WF2

“Living life in limbo”: A qualitative study exploring the treatment decision-making experience in a diverse population with advanced chronic kidney disease

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

Background:
Patients reaching end-stage kidney disease (ESKD) face complex treatment decisions, with far-reaching implications for future health and quality of life. Studies investigating decision-making in multi-cultural cohorts with chronic kidney disease are lacking. This study aims to explore the experience and process of treatment decision-making, including barriers and facilitators, within an ethnically, socioeconomically and culturally diverse population at or approaching ESKD.

Methods:
We used maximum variation, purposive sampling to select adult patients, with an estimated glomerular filtration rate (eGFR) <20, who had been under the care of an Advanced Kidney Care clinic for at least six months. We conducted semi-structured interviews, which were audio recorded and transcribed verbatim. A reflexive thematic analysis approach was used to inductively code transcripts and identify themes.

Results:
A total of 18 participants were included; nine men and nine women (Table 1). Median age was 62 (range 19 - 87). The sample was comprised of five white, seven Black and three South Asian participants, as well as three from other minority ethnic groups. Seven participants spoke a first language other than English, of which one required an interpreter. Median eGFR was 12.9ml/min/1.73m2.

Five central themes were identified: (i) Weighing up of perceived risks and benefits in treatment selection is highly subjective and informed by individual priorities, circumstances and experience. (ii) Expectations, trust and the perceived role of the doctor in facilitating decision-making differed broadly and were influenced by social circumstances, culture and the perceived balance of power in the relationship. Participants from more socioeconomically advantaged backgrounds described equitable, peer-to-peer relationships; those from more deprived backgrounds tended to perceive the dynamic as more hierarchical. (iii) Closely linked to the previous theme, participants ability and willingness to engage in collaborative, shared decision-making, and the value they placed on their own agency, existed on a spectrum. (iv) Identity (who people are and how they relate to the world around them) impacts the ways in which they seek both information and emotional support in decision-making. Language, lack of confidence interpreting medical information and emotional distress were barriers to knowledge seeking. (v) Participants illness perception (personal understanding and beliefs about their illness), and the lived experience

of health challenges that they brought with them, coloured the treatment decision-making process and informed their approach to it.

Conclusion:
This study explores the phenomenon of treatment decision-making at ESKD within a uniquely diverse cohort, which includes under-represented groups such as those with lower educational attainment and non-English speakers. Our findings have improved transferability to multi-cultural and multi-ethnic CKD populations, compared to previous studies. For participants, the experience of decision-making was complex, highly individual and often emotionally fraught. Both the barriers to decision-making that they encountered and the strategies they employed to manage those decisions were influenced by multiple factors, including language, health literacy, social support and prior experience. Our findings highlight the challenges in guiding diverse populations through their decision-making and identify potential inequities in the experience, particularly amongst vulnerable groups such as those with language limitations or lower health literacy.

WF3

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

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

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. Much of the research into the use of e-PHRs for patients with chronic diseases has focussed on adults, and knowledge of e-PHR uptake among families caring for children and young people is limited. In this study we describe usage of an e-PHR amongst children on kidney replacement therapy (KRT).

Method

This retrospective cohort study included all children under 18 years of age receiving KRT on 31/12/2023 at one of 10 UK kidney centres using the e-PHR Patients Know Best (PKB). PKB data on logins by children or their carers during 2024 were merged with data from the UK Renal Registry. Login status was described by patient characteristics (age, sex, ethnicity, index of multiple deprivation quintile (IMD), KRT modality, primary kidney disease (PKD)). Login frequency was calculated as the number of logins per month over the login period (first to last login date for each child). 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 684 children included, 69 (10.4%) had at least one login in 2024, with 2,474 logins in total during the year. Older children and those of white ethnicity were more likely to have a login in 2024 (Table 1). Amongst children with a login, the median number of logins per month was 3.47 (interquartile range (IQR) 2.30-7.85). The median was higher in children on dialysis (n=12, median (IQR) 12.4 (8.6-16.5)) compared to those with a transplant (n=57, median (IQR) 3.0 (2.0-5.4), and higher in children with glomerular disease (n=17, median (IQR) 7.6 (2.8-12.2) compared to other PKD. Amongst the 1,491 patient-days with at least one login, 66.2% logged in once, 19.0% twice and 14.8% three or more times. Logins varied by time of day, day of the week, and month ($p<0.0001$). Logins decreased from morning (38.5% 952/2,474) till night (5.0% n=124). The most common login day was Tuesday (18.2% n=449) and Sunday the least common (5.5% n=135). Logins were highest the last 3 months of the year (Fig.1), though 10% of children/carers did not log in before October.

Discussion

This was the first study to investigate usage patterns of an e-PHR for children on kidney replacement therapy. Overall usage of the e-PHR was lower than in previous work in adult kidney patients. There were significant differences in usage amongst different groups, though the sample size was small. Higher uptake amongst teenagers (possibly driven by smartphone ownership) presents an opportunity to support self-management and provide continuity as they transfer to adult nephrology services.

WF4

Effectiveness of weight loss interventions on outcomes after kidney transplantation: a systematic review

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

Background: Weight gain occurs in up to 70% of kidney transplant recipients (KTRs) within the first year after transplantation, with typical increases of 5 to 10% in body weight. Such weight gain is associated with adverse graft outcomes, increased mortality, and reduced quality of life (QoL). Managing post-transplant obesity is therefore a critical component of optimising long-term patient and graft survival. Several surgical and non-surgical strategies have been implemented to support weight management in KTRs, but their comparative effectiveness and safety remain uncertain.

Aim: To systematically evaluate the impact of weight loss interventions, including bariatric surgery, dietary modification, and structured exercise, on weight change, graft function, and QoL in adult KTRs.

Methods: This systematic review was conducted in accordance with PRISMA guidelines. Five databases (MEDLINE, Web of Science, CINAHL, CENTRAL, EMBASE) were searched for studies published between 2014 and 2025. Eligible studies included randomised controlled trials and cohort studies involving adult KTRs who underwent intentional weight loss interventions. Primary outcomes were changes in body mass index (BMI) or weight, graft function (estimated glomerular filtration rate and serum creatinine), and QoL. Study quality was assessed using the Critical Appraisal Skills Programme (CASP), with risk of bias evaluated using RoB2 and ROBINS-I tools.

Results: Sixteen studies were included, comprising eight randomised controlled trials and eight non-randomised studies. Bariatric surgery resulted in consistent and sustained BMI reductions of 10 to 15%. In studies that measured graft function, outcomes following bariatric surgery were preserved or improved, and no increases in rejection rates or perioperative complications were reported. Most bariatric surgery studies also reported improvements in QoL. Dietary interventions improved QoL, particularly in emotional and fatigue domains, but showed no consistent effect on weight reduction. Graft function was rarely assessed in dietary studies and showed no change where reported. Exercise interventions, which varied in type, duration, and intensity, improved QoL but showed no consistent effect on weight and no change in graft function.

Table 1 (attached) summarises the comparative effect of each intervention across weight, graft, and QoL outcomes, with bariatric surgery emerging as the most consistently effective approach.

Conclusion: Bariatric surgery is the most effective intervention for post-transplant weight management, providing consistent benefits across weight and QoL outcomes while preserving graft function. In contrast, dietary and exercise interventions offer QoL benefits but do not influence weight or graft function. Large multi-centre trials with adequate sample sizes, standardised outcome measures, and longer follow-up are needed to inform clinical practice in this patient group.

WF5

CardioRenal Metabolic Diseases: Using a personalised care approach to improve well-being and reduce future risk of advanced kidney disease: patient and clinician perspectives.

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

Introduction:
Cardiorenal metabolic (CRM) disease, is defined by the co-location of obesity, diabetes, chronic kidney disease and cardiovascular disease. With improved patient engagement seen to be associated with improved outcomes and experiences, the Harrow CRM project introduced a multidisciplinary pathway, to provide proactive, holistic care through extended consultations and personalised care planning. Alongside quantitative outcomes, understanding patient and clinician experiences is essential in evaluating the acceptability, feasibility, and sustainability of this new care model. This study reports early qualitative insights from patients and staff engaged in the CRM pathway.

Methods:
Semi-structured interviews were conducted at 5 PCNs across Harrow amongst 18 patients and 22 staff (GPs, pharmacists, physician associates, nurses, care coordinators, and reception staff). An additional 14 staff completed an anonymous survey. Participants were purposely sampled to represent those attending or delivering CRM appointments. Interviews were conducted in person and virtually, analysed thematically using Nvivo, and triangulated with survey findings. All patients had attended at least one CRM appointment, with interviews completed following either an initial or follow-up consultation.

Results
Patients consistently described the CRM appointments as distinct from routine care, valuing the longer consultation times, proactive invitations, and holistic focus covering lifestyle, mental health, sleep, and social wellbeing. Patients reported feeling listened to, cared for, and more confident in managing their health. Many expressed greater motivation to make lifestyle changes, driven by personalised explanations of test results, culturally appropriate advice, and accountability through follow-up. Several described measurable behaviour change, including weight loss, dietary changes, and self-monitoring of blood pressure or blood sugars.

Clinicians reported increased confidence in health coaching and lifestyle medicine, alongside enhanced knowledge in multimorbidity prevention. Shadowing and role-play were viewed as the most useful training formats. Most staff valued the clinics as more rewarding than routine consultations, describing greater professional fulfilment from seeing patients make positive changes and satisfaction from having a more collaborative partnership with the patient taking a central role in the conversation. Operational staff were less likely to report direct benefit. Some challenges were identified, including patient non-attendance, incomplete pre-appointment questionnaires, time constraints in covering all expected elements, and variation in delivery between sites. While most patients and staff supported the model, some clinicians questioned the balance between lifestyle focus and pharmacological management.

Discussion:

Patient and staff experiences indicate that the CRM pathway has been successful in providing a specialist pathway for individuals with CRM, with this study suggesting improved patient activation, motivation, and self-management. The model also enhances clinician knowledge and satisfaction and strengthens multidisciplinary working. The study highlights the importance of simplifying training requirements, improving patient engagement strategies, and ensuring clarity on core versus adaptable pathway elements. Sustainability will depend on continued funding, demonstrable clinical impact, and embedding CRM approaches into routine care.

Conclusion:

The Harrow CRM pathway has been positively received by patients and staff, offering a more holistic, personalised, and preventative model of care. Insights highlight the potential for improved patient activation and professional fulfilment, while also identifying operational challenges that must be addressed to sustain and scale the model.

WF6

Amplifying the Patient Voice in Haemodialysis Cannulation: Insights from the Needling PREM (NPREM) and Implications for Quality Improvement

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

Introduction:
The Kidney Patient Reported Experience Measure (Kidney PREM) is a national survey designed to capture the views of people living with chronic kidney disease across the UK. Over the past three years, national PREM scores relating to needling have shown a gradual decline, from 5.88 in 2022 to 5.82 in 2024 (7-point scale). In Nottingham, scores have consistently fallen below the national average, with a local mean of under 5.5, emphasising the need to explore this aspect of care in more depth (Kidney Care UK, 2024). A Needling PREM (NPREM) was developed and validated to allow more detailed exploration of meaningful patients' experiences of haemodialysis cannulation, including comfort, technique, communication, and overall confidence (Moore et al., 2025).

Methods:
The NPREM was administered in paper format across the main dialysis unit and four satellite units of the local Trust. Eligible participants were adult haemodialysis patients who had been cannulated for more than three months, using an arteriovenous fistula or graft, and able to complete the survey independently. Exclusion criteria included time on HD lower than 3 months, peritoneal dialysis, communication or cognitive barriers and patients with tunnelled lines. All responses were entered into an Excel spreadsheet, with data organised by dialysis unit. The survey was conducted between 7th July 2025 and 1st August 2025.

Results:
Out of 275 eligible haemodialysis patients, 86 completed the NPREM (31% overall response rate), with unit-level response rates ranging from 18% to 53%. The overall mean NPREM score was 5.73 (SD = 0.95), with a mean overall needling experience score of 6.22 (95% CI: 5.99–6.44). Of the five domains evaluated, "communication with the team" (mean 6.26) and "working together" (mean 6.04) received the highest ratings, while "my experience" (mean 5.22) and "my fistula/graft and needling" (mean 5.39) received the lowest. These findings suggest that although patients valued teamwork and communication in general, there is still room for improvement in areas pertaining to their individual needling experiences and confidence.

Discussion:
This first use of the NPREM has provided valuable insight into patient experiences of haemodialysis cannulation. Results highlight areas of strength, particularly in staff communication and teamwork, but also reveal opportunities to improve patients' personal experience and confidence with needling. The next steps will involve a thorough

investigation of inter-unit variation and the creation of targeted follow up actions within individual units. The NPREM will be re-administered once improvement measures have been implemented to evaluate their effect on patient-reported outcomes. The ultimate aim is to integrate NPREM into routine care to monitor needling experience over time.

References:

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WF7

Real-world use of Sodium-glucose cotransporter-2 Inhibitors in Kidney Transplant Recipients with and without diabetes

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

Background

Sodium-glucose cotransporter-2 inhibitors (SGLT2i) have demonstrated cardiovascular and kidney benefits in non-transplant populations with diabetes, chronic kidney disease (CKD) and heart failure. Research regarding their use and safety in kidney transplant recipients (KTRs) remains limited. The aim of this study was to assess our experience of using SGLT2i in KTRs in terms of safety and efficacy.

Methods

This was a retrospective observational study at a specialist tertiary centre for renal transplantation and diabetes care. All individuals who were initiated on a SGLT2i, prior to the cutoff date of the first of November 2024, were analysed. Data were collected for baseline demographics, transplant related data, and safety outcomes, including reported adverse effects and discontinuation rates. Other metabolic parameters, such as HbA1c, eGFR, blood pressure and lipid profiles were assessed at baseline and yearly thereafter.

Results

Among 226 KTRs, the median age was 62 [53-68] years and 88.1% had diabetes. Median follow-up time was 25 months [13-35]. Dapagliflozin (86.7%) was the commonest SGLT2i used. Adverse events were reported in 68 people (30.1%) and discontinued in 53 people (23.5%) Urinary tract infections occurred in 14.2% of individuals and were the primary reason for discontinuation (7.5%). UTIs and genital mycotic infections were observed more frequently in female users. Other reasons for discontinuation included allergic reactions (n=5), graft dysfunction (n=3) and diabetes ketoacidosis in the context of Covid-19 infection (n=1). The median time of discontinuation post initiation was 13 [6-24] months.

In those who continued the SGLT2i, significant reductions were observed in HbA1c (in people with diabetes), systolic blood pressure and diastolic blood pressure at 12 months of follow-up compared to baseline. The estimated glomerular filtration rate (eGFR) remained stable across the follow-up period. Reductions in the urine protein-to-creatinine ratio and body weight were observed, although not statistically significant.

Discussion

SGLT2i use in KTRs improved glycaemia and blood pressure whilst maintaining a stable eGFR at long-term follow-up. These findings are in line with previous studies, providing further evidence supporting the use of SGLT2i in KTRs. Whilst treatment was generally safe, higher infection rates were reported, particularly in female KTRs, highlighting careful consideration of risk and benefits for this population. Education and sick day rules should be provided for people initiating on SGLT2is.

WF8

Reduction of hospital length of stay with introduction of Virtual AKI ward service

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

Introduction

Acute kidney injury (AKI) remains a common presenting complaint with an estimated 20% of newly admitted patients suffering from this (NHS England (2014)). As well as impacting on morbidity and mortality it also prolongs hospital length of stay. Thus, in association with the hospital at home team, we developed an acute AKI virtual ward which allowed for early discharge along with on-going monitoring of this cohort of patients. Patients continued to have daily clinical reviews through questionnaires and objective measurements of BP, urine output and daily weights. There was the ability for this to be followed up by phone-calls or GP visits. Blood tests were also performed either at the patient's home or local phlebotomy unit. There was a daily MDT between the AKI team at the hospital, attended by a renal consultant, pharmacist and a AKI nurse, with the community HAH team.

The service was started on the 1st January 2024 and we wanted to explore the impact of the service on length of stay

Method

We used the comparative health knowledge system (CHKS) to pool all the data related to length of stay in patients with a diagnosis of AKI. We compared the length of stay from 1st January to 31st December 2024 with the same date range in 2022 and 2023, before the AKI virtual ward service had started. We conducted an unpaired T-test to explore the statistical significance of the results.

Results

In 2022, there were 807 AKI patient with a mean average length of stay of 4.6 days; In 2023, there were 716 patients with an average length of stay of 4.9 days; In 2024, there were 798 patients with an average length of stay of 3.8 days (please see table 1).

The unpaired T-test comparing the data between 2023 and 2024 showed a statistically significant reduction of length of stay by 1.1 day per patient, with a p value of 0.0001.

Discussion

The introduction of the AKI virtual ward appears to have significantly reduced the LOS of patients with AKI. Although there are other confounding factors which have not been explored, such as a drive for NHS hospitals to prioritise discharge, there is no doubt that this service has resulted in a positive impact on LOS. The estimated cost of a hospital bed is around £345 per day and if extrapolated to the total number of bed days, there is potentially a saving of £302,841 in 2024. We believe that the Virtual AKI ward service is vital for optimising care for patients outside of the hospital environment. The service also extends to prevention of admission, such as, with a number of frail patients who can continue to have care in their home.

References:

NHS England (2014); Patient safety alert. Standardizing the early identification of acute kidney injury. . https://www.england.nhs.uk

WF9

Improving how patients manage their fluid restriction with the aid of a measured cup

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

Introduction

The majority of patients on haemodialysis are advised to restrict their salt and fluid intake to minimise interdialytic fluid gain. However, adherence remains a challenge for some. On our haemodialysis unit, single-use cups of variable sizes were used to provide drinks, cups currently used on the unit held 350mls which it was advised only be half filled. In addition, patients also faced cups with different sizes in the community. We therefore aimed to survey patients' perception and experience of fluid restriction and introduced a reusable, standardised cup for all our haemodialysis patients.

Method

An eight-question survey was conducted in March to examine in-centre haemodialysis patients' understanding and experience of fluid restriction, explore potential interest in a reusable, standardised cup to facilitate fluid adherence and reduce single-use plastic cups on the unit.

We then rolled out a standardised cup. The cup was suitable for travel and would enable patients to bring the cups with them to use during treatment, as well as at home. The cup has an internally reduced capacity and was provided with a patient information leaflet and staff guidance. The aim was to simplify and facilitate fluid restrictions adherence on the unit and in the community.

Results

Of the 290 in-centre haemodialysis patients, 50 patients were randomly selected and completed the survey. 58% were male. Amongst those 70% were aware that they had a fluid restriction in place, of whom only 16% knew their advised restriction volume (within 100mls of allowance). 64% of patients understood why fluid restriction was important. Patients were also asked how difficult the found sticking to a fluid restriction,18% reported never, 32% sometimes and 24% always. Overall, the latter group had higher interdialytic weight gain (IDWG) compared to their counterpart (mean IDWG 2.1kg vs <1kg). Most (94%) never brought their own cups from home to dialysis. 32% felt that the current cups provided on the unit were too big and did not help with their fluid restriction, 24% believed the cups to be adequate whilst 36% felt that they were missing out because the cup was half-filled.

Overall, 78% were interested in a reusable, standardised cup to facilitate fluid restriction and would use it regularly at home and on the unit. 78% also expressed that unit being more eco-friendly was important.

After the roll out of the new cups, we audited their use. It was found that 54% of early shift patients, 23% of late shift patients and 17% of the twilight shift patients were bringing their cups with them to use during treatment.

Conclusion

The survey identified a need for intervention to help patients understand and manage their fluid restrictions. The project has risen awareness around fluid restrictions and gives patients autonomy to control their intake. The reusable, standardised cups also align with our centres incentives to go green and become more sustainable by reducing the use of disposable cups and reducing waste.

WF11

The London Kidney Network Supportive Care Audit: improving data; understanding impact.

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

Introduction

London Kidney Network (LKN) supports 7545 dialysis and 2733 AKC patients GFR < 15. Its supportive care (SC) workstream leads pathway definition, creation of educational resources and data analysis. Some frailer patients forgo dialysis opting for tablet based, quality of life conservative (CC) /(SC). Others beginning renal replacement (RRT) despite frailty or developing it later need parallel SC. SC lacks a nationally agreed data set. We sought to develop consistent London SC metrics across all 7 units. Ongoing work measures impact of pathway choice and advance care planning (ACP) on quality of care and resource utilisation.

Methods

We audited 7 renal units 1/03/25- 31/8/25. Data included consistency of Clinical Frailty Scoring (CFS) across modalities and choice of CC in AKCC at three time points. Variation in age distribution led to analysis of cohorts by age. Cumulative data at units showed numbers starting dialysis with CFS >/= 6, completion of ACPs before death, and mortality in first 180 dialysis days (table1). Work in progress reviews electronic records for ACP status and place of death as markers of care quality and days in hospital in year preceding death for resource utilisation. We present early data (complete data anticipated by UKKW).

Results

Figures 1 to 3

Most trusts achieved high rates of CFS scoring in AKCC with a significant increase in scoring across London between March and August 25 ($p<0.0001$).

At March 25 there was significant variance across all Trusts in all treatment modalities in levels of CFS completion ($p< 0.00001$).

Combined data, however, shows no significant difference in completion rate by modality ($p= 0.1104$).

High numbers of patients choose CC without significant variation across Trusts if age over 60 ($p = 0.086$) but significant variation if compared for age over 80 (38.8% to 73.4% of individuals ($p = 0.033$).

There were no significant changes between March and August 25 for either age group in numbers for CC ($p = 0.1852$ and $p = 0.066$).

Early data suggests no correlation between CFS completion rates and high levels CC.

Data showed variation in % of patients beginning dialysis with CFS +/> 6 between 4.0 and 19.4%.

Mortality within 180 days of dialysis was broadly similar across Trusts.

Discussion

CFS scoring varied across Trusts despite creating automated data points and staff education.

Rates of frailty scoring did not appear to correlate with rates of CC. This may reflect lack of association or bias toward recording CFS in the frailest patients.

Assessment of age distribution improves comparative rates of CC. High numbers of patients over 80 were choosing CC consistent with observational data suggesting no survival benefit.

A small % of patients with high frailty still begin dialysis - further work may differentiate missed opportunities for CC or informed patient choice.

High rates of CFS scoring achieved in haemodialysis offer opportunities to refine quality metrics by frailty level.

We believe this is the first time an English region has provided extensive metrics for frailer CKD 5 patients. LKN SC work has prompted geriatrician inclusion in 5/7 London units.