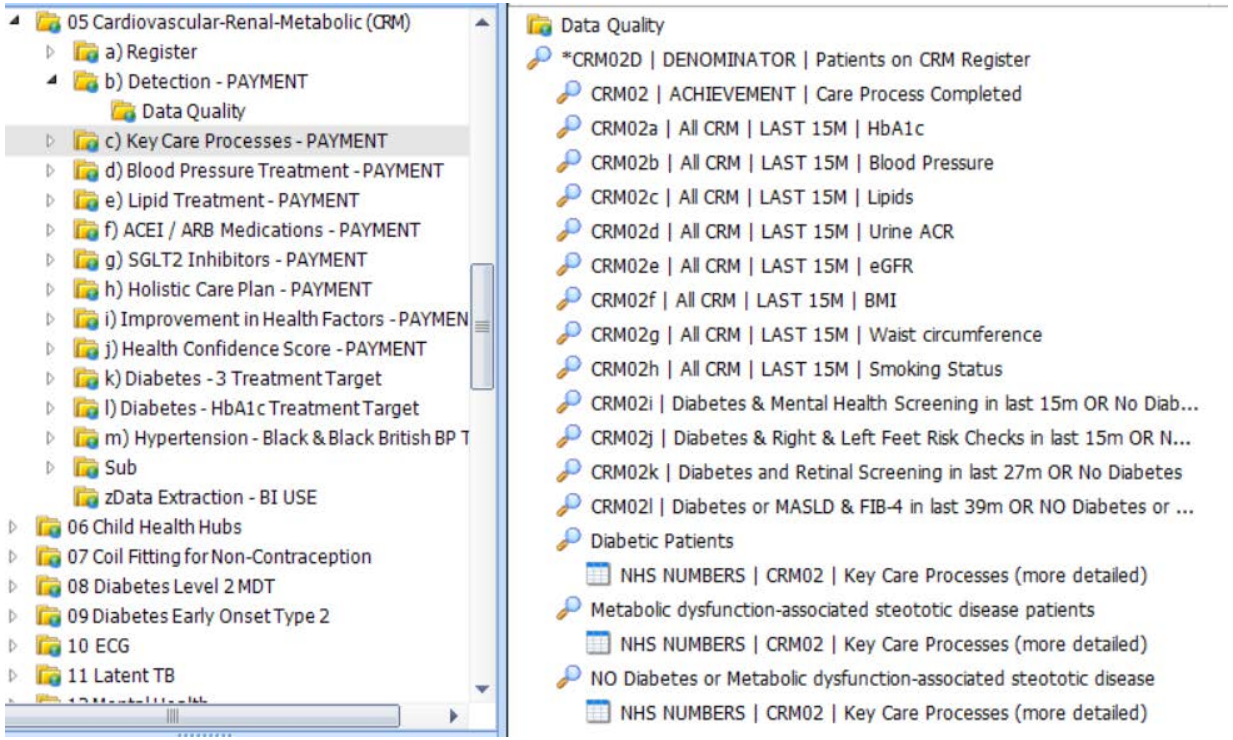
- Cohort: All CRM patients
- Achievement: All care processes completed (CRM02)
- CRM02a-l – Breakdown of care processes

Note:

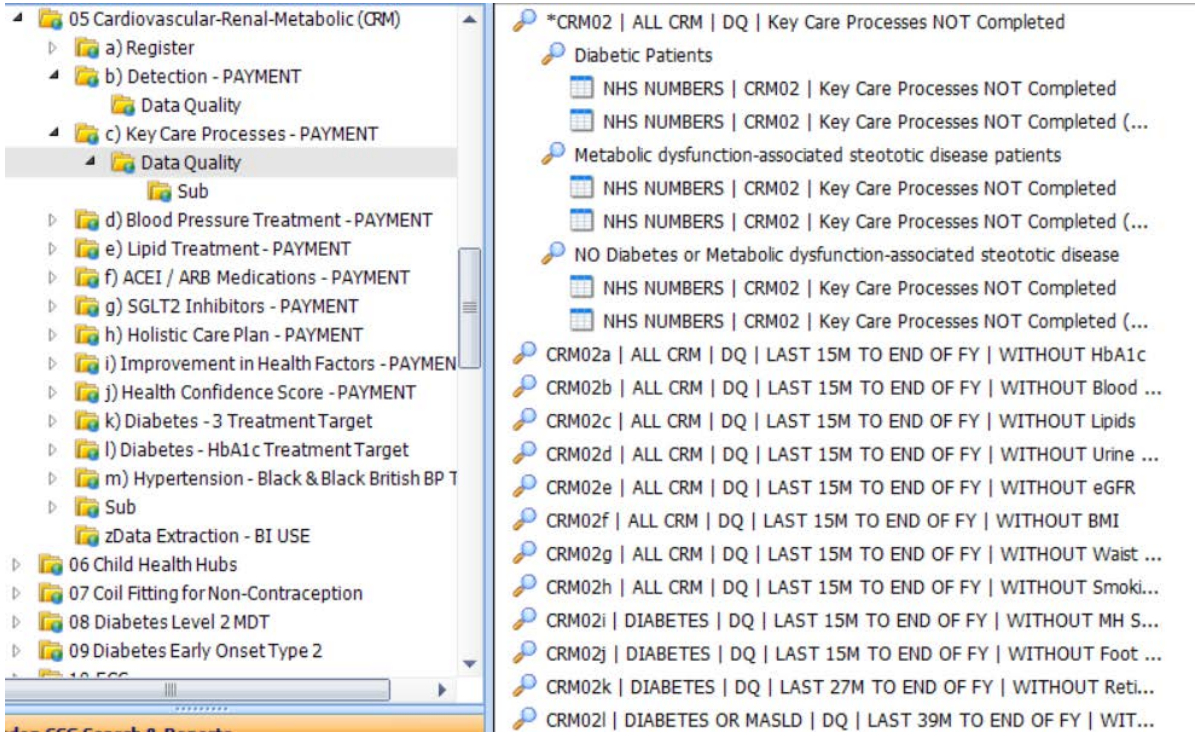
- Waist circumference (new metric)
- Diabetic patients only:
  - Mental health screening
  - Left & Right foot risk classification
  - Retinal screening
- Diabetic & MASLD
  - FIB-4

CRM02: EMIS Searches

Achievement



Data Quality



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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
CRM02Nl | 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
CRM02l | DIABETES OR MASLD | WORK TO DO | LAST 15M TO END OF FY | MISSING FIB-4

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Blood Pressure Treatment

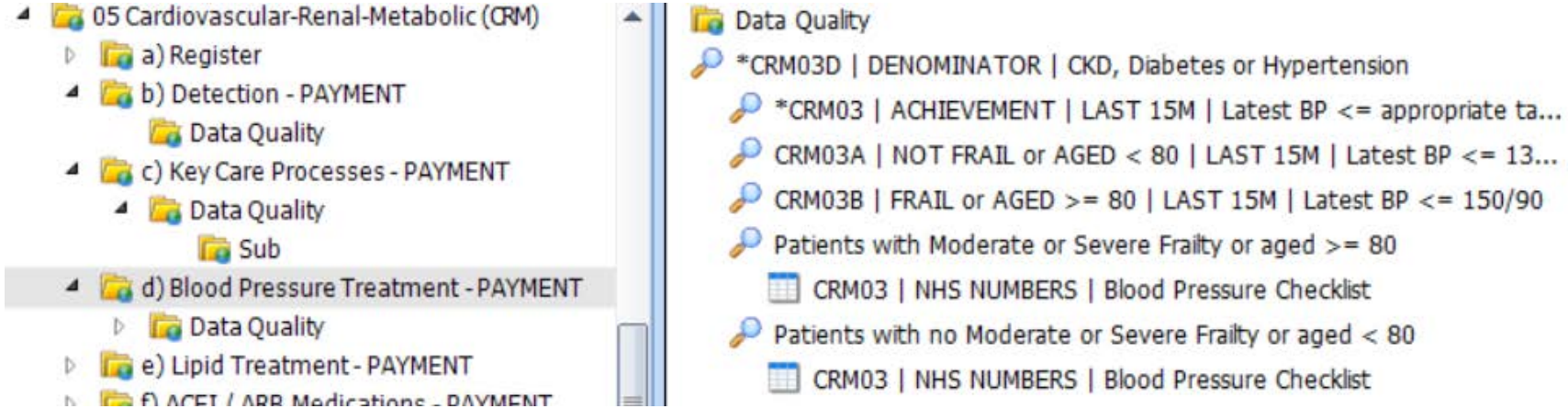
CRM03 – Blood Pressure Treatment

- 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 ≤ 130/80
  - Moderate or Severe Frailty or aged ≥ 80 with BP target ≤ 150/90

CRM03: EMIS Searches

Achievement



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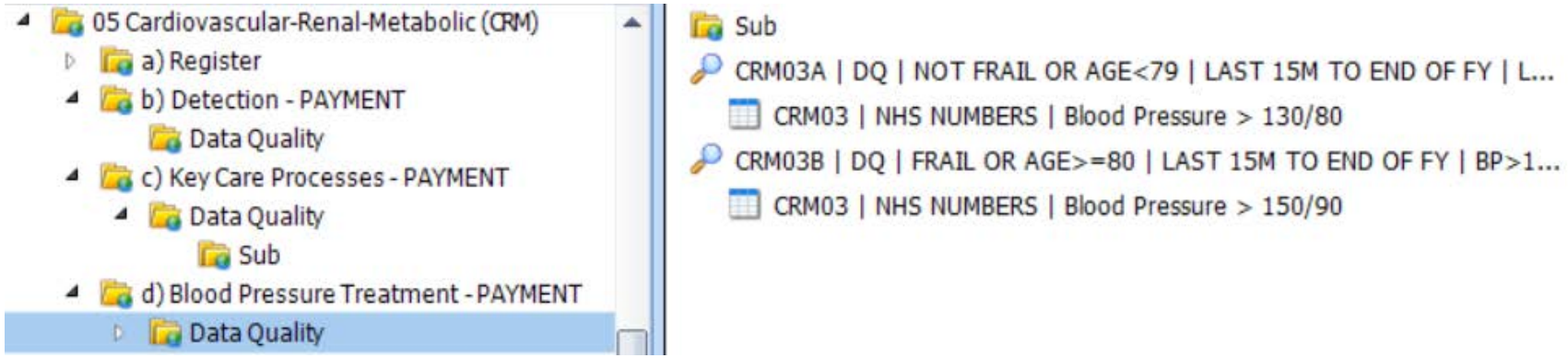

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CRM03: SystmOne Searches

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 <= 130/80 with no Frailty or aged < 80 or <= 15..

Data Quality

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

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Prescribing

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CRM04-6 – Prescribing/Medication Metrics

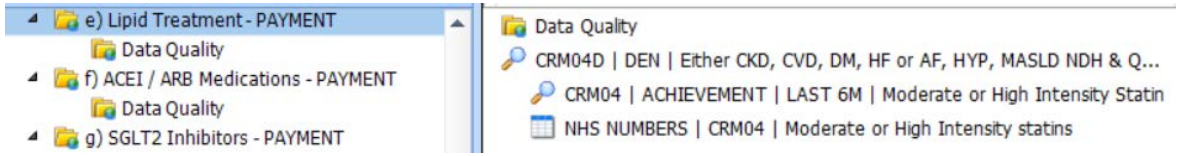
- **Lipid Lowering Therapy**
  - Cohort Group 1: CKD, Stroke/TIA, CHD, PAD, Diabetes, or HF
  - Cohort Group 2: AF, Hypertension, MASLD, NDH and latest QRISK > 10%
  - Achievement: Moderate or high intensity statins prescribed in last 6 months
- **ACEI/ARB Medications**
  - Cohort Group 1 : CKD and Urine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

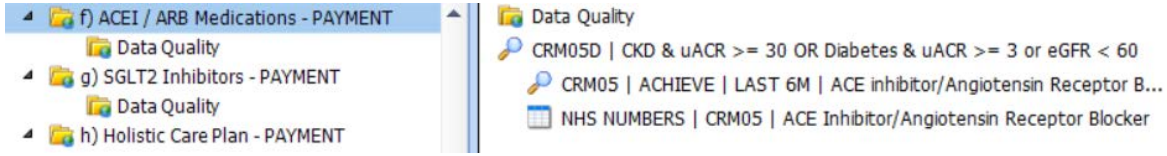
SGLT-2 Inhibitors

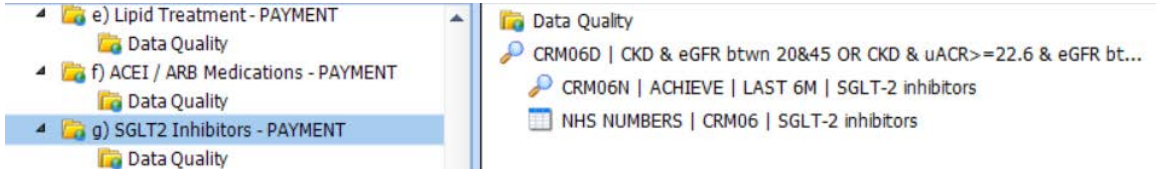
- Cohort Group 1: CKD and latest eGFR between 20 and 45
- Cohort Group 2: CKD and latest eGFR between 45 and 90 and Urine ACR ≥ 22.6
- Cohort Group 3: Type 2 Diabetes
- Cohort Group 4: Heart Failure
- Achievement: SGLT-2 inhibitors prescribed in last 6 months

CRM04-6: EMIS Searches

Achievement







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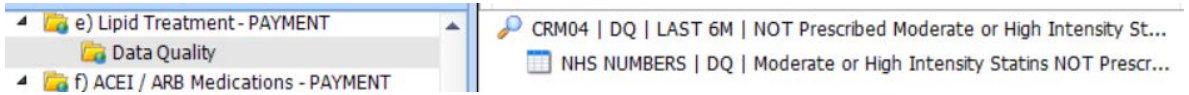

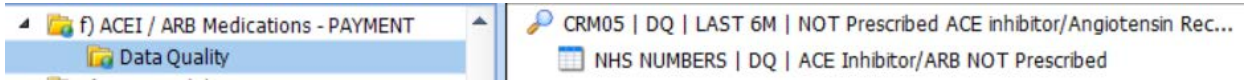

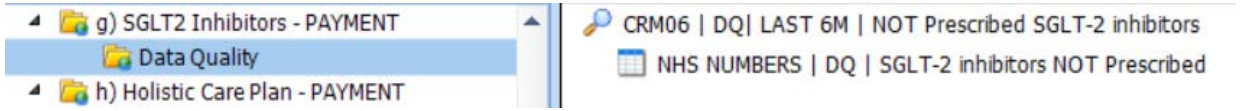

CRM04-6: SystmOne Searches

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

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Holistic Care Plan

CRM07 – Holistic Care Plan

- Cohort: **Groups 1 & 2**

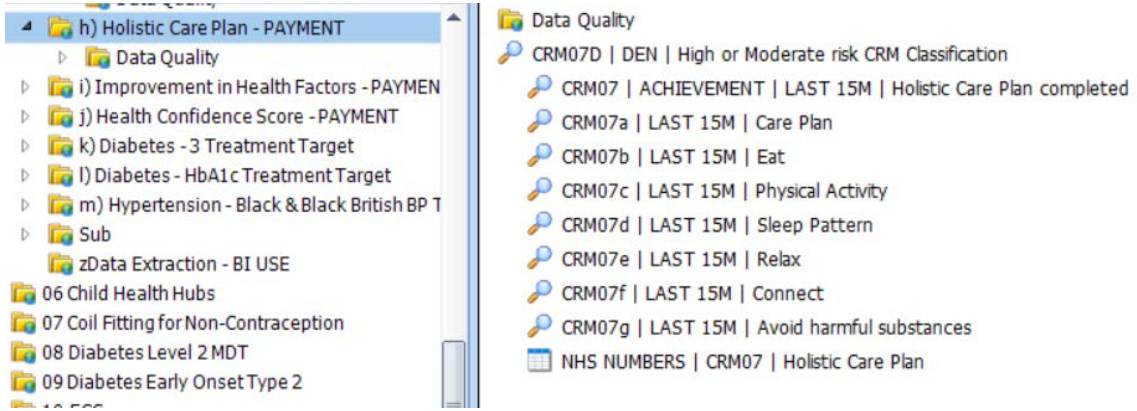
- Achievement: All components of holistic care plan is completed (CRM07)
- CRM07Na-g: individual components of holistic care plan
- All elements to be completed in last 15 months

Note:

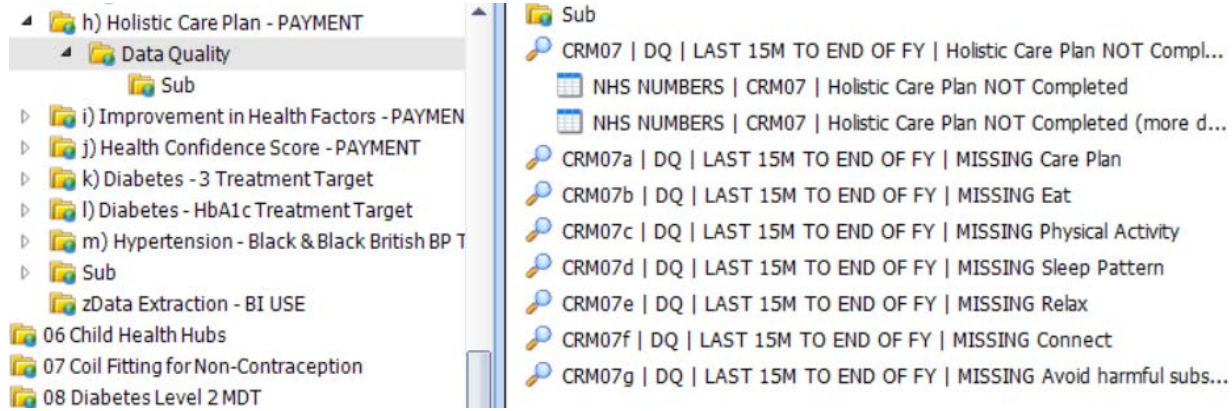
- CRM07Ng - Avoid harmful substances (3 items need to be completed)
  - Smoking
  - Alcohol
  - Drugs

CRM07: EMIS Searches

Achievement



Data Quality



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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

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Improvement in Health Factors

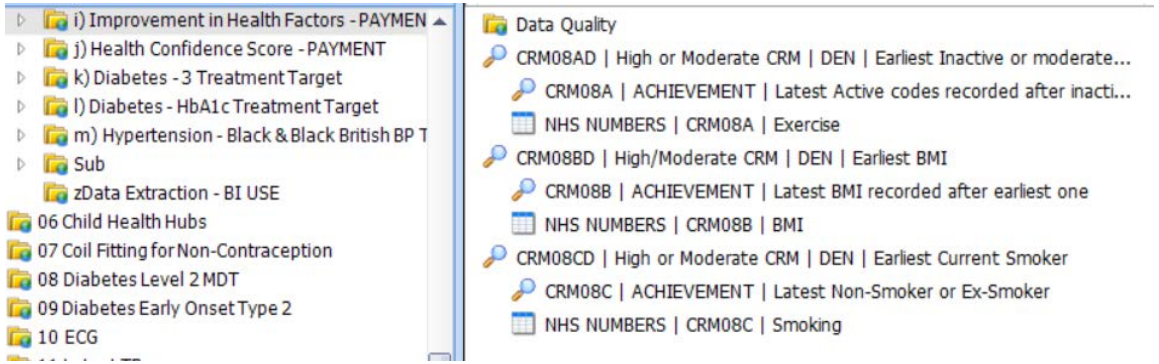
CRM08 – Improvement in Health Factors

- Cohort: **Groups 1 & 2**

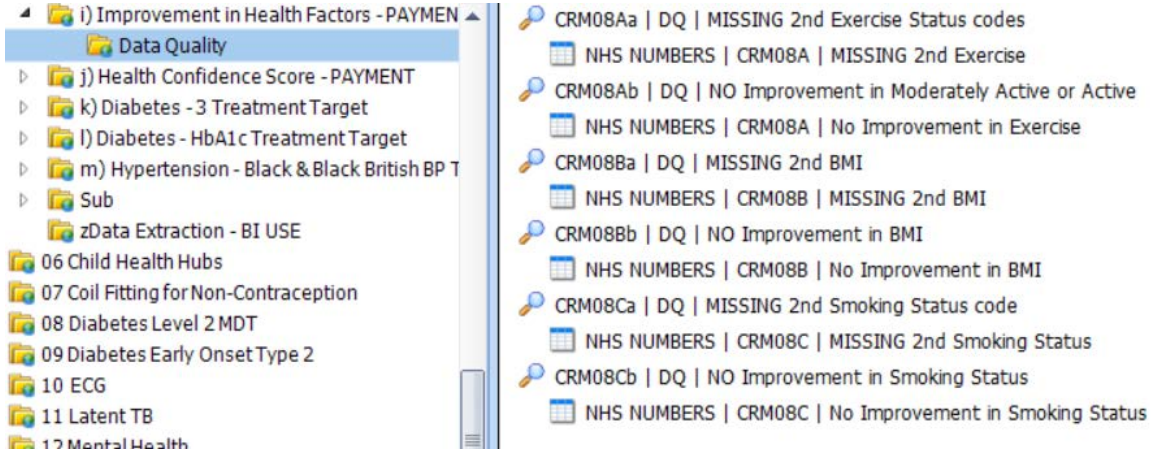
- Achievement: Improvement in any of exercise, BMI or smoking indicators
- E.g. Exercise
  - Cohort: earliest inactive/no exercise or moderately inactive coded between 01st Jan 26 – 31st Dec 26
  - Achievement: latest active or moderately active coded between 01st Jan 26 – 31st Mar 27 (recorded after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

CRM08: EMIS Searches

Achievement



Data Quality



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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

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Health Confidence Score

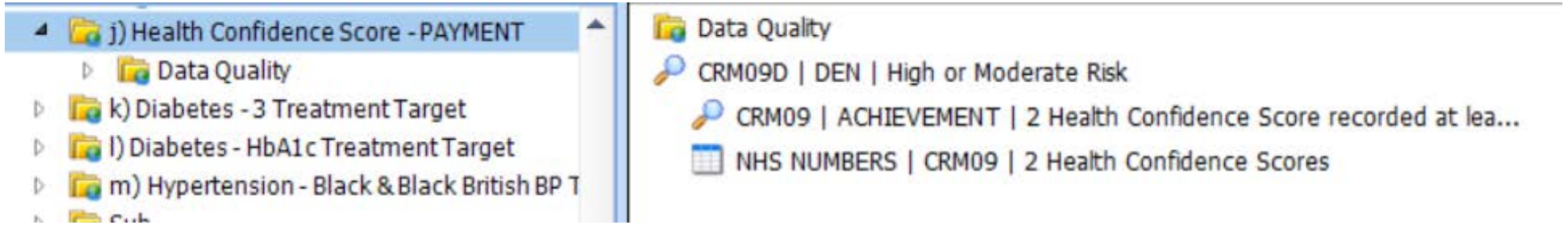
CRM09 – Health Confidence Score

- Cohort: **Groups 1 & 2**

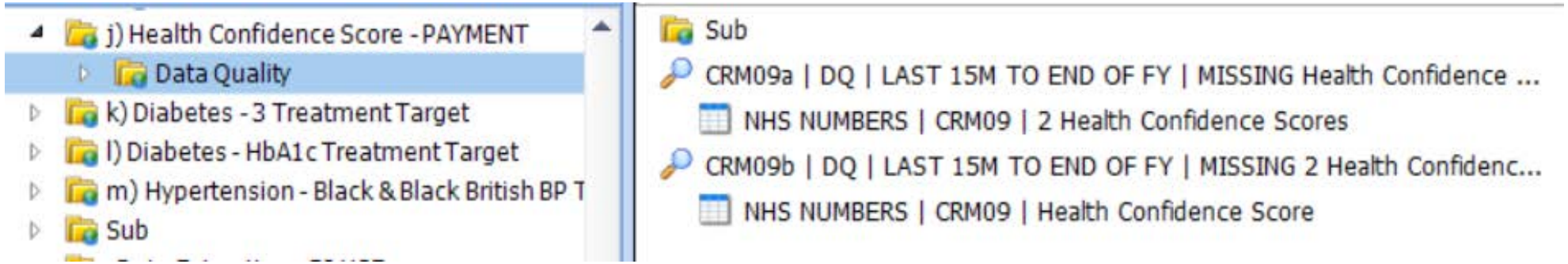
- Achievement: 2 Health Confidence scores recorded at least 1 month apart

CRM09: EMIS Searches

Achievement



Data Quality



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