

TF1

Understanding children and young people's experiences of kidney care: Phase 1 in the development of a paediatric kidney patient reported experience measure for under 18-year-olds

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

Introduction

The Kidney Patient-Reported Experience Measure (PREM) is a key tool in helping kidney units understand about patient experiences of care and identify areas for improvement. With over 80,000 responses, it is the largest measure of CKD patient experiences for those over the age of 17. Children and young people (CYP) also want to provide feedback about their hospital experiences; despite this, few PREMs exist that capture the views of young people. Capturing experiences of care of this young group is important to influence and inform current and lifelong kidney patient care.

Methods

A two-phase observational study using mixed-methods was conducted. Phase 1 (which will be the focus of the presentation) collected data from CYP, parents/carers, and professionals via focus groups and age-specific semi-structured interviews, exploring CYPs' experiences of kidney care and perspectives on factors impacting those experiences. Phase 2 used themes developed in phase 1 to create a pilot version of the Paediatric Kidney PREM, co-developed with CYP, parents/carers, clinicians, and academics, including age-appropriate items and scales to be piloted and tested. Co-production methodology used throughout this research, involving CYP, parents/carers, and professionals at every stage, including interpreting and sense checking findings and identifying key messages, ensured that the PREM items would not only be relevant and comprehensible but also meaningful to those who will use them.

Results

Thematic content analysis of phase 1 data produced 10 key themes comprehensively capturing CYPs' experiences of kidney care (Figure 1): coordinated care, access to whole MDT care team, at hospital, communication, information, personalised care, support, impact on lifestyle, education, and strength and learning through kidney disease.

Panels including CYP and parents/carers and professionals then produced 480 candidate PREM items addressing these themes. The relevance of items for different age groups were carefully considered; therefore, questions pertaining to transition to adult care were included but would only be presented to those aged 12+ years. Following a consensus survey to ascertain item relevance and importance, 229 items were assessed via cognitive interview with CYP and parents. The interview data informed development of age-appropriate pilot paediatric kidney PREMS for 4–6-year-olds (15 items), 7–11-year-olds (28

items) and 12–17-year-olds (43 items). A parent/carer proxy PREM was also created containing 49 items.

Discussion

Reliability and validity of the pilot surveys will be assessed in a future study to ensure that the included items collect accurate, consistent, and meaningful data for services. Final versions of the surveys will then be produced for use across the NHS.

The Paediatric Kidney PREM will enable direct feedback from CYP to kidney care teams, with findings having the potential to inform service development, quality improvement, and research at both local and national levels. Development of age-appropriate PREMs, giving all patients access to the benefits of a national Kidney PREM, supports access to equitable person-centred care across the lifespan, ensuring that all patients know that their voice matters. The Paediatric Kidney PREM development process can also serve as a model for the development of other condition-specific, age-appropriate experience measures in other paediatric specialties.

TF2

Ambulatory kidney care: Enhancing patient experience through development of a renal assessment and procedure unit.

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

Introduction

Across medicine there is a shift towards ambulatory clinical management, and this has particular relevance in renal medicine. The importance of admission avoidance is highlighted by both NHS England and GIRFT, with its potential to improve patient experience and reduce risk associated with inpatient hospital stays, including deconditioning, infections, and venous thromboembolism. Presentations in kidney medicine that lend themselves to ambulatory management include vascular access interventions, urgent referrals such as nephrotic syndrome, and managing peritoneal dialysis-related complications. This project aimed to align with GIRFT principles, improving flow and experience of patients through urgent and emergency care through direct speciality assessment. Locally, the absence of a dedicated space for such reviews resulted in prolonged waits in the medical assessment unit or avoidable inpatient admissions.

Methods

We undertook a service improvement project to establish a renal assessment and procedure unit (RAPU), running a pilot over an 8-week period from May-July 2025. This was designed with input from the wider multidisciplinary team, including nurses, service managers and renal physicians. The unit comprises one bed space, five ambulatory chairs, and a procedure room, all located within the existing renal footprint.

Results

During the 8-week pilot there were 201 patient encounters. Clinical assessment within RAPU avoided 53 emergency department presentations and saved 77 inpatient bed days. We facilitated 36 interventional procedures that included tunnelled line insertion, renal biopsy, and arteriovenous fistula intervention. No patients had unplanned admissions in the 30 days following their RAPU review. Both quantitative data and patient feedback suggested the new pathway enhanced experience, with patients highlighting reduced waiting times, improved continuity and a preference for the renal-specific environment.

Discussion

Establishing an ambulatory renal assessment and procedure unit is feasible within an existing renal service without additional financial investment. Re-allocation of space from the inpatient bed base was a key challenge and required MDT collaboration at trust level. Our pilot suggests this model can improve patient experience, reduce unnecessary hospital attendances and save inpatient bed days. Longer-term follow-up is required to comprehensively assess patient outcomes, but no adverse consequences were identified during the pilot. The next phase of the project will involve extending the existing pilot,

securing additional staffing, enhancing IT support, and refining the physical environment to better meet patient and service needs.

TF3

The successful conversion of a two operator native kidney biopsy service to single operator, with the subsequent creation of a national native kidney biopsy guideline working group

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

Introduction

Percutaneous native kidney biopsy is essential for diagnosis and management of renal diseases. Traditionally, some centres in the UK have used a two-operator model, requiring both a nephrologist and a sonographer. However, rising demand and increasing prevalence of chronic kidney disease have created unacceptable delays in service provision, with waiting times extending up to six months in some centres. This project aimed to convert a two-operator point-of-care ultrasound (POCUS) biopsy service into a single-operator model, with objectives of reducing waiting times and maintaining or improving complication rates. A secondary aim was to lay the groundwork for a UK-wide clinical guideline for native kidney biopsy.

Methods

A stepwise service redesign was undertaken. The new model placed procedural responsibility entirely within the nephrology service, supported by governance changes including: development of new standard operating procedures, ultrasound machine decontamination protocols, role adaptation for coordination of biopsy lists, and data capture via a bespoke electronic platform. External training in ultrasound physics and optimisation was undertaken by the lead author with assistance from the UKKA Diagnostic and Interventional Nephrology Special Interest Group (UK-DIN SIG). Biopsies were performed using 18-gauge Argon needles, with immediate adequacy checks by a histopathology technician. Outcomes included waiting times, sample adequacy, complication rates and operator variability. In parallel, a national project was initiated to establish a working group for guideline development, informed by the recent IGNITE Nephwork multicentre study highlighting inter-centre variation in practice.

Results

Over 100 biopsies were completed under the single-operator model within six months. Waiting times fell from 4–6 months (median 92 days, maximum 183 days) to approximately 10 days, with urgent cases expedited further. Complication rates were lower than in the preceding two-operator model. Clinically significant events included three transfusions (~1/33), two cases of frank haematuria (1/50), and one arterial embolization (1/100); no nephrectomy or deaths were reported. In contrast, historical data showed higher transfusion (3/44) and embolization (2/44) rates. Adequacy was generally acceptable, with an average of 11 glomeruli per biopsy across the first 65 cases, though some inter-operator variability was observed. Analysis showed that significant complications occurred only with procedures requiring more than one needle pass. Parallel progress has been made towards national guidance, including consensus-building with nephrology stakeholders and proposal submission to the UKKA guideline committee.

Discussion

Conversion to a single-operator model markedly improved biopsy service capacity, reducing waiting times and complications while maintaining diagnostic adequacy. Factors likely contributing to improved safety include the use of 18-gauge needles rather than the previous 14-gauge, and a smaller, more experienced operator pool. Regular practice may be more important than seniority in reducing risk. The project highlights the importance of collaborative work amongst UK nephrologists and the essential role UKKA Special Interest Groups are performing, with particular reference to the UK-DIN SIG in this case. Finally, preliminary work towards national guideline development has identified key areas requiring standardisation, such as needle gauge selection, blood pressure targets, aspirin protocols and DDAVP use. These may represent important steps towards optimising biopsy services and establishing the first national procedural guideline for native kidney biopsy.

TF4

Paediatric Kidney Patient Reported Experience Measure - developing and validating an experience measure for under 18-year-olds

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Background

Chronic Kidney Disease (CKD) requiring dialysis or transplant affects 63.8 per million age related population in under 16-year-olds in the UK, equating to 812 patients with a further 3000 children and young people (CYP) with CKD who may progress to needing kidney replacement therapy. Although the Kidney Patient Reported Experience Measure (Kidney PREM) is well established in the adult CKD population, currently no validated patient reported experience measure exists to inform improvements in the quality of care these CYP receive.

Therefore, the aim of this NIHR-funded study was to develop the first validated, reliable PREM for use with children and young people under 18 years of age who receive specialist nephrology care, so that all ages can receive the benefits of a national Kidney PREM.

Methods

This is an ongoing multiphase, mixed-methods study. Figure 1. In phase 1, focus groups/semi-structured interviews were performed with CYP with CKD, parents/carers and members of the nephrology multidisciplinary team (MDT) from five UK paediatric kidney centres. Findings were used to generate a set of themes encompassing experiences of care. In phase 2, items were subsequently developed based on these themes during workshops which comprised young people (aged 12+ years), parents/carers, adults with experience of children's services, MDT members and academics. An online consensus survey captured relevance and importance of each item, using 4-point Likert scales. Items were then tested with cognitive interviews, using the 'think-aloud' method, to ensure comprehension and suitability. After edits, the surveys were piloted online using Qualtrics software, using results to reduce the number of items or to reword as appropriate.

In phase 3, currently underway, the updated surveys are being further evaluated as part of the national Kidney PREM annual cycle, with patients/carers from all 13 paediatric sites eligible to participate. Some will be invited to repeat the survey in 4-6 weeks to test its reliability.

Results

Ten themes of care were identified in phase 1, reported elsewhere. Age-appropriate items were developed, with separate surveys for 4-6-year-olds, 7-11s, 12-17s and for parents/carers. Over 400 items were initially generated and tested across the ten themes, Table 1. The number of items reduced iterative across each study phase, Table 2. The final surveys contained 11 items (4-6s), 21 items (7-11s), 32 items (12-17s) and 37 items (parents/carers). A 1 to 7 Likert scale was used for 12-17-year-olds and parents/carers, in line with the adult Kidney PREM. However, response options were adapted for the younger age groups, utilising 'smiley faces' on a 1-3 Likert scale for 4-6s and a 1-5 scale for 7-11s, Figures 2-3.

Discussion

Data collection is underway, with results expected autumn 2025. The Paediatric Kidney PREM, coproduced with patients, carers and staff, will enable centres to measure their patients' experiences, giving a voice to this vulnerable population. It captures the aspects of care most important to families, and its regular use alongside the adult Kidney PREM will ensure that experiences of care can be used to improve kidney services across the UK.

TF5

Automated search algorithms for medication safety in chronic kidney disease: a primary care quality improvement study

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INTRODUCTION

Chronic kidney disease (CKD) is a prevalent condition in the UK, affecting approximately 2% of adults over 35 and 5% of those over 75. Safe prescribing in CKD is particularly important due to the risk of adverse drug effects when doses are not adjusted to renal function. At our practice, the CKD register appeared incomplete, and some patients may have been prescribed doses inappropriate for their renal function. Monitoring and safe prescribing in primary care can be challenging due to workload pressures, funding constraints, and reliance on accurate electronic coding.

METHODS

The aim of this quality improvement project is to ensure all patients with CKD were on appropriate doses for their renal function. Primary outcomes included register completeness and medication changes. A plan-do-study-act (PDSA) approach was used. Automated EMIS searches identified uncoded CKD patients and, separately, CKD patients potentially receiving doses above BNF guidelines. Searches were created on EMIS for 54 medications used to treat long-term conditions outlined by the Quality and Outcomes Framework (QOF) for 2024-2025. It ensured all patients who fit the criteria for CKD are coded at the correct stage and created a list of patients needing review.

RESULTS

First round results

In the first PDSA cycle, the CKD register increased from 153 to 278 patients, an 82% growth highlighting many uncoded patients. Twenty patients were flagged for potentially inappropriate doses. Following GP review, three patients had their medications adjusted in line with BNF guidance. The BNF adopts a conservative approach, and some patients were managed under secondary care where treatment differed.

Second round results

In the second PDSA cycle, the search criteria were refined to increase sensitivity by incorporating additional guidance for renal impairment. This identified one further patient with CKD, bringing the total register to 279. Eighteen patients were flagged for review, with five requiring medication changes. The refinement increased the sensitivity of the searches

from 15% in cycle one to 28% in cycle two. Patients in cycle two did not receive medication changes for the same reason as in cycle one.

DISCUSSION

This project highlights the potential use of EMIS searches as an automated safety check alongside medication reviews. The large increase in the CKD register during cycle one indicates CKD coding remains an issue. Although only a proportion of flagged patients ultimately required medication changes, the process improved oversight and reduced the risk of inappropriate prescribing in a high-risk patient group. With the new GP contact for 2026 focusing on cardiovascular health, it is important for practices to ensure proper coding of CKD and management to ensure better outcomes for patients. In future, additional blood tests could be added to cycles such as lipids to reduce delays and risk in patients with CKD and cardiovascular disease. This approach could be adopted in other general practices to improve CKD coding and prescribing safety. EMIS search details are available from the corresponding author.

TF6

The association between income sufficiency and patient experience using results from the Kidney Patient Reported Experience Measure (Kidney PREM) 2024

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

Background

The annual Kidney Patient Reported Experience Measure (Kidney PREM) captures experiences of care from individuals attending UK adult kidney centres. Although the validated measure remains unchanged, demographic questions have evolved so that differences by participant characteristics can be explored. Since 2022, participant deprivation has been assessed using the first half of their postcode to identify their Office of National Statistics-defined lower-layer super output areas, mapping these to each nation's Index of Multiple Deprivation. Differences in Kidney PREM scale scores by deprivation were apparent, though small in magnitude. However, assessing deprivation based on participants' areas of residence rather than individual circumstances has limitations. To overcome this, an income-related question was introduced in 2024, based on the Understanding Society UK Household Longitudinal Study. Variation in Kidney PREM scale scores by participants' responses to this question was explored.

Methods

Standard Kidney PREM data collection methods were repeated in 2024, with participation across eight weeks (September-November). Participants were asked, "does your household income meet your everyday need for things such as accommodation, food, clothing and other daily necessities?". Answers used a 5-point Likert scale: "I have more than enough money to meet my daily needs", "I have enough money to meet my daily needs", "I just about have enough money to meet my daily needs", "I don't have enough money to meet my daily needs", "I regularly go without essentials". Options for "I don't know" and "I'd rather not say" were available.

Kidney PREM items were scored from 1 to 7, with scale scores calculated across the entire experience measure. Income sufficiency was summarised by demographic group (age [years], gender, ethnicity, treatment modality). A linear regression model was fitted, with Kidney PREM scale scores as the outcome, adjusted for income sufficiency and participant demographics.

Results

Kidney PREM scale scores ranged from 1 to 7 (median 6.35, interquartile range 5.65 to 6.74). The Likert scale was used by 12,137 participants, 91% of all Kidney PREM respondents. A larger proportion of older (65+ years) participants reported at least "enough", Figure 1. Just 7 of 35 (20%) participants of non-binary/other gender reported this. White individuals

reported they “regularly go without” and “don’t have enough” least often (8.5%) and black participants most often (31.9%). Just over half of those receiving in-centre haemodialysis reported at least “enough”; the case for over 70% of those not receiving kidney replacement therapy.

Model results showed large differences in Kidney PREM scores by income sufficiency, those reporting “enough” or “more than enough” scoring 0.84 (95% CI 0.72 to 0.97) and 0.85 (0.72, 0.98) more than those who “go without”. Adjusted means are shown in Figure 2.

Discussion

Initial analysis has demonstrated that, adjusted for demographics, a participant’s experience of care is related to the sufficiency of their income. This work confirms that those subject to deprivation experience their kidney care more poorly. Further work is needed to understand the reasons for these differences in patient experiences so that improvements can be made to care and inequity reduced.

TF7

Artistic expression and graphic storytelling to raise awareness of ADTKD within nephrology practice

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Introduction

Autosomal dominant tubulointerstitial kidney disease (ADTKD) is an under-recognised genetic cause of chronic kidney disease that frequently presents as chronic kidney disease of unexplained cause (CKDx). Delays in diagnosis limit opportunities for counselling, surveillance, and family planning. Traditional clinical descriptions often fail to capture either the lived reality of genetic disease or the educational needs of nephrologists. Creative approaches, including visual art and storytelling, offer novel ways to bridge this gap.

Methods

We collaborated with patient advocates and a medical illustrator to create two forms of artistic expression:

1. Illustrated artworks conveying the personal and intergenerational experience of living with an inherited kidney disease.
2. A graphic cartoon designed to educate nephrologists on ADTKD, depicting inheritance patterns, progressive tubulointerstitial pathology, and the positioning of ADTKD within the CKDx framework.

Artwork and cartoon narratives were co-developed with clinical and patient input to ensure accuracy and authenticity.

Results

The illustrated artworks provided a powerful visual medium to communicate emotions often difficult to express verbally, such as uncertainty, resilience, and the burden of passing disease through generations. The graphic cartoon distilled complex genetics and pathophysiology into an accessible, memorable storytelling format. Together, these creative outputs translated both patient experience and disease mechanisms into engaging resources for education and awareness.

Discussion

This work highlights the potential of creative communication to enhance recognition and understanding of rare kidney diseases in clinical practice. By situating ADTKD within the CKDx paradigm and employing artistic media, we developed resources that resonate with both patients and nephrologists. Such approaches may support earlier recognition, improve counselling, and foster greater empathy within the nephrology community. Extending this model to other genetic disorders could strengthen education and patient engagement across renal medicine.

TF8

Establishing a renal CAT group to enhance evidence-based nursing practice

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

Background: Evidence-based practice (EBP) is central to improving patient outcomes and service quality, yet opportunities for nurses to engage in translating evidence into practice remain limited. Nurses constitute the largest proportion of the renal workforce, but their contributions to quality improvement (QI) and research are often under-represented. National initiatives such as the Kidney Quality Improvement Partnership (KQIP) demonstrate the importance of collaborative approaches, but a recent literature review identified no published examples of renal-specific Critically Appraised Topic (CAT) groups. To address this gap, we developed a Renal CAT group within our NHS Trust to create a structured platform for nurses to critically appraise evidence, develop ideas, and implement practice change.

Methods: The CAT group was established in 2024 with membership including renal nurses, a research nurse, and a clinical librarian, meeting monthly with additional ad hoc support as required. Engagement was offered through two complementary streams. Stream 1 focused on collaboration with the in-house renal education module, where group members attended student project presentations and provided mentorship to develop selected ideas into QI initiatives. Stream 2 was open to the wider renal department, enabling staff to approach the group directly with practice-based questions or ideas for change.

Across both streams, a structured process was followed. Initial ideas were refined into answerable clinical or practice questions, which informed literature searches conducted by the clinical librarian. Relevant research, guidelines, and quality improvement evidence were then critically appraised and summarised in an accessible format, highlighting implications for local practice. Findings were fed back to participants alongside tailored guidance on feasibility, resources, and alignment with departmental priorities. Where projects progressed, the CAT group supported the next steps, including audit design, QI methodology, poster preparation, and conference submission. This systematic pathway enabled staff to move from idea generation through evidence appraisal to implementation and dissemination.

Results: During the first year, the group engaged with participants from both streams. This activity generated multiple poster presentations accepted at UKKW 2025, with additional submissions prepared for UKKW 2026. Notably, all presenting authors were first-time conference attendees, demonstrating the group's ability to build confidence and capability among nurses new to research. The group has supported the implementation of tangible practice changes. For example, a falls prevention project progressed from an initial idea to a departmental initiative.

Discussion: The Renal CAT group has demonstrated feasibility, scalability, and impact as a novel way to support EBP in nursing. It provides a structured, sustainable framework that empowers nurses to move from ideas to implementation, supported by librarian-led evidence appraisal and peer collaboration. Outcomes to date highlight improved research

confidence, greater nurse visibility at national conferences, and translation of evidence into tangible service changes.

To our knowledge, this is the first reported example of a renal-specific CAT group. The model offers a replicable approach that could be adopted by other NHS Trusts and specialties, With future evaluation focusing on sustainability, long-term outcomes of implemented changes, and its role in fostering a culture of nurse-led innovation.

TF9

Usage patterns of electronic personal health records in adult patients receiving kidney replacement therapy

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

Introduction

Electronic personal health records (e-PHRs) allow individuals to view their health information (e.g. test results and medications) with the aim of enabling self-management and shared decision-making. Previous work highlighted inequities in the uptake of a new e-PHR for adults receiving kidney replacement therapy (KRT). In this study we describe usage amongst registered patients and explore variations by patient characteristics.

Method

This retrospective cohort study included all adults receiving KRT on 31/12/2023 at UK kidney centres using the e-PHR Patients Know Best (PKB). PKB data on registration and logins during 2024 were merged with data from the UK Renal Registry. Whether a patient logged in at least once ("activated") and login frequency was examined by age, sex, ethnicity, index of multiple deprivation quintile (IMD), KRT modality, primary kidney disease (PKD) and when the patient started KRT (2023 or earlier). Frequency was calculated as the number of logins per month over the login period (first to last login date for each patient). The number of logins per patient-day, and the distribution of the day, month, and time of logins (morning 6am-12pm, afternoon 12pm-6pm, evening 6pm-11pm, night 11pm-6am) was calculated over all logins.

Result

Of the 52,950 patients included, 16,455 (31.1%) were registered on PKB at the end of 2023. 89.9% (14,796/16,455) of registered patients were "activated" with at least one login in 2024. Younger patients, females, those in less deprived areas and transplant patients were more likely to be activated users (Fig.1). Amongst activated patients, the median number of logins per month was 3.00 (interquartile range (IQR) 1.67-5.83). The median was higher in older patients, females, haemodialysis patients and those who started KRT in 2023, and there was variation by PKD and ethnicity (Fig.2). Amongst the 453,346 patient-days with at least one login, 73.1% logged in once, 16.6% twice and 10.3% three or more times. Logins varied by time of day, day of the week, and month ($p < 0.0001$). Logins decreased from morning (35.8% 244,380/682,372) till night (9.5% $n=64,509$). The most common login day was Thursday (18.5% $n=126,360$) and Sunday the least common (6.3% $n=43,201$). Logins were highest in January and lowest in December.

Discussion

This was the first study to investigate usage patterns of an e-PHR for kidney patients. We showed that not all registered patients were activated users, and there were differences in

usage amongst patient groups. Contrasting patterns for activation and frequency were seen: transplant patients were more likely to be activated users than dialysis patients, but had lower login frequency, possibly due to having fewer results to view. Older patients were less likely to be activated, but once activated had higher levels of usage than younger patients. Although registered patients in deprived areas were less likely log in at all, there were no differences in login frequency. This suggests that initial effort to encourage older users and those from deprived areas should lead to sustained engagement rather than usability being the issue. Further work will include looking at logins following test results.

TF10

Rapid Renal Relief: Establishing a Renal Assessment Unit at a DGH that improved specialist care delivery and slashed A&E wait time.

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

Background: Emergency presentations of patients with chronic kidney disease (CKD) and acute kidney injury (AKI) represent a significant challenge for the NHS, contributing to emergency department overcrowding, prolonged waiting times, and delayed specialist input. National data consistently demonstrates that renal patients experience disproportionately long emergency department stays (11 hours nationally), with poor outcomes and poor patient experience. This chief registrar-led quality improvement initiative aimed to establish a dedicated Renal Assessment Unit (RAU) at New Cross Hospital, Wolverhampton, to simultaneously reduce emergency department congestion while delivering superior, specialist-led nephrology care aligned with NHS England's Same Day Emergency Care framework.

Methods: The initiative drew inspiration from successful RAU models at Sheffield and Hammersmith hospitals, conducting site visits and adapting their established frameworks to meet local requirements. Comprehensive baseline analysis examined emergency presentations across multiple timeframes to establish robust benchmarking data. Historical analysis revealed 489 AKI and 122 CKD presentations over five months in 2023, with 61 CKD patients identified as ideal RAU candidates representing potential savings of 37.16 admission days. Contemporary data from August-October 2024 demonstrated escalating demand with 534 total attendances, 236 admissions, and concerning average department dwell times of 659 minutes. This benchmarking and the presentation of evidence helped confirm the need for an RAU and helped kickstart its development. The comprehensive two-year development of the RAU required extensive multidisciplinary collaboration between renal medicine, emergency medicine, acute medicine and nursing directorates, utilizing established quality improvement methodologies.

The RAU pilot programme launched in April 2025, utilizing dedicated space within the Emergency Department Same Day Emergency Care (SDEC) facility. Stringent inclusion and exclusion criteria were developed to ensure patient safety while maximizing clinical effectiveness. These encompassed advanced CKD patients requiring intervention, renal replacement therapy patients presenting with complications, patients requiring specialized intravenous therapies, post-hospitalization monitoring cases, and complex AKI presentations. Safety protocols excluded patients with significant physiological compromise, ensuring appropriate case selection. An expedited referral system was established enabling direct specialist access from satellite dialysis units, primary care providers, and internal hospital teams, bypassing traditional emergency department triage pathways.

Results: Pilot evaluation covering April-June 2025 demonstrated exceptional clinical and operational performance across 31 specialist assessments, representing diverse case complexity from multiple referral sources. The service demonstrated remarkable operational efficiency with 87% of patients receiving same-day clinical resolution and

structured community follow-up arrangements, representing a transformational improvement from historical admission patterns. Only 13% of patients required inpatient admission, demonstrating effective patient selection and clinical management protocols. The RAU successfully managed complex nephrology presentations including post-transplant complications, electrolyte disorders, vascular access dysfunction, fluid overload management, and AKI surveillance, with projected daily capacity of 2-5 patients based on established referral patterns.

Conclusions: This chief registrar-initiated service transformation demonstrates how strategic clinical leadership, robust stakeholder engagement, and systematic pathway redesign can simultaneously reduce emergency department pressures while delivering enhanced, specialist-led kidney care. The RAU model represents a scalable solution with significant potential for national implementation, offering measurable improvements in both operational efficiency and patient outcomes through innovative resource optimization and clinical excellence.

TF11

Right care, right place: A nurse led renal assessment unit enhancing patient experience and delivering safer smarter urgent renal care.

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

Introduction

Following the merger of two acute trusts in Cheshire and Merseyside, the Renal Hub now serves a population of over one million. Rising acute renal transfers, increasing emergency department (ED) demand, and persistently high bed occupancy, highlighted the need for change, particularly given the impact on patient experience. In response, we established a nurse-led Renal Assessment Unit (RAU), to provide same-day specialist care as an alternative to ED attendance and admission. The RAU has improved patient experience, reduced delays, and helped relieve pressure on both ED and renal inpatient services. RAU has now been operational as a pilot for over 6 months.

Methodology

Using the AMB scoring tool and local consultation, we developed clear referral criteria with defined inclusion and exclusion parameters, to ensure appropriate patient selection.

This structured approach supports timely care, reduces unnecessary admissions and ensures patients needing acute care, are managed via the correct channels. The referral process flagged cases outside the criteria and prompted clinical discussion.

The pilot Renal Assessment Unit (RAU) was launched, operating 8am–8pm, five days a week, led by the Renal Acute Care Nurse Practitioners. During the pilot, we manually collected data for 6 months.

Results

In 6 months, we recorded 682 attendances, including 448 new referrals. Overall, 37% avoided ED, rising to 52% among new referrals. RAU has successfully achieved 86% ED avoidance by providing an alternative pathway for patients who previously would have required urgent renal care in ED.

Data collection revealed that all patients reviewed historically did not require ED, and as such, have been categorised as "NA." These patients represent 39% of the referrals. They require urgent nephrology input, but their condition does not necessitate ED-level care. In the past, these patients would have been directed to an urgent clinic stream sometimes waiting up to weeks for review. However, they can now be seen in a more timely and appropriate setting. Supporting earlier intervention and helps prevent deterioration, aligning with a core principle of the NHS 10-year plan.

Of the 682 attendances, 14% (98 patients) required admission. Notably, 73% of these admissions were managed directly through the RAU, bypassing ED and thereby reducing its overall burden.

Electrolyte imbalance was the most frequent referral reason, accounting for 25% of all new referrals. Among these cases, 52% involved hyperkalaemia, which prior to the RAU was classified as a medical emergency requiring ED management.

Conclusion

The nurse-led Renal Assessment Unit has transformed urgent renal care, achieving 86% ED avoidance, reducing ED pressures and regional renal services. With only 6% of referrals from ED, the service has reduced the nephrology burden in emergency care. Additionally, 18% (85) of new referrals were Nephrology ward discharges, with RAU enabling early discharge and aligning with the NHS 10-year plan to strengthen hospital-to-community care.

RAU provides an alternative pathway that improves patient flow, ensures timely care, and enhances patient experience through improved feedback. A structured referral process delivers safe, effective care, and pilot data confirms RAU as a sustainable model for specialised renal services.