TI1

Health Inequalities in kidney Disease: meeting the urgent need to identify Early disease in high-risk commuNities (HIDDEN)-Acceptability

Mrs Roseline Agyekum[2], Rachel Musomba[3], Neerja Jain[4], Kathryn Griffiths[2], Mariam Molokhia[2], Kate Bramham[2]
[1]King's College Hospital, [2]King's College London, [3]Africa Advocacy, [4]Kidney Research UK

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

Background CKD rates are disproportionately high among African and Caribbean communities in the UK, driven by diabetes, hypertension, and wider social and structural factors. Traditional clinic-based screening models often fail to engage these populations due to cultural incongruence, healthcare mistrust, and logistical barriers. The HIDDEN CKD study was developed to co-design and implement a culturally congruent, peer-led community screening intervention. Acceptability was evaluated using a newly developed measure adapted from Sekhon's Theoretical Framework of Acceptability (TFA).

Methods We employed a sequential exploratory mixed methods design. A qualitative narrative inquiry with community members identified barriers, enablers, and culturally relevant dimensions of acceptability. These narratives informed the co-development of a quantitative acceptability questionnaire, structured around these domains: emotional and cultural safety, procedural ease, practical fit, understanding and value, confidence and advocacy, follow-up and motivation, and peer educator support. The intervention was delivered at community-based events led by trained peer educators ("kidney ambassadors"), with recruitment through local leaders, faith-based organisations, and social networks. The acceptability questionnaire was administered via WhatsApp post-screening. Sociodemographic data, self-reported medical diagnoses, and event setting were recorded. Internal consistency of the refined scale was assessed using Cronbach's α and McDonald's ω. Exploratory factor analysis examined the instrument's structure. Associations between demographic variables and domain responses were tested using appropriate statistical methods.

Results 889 out of 1070 (83.0%) participants completed the acceptability questionnaire (45.0% male; Mean age 52.2[14.1]). Most self-identified as Black African 642 (72.2%) or Black Caribbean (10.5%), with high educational attainment (48.0% university degree). Across all domains, 85% of participants agreed or strongly agreed with positive acceptability statements. The highest were PE support (99.6%), understanding and value (98.9%), and emotional and cultural safety (97.8%). Ethnicity was the only demographic variable significantly associated with the statement "I felt culturally and/or spiritually comfortable participating" ($p < 0.05$), with West African participants reporting the strongest endorsement (88.0% combined agreement). White British participants had slightly lower agreement (75.8%). Absolute disagreement in all groups was rare ($n = 3$). No significant associations were found between positive acceptability statements for age, gender, education, or event setting. Internal consistency of the refined scale was high (ω = 0.815; α = 0.785). Factor analysis indicated multiple dimensions, with cultural respect, emotional safety, and empowerment forming the core, and peer educator support and motivational engagement emerging as secondary factors.

Discussion The findings demonstrate that culturally congruent, peer-led CKD screening can achieve high acceptability in African and African Caribbean communities. Cultural identity emerged as a key determinant of perceived emotional and spiritual safety, showing a strong correlation with ethnicity, reinforcing the need for culturally informed (CI) approaches in healthcare delivery. The intervention’s success was underpinned by systematic community engagement, co-creation with local leaders, and the integration of cultural and spiritual dimensions into both content and delivery.

Conclusions The HIDDEN CKD model offers a replicable framework for designing and evaluating community-based screening programmes that are both scientifically robust and socially responsive. The acceptability instrument provides a transferable tool for further validation through assessing interventions in other underserved populations. Embedding cultural, emotional, and spiritual dimensions into health interventions is essential for building trust, enhancing comprehension, and motivating sustained engagement.

TI2

Establishing a National Benchmark: Transforming CKD Detection and Care in North West London through the DISCOVER-NOW Programme

Mrs Joana Teles[1], Dr Neville Purssell[2], Dr Tony Willis[2], Dr Raakhee DeSilva[2], Dr Eleonor Sandhu[1], Laksha Satchitananthan[2], Prof Jeremy Levy[1], Prof Fred Tam[1], Benjamin Pierce[3], Dr Rakesh Dattani[3], Zia Ul-Haq[3], Ganesh Sathyamoothy[4], Dorota Chapko[4], Kabelo Murray[4], Linda Tarm[5], Matthew Wyatt[3], Livi Bickford-Smith[6], Jess Horne[6], Dr James Tomlinson[1], Sophie Walker[6], Andrew Frankel[1]
[1]Imperial College Healthcare NHS Trust , [2]North West London Integrated Care Board, [3]Imperial College Health Partners , [4]National Institute for Health and Care Research, [5]London Kidney Network , [6]AstraZeneca

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

Introduction

Chronic Kidney Disease (CKD) is a major public health challenge in England, many undiagnosed until advanced stages, leading to avoidable complications and high NHS costs. Between April 2022 and October 2023, the DISCOVER-NOW project was implemented in North West London(NWL), funded by the National Insights Prioritisation Programme and delivered with the NWL Integrated Care System, the Applied Research Collaboration, the London Kidney Network, and AstraZeneca. NWL was selected due to its large, diverse population and high CKD burden, providing an important testbed to improve early identification, equitable access, and management of CKD.

Methods

The programme combined a Design Workstream, which co-produced patient and clinician informed innovations, with a Retrospective Study Workstream, which examined system-level challenges and built the case for earlier CKD intervention. Key barriers included inconsistent coding and limited risk stratification in primary care. Through co-design workshops with over 30 stakeholders, four innovations were prioritised: (1) culturally inclusive education/diagnostic pathway, (2) enhanced test reporting with embedded guidance, (3) integrated risk stratification tools, (4) strengthened annual diabetes review to support CKD detection.

Testing took place in two phases. Phase one piloted simple prototypes with small groups of patients and clinicians to assess feasibility. Phase two incorporated feedback to refine solutions for a formal Quality Improvement evaluation and weekly co-design sessions.

Results

Using data from the Cardiovascular Disease Prevention Audit (CVDPREVENT), NWL demonstrated marked improvements in CKD care compared to national benchmarks. By March 2025, NWL was the leading Integrated Care Board (ICB) nationally for CKD performance, with consistent gains from 2023 to 2025. Uncoded CKD prevalence decreased from 0.28% (2023) to 0.10% (2025), outperforming the national rate of 0.45%. Monitoring improved substantially: annual eGFR testing increased from 87.4% (2023) to 92.9% (2025), above the national average of 90.7%; uACR monitoring rose from 50.4% (2024) to 70.1% (2025), exceeding the national average by 17.7 percentage points. Renin–angiotensin antagonist use among eligible patients increased from 73.4% (2023) to 76.2% (2025), compared to the national figure of 71.5% (table 2). Data on SGLT2i use are not yet available.

Conclusion

The DISCOVER-NOW programme has delivered sustained, system-wide improvements in CKD coding, monitoring, and treatment across NWL. These advances reflect the successful embedding of innovations into routine practice, strong stakeholder collaboration, and alignment with population health priorities. By integrating patient-centred design with system intelligence, NWL has established a scalable model for early CKD detection and management that now sets the national benchmark and contributes significantly to cardiovascular disease prevention. Importantly, these outcomes have been supported by a decade-long evolution of integrated kidney care services and the alignment of financial incentives to primary care management of CKD. This evolution has included virtual clinics, e-advice lines, and educational programmes for patients and professionals. More recently, two additional strategies have been introduced: For Kidneys' Sake, a podcast to upskill primary care clinicians, and an outreach service providing point-of-care testing in underserved communities.

Limitations

Current data does not allow attribution of outcomes to specific interventions, and causal pathways remain to be established. Further evaluation is underway

TI3

Improving CKD Diagnosis and Engagement Through Community Outreach in Diverse and Deprived Populations: A Scalable Model for Primary Care Integration

Kathleen Lynch[1], Amman Beg[1], Darren Duffield[1], Thushara Dassanayake[1], Jazz Gill[3], Dr Kuldhir Johal[2], Vena Sinclair[1], Prof Jeremy Levy[1], Dr Andrew Frankel[1], Judith George[2], Dr Parvinder Garcha[3], Sreeparna Roy[2], James Connell[2], Mohammad Haidar[2], Mrs Joana Teles[1]
[1]Imperial College Healthcare NHS Trust , [2]North West London Integrated Care Board, [3]Hounslow Public Health (Health Outreach Team), [4]Hounslow Family Practice

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

Introduction

North West London is among the best performing Integrated Care Boards (ICBs) in relation to chronic kidney disease (CKD) management as documented in the CVD Prevent data. However, GP-recorded prevalence of CKD across the region is only 2.49%, significantly below the national average of 4.4%. This suggests a large number of individuals with CKD are either undiagnosed or not appropriately coded within primary care systems. The disparity is likely to reflect underlying health inequalities, particularly affecting deprived and minority communities.

An outreach community service was developed to identify individuals at higher risk of CKD, with particular focus on underserved populations. The programme was funded by NHS England

Methods

The pathway was co-designed in partnership with primary care, nephrology services, public engagement teams, and outreach public health teams. Communities from Black, Asian, and Minority Ethnic (BAME) backgrounds were identified in partnership with borough-level public health and engagement teams, and prioritised using Core20PLUS5 criteria.

Point-of-care testing was offered at community-based health events, including blood pressure checks and semi-quantitative urine albumin-to-creatinine ratio (uACR) testing. Individuals received same-day results, personalised health education, and tailored recommendations. Education was provided by kidney nurse specialists and a renal dietitian. Participants were encouraged to engage with their GP practices, supported by a summary letter detailing results and next steps, which was also shared directly with practices through electronic records or written correspondence.

Results

Between January and August 2025, eight community health events in Hounslow (average attendance 56.5 per session (range 33–96) screened 452 individuals (mean age 57, range 19–98). Most participants (88.3%, n=399) were from BAME backgrounds, predominantly Asian (75%), and 70.6% (n=319) lived in deprived areas (Graph 1)..

Abnormal uACRs were common, averaging 41.4% across sessions (range 21.9–63 %), graph 2-3). Individuals with abnormal uACRs had a mean age of 61 years (range 19–91), representing a group for whom medical intervention is likely to provide meaningful benefit (graph 4).

Of 181 participants completing evaluation, overall satisfaction was high (mean 4.66/5). Most (86%) felt confident promoting kidney health testing to others. Positive feedback emphasised accessibility, rapid results, group discussions, translation support, and direct engagement with specialists.

Conclusion

This community outreach programme shows that co-designed, targeted interventions can effectively identify individuals at high risk of CKD who might otherwise remain undiagnosed. The high rate of abnormal uACRs among socially deprived and ethnically diverse groups highlights the importance of extending screening services into communities. Beyond screening, the model provided same-day education, practical resources, and direct integration with GP services, supporting earlier diagnosis, medication optimisation and health literacy. Positive participant feedback confirms the accessibility and acceptability of this approach, with evidence of wider family and community benefit.

Discussion

The programme offers a scalable model to reduce inequalities in CKD detection and management. Data sharing agreements are essential to optimise clinical advice, ensure efficient use of NHS resources, and enable system-level evaluation. Ongoing work will clarify how many abnormal uACRs represented new findings and assess follow-up engagement after testing.

TI4

Evolving demographic trends in incident kidney replacement therapy in the UK, 2009–2023

Dr Nithin Bodapati[1,3], Dr Anna Casula[1], Dr Retha Steenkamp[1], Professor James Medcalf[1,4], Professor Dorothea Nitsch[1,2]
[1]UK Renal Registry, [2]London School of Hygiene and Tropical Medicine, [3]University of Bristol, [4]University of Leicester

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

Background:
Kidney replacement therapy (KRT) is a resource-intensive intervention with major implications for service planning and health equity. Annual registry reports describe activity, but they do not evaluate long-term demographic shifts or place UK trends in international context. Understanding who is starting KRT, and how this is changing, is essential to anticipate demand and allocate resources judiciously.

Methods:
We analysed incident KRT cases reported to the UK Renal Registry from 2009–2023. Crude incidence rates (per million population, pmp) were calculated and stratified by age, sex, ethnicity, diabetes status, and initial KRT modality. Temporal trends were modelled with simple linear regression. Slopes were reported as annual changes (pmp/year or percentage points/year).

Results:
Across 15 years, incident KRT rates increased from 138.2 pmp (2009) to 158.3 pmp (2023). The steepest growth as shown in Figure 1, occurred in middle-aged adults: incidence rose steadily in the 50–59 (+2.6 pmp/year) and 60–69 (+3.2 pmp/year) groups, while declining among those aged ≥70 (70–79: –3.3 pmp/year; 80+: –3.7 pmp/year.

Figure 2 shows that haemodialysis (HD) remained the dominant initial modality (75.3% in 2023), with minimal decline (–0.014 percentage points per year). Peritoneal dialysis (PD) remained broadly stable at around 19% of incident KRT, while pre-emptive transplantation accounted for 6.6% in 2023 and showed a modest decline (–0.03 percentage points per year). During the pandemic years, PD uptake rose transiently while pre-emptive transplantation fell sharply.

From 2009 to 2023, men accounted for 62–65% of incident KRT, with incidence rising from 175 to 207 pmp (+2.7 pmp/year) versus 103 to 112 pmp in women (+0.8 pmp/year). Despite this disparity, the proportion starting KRT for diabetic nephropathy was similar in both sexes and increased steadily (~0.6 percentage points per year) as shown in figure 3.

Although the population is ageing across all ethnic groups, with more people now entering high-risk age bands, ethnic disparities in dialysis incidence remain marked (Figure 4). Minority ethnic groups (Asian, Black, Mixed, Other) continue to show substantially higher incidence rates per million population than the White population at nearly every age. When comparing 2011 with 2021, incidence rates among Asian and Black groups were generally stable or showed modest declines. In contrast, rates among White individuals increased slightly, although they remained the lowest across all ethnicities. The Mixed group demonstrated the most pronounced rise in incidence across most age categories.

Conclusion:

The UK incident KRT population is becoming younger, more often male, more ethnically diverse, and more affected by diabetes. Incidence is falling in older adults but rising in middle-aged groups, who will require longer treatment courses and intensify service pressures. Modality use has changed little over 15 years, with haemodialysis remaining dominant. Meeting these challenges will require equitable access, stronger CKD prevention, service adaptation for a younger and more diverse population.

TI5

World kidney day celebrations: 15-year analysis of health check events

Rohan Drawid[1], Maharsh Pandya[1], Sohan Shah[1], Bhavna Pandya[1]
[1]Royal Liverpool University Hospital

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

Background:
Chronic kidney disease (CKD) is a major public health concern worldwide and is often not recognised until later stages. Detecting risk factors such as hypertension, diabetes, and proteinuria at an earlier point can help to slow progression and reduce complications. World Kidney Day (WKD) is celebrated globally on 2nd Thursday of March every year since 2006. Our renal centre carries out health check events in form of drop-in clinics for hospital staff and visitors and for the community as at Railway station and shopping mall since 2009. The health checks include blood pressure, cholesterol, blood glucose, urinalysis and heart rate. In England, it is estimated that around one in four adults has hypertension, though only about two-thirds are included on GP registers, suggesting a considerable level of undiagnosed disease. Diabetes prevalence is also relatively high in the Northwest, with Merseyside consistently reporting rates above the national average. The aim for health check events is to identify risk factors in the community early as screening at one-stop clinic.
Methods:
Data from health screening events held on World Kidney Day across Merseyside between 2009 and 2024 were analysed. A total of 3,490 individuals underwent measurement of blood pressure, capillary blood glucose, pin prick cholesterol, dip-stick urinalysis, and heart rate, BMI/Weight. Prevalence of risk factors and data completeness were explored using descriptive statistics.
Results:
Attendees had a mean age of 62.9 years; two-thirds (67.3%) were women. Hypertension, defined as systolic ≥140 mmHg or diastolic ≥90 mmHg, was found in 40.2% of participants (systolic blood pressure ranged from 83 to 235 mmHg, while diastolic blood pressure ranged from 40 to 144 mmHg), a figure that exceeds both local and national GP-recorded prevalence. Raised capillary blood glucose (>7.0 mmol/L) was observed in 8.7% (ranging from 3 to 13.8mmol/L), indicating possible undiagnosed diabetes or pre-diabetes. Of the 2,247 individuals who provided a urine sample, 14.3% showed proteinuria. 12.1% of attendees had blood in urine as shown on urinalysis. Cholesterol measurements ranged from 1.0 – 10.0mmol/L with a mean value of 5.19 mmol/L, broadly similar to national levels. Heart rate was recorded in 65.1% of attendees, averaging 76.8 bpm, ranging between 44 to 139 bpm, with a median of 76bpm. Feedback from all the attendees at these events was unanimously excellent.
Conclusion:
World Kidney Day health checks in Merseyside identified a substantial burden of undiagnosed hypertension, abnormal glucose, and early renal risk markers within the community. These findings reflect the wider Northwest picture of elevated cardiovascular and metabolic risk, as well as national evidence that many cases remain undetected in routine care. Events like this, can help identify risk factors in the community and prevent

short- and long-term complications. World Kidney Day health check events provide a useful platform to promote awareness and offer opportunistic screening in the community.

TI6

Epidemiology and characterisation of uncontrolled and resistant hypertension in England: An electronic health record-based study

Terry McCormack[1], Ellen Hubbuck[2], Ben Heywood[2], Kiera Lochead[3], Mara Habash[4], Dr He Gao[3], Jil Billy Mamza[3]
[1]Institute of Clinical and Applied Health Research, Hull York Medical School, [2]Human Data Sciences, [3]Medical and Scientific Affairs, BioPharmaceuticals Medical, AstraZeneca, [4]Market access, BioPharmaceuticals Medical, AstraZeneca

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

Introduction

Hypertension (HTN) is a major cardiovascular risk factor. Uncontrolled hypertension (uHTN) and resistant hypertension (rHTN) refer to blood pressure that remains above recommended target levels despite the use of ≥2 and ≥3 antihypertensive medications, respectively. This study aims to use real world data to provide a contemporary view of the prevalence and patient characteristics of hypertension in England.

Methods

In this retrospective observational study, anonymised, linked primary and secondary care data (Clinical Practice Research Datalink [CPRD Aurum database] and Hospital Episode Statistics) were used to describe individuals diagnosed with hypertension between January 2018 and March 2023 (overall HTN). uHTN and rHTN were defined as a first blood pressure (index date) above 140/90 mmHg while receiving at least two and three antihypertensive medications concurrently for ≥30 days, respectively. The source population for annualised prevalence estimate presented eligible patients aged ≥18 years in that calendar year. Descriptive statistics were used to characterise the patient cohorts.

Results

In this study sample, 2,045,047 patients were diagnosed with HTN from primary care or secondary care as of 31 March 2023. Over the period from 2018 to 2022, in the source population annualised prevalence of uHTN and rHTN was highest initially (5.1% and 2.1% in 2018), decreased substantially in 2020 (3.2% and 1.3%) and showed a modest increase thereafter (3.8% and 1.5% in 2022) (Figure 1). Within the overall diagnosed HTN population, prevalence uHTN and rHTN exhibited a similar trend. There were 532,015 incident HTN patients during the study period, of which 130,105 met the inclusion criteria; 89,291 (68.6%) patients were uHTN and among these 31,592 (35.4%) were rHTN. Both mean age at index (ranging from 60 to 62 years) and proportion of males increased with greater hypertension severity, reaching 58.1% male in the rHTN group (Table 1). Obesity defined by body mass index ≥30 kg/m² was more prevalent in rHTN (34.8%), compared with uHTN (33.2%) and overall HTN (25.5%). Mean systolic blood pressure was highest in rHTN (150 mmHg [SD=14.6]) in the three cohorts. Comorbidities were more notable in rHTN, with heart failure (12.4%), chronic kidney disease stage 3–5 (11.6%), coronary artery disease (18.8%), atrial fibrillation (13.0%), type 2 diabetes (18.9%), dyslipidaemia (21.1%) and rheumatic disease (34.6%) all exceeding rates in uHTN and overall HTN. In uHTN and rHTN, 8.2% and

23.2% of patients were on at least four antihypertensive medications, respectively. MRAs were only used by 1.8% of uHTN patients and 4.3% of rHTN patients.

Discussion

Hypertension remains a major public health concern, characterised by a high prevalence in the population. Although a recent decrease in prevalence was observed, potentially attributable to fewer patients diagnosed during the COVID-19 pandemic, the overall burden of disease persists. Patients with resistant hypertension carry a greater comorbidity burden and require more optimised therapy relative to those with uncontrolled hypertension and the general hypertension population.

TI7

Does Better Coding Mean Better Care? An Analysis of CKD Recording and Management in Primary Care in Hampshire and Isle of Wight

Dr Bhargav Sunil Raut[3], Professor Dianna Smith[1], Dr Kristin Veighey[1,2], Professor Simon Fraser[1]
[1]University of Southampton, [2]Research & Development, University Hospital Southampton, [3]University health service

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

Introduction:

This study aims to investigate the relationship between Chronic kidney disease (CKD) diagnosis coding accuracy, management quality, and socio-economic deprivation across general practices in Hampshire and Isle of Wight (HIOW). CKD is a significant health concern requiring early recognition through accurate diagnosis, coding, and appropriate management in primary care. There is some historic evidence that coding is essential for identifying cases, but it remains unclear whether better coding consistently translates into improved clinical care.

Methods:

Data were analysed from 130 primary care practices across HIOW Integrated Care Board using publicly available sources, including CVD Prevent, NHS Digital and the Ministry of Housing, Communities & Local Government. Key variables of interest included postcode, percentage male patients, percentage uncoded CKD (main outcome), percentage blood pressure control, percentage RAAS treatment, percentage lipid-lowering therapy, and Index of Multiple Deprivation (IMD) rank. All indicators, including IMD rank, were measured at the general practice level rather than at the individual patient level

Spearman’s rank correlation was used initially to assess non-parametric associations between percentage uncoded CKD and predictors (percentage male, BP control, RAAS treatment, lipid-lowering, and IMD rank). Subsequently, single linear regression models were run for each predictor, confirming data were normally distributed. Finally, a multiple linear regression model was developed with percent uncoded CKD as the outcome, including all significant predictors.

Results:

The proportion of uncoded CKD cases varied between practices, ranging from a low of 0.03% up to 3.49%, indicating substantial variability in CKD diagnosis coding across the region.

An initial analysis found weak or no correlations between uncoded CKD percentages and predictors such as deprivation (IMD rank), demographic factors (percent male patients), and treatment quality indicators (blood pressure control, RAAS treatment, lipid-lowering therapy).

After adjusting for these variables together in a multiple linear regression model, no significant associations were identified with uncoded CKD percentage. The model explained 1.8% of the variation in coding rates between practices ($R^2 = 0.018$), and the overall model was not statistically significant (ANOVA $p = 0.923$). No predictor individually reached significance (all p-values > 0.05).

Residual analysis indicated assumptions of normality were met.

Overall, deprivation, demographic, and treatment variables do not significantly explain differences in uncoded CKD coding.

Discussion:

This study showed that sociodemographic factors and clinical indicators related to kidney care quality did not explain the variation observed in CKD coding across primary care practices in HIOW. The commonly recorded variables, including IMD rank, percentage of male patients, and treatment quality markers such as blood pressure control, RAAS inhibitor use, and lipid-lowering therapy, collectively accounted for a small fraction of the differences seen in CKD coding rates. None of these predictors showed a statistically significant association with uncoded CKD percentages.

This suggests that other unmeasured factors, such as practice-level processes, clinician coding behaviours, patient engagement, or data quality issues, may play a more important role in explaining why CKD coding accuracy varies. Additional efforts should focus on uncovering the underlying factors influencing CKD coding accuracy to enhance consistency and quality of diagnosis recording in primary care.

TI8

Real-world evaluation of kidney failure risk equation implementation: impact on nephrology referral patterns under updated NICE and KDIGO guidelines

Chandhini Suresh[1], Dr Rupert Major, Dr Matthew Graham-Brown, Dr Paul Cockwell, Dr James Medcalf
[1]Glenfield Hospital, Leicester

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

Introduction

The Kidney Failure Risk Equation (KFRE) has been incorporated into the 2021 NICE chronic kidney disease (CKD) guideline, replacing previous eGFR-based thresholds with a 5-year kidney failure risk cut-off of ≥5%. The 2024 KDIGO guideline adopted a similar approach. These updates mark a shift towards risk-based referral, but real-world evaluation of their clinical impact remains limited.

Methods

We analysed anonymised Google Analytics data inputs and outputs from an online KFRE calculator (www.kidneyfailurerisk.co.uk) for data from 1st February 2024 to 31st May 2025. 143,243 uses of the website were available for analysis. KFRE 5-year risk was independently calculated by two separate individuals using R and Stata 18.0 respectively. Bland–Altman analysis, and diagnostic accuracy statistics. Referral classifications were compared between the 2014 NICE criteria (eGFR <30 ml/min/1.73m² or ACR ≥70 mg/mmol) and the 2021 criteria (KFRE ≥5% or ACR ≥70 mg/mmol).

Results

Data inputs had a median age of 75 years (IQR 63–82), 54.9% were male, mean eGFR was 39.6 ml/min/1.73m² (SD ±12.8), and median ACR was 6.5 mg/mmol (IQR 1.7–35.0). KFRE values demonstrated excellent concordance between calculated and online outputs (R^2=1.00; mean difference 0.01%). Assuming all inputs were from primary care, potential referral eligibility were similar under both frameworks (2014: 35.3%; 2021: 35.0%), but 10.5% of patients were reclassified. The 2021 guideline preferentially identified younger, proteinuric patients with preserved eGFR, while the 2014 criteria captured predominantly older, low-eGFR patients with minimal proteinuria.

Discussion

To our knowledge, this is the largest analysis of real-world use of the KFRE. Our analysis firstly demonstrates the robustness of the KFRE calculations from the UK Kidney Association’s website. Secondly, we demonstrate that adoption of KFRE-based referral criteria reclassifies approximately one in ten patients compared with 2014 NICE guidance. Several limitations must be acknowledged. First, the dataset was derived from anonymous website inputs and it is not possible to determine whether multiple entries relate to the same individual. Secondly, for reclassification we assumed all inputs to the website were from primary care. Thirdly, as this was a cross-sectional analysis, longitudinal outcomes such as progression to kidney failure could not be assessed.

These findings underline the potential impact of KFRE adoption on nephrology service planning.

TI9

When everyone is counted, what determines who receives dialysis or gets a kidney transplant?

Dr Robert McLaren[1], Dr Timothy Jones[3], Dr Lucy Plumb[1,4], Prof Fergus Caskey[1,2], Dr Barnaby Hole[1,2]
[1]Population Health, University of Bristol, [2]Richard Bright Renal Unit, North Bristol NHS Trust, , [3]Musculoskeletal Research Unit, Translational Health Sciences, Bristol Medical School, University of Bristol, Southmead Hospital, [4]UK Renal Registry

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

Since the UK Renal Registry only reports on the population receiving kidney replacement therapy (KRT: dialysis and transplantation) we don’t know how many people in England get kidney failure. Approximately 8,000 start KRT every year. In other high-income countries, almost as many develop kidney failure, but never receive KRT. Knowing this information is a priority for planning NHS kidney services and ensuring equitable access to kidney failure treatments.

We analysed General Practice data (CPRD) and linked NHS hospital episode statistics to identify England residents aged ≥18 years who developed kidney failure between 2013 and 2020. Kidney failure was coded as incident when eGFR fell <15 for >90 days, or upon presence of a treatment code suggesting KRT had been initiated for chronic kidney disease. Individuals’ age, sex, socioeconomic status, ethnicity, comorbidities and electronic frailty index were used to model the likelihood of KRT initiation, using a competing risks analysis.

19,474 individuals with incident kidney failure were identified. 12,100 (62%) received KRT before death or end of follow-up. In our descriptive analysis of those who died during follow up, those who commenced KRT experienced more inpatient admissions (6 vs 3) and outpatient appointments (15 vs 6) in the last year of life and were more likely to die in hospital (62.5% vs 45.7%). Initiation of KRT fell with rising age and frailty index. In the competing risks analysis, increasing age and frailty, female sex, white ethnicity, and socioeconomic advantage were independently associated with lower likelihood of KRT.

A substantial proportion of individuals in England reached kidney failure and never started KRT. This heterogenous group includes those who died prematurely before KRT initiation; those whose kidney disease was stable, despite reaching diagnostic thresholds for kidney failure; and others who decided to receive conservative kidney management, rather than KRT. These individuals are older and frailer than the comparable group who received dialysis or kidney transplants. By describing this population, our work is a step closer to informing the development of NHS kidney services that meet the needs of the entire kidney failure population.

TI10

Bridging the Gap in Healthcare: Chronic kidney disease case finding in people with drugs and alcohol dependencies

Dr Harsha Wodeyar[1], Zoe Gillman, Anthony Duffy, Dr Paula Parvulescu
[1]University Hospitals of Liverpool Group

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

Background

Individuals with substance misuse disorders face significant barriers to healthcare, often resulting in poorer outcomes. Stigmatisation, fragmented care pathways, and socio-economic inequalities exacerbate these challenges, particularly in managing conditions like CKD, which progresses silently. Heroin-associated nephropathy and ketamine-induced renal damage contribute to acute kidney injury and end-stage renal disease, often presenting late in care. This highlights the urgent need for integrated, inclusive healthcare models.

Method

We developed an outreach multi-specialty model to address poly-morbidity in the community Drug and Alcohol Treatment services within Liverpool. Five clinical specialities (Hepatology, Respiratory, Cardiology, Diabetology and Nephrology) from University Hospitals of Liverpool Group collaborate to deliver daily clinics, with specialist nurses leading clinic delivery with support from specialty consultants. Patients undergo targeted case finding for long-term conditions (LTCs). Those with LTCs identified are offered ongoing care through the outreach clinic.
The renal component is delivered by a Renal Advanced Nurse Practitioner and a Consultant Nephrologist, supported by a project manager and a Consultant in Public Health Medicine.

The clinic runs on a drop-in basis for clients accessing NHS drug dependency support. Opportunistic screening includes capillary creatinine testing, eGFR calculation, urine Albumin-Creatinine Ratio, and blood pressure checks.
Abnormal findings, such as elevated ACR, reduced eGFR, or high BP, prompt a detailed review timed with the client's follow-up visits for drug rehabilitation. Positive cases are discussed in a multidisciplinary team. Morning 'risk' meetings with key workers ensure staff promote screening to all clients.

Results

From November 2024 to September 2025, 132 patients have been screened over four sites.

15 patients screened positive and were treated as follows:

- G1A2/G1A3 – 6 patients, all young ketamine users. Of these 6 patients, 1 had pre-renal Acute on Chronic Renal Failure that resolved on follow up. Patients were given 'kidney health' education.

- 3 patients with G2A2/A3, ketamine users. All 3 patients had acute on chronic renal failure, all of which resolved on follow up. Patients were given ‘kidney health’ education.
- 1 patient with G2A2 with hypertension was treated with calcium channel blocker.
- 2 patients with G3aA1 received education and monitoring.
- 1 patient identified with G3bA1 was treated with statin and Empagliflozin.
- 1 patient with G3aA3 died before appointment.
- 1 CKD G4A3 was prescribed folic acid, ferrous fumarate and calcium channel blocker and requires consultant clinic follow up.

Of the 15 patients, 13 were newly diagnosed and 2 were known CKD, but had not engaged with primary care. The observed prevalence of CKD in this vulnerable group is 11%.

Key challenges include difficulties in conducting screening tests, transporting samples, and engaging clients. To overcome this, capillary creatinine testing was introduced to simplify renal screening, and logistical support was improved. Collaboration with key workers and prescribing teams has enhanced client engagement.

Project Conclusion

Offering clinics concurrently with visits to drug and alcohol services that are trusted and known to service users increase accessibility and acceptability of testing and treatment, thus creating opportunities for early detection and treatment of long-term conditions in this vulnerable population.