WB1

Growth Differentiation Factor 15 (GDF-15): Associations with Anorexia, CKD Progression and Mortality in Chronic Kidney Disease

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction

Anorexia is common in CKD, impairing quality of life, yet its cause remains unclear, and treatment options are limited. Since the identification of its hindbrain receptor in 2017, Growth Differentiation Factor 15 (GDF-15) has emerged as a key mediator of anorexia and cachexia. A recent phase 2 b trial of ponsegromab, a monoclonal antibody targeting GDF-15, showed improvement in weight and appetite in people with cancer. In CKD, circulating GDF-15 levels are known to rise with disease progression and are associated with mortality. Despite this and the high prevalence of anorexia in CKD, no study has examined whether GDF-15 contributes to appetite loss in this setting. Addressing this gap is essential to understanding the mechanisms underlying anorexia in CKD and identifying therapeutic targets.

Methods

NURTuRE-CKD is a prospective, multicentre cohort study of individuals with non-dialysis CKD recruited from 16 UK nephrology centres. At baseline, blood GDF-15 levels were measured in 2,929 participants, and, as part of the IPOS-Renal survey, 2,865 provided self-reported appetite ratings over the preceding three days (0 = no impairment to 4 = overwhelmingly impaired). Associations of GDF-15 with poor appetite, CKD progression, and all-cause mortality were examined using unadjusted and adjusted logistic regression and Cox proportional hazards models, both in the overall cohort and within eGFR strata (>45, 30–45, and <30 ml/min/1.73 m²). CKD progression was defined as a ≥40% decline in eGFR, incident eGFR <15 ml/min/1.73 m², or initiation of dialysis. Correlations of GDF-15 with eGFR, creatinine, and cystatin C were assessed using Pearson's correlation coefficient.

Results

Overall, 786 people (27%) reported impaired appetite, 893 (32%) experienced CKD progression, and 527 (18%) experienced all-cause mortality, over a median 50-month follow-up period. Median (IQR) GDF-15 levels were 2,503 (1,605, 3,851) pg/ml. GDF-15 levels were higher in those with poor appetite (2,965 vs 2,350 pg/ml [p <0.001]), CKD progression (3,024 vs 2,145 pg/ml [p <0.001]) and mortality (3,943 vs 2,241 pg/ml [p <0.001]). There was a stepwise increase in GDF-15 levels as appetite worsened [p <0.001] (see Figure 1). In fully adjusted models, per doubling of GDF-15, the risk of poor appetite increased by 42%, CKD progression by 30% and all-cause mortality by 80% (Table 1). GDF-15 levels correlated negatively with eGFR creatinine (rho -0.55) and eGFR cystatin C (rho -0.67).

When examined in individual eGFR strata, GDF-15 remained independently associated with poor appetite (Table 2).

Discussion

Impaired appetite was common in this non-dialysis CKD population, affecting over 25% of people. In this study, we show for the first time that GDF-15 is independently associated with poorer appetite in CKD. Although correlated with eGFR, GDF-15 remained independently associated with appetite loss in adjusted models and within individual eGFR strata. GDF-15 was also independently associated with CKD progression and all-cause mortality. Our findings suggest that GDF-15 may play a causal role in the anorexia of CKD, and treatments targeting GDF-15 could have therapeutic potential for improving appetite and possibly also progression and survival in CKD.

WB2

A Self-management approach to hypertension associated with CKD – the SMaRT BP CKD randomised feasibility trial.

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction
Blood pressure (BP) control is a key therapeutic intervention in chronic kidney disease (CKD) but meeting BP targets is challenging. The SMaRT BP CKD trial aimed to assess the feasibility of supported self-management of BP for participants with CKD in secondary care using an approach previously trialled successfully in primary care.

Methods
SMaRT BP CKD was a single centre randomised feasibility trial. Eligible participants were recruited from CKD outpatient clinics, had CKD stages 1-4, were aged >18years, prescribed <4 anti-hypertensives and were invited based on an average clinic BP in the preceding 12 months of >120mmHg, or >130mmHg systolic if they had diabetes. Eligibility was confirmed with an unobserved standardised BP reading. Participants were randomised 1:1 to either intervention or standard care. The self-management intervention was home BP monitoring (Microlife WatchBP) and an agreed medication escalation plan. Participants assessed the need for treatment escalation based on a week of home readings monthly, and contacted the research team for prescriptions. Standard care included nephrology clinic visits but not home BP monitoring.

Results
Between July 2023 and May 2024 58 of 366 eligible participants (16%) were recruited; 23 participants in the intervention group and 29 in standard care completed 12 months of follow up
Median (IQR) baseline systolic BP (SBP) for the cohort was 143 (135-154) mmHg and diastolic BP (DBP) 79 (70-89) mmHg. Median eGFR for the cohort was 32 (28-53)ml/min/1.73m2 and median urine ACR 24.9 (5.4-82.6) mg/mmol. Standardised BPs for both groups at baseline, six and twelve months are shown in Table 1 and Figure 1. At six months there was a -5.8 (-14.4 to 2.6)mmHg difference between groups (p=0.175) and at twelve months this was 3.9 (-4.7 to 12.5)mmHg (p=0.371).
The median number of home BP readings taken by participants in the intervention group was 77 (42-84) of an expected 84 (92%). Six participants failed to take a sufficient number of home BP readings in the last six months of the trial. At twelve months the median number of treatment escalations (either increased dose of anti-hypertensive medication or additional agent) was 1 (0-1.5) in standard care and 2 (0-3) in intervention (p=0.036). However, in the intervention group seven participants discontinued at least one anti-hypertensive versus two in the control group. There were no significant differences in adverse events between groups at twelve months. At twelve months the mean difference in

eGFR between groups was -6.32 ml/min/1.73m2 when adjusted for baseline eGFR 42 (39-44) and 35 (33-38) ml/min/1.73m2 p=<0.001.

Discussion

Participants were willing to be randomised to and complete a self-management BP intervention and the intervention appeared to be effective in first six months, but the effect was not sustained in the latter six months of the trial. A reduction in home BP readings completed, more anti-hypertensives stopped and a greater drop in eGFR in the intervention group may have contributed to the attenuated effect. A definitive randomised control trial is required and the results of this feasibility study will be important to inform the trial design.

WB3

Enablers and barriers to SGLT2 inhibitors prescription for chronic kidney disease in primary care - results of a focus group qualitative study

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction
Following several landmark trials reporting substantial renal and cardiovascular benefits, NICE recommends SGLT2-inhibitors as add-on therapy to renin-angiotensin system antagonists, a new standard of care in chronic kidney disease (CKD). However, this remains incompletely implemented. As most people with CKD are managed in primary care, we aimed to better understand the enablers and barriers to SGLT2-inhibitor prescription in CKD among primary care health care practitioners (HCPs) and potential approaches to optimise their use.

Methods
Between April-Aug 2025 we conducted a qualitative focus group research study of primary care HCPs involved in the care of patients with CKD. Practices with very high or very low prevalence of SGLT2-inhibitors prescription were purposively sampled. The focus groups explored HCP's knowledge and belief on SGLT2-inhibitors prescription in CKD, enablers and barriers to its use and ideas for practical interventions to facilitate equitable access. The focus groups were recorded, transcribed verbatim and analysed via NVivo software using inductive thematic analysis as described by Braun and Clarke.

Results
Four focus groups were conducted with a total of 29 participants, including GPs, clinical pharmacists, advanced clinical practitioners, practice nurses and health care assistants. Most focus groups noted that the current CKD management in the primary care is generally 'reactive' rather than 'proactive'. Factors that facilitated prescribing largely evolved around CKD education, prescribers' confidence, multidisciplinary support, system prompts and clear communications with patients. Significant numbers of barriers were highlighted and they were categorised into (1) patient-related factors: CKD as asymptomatic condition, lack of awareness of CKD, non-engagement with uACR testing or follow-up, specific patients' characteristics, increased medication burden and concerns on potential side effects; (2) HCP-related factors: unfamiliar with guidelines or evidence of SGLT2-inhibitors benefits in CKD, variation in prescribing criteria, pre-requisite to SGLT2-inhibitors prescription, lack of awareness of CKD review template, lack of dedicated primary care CKD team; (3) system-related: time constraint and lack of financial incentives. Proposed mitigation strategies included improving public awareness of CKD, providing more supportive patient-facing information on SGLT2-inhibitors, delivering primary care CKD education regularly, simplifying prescribing guidelines, implementing CKD review templates incorporating SGLT2-inhibitors, appointing a CKD champion in each practice, developing automated electronic

prompts to identify eligible patients and incentivise CKD care through Quality and Outcome Framework (QOF) and performance dashboard. The themes and subthemes are outlined in supplementary Figure 1.

Discussion

Adoption of SGLT2- inhibitors in CKD management is influenced by an array of patient, HCP and system and financial factors. Key barriers include low disease awareness, clinical unfamiliarity and absence of structured incentives, while enablers such as clear communication, multidisciplinary approaches and system prompts provide a foundation for improvement. Optimising SGLT2-inhibitors use in CKD in primary care will require a multi-faceted strategy that addresses educational gaps, simplifies prescribing pathways and embeds CKD management into performance frameworks.

WB4

Socioeconomic and demographic characteristics of patients on the Accelerated Advanced Kidney Care Pathway for unheralded dialysis starts in northwest London: A retrospective analysis

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction

The Accelerated Renal Pathway (ARP) offers intensive one-to-one support for dialysis planning for unplanned starters. First-year data showed many faced barriers in transitioning to home dialysis. This study examines the influence of socio demographic variables on outcomes and using the latest Index of Multiple Deprivation (IMD), relate to unplanned starts and possible barriers to early engagement and home therapies uptake.

Method

Socioeconomic data of all patients on the pathway were analysed and correlated with modality choice and barriers to access home therapy. Electronic patient records and the latest IMD were used to correlate therapy selection with patient backgrounds and assess whether these factors influenced changes in dialysis modality.

Results

From April 2024 to July 2025, 120 patients were accepted in the accelerated pathway; the majority of patients commencing dialysis were male, accounting for 77% (n=93) of the cohort. Median age was 57 years (range 17-93). The cohort included patients from Black, Asian and Minority Ethnic (BAME) backgrounds with the majority from Asian background comprising 37% (n=44) of the total (Table 1).

Language barriers were evident, with only half of the patients (n=60) having English as their primary language, while 17% (n=21) required interpreting services. The remaining 33% (n=39) either spoke English as a second language or had family interpreting for them. Among the English-speaking patients, 55% (n=33) were from a BAME background. Employment data revealed that 64% (n=77) were not working, comprising 53% (n=64) unemployed and 11% (n=13) retired.

In terms of housing, 66% (n=79) lived with someone, 6% (n=7) recently relocated to northwest London, 4% (n=5) were asylum seekers living in hotels, and 2% (n=3) were homeless. The majority of patients, 19% (n=23), were concentrated in the borough of Hillingdon, followed by Brent and Hounslow, 18% (n=22) and 17% (n=20) patients respectively. 55% (n=65) lived in deprived areas and 93% (n=103) were within boroughs with the most barriers to access housing and services (table 2).

At presentation, 43% (n=52/120) patients opted for home dialysis however 52% (n=27/52) remained in ICHD at 90 days of which 11% (n=3) awaiting transfer to home therapies. Main

barriers to home therapies were housing issues 33% (9/27) and changed preference 41% (11/27) influenced by peers, motivation and convenience (figure 1).

In the group that opted for home therapies (n=16), 69% (n=11) did not speak English as first language and 12% (n=2) required interpreter services. The majority were employed 75% (n=12), of Asian descent 63% (n=10), with mainly residing in the borough of Brent 25% (n=4) and Hounslow 25% (n=4) (table 3).

Conclusion

The accelerated pathway enabled unplanned starters to access home therapies, with employment positively linked to uptake. Despite socioeconomic and linguistic diversity, deprivation was not a limiting factor. While housing was unmodifiable, patient choice was the main barrier. This underscores the service's ability to offer personalised care and creates an opportunity to explore the role and impact of home therapies peer support in addition to the existing ad hoc peer support service.

WB5

The implementation of NICE guidelines for chronic kidney disease in UK Hospital Trusts: A cross-sectional National survey

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction:
This study assessed the local implementation of selected national NICE guideline recommendations for the care of patients with chronic kidney disease (CKD). This was a national survey of secondary and tertiary care renal units across the United Kingdom (UK). The survey was circulated to all UK renal units through the UK Kidney Association (UKKA) network and advertised through the UKKA 'eNEWS'. The survey was completed in JISC online surveys and was open from 27/11/2024 to 03/02/2025. Respondents were kidney specialists (doctors, nurses and allied health professionals) from UK acute hospital trusts.

Methods:
The survey assessed whether guideline recommendations from NICE guideline NG203 (Chronic kidney disease: assessment and management), sections 1.1-1.5 were fully, partially or not implemented. These sections cover:

- 1.1 Investigations for CKD
- 1.2 Classification of CKD in adults
- 1.3 Frequency of monitoring
- 1.4 Information and education for people with CKD
- 1.5 Risk assessment referral criteria and shared care

Additionally, the survey established whether units had developed local policies to support the implementation of relevant guideline recommendations. A separate analysis assessed whether the provision of local policies associated with implementation of NICE guideline recommendations. Odds ratios (OR) were calculated for each centre as well as overall to assess whether the presence of local policy associated with the implementation guideline standards.

Results:
There were responses from 31 renal units across all regions in the UK. There was considerable variation in the consistency of implementation of guideline recommendations. For sections 1.1, 1.2 and 1.4 NICE guideline recommendations were fully implemented by over 50% of participating units. For sections 1.3 and 1.5 NICE guideline recommendations were fully implemented in 42% and 30% of units, respectively (figure 1). Local policies were variably available to support implementation of guideline recommendations both between units and between guideline sections (figure 2). There was a clear relationship between full and partial implementation vs no implementation of guideline recommendations and the availability or non-availability of supporting local policy documents (OR: 5.55, 95% CI 3.37-9.15, $p<0.01$).

Conclusions:
Implementation of guidelines for the care of patients with CKD was highly variable. The successful implementation of NICE guidelines associated with the provision of local policies. The factors that support development of local policies to facilitate the delivery of guideline directed medical care should be explored. Strategies should be developed to support the development or adaptation of local policies that enhance the delivery of guideline directed medical care for patients with CKD.

WB6

Introduction of a geriatrician-led renal frailty clinic can assist with decision making and advance care planning

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction:

Prevalence of older people with chronic kidney disease is rising, and people with chronic kidney disease are becoming older and increasingly multimorbid. As such, the needs of this group are changing, and healthcare systems need to adapt to serve patients with more complex, diverse, biopsychosocial needs. We introduced a geriatrician-led 'Frailty' service into our renal centre to address this.

Aim:
The aim of the project is to ensure that all patients with chronic kidney disease and frailty in our centre are offered the opportunity to have a geriatrician-led holistic review.

Methods:
We introduced a dedicated renal frailty clinic, led by a renal liaison geriatrician, and supported by frailty and advanced care planning nurse specialists. The purpose was to assess and treat frailty syndromes, discuss renal replacement therapy modalities, and offer advance care planning, to patients living with frailty and kidney disease.

This process is iterative. Over time, we have 1) assessed attendance rates at clinic and patient outcomes and modified referral criteria 2) gleaned feedback from key stakeholders 3) delivered teaching and training sessions to all staff 4) performed deep dive reviews into specific cases and discussed them in our centre's Morbidity and Mortality meetings.

Results
Since February 2024, 269 outpatient appointments have been held, of which 238 were first appointments and 31 were follow up appointments. The commonest reason for referral was for discussion of renal replacement therapy modality in individuals with chronic kidney disease stage 5, followed by referral for advance care planning, then reviews for optimization of general frailty.

In patients who were referred for decision regarding renal replacement therapy, there were notable changes in decision following geriatrician review (Table 1). In particular, 100 patients were 'undecided' regarding dialysis modality prior to geriatrician review, whereas only 38 patients were undecided after review. 39 individuals had opted for conservative care prior to geriatrician review, and 93 patients opted for this choice after review.

A ‘Universal Care Plan’ – documentation of preferences for care at the end of life - was initiated or completed for 55 patients following clinic review.

Of all outpatients seen, 25 patients had died when reviewed at 18 month follow up (Table 2). Of those whose circumstances of death are known, only 3 died at home receiving palliative care, or in a hospice. Eight died in hospital receiving palliative care, 4 died in acute hospital wards but not receiving palliative care (but had treatment escalation plans in place), and 5 died receiving active medical management with no palliative care and no treatment escalation plan.

Conclusion:
The introduction of a renal frailty clinic may have a role in supporting patients to make individualized decisions for renal replacement therapy and advance care planning. It also allows for other geriatric syndromes to be addressed. However, in the patients who died in our cohort to date, only a minority died at home or receiving palliative care, suggesting that ongoing iterative education and service changes are needed.

WB7

A retrospective cohort study of a combined Cardio-renal service: does it improve outcomes?

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction

Cardiorenal syndrome (CRS) is a set of conditions with complex pathophysiology, resulting in misdiagnosis, healthcare challenges and increased mortality. A weekly combined cardiorenal clinic (CRC) comprising of cardiologists and nephrologists was designed for a more cohesive approach to improve systemic management, reduce outpatient attendances and streamline care for patients with CRS. We aim to evaluate this service and its outcomes.

Methods

A retrospective cohort study in a district general hospital was conducted from March 2021 to present on service-users. Data was collected from electronical records, multi-disciplinary team (MDT) minutes and laboratory results.

Results

213 individuals were reviewed, mean age was 74.6±15.3 years, 69% (n=147) were male. Length in CRC service was 21.8±7months. Prior to CRC, mean systolic blood pressure (SBP) 137.4±23.9mmHg vs post-CRC 136.9±23.8 mmHg. Diastolic blood pressure (DBP) prior to CRC was 77.8± 6.6mmHg vs post-CRC 77.5±17.2mmHg.

CRC intervention resulted in a decline in weight (pre-CRC 88.5±22.4kg vs post-CRC 84.4±21.23kg, $p<0.0001$). Delta estimated glomerular filtration rate (eGFR) improved after CRC intervention (pre-CRC ΔeGFR -6.9±11.4 vs post-CRC ΔeGFR -2.7±12.4mL/min/1.73m², $p=0.0023$).

21.6%(n=46) had a diagnosis of heart failure with preserved ejection fraction (HFpEF), and 57.3%(n=122) had a diagnosis of heart failure with reduced ejection fraction (HFrEF). There was a correlation in the HFpEF subgroup between greater ΔSBP and increased likelihood of admission after CRC-intervention ($r=-0.275$, $p=0.0062$). Conversely, in the HFrEF subgroup, improved ΔGFR post-CRC intervention was associated with reduced likelihood of hospital admission ($r=-0.738$, $p=0.0061$).

30%(n=63) mortality during time in CRC service. Mortality was associated with a greater decline in ΔDBP -16.5±33.6 mmHg vs alive –5.6±31.4mmHg, $p=0.03$. In parallel the deceased subgroup had significantly lower 1-year DBP (69.9±12 mmHg vs alive 80.2±17.9mmHg, $p<0.0001$) compared to those alive.

Discussion

These results demonstrate a positive impact on slowing the rate of renal function decline through a combined CRS service. A significant reduction in weight was also identified however, due to the limitations of the study, it cannot be appreciated whether the weight loss was related to diuretic therapy or weight management.

Blood pressure targets were aligned with CKD guidelines but did not account for the concomitant pathophysiology of HF. Interestingly, more aggressive blood pressure (particularly DBP) control may be a poor prognostic indicator, potentially resulting in an increased mortality risk. Additional confounding factors attributing to this association need to be explored, and guidance regarding blood pressure control in medically co-morbid individuals may need to be addressed and tailored.

Furthermore, CRC service demonstrates improvements in hospital admissions for patients with HFrEF, suggesting a both treatment and preventative effect in patient outcomes and experience.

Summary

CRC reduces the number of outpatient attendances, reducing NHS costs and service-user expenses. Results suggest a positive impact on clinical outcomes, namely improved renal outcomes. Further exploration into clinical targets needs to be undertaken to tailor optimal parameters to slow disease progression.

WB8

Eligibility for glucagon-like-peptide-1 agonists in a secondary care chronic kidney disease cohort.

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction: The FLOW study reported favourable kidney and cardiovascular outcomes with the use of Semaglutide in CKD in type 2 diabetes (T2DM). However, Semaglutide is not yet licensed in the UK for this purpose. Currently, GLP1As are recommended by NICE in the management of T2DM and weight loss. However, resource constraints mean that NHS organisations further restrict access. The local Joint Area Prescribing Committee (JAPC) limits use to patients with T2DM, an HbA1c ≥58 mmol/mol, BMI ≥35 kg/m2 and in receipt of an oral diabetes therapy. We sought to examine the prevalence of obesity and GLP1A use in a single-centre secondary care CKD cohort and explore the potential number of patients who were eligible for GLP1A based on national recommendation and local guidelines.

Methods: This is a retrospective audit of all CKD patients seen in our renal unit between Jan 1st-Dec 31st 2024. Low clearance, dialysis and transplantation patients were excluded. Data on demographics, clinical details and laboratory results were collected from electronic clinical records and the local renal database. Descriptive analysis was performed using Excel.

Results: Of the 3962 CKD patients, 2677 had a BMI recorded: 621 (23%) <25kg/m2, 977 (36%) 25-29.9kg/m2, 611 (23%) 30-34.9kg/m2, 468 (18%) ≥35kg/m2. In total, 1079 patients (43%) had a BMI ≥30 kg/m2 - their mean age was 63 (SD:16) years and 168 (15%) had T2DM. 95 (9%) had CKD G1, 179 (17%) G2, 169 (15%) G3a, 278 (25%) G3b, 248 (23%) G4, 2 (0.2%) G5. The median uACR of the obese patients was 9.2 (IQR 2.1-45.4) mg/mmol. Ten had a primary renal diagnosis of FSGS due to obesity.

Only 31 patients in the cohort (1.2%) were receiving GLP1A : 10 oral Semaglutide and 21 subcutaneous GLP1As. Two further patients were on Tirzepatide. The mean age of patients receiving GLP1A was 67 (SD:11) years, 55% were female. The mean BMI was 35 (SD:5)kg/m2 and 94% had T2DM. None of the patients with FSGS due to obesity received GLP1A.

Based on the BMI criteria in the NICE Semaglutide guidance for weight loss, and excluding patients with T1DM & eGFR <15/not recorded, 959 (35%) patients were eligible for GLP1A based on BMI criteria ≥30 kg/m2 and 467 (17%) patients were eligible based on BMI criteria ≥ 35 kg/m2. Based on the local JAPC criteria, 51 patients were eligible for GLP1A (1.9%). Only 10 of these patients were prescribed GLP1A.

Conclusion: Obesity is a highly prevalent co-morbidity amongst our CKD cohort. 35% of the cohort may be eligible for GLP1A based on current NICE guidance, while only 1.9% fulfilled stricter local criteria. However, only 1.2% were receiving GLP1A or GIP+GLP1A. We plan to highlight those who were eligible as per local JAPC criteria to be considered for GLP1A to their primary care physician. The potential roles of GLP1As and GIP/GLP1As in CKD

management are fast-evolving research areas, and future clinical guidelines should be updated to reflect the emerging evidence.

WB9

Utilising the Theoretical Domains Framework to assess barriers and facilitators to the use of urinary albumin-creatinine ratios for CKD diagnosis in primary care

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction:

Chronic Kidney Disease (CKD) is a major public health concern associated with high morbidity, mortality and healthcare costs. Early detection through effective diagnosis is essential to initiate appropriate disease-modifying therapies to slow progression and improve outcomes. The urinary albumin-creatinine ratio (ACR) is vital for early diagnosis, to ensure appropriate coding and risk stratification, yet the uptake in primary-care remains poor. This study aimed to assess the barriers and facilitators influencing the uptake of ACRs in primary care to inform the development of strategies to enhance its uptake and ultimately improve patient outcomes.

Method:.

We conducted qualitative semi-structured online interviews with primary care staff (GPs, nurses, ANPs, HCAs) involved in CKD diagnosis across Cheshire and Merseyside ICB. Participants were recruited through email and professional networks, using a convenience sampling approach. Interviews (30–45 minutes) followed a TDF-based guide, with informed verbal consent obtained. Transcripts were de-identified, manually coded using a TDF framework, and the results triangulated with AI analysis. Data were stored securely on LUHFT servers and reviewed by investigators to ensure rigour. Ethical approval was obtained from the Research Ethics Committee.

Twenty participants were interviewed from January to July 2025, consisting of 16 general practitioners, 3 practice nurses and 1 senior pharmacist from 17 different Practices. Due to data saturation recruitment was stopped after 20 interviews.

Results:

Financial incentives (QOF) help shape ACR testing behaviour, with testing rates dropping when payments are removed. Mitigating this are professional values, “it's about the quality of diagnosis” (D8). In one instance, the respondent claimed that fifty per cent of urine samples aren't returned; however, immediate collection can improve rates. Factors such as patient demographics, practice systems and the availability of toilets in practices influence return rates. Recalling guidelines can impose a cognitive load and external aids such as wall charts can help: “I don't keep space in my brain for that type of thing” (E1). Table 1 summarises key elements identified in this research. Stress can impact clinical decision-

making quality, “You might just take the easier options” (D15), however well-organised practices buffer stress and adaptation/resilience develop over time. Unclear roles and poor coordination can undermine systematic CKD care. However, clear protocols, role definitions, regular team communication, nursing leadership in chronic disease and GP focus on complex cases can address this. The problem seems to be less about role confusion per se and more about absence of systematic role design across primary care. Overall, there would be benefits to spreading local innovations and cross-practice learning.

Discussion

Improving ACR uptake hinges less on clinician motivation and more on system design: financial incentives alone are fragile, while practical fixes (on-site sample collection, better follow-up, adequate facilities), clear team roles, and easy-access decision aids consistently drive results. This abstract provides new insight into concrete system fixes and offers a simplified checklist (Table 1) that primary-care teams can use to boost uACR testing in their own region, supporting earlier CKD detection and more equitable care.

WB10

Scalable medicines optimisation in CKD: integrated care programme update and impact on prescribing of finerenone and sodium zirconium cyclosilicate

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WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction

Within our healthcare system we have a commissioned integrated CKD care programme to improve earlier detection, risk stratification, and management between primary and secondary care (1). Medicines optimisation pathways have been embedded within multidisciplinary team workflows. Finerenone and sodium zirconium cyclosilicate (SZC) represent important novel therapies for CKD and heart failure, but national prescribing data suggest underutilisation despite NICE approval (2,3,4). We provide an update to the programme's outcomes and prescribing patterns.

Methods

Rates for finerenone were estimated using national type 2 diabetes prevalence data combined with KDIGO 2024 estimates of CKD stage 3a–4 with A2–A3 albuminuria. Data for each integrated care meeting were collected. Open-source prescribing data were obtained from OpenPrescribing.net (2) and analysed in Stata 18.0. All data and code to run the analysis are available on request from the authors.

Results

Within our ICB, 2,816 clinical discussions involving 1,828 people with CKD were undertaken up to 29th May 2025. Comorbidity burden remained high: 79.2% had hypertension, 54.2% diabetes, and 15.8% heart failure. A total of 1,358 (48.2%) MDT episodes led to medicines optimisation, while 296 (10.5%) and 228 (8.1%) resulted in expedited or avoided referrals, respectively.

Following NICE (March 2023) and local approval (May 2024) of finerenone, prescribing rates were significantly higher in integrated care active areas in the following year: 95 prescriptions (4.27/100 eligible/year) versus 36 (1.96/100 eligible/year) in non-integrated care areas ($p<0.001$). Smaller but significant differences were also seen for SZC (58 vs 34 prescriptions, $p<0.001$).

Discussion

This integrated CKD programme continues to identify a high-risk, multimorbid population, while adoption of novel therapies remains limited nationally. Our programme provides a scalable, evidence-based, digital infrastructure for medicines optimisation and risk stratification, enabling faster and more equitable uptake of cost-effective therapies such as finerenone and SZC. Open-source prescribing data provided a minimal-burden method for tracking adoption across ICBs.

Conclusion

Integration of prescribing data into LUCID highlights opportunities for medicines optimisation and accelerated adoption of novel kidney therapies. The persistent gap between evidence and practice for finerenone and SZC underscores the importance of system-level strategies such as our programme in achieving equitable, evidence-based CKD care.

References

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