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P003 -Does presumed care mean missed care? Establishing a new clinic service for patients with PTDM

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Background: Post Transplant Diabetes Mellitus (PTDM) is a risk of transplantation and is shown to potentially have a detrimental effect of transplanted graft function and patient survival. There are very few centres with a focussed management service for this group. There can be a variety of different staff groups involved in a patients diabetes management and poor specialist continuity as well as lack of patient understanding about their conditions are known barriers to patient healthcare (1). We have established a monthly diabetes renal transplant clinic which incorporates this patient group and in addition a PTDM management guideline to improve the quality of care this group receives.

Aims: To review who is involved in the diabetes management in this patient group and assess the outcomes of establishing a specialist diabetes clinic running parallel to the renal transplant clinic.

Methods; Patient (7 PTDM patients) and staff (8 Renal unit members) questionnaires were completed. A monthly Diabetes Transplant clinic was established in our hospital which runs parallel to the renal transplant clinic. This is consultant-led and supported by a diabetes specialist nurse. Transplant patients with either pre-existing diabetes (Type 1 or Type 2) or PTDM can be referred. Here we have assessed outcomes from the PTDM cohort.
Results: Multi-disciplinary staff questionnaires revealed variability on who is thought to be leading a patients PTDM care and consequently there is likely to be inconsistent management and the potential for 'gaps' to occur. Furthermore, the patient questionnaire revealed large uncertainty about their diabetes management, with 47% naming more than 1 provider leading their care, care being spread across different disciplines, and even 1 patient who couldn't name who was managing their diabetes.
(Graph 1)
This ambiguity about diabetes management is a negative factor in patient care that could contribute to sub-optimal management.
Since establishing the specialist joint diabetes & renal transplant clinic, and thus having established a clear pathway on PTDM patients management, we have seen 74% have improved HbA1C's at 12 months with the overall average reducing from 73 to 53 mmol/mol, and 77% have an objective benefit including entry into surveillance schemes, review of technique, needle sites, administration and carb counting as well as discussion about pancreatic transplantation options. Additionally patients report increased confidence in their diabetes care since starting this clinic and when asked 'do you find this clinic beneficial?' the mean score was 9.39/10. We have established a clear line of communication for MDT discussion about additional patients with complex management.
Conclusions: Having an established joint clinic to focus on a transplant patients' diabetes is proving successful amongst our population. With improved confidence in care, level of education received and HbA1'c's closer to target, patient's are receiving better care without having any extra clinic attendances. Getting this right early, confers extra protection to their graft.

References
1- Lo C, Teede H, Fluchar G, Gallagher M, Kerr P, Ranasinha et al. Gaps and barriers in healthcare provision for co-morbid diabetes and chronic kidney disease; a cross sectional study. BMC Nephrology 2017;18:80