TB1

Efficacy of ravulizumab on proteinuria response by baseline proteinuria or eGFR: A post hoc analysis of the SANCTUARY trial

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Introduction: In this phase 2 randomized controlled double-blind trial (NCT04564339), adults with IgA nephropathy (IgAN) received the complement C5 inhibitor ravulizumab (intravenous; q8w) or placebo for the first 26 weeks. Early and clinically meaningful reduction in proteinuria was observed. Here, we evaluate whether this benefit was independent of baseline (BL) proteinuria or estimated glomerular filtration rate (eGFR) at BL.

Methods: A post-hoc analysis assessed the impact of BL proteinuria and eGFR on treatment effect of RAV on proteinuria at Week 26. A mixed model for repeated measures was used to analyze the change from BL in log-transformed spot urine protein-to-creatinine ratio (UPCR) including an interaction term for either treatment group by BL spot UPCR or treatment group by BL eGFR.

Results: In the primary model without the interaction term, Week 26 UPCR reduction was –38.1% (95% CI: –48.3%, –26.0%) for RAV vs –15.3% (–34.0%, 8.8%) for placebo. In the model with treatment by BL spot UPCR interaction, reduction was similar: –38.2% (–48.3%, –26.0%) for ravulizumab and –15.3% (–34.0%, 8.8%) for placebo. For each 1-point increase in BL spot UPCR, there was a non-significant increase of 8% in the treatment effect (interaction coefficient=0.92, P=0.6; Fig 1). Similarly, in the model with treatment by BL eGFR interaction, reduction was similar, and the interaction was non-significant (interaction coefficient=0.00; P=0.8; Fig 2).

Conclusion: In this post-hoc analysis, BL proteinuria and eGFR did not significantly modify the treatment effect of ravulizumab on proteinuria at Week 26, suggesting that ravulizumab reduces proteinuria across a range of disease severity at treatment initiation.

TB2

Burden and impact of undiagnosed cognitive impairment in advanced chronic kidney disease: An interim analysis of the CogCKD study cohort

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Background:
Cognitive impairment (CI) is common in chronic kidney disease (CKD). However, studies in representative cohorts are minimal. The CogCKD study aims to investigate undiagnosed CI in an ethnically, socioeconomically and culturally diverse population with advanced CKD. This interim analysis was pre-specified to compare the recruited study cohort to the source population, in order to assess progress in recruiting a representative sample, as well as providing an early estimate of prevalence of CI.

Methods:
All adult patients, with an estimated glomerular filtration rate ≤ 25, who have been newly referred to our centre's Advanced Kidney Care Clinic (AKCC) and have no existing diagnosis of CI are invited to take part in CogCKD. Detailed socioeconomic data is collected and cognition is assessed using the Rowland Universal Dementia Assessment Scale (RUDAS), a screening tool validated for use in intercultural settings. A cut-off score of 25/30 for CI is applied. We compared the demographic characteristics of the recruited study sample to the incident AKCC population from June 2022 to June 2025. The proportion of participants with undiagnosed CI was calculated.

Results:
From December 2024 to August 2025, 100 (out of a target of 380) eligible, incident participants have been included in the study; representing an 87% participation rate (Figure 1). The historical AKCC population includes 1494 patients (Table 1). The study sample is younger than the AKCC population. The proportion of Black participants is higher in the study sample; whilst the proportion of South Asians and those from other ethnic groups is slightly lower. The distribution of socioeconomic strata is similar between the groups. In our sample, 7% of participants required an interpreter; comparable to an estimated 5% of AKCC patients.

The median RUDAS score in the study cohort is 25 (IQR 24 to 27) and overall prevalence of CI is 36%. Amongst 50 participants < 65 years of age, 15 (30%) had CI. Prevalence of CI was higher amongst those 65 or older at 21/50 (42%). CI was driven mainly by deficits in praxis, visuoconstructional drawing, judgement and memory. There was no evidence of a difference in the prevalence of abnormalities in judgement between younger and older people (56 versus 46%, p = 0.317).

Conclusion:
Our current sample contains the largest proportion of ethnic minority groups of any European cognition study in CKD. At this early stage, participation rate is high and our study population is representative of an urban, multi-cultural advanced CKD population. Recruitment across the range of the AKCC population been aided by support from our patient collaborators and integration of the recruitment process into the multidisciplinary team. Ongoing strategies will focus on accessibility for older people and representation of South Asian and other minority groups.

At this stage, the study lacks power to draw robust assumptions about prevalence of CI. Nevertheless, our early data suggests that undiagnosed CI is common in this population, including amongst younger people. This is driven in large part by abnormalities in executive function, a clinically important finding at this point in the patient journey.

TB3

A primary care perspective of virtual multidisciplinary team meetings with Nephrology – A blueprint for the future of collaborative care?

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Introduction
Following the December 2023 NICE guidance recommending SGLT2 inhibitors (SGLT2i) for chronic kidney disease (CKD) and their proven cardiovascular, renal and metabolic benefits, our practice launched a quality improvement project (QIP) to improve CKD care. Building on the success of virtual multi-disciplinary team (MDT) meetings in other parts of the country, we partnered with our local tertiary nephrology centre to pilot virtual CKD MDTs.

Method
The QIP focused on four main areas.

First, we identified patients with unrecognised CKD through electronic searches of blood and urine albumin–creatinine ratio (ACR) results. At-risk patients were screened and coded on diagnosis, supported by improved uptake of NHS health checks. To enable this, urine ACR was added to the checks and healthcare assistants were upskilled in the importance of reminding patients to provide an ACR sample.
Second, we strengthened monitoring, ensuring patients with CKD were invited for regular reviews to detect deterioration.

Third, we created searches to identify patients who could benefit from SGLT2i. These targeted those with multi-morbidity (CKD with type 2 diabetes and/or heart failure) or with clinically significant microalbuminuria not on renin–angiotensin system (RAS) therapy. Patients with severe frailty or palliative needs were excluded.

Fourth, eligible patients were contacted by telephone and offered SGLT2i. Calls also served as holistic reviews, covering blood pressure, medication safety, and optimisation of therapies such as RAS blockade, statins and other diabetic medication.

Complex cases were referred to a bi-weekly virtual MDT attended by a consultant nephrologist. Other clinicians at the practice could also refer patients they had seen to be discussed at the MDT. Beyond SGLT2i decisions, the MDT addressed issues such as declining renal function, prioritising pharmacotherapy, and when to refer to secondary care.
Results

The project improved knowledge and confidence in CKD management across the practice. Measurement of the kidney failure risk equation (KFRE) increased markedly: in patients with CKD stages 3a–5, coded KFRE rose from 1% to 83% between 01/01/2024 and 01/01/2025. Secondary care colleagues gained greater insight into managing related co-morbidities, particularly diabetes and heart failure. Importantly, outpatient referrals and advice-and-

guidance requests to nephrology declined, reflecting more effective primary care management.

Discussion

Accurate coding, diagnosis and monitoring of CKD were vital foundations for this work, enabling meaningful engagement with the virtual MDT. Virtual MDTs are increasingly recognised as efficient, collaborative ways to manage complex long-term conditions across specialties.

This pilot has helped evidence the benefits of virtual MDTs to stakeholders and commissioners for wider rollout of virtual CKD MDTs. Expansion is planned across our primary care network and, in time, at integrated care board (ICB) level. Such collaboration between primary and secondary care has the potential to improve patient outcomes, reduce referrals and optimise healthcare resources.

TB4

Mixed Methods Evidence Synthesis for Equity: To Identify Inclusive Education and Information Interventions for All People Managing Early-Stage Chronic Kidney Disease

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Introduction:
Preventing progression from earlier stages of chronic kidney disease (CKD) to end-stage kidney disease is key to the management of CKD. However, the effectiveness and cost-effectiveness of interventions aimed at delivering information and education to patients with early-stage CKD and their families remains unclear.
Methods:
A linked mixed methods evidence synthesis was conducted (NIHR HTA Award 157908; PROSPERO CRD42024544810), consisting of two systematic reviews (quantitative and qualitative) of interventions providing information and education in Stages 1-4 CKD. Electronic databases were systematically searched from inception, to 4th June 2025. 10,992 records were identified, after deduplication 10,782 were screened with 10,356 excluded at title and abstract and 426 assessed for eligibility at full text.
Results:
Forty-three RCTs (12,244 participants) were eligible for inclusion in the effectiveness review, with 11 studies eligible for the cost effectiveness and resource use review (4 cost effectiveness studies, with 6 RCTs and 1 qualitative study with resource use data), and 13 qualitative studies (276 participants) eligible for the qualitative review.
Multi-component interventions (i.e. education plus other components) work the best to produce improvements in some important clinical and person-centred outcomes, and interventions were cost-effective.
Exploratory quantitative analysis revealed that education with behaviour change techniques or education content including CKD in combination with lifestyle (Diet/Exercise) and medicines provided some indication of improved outcomes. Delivery of the intervention may work better with person-to-person interaction. However, the evidence is very uncertain and of mixed quality.
Thematic synthesis revealed the following factors that influence successful intervention delivery:

- Behavioural support helps with goals and planning, feedback and monitoring.
- Multi-faceted education to explain why diet, exercise and medicines are important for kidney health.

- Remote approaches are acceptable as flexible but still need opportunities to ask questions and clarify issues.
- Structured, manageable content is needed to build knowledge and confidence over time.
- Personalise interventions by tailoring education to CKD stage, and cultural/language needs.

The quantitative and qualitative findings have a degree of overlap and corollary suggesting some intervention elements may be more successful than others for supporting self-management behaviour change and beneficial changes in clinical outcomes.
There were a number of evidence gaps including the experiences of providers (healthcare professionals and peers) delivering interventions and families/carers receiving interventions. Certain age groups were missing, with limited UK data and limited reporting of equality, diversity and inclusivity in intervention design, delivery and evaluation.
Discussion:
This comprehensive evidence synthesis has highlighted several gaps in current research and implications for practice. Education only interventions, compared with either usual care or an active control did not show any significant improvements. However, those that combined educational interventions with other active ingredients such as behavioural change techniques, do seem to provide benefits, which was strengthened by the qualitative synthesis findings. However, the included studies had relatively small effect sizes with a lack of precision and unexplained heterogeneity, reducing overall certainty.
Several evidence gaps and priorities for recommendations have been co-developed with key stakeholders to guide future research regarding information and education in early CKD.

TB5

Chronic kidney disease progression is attenuated in post-menopausal women receiving hormone replacement therapy (HRT): a retrospective cohort study

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Introduction: The global prevalence of non-dialysis chronic kidney disease (CKD) is higher in females than males. However, males with CKD are more likely to experience faster progression to kidney failure and have a higher mortality. Differences in traditional risk factors between the sexes, such as higher rates of hypertension, smoking and poorer health behaviours amongst males do not fully account for this disparity. Moreover, although CKD is more common in females overall, this pattern changes according to reproductive age and hormonal status where eGFR decline appears to be faster in post-menopausal women than age-matched men. These observations have led us to hypothesise that females have intrinsic biological protection which is potentially mediated by oestrogen's protective effects on the kidney; and that supplemental oestrogen (in the form of hormone replacement therapy (HRT)) may reduce the rate of eGFR decline in post-menopausal women.
Objective: To evaluate the effect of oral oestrogen-based hormone replacement therapy (HRT) on chronic kidney disease progression in post-menopausal women.
Methods: This was a retrospective cohort study utilising the TriNetX Global Collaborative Network, which comprises de-identified electronic health records from 152 healthcare organisations worldwide. The study employed the TriNetX Compare Outcomes platform and was conducted on 5th September 2025. We extracted two groups of post-menopausal women one group prescribed oral HRT and the not prescribed HRT. The renal composite outcome measure was defined as eGFR ≤15 or requirement for renal replacement therapy. Inclusion criteria consisted of women aged 50 to 90 years with at least 4 recorded eGFR values calculated using the MDRD formula. For the HRT group women coded as receiving HRT (ICD-10 Z79.890) were included (n = 44,1754 pre-matching). The control group were women with no diagnosis or prescriptions for any form of oestrogen or HRT (n = 5,617,991 pre-matching). The index date was defined as the earliest date meeting the inclusion criteria with follow-up for outcomes until 5th September 2025. To minimise confounding 1:1 propensity score matching was used. Propensity scores were derived from a logistic regression model incorporating baseline demographics, comorbidities, and laboratory values.
Results: Baseline characteristics were well balanced with n= 441 754 in each group post-matching. The prevalence of diabetes, hypertension, and cardiovascular comorbidities were similar across groups. Over follow-up, the HRT group had significantly lower rates of kidney failure (Figure 1) with a hazard ratio of 0.799 (95% confidence interval 0.789 to 0.811). We

also observed a dose-dependent response in our cohort, where those women receiving oral HRT for a longer duration had the greatest benefit in relation to slowing the development and progression of CKD (Figure 2).
Conclusions: Our data demonstrate in a large retrospective cohort of post-menopausal women that oral oestrogen-based HRT reduces the rate of progression of CKD in a dose-dependent manner. To our knowledge this is the largest population-based study to demonstrate these effects and the first to show a dose-dependent response. These findings support a nephroprotective role for oestrogen in CKD and highlight the need for prospective evaluation and mechanistic studies to further investigate this benefit.

TB6

Group consultations in chronic kidney disease: improving patient education and treatment optimisation

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Introduction: Chronic kidney disease (CKD) is a progressive condition that is often diagnosed late, with many patients unaware of their diagnosis. Nationally, it is estimated that 1 in 7 patients with CKD are unaware of their diagnosis. In South East London, data shows that at least one-third of patients do not have their treatment optimised, particularly in areas such as blood pressure control, proteinuria management, and lipid-lowering therapy. Group consultations have emerged as an efficient approach to educate multiple patients simultaneously, promote self-management, and optimise treatment as per national and local clinical guidelines. This project aimed to assess the implementation and outcomes of group consultations for patients with stage 3 CKD within the local population.

Methods: Patients aged 18–90 years with stage 3 CKD, clinically stable but suboptimally managed in blood pressure, proteinuria, or lipid-lowering therapy, were invited to group consultations. Each session accommodated a maximum of 10 participants and lasted 120 minutes, comprising a patient education session followed by individual consultations within the group. The sessions were jointly delivered by a facilitator (social prescriber link worker) and a clinician (pharmacist). The objectives were to: (1) educate patients on kidney health to prevent or slow CKD progression; (2) initiate or optimise statin therapy to reduce risk of cardiovascular events; (3) initiate or titrate angiotensin-converting enzyme inhibitors (ACEi) or angiotensin II receptor blockers (ARB) for patients with high urine ACR or uncontrolled blood pressure; (4) initiate sodium/glucose cotransporter 2 inhibitors (SGLT2i) for proteinuria management; and (5) increase patient access to lifestyle support via social prescribing. Data on clinical interventions and patient-reported outcomes were collected across sessions.

Results: Between August 2023 and July 2025, 19 group consultations were conducted with 131 patient participants. Lipid-lowering therapy was offered to 90 patients, 72% commenced treatment during or after sessions. ACEi or ARB therapy was offered to 34 patients, with 73% starting treatment. Four patients were initiated on SGLT2i. Post-session feedback showed 71% of participants felt ‘confident’ or ‘very confident’ in understanding CKD, with 28% ‘somewhat confident’. In terms of comparative value, 78% found the group format more beneficial than traditional one-to-one consultations, and 19% found it “somewhat more beneficial”. Confidence in CKD treatment also increased, with 55% reporting “confident” or “very confident” levels, and 37% “somewhat confident.” Regarding recommendations, 82% were “likely” or “very likely” to recommend the session, and 14% were “somewhat likely.” Qualitative feedback highlighted that sessions were informative, improved understanding of CKD, and clarified management plans.

Discussion: Group consultations for patients with stage 3 CKD provided an effective platform for patient education, peer learning, and timely optimisation of evidence-based therapies. This approach led to high rates of treatment initiation, and enhanced patient-reported confidence in disease understanding and management. Integrating social prescribing also expanded access to lifestyle support services. These findings support the role of group consultations as a scalable model to address gaps in CKD care, enhance patient empowerment, and improve adherence to clinical guidelines in primary care settings.

TB7

Implementation of a Multimorbidity Kidney Point-of-Care Clinic in a Community Pharmacy setting to Optimise Chronic Kidney Disease Management

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Introduction

Chronic kidney disease (CKD) is a prevalent long-term condition associated with increased cardiovascular and renal morbidity and mortality. Although evidence-based treatments are available, therapeutic inertia and limited access to specialist care can delay timely optimisation. Point-of-care (POC) testing using finger-prick capillary samples enables rapid, accessible, and real-time results to support earlier intervention and patient engagement. This pilot aimed to evaluate the feasibility and acceptability of a pharmacist-led POC CKD clinic delivered in a community setting, supported by primary care and specialist teams.

Methods

A pharmacist-led CKD POC clinic was implemented over a six-week period, operating twice weekly. Adults were eligible if they had an estimated glomerular filtration rate (eGFR) between 20–80 mL/min/1.73m² and a urine albumin:creatinine ratio (uACR) >3 mg/mmol for those with diabetes or ≥22.6 mg/mmol for those without diabetes. Exclusion criteria included advanced renal disease (eGFR <20 mL/min/1.73m²), contraindications to angiotensin-converting enzyme inhibitors (ACEi), angiotensin receptor blockers (ARB), or sodium-glucose co-transporter 2 inhibitors (SGLT2i), serum potassium >5.0 mmol/L, or current nephrology follow-up.

Eligible patients were identified through electronic health record searches and manually screened. Each clinic appointment included blood pressure measurement and POC testing for creatinine, eGFR, and potassium using a validated POC device. A locally developed protocol guided same-day initiation or optimisation of ACEi, ARB, SGLT2i, and lipid-lowering therapies in line with national guidelines. Pharmacist interventions were supported by remote access to a specialist renal pharmacist or registrar. Governance processes were established with oversight from local commissioning structures.

Results

From 97 patients identified, 27 met inclusion criteria and were invited to attend. All attendees received individualised CKD counselling and comprehensive medication reviews. The majority were initiated or optimised on evidence-based therapies, including ACEi/ARB, SGLT2i, and statins. Patient feedback indicated high satisfaction with service accessibility, communication, and convenience.

Quantitative clinical outcomes are being collected over time, including rates of therapy optimisation, changes in renal function, and cardiovascular outcomes. Initial qualitative feedback suggests that immediate access to results improved patient understanding and engagement.

Discussion

This pilot demonstrates that a pharmacist-led CKD POC clinic is feasible, acceptable to patients, and clinically beneficial when integrated into community-based care. Rapid diagnostics facilitated real-time decision-making, reducing delays between assessment and intervention and addressing therapeutic inertia. By embedding specialist-informed protocols into routine practice, this model supports proactive multimorbidity management and could alleviate pressure on general practice.

While limited by a small initial cohort, potential selection bias, and short follow-up, early findings indicate that expanding this approach could improve CKD management in underserved populations. This pilot highlights the value of integrating pharmacists and POC testing into community pathways to deliver timely, guideline-led care closer to home.

TB8

Are we optimising medications for our Chronic Kidney Disease (CKD) patients? An audit of the nephrology service at a tertiary hospital in South-East London

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Aim:
To assess if patients with CKD at our centre are on optimal medical management based on national and local guidelines, identify key treatment gaps and explore barriers to providing best care

Objectives:
1. To evaluate compliance with NICE and CESEL guidelines for Renin-aldosterone - angiotensin inhibitors (RAASi), Sodium-glucose-cotransporter-2 inhibitors (SGLT2i) and statin therapy in patients with CKD and T2D
2. To assess current use and optimisation of finerenone, and identify patients eligible for initiation
3. To explore barriers to optimal therapy through review of electronic health records (EHR) and London Care Record (LCR).

Introduction:
CKD affects ~ 10% of the global population, and significantly increases the risk of cardiovascular events and kidney failure. Disease progression can be delayed through evidence-based pharmacological treatments, following a stepwise approach recommended by national guidelines such as NICE, and at a local level, such as CESEL (Clinical Effectiveness South East London). Finerenone is licensed for Diabetic Kidney Disease (DKD) G3-4 with albuminuria, and listed as Amber-2 rated in South-East London (SEL), requiring specialist initiation and monitoring for six months.

Methodology:
Audit Standards were derived from NICE and CESEL guidelines, which are locally adopted at the Trust.
Retrospective data were collected for all current renal clinic patients in June 2024, and data were analysed up until May 2025.
Inclusion criteria were CKD G1-4, ACR >3 mg/mmol. Exclusion data were Transplantation, Dialysis, Supportive Care and Deceased patients. Certain renal disease codes were also excluded, such as vasculitis.

Results:
We identified 523 patients eligible for the study and reviewed their treatment against recommendations in CESEL

The audit showed levels of RAASi use similar to national data and high levels of dose optimisation (76.3%), higher than local ICB level SGLT2i use (58.5% for patients with T2DM and 46.4% for CKD with no T2DM). Statin use was at 57.6%, lower than the national and local levels of use.
At the time of sampling, 13.4% of total patients were eligible for the initiation of finerenone, yet none had it prescribed. This reflects the gap between guideline expectations and the practical implementation of newer therapies in a real-world setting.

Lack of documentation was a common barrier to not achieving full compliance with the standards. However, approximately 18% of patients were not prescribed therapy by primary care following clinic recommendations, highlighting the need for stronger communication pathways.

Discussion:
While RAASi and SGLT2i use was encouraging, the gap between finerenone eligibility and initiation highlights missed opportunities. The suboptimal management of CKD patients could be attributed to documentation gaps and poor cross-sector communications. Finerenone had recently been recommended by NICE and added to CESEL at the time of data collection; therefore, widespread implementation cannot be expected due to recent local formulary approval and ongoing pathway integration.

A repeat audit is recommended following wider finerenone rollout, and system-level improvements such as EHR-based prompts and shared-care documentation that could enhance treatment optimisation.

TB9

SGLT-2 inhibitors in CKD: Are we meeting the 2023 UKKA guidelines? A phase 3 audit at a renal centre in the South West of England

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Introduction: SGLT-2 inhibitors have been shown to slow chronic kidney disease (CKD) progression across patient groups, regardless of diabetes status, reducing the risk of kidney failure, cardiovascular events and mortality. In April 2023, the UK Kidney Association (UKKA) updated its guidance on the use of SGLT-2 inhibitors in those with CKD following new evidence from the DELIVER and EMPA-KIDNEY trials which included many non-diabetic participants. Despite the benefits of SGLT-2 inhibitors, implementation, particularly in patients without type 2 diabetes (T2DM), remains suboptimal. Our aim was to assess current SGLT-2 inhibitor prescribing in CKD patients at our hospital against the updated UKKA guidance, identify gaps, and highlight opportunities for improvement.

Methods: We undertook the third cycle of a retrospective audit as a quality improvement project. All patients seen by the renal team between January 2025–March 2025 were screened against predefined inclusion and exclusion criteria. Prescribing of SGLT-2 inhibitors was measured at baseline (cycle 1), after an initial intervention (cycle 2), and again following the 2023 UKKA guideline update (cycle 3). Data was stratified by diabetes status, comorbidities and eGFR/uACR thresholds. Changes in prescribing over time were analysed to assess improvement.

Results: We identified 183 patients who met the audit's inclusion criteria. Of these, 144 met the 2023 UKKA criteria for SGLT-2 inhibitor therapy. Overall, 63 (44%) were prescribed an SGLT-2 inhibitor (60 dapagliflozin, 3 empagliflozin), compared with 35% and 50% in cycles 1 and 2 respectively (Figure 1). There were 63 patients with T2DM, 56 were eligible for SGLT-2 inhibitor therapy and 29 (52%) were on treatment. There were 110 patients without T2DM, 89 of these were eligible for SGLT-2 inhibitor therapy and 34 (38%) were on treatment. Patients with T2DM were more likely to be prescribed SGLT-2 inhibitors than those without T2DM (Figure 2). Among eligible patients with T2DM and heart failure, 64% were treated, and among those with coronary artery disease, 45% received therapy, both up from 20% in cycle 1. Among those without T2DM, SGLT-2 inhibitor uptake was highest in patients with symptomatic heart failure (55%) or eGFR>20 mL/min/1.73 m^2 + uACR>25 mg/mmol (50%). It was lowest in those with eGFR 20-45 mL/min/1.73 m^2 and uACR<25 mg/mmol (24%) (Figure 3). Twenty-seven percent of non-diabetic patients lacked a recorded uACR.

Discussion: In summary, this third-cycle audit showed a fall in the proportion of eligible patients prescribed SGLT-2 inhibitors compared with cycle 2 (50% vs 44%), highlighting the need to raise awareness of the updated UKKA guidance. Prescribing remains higher in patients with T2DM, especially those with comorbidities, but lower in those without diabetes. Improving uACR testing and systematically identifying non diabetic patients with

eGFR 20-45 mL/min/1.73 m^2 and uACR <25 mg/mmol may improve uptake. Potential interventions to achieve this include introducing an order set and staff education. We plan to expand trust-wide awareness and re-audit after these interventions to monitor progress.

TB10

Accelerated Advanced Kidney Care Pathway for unheralded dialysis starts – 2-year outcomes

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TUESDAY - Moderated Poster Session, HALL Q, March 10, 2026, 16:00 - 17:00

Introduction

The accelerated pathway is a 90-day pathway targeting patients unknown to renal services who present with ESKD. Funded by the NHSE 3P project, it focuses on education, transition to home therapies, definitive access for dialysis and access to transplantation within 90 days. The pathway was implemented in April 2024 and has now expanded to include known patients with a rapid, unexpected decline in renal function.

Method

Inclusion criteria for the pathway: 1) estimated GFR <15 mL/min and 2) not known to renal services or experienced a rapid decline in function. The pathway aimed for 40% definitive access creation, 10% transition to home therapies, 100% transplant workup initiation, and 60% transplant list activation within 90 days. Patients received education from a clinical nurse specialist within 7 days, followed by specialist review within 21 days to plan RRT and initiate transplant workup. After 90 days, patients were discharged to their dialysis unit or local nephrology team.

Results

Between April and September 2025, 127 patients were initiated on the pathway. The cohort was predominantly male (79%, n=100), with a median age of 57 years (range: 17–93). Ethnic distribution included Black, Asian and other minority groups (Table 1).

At presentation, 59 (23%) patients required acute haemodialysis (HD). For ongoing treatment, 53 (42%) chose HD, 60 (47%) peritoneal dialysis (PD), 5 (4%) opted for conservative management, and 9 (7%) did not engage (Table 2).

Among patients who chose HD, 27 (51%) had an arteriovenous (AV) fistula created, with a mean time of 67 days (range: 8–150); 2 had future dates. Of the 60 who chose PD, 23 (38%) had PD catheters inserted (mean time: 39 days) but only 18/60 (30%) were established on PD with 2/60 (3%) patients awaiting conversion to home therapies. The rest remained on ICHD, several reasons including unsuitable housing, clinical reasons and preference change (Figure 1).

9 (7%) patients recovered renal function, 11 (9%) died, 6 (5%) have not completed 90 days, 3 (2%) disengaged, and 7 (6%) awaiting RRT (Table 2).

56 patients had clear contraindications to transplantation. Transplant work-up was initiated in 71 patients (100%). Of these, 19 (27%) were activated on the waitlist (1 transplanted after 7 months), 44 (62%) are undergoing further work-up, while 43/127 (34%) were unsuitable,

and 13/127 (10%) declined or disengaged. Clinical complexity and additional need for cardiac work-up was the main barrier for transplant activation at 90 days.

60 patients completed the 90 day pathway: 44 (73%) on HD, 12 (20%) on PD, 1 (2%) on home HD, and 3 (5%) referred to AKCC. 17 (28%) AV fistulas were created, mean time of 43 days (8 to 88 days). Transplant work-up was initiated in 47 patients and 19 (40%) were activated with a mean time to activation of 51 days (Table 3).

Conclusion

The accelerated pathway targeted a diverse cohort and significantly improved access to home therapies, definitive dialysis access and transplantation. Social barriers were identified and targeted interventions are necessary to further improve the pathway outcomes.