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ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

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EDITORIAL

Light at the end of the tunnel...

Mark Savage
Editor, ABCD Newsletter

In December 2007 ABCD, Diabetes UK, the Primary Care Diabetes Society, the Community Diabetes Consultants Group and the Royal College of Nursing Diabetes Forum published a joint position statement (http://www.diabetologists.org.uk/shared_documents/notice_board/joint_statement_v4.pdf). The driver for this statement was the uncertainty felt by both patients and healthcare professionals resulting from continuing NHS reforms. All signatories attest that people with diabetes should have equal access to the best possible diabetes care on the basis of need, which is essentially a repetition of the great ideal articulated at the time of the setting up of the NHS in 1948, albeit with the focus on diabetes. I am sure there are very few people, be they politicians, doctors, nurses or other, who would disagree in principle with this statement. Indeed, the Diabetes National Service Frameworks published in England as well as the devolved Celtic countries have the same aim. So, why the need for a statement at all?

In recent years we have had a purchaser/provider split which in many ways has been nominal only. The traditional providers have been district general hospitals with the government now aiming to expand the provider portfolio into the private sector. On the purchasing side (now termed commissioning) we have, at least in England, Primary Care Trusts (PCTs). The problem has been of course that the PCTs were both provider as well as purchaser/commissioner. It was noted by both professional and patient groups that this political structure led on occasion to unplanned, and indeed large, transfer of responsibility for patient management between various organisations: primarily between established diabetes clinics in specialist care settings to general practice/practice nurse run diabetes clinics within the primary care sector. None of the organisations who produced the joint position statement have any

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issues with the majority of patients being managed in primary care, indeed, this is a fact of life that everyone is essentially happy with. What concerned people was the *unplanned* shift of many patients.

Diabetes Networks have been proposed by the Departments of Health in all the countries of the UK as a means of organising local diabetes care (although they do have different names in the different countries of the UK). Indeed, the position statement emphasises the role of the Network (unfortunately however, some PCTs have ignored their Networks and they have been "suspended" - eg Sheffield). So, who should be on a Network? It should include users of the service, providers (in all their forms) and commissioners. The effectiveness of Networks is, as usual, rather variable with some recently having almost achieved the role of being *de facto* commissioners, whilst others remain essentially ineffective or non-existent. Those that have been relatively effective have found the diabetes commissioning toolkit produced by the Primary Care Diabetes Society (with input from ABCD) to be particularly helpful, particularly as it was endorsed by the National Diabetes Support Team (in England).

Nevertheless, those of us who have worked in the National Health Service for some time are aware that the only constant in NHS politics is that change is never-ending. In England we have moved from having PCTs who are both providers and purchasers/commissioners to having the PCTs being forced to formally separate their commissioning and provider roles. This was done primarily to avoid rather obvious conflicts of interest, but, as is common with more change, this seems to be generating more confusion. There is some reluctance in some PCT commissioning arms to take part in diabetes Networks as they perceive themselves now to be under an obligation to be "whiter than white" and thus must not "sup with the devil" by talking directly to providers and users in the forum of a diabetes Network. It is to be hoped that this is a minority view, and indeed it is likely that the rules will be clarified over the next year or two. As always seems to be the case, at least within the context of the United Kingdom NHS, one of the problems would appear to be that commissioners have limited understanding of the services they are commissioning and the recent changes, again at least in England, have separated the commissioners even further from the knowledge base that they require to access in order to fully understand what they are buying on behalf of the taxpayer. How is this paradox to be resolved? There appears to be no straightforward answer, the obvious one of commissioners employing nurses, consultants, general practitioners and users to advise them immediately brings up the risk of other conflicts of interest. So, how are diabetes specialists to address the new paradigm that appears to be evolving within England?

Essential skills have been taught to consultants who have attended the King's Fund Diabetologists Course which is a two week event which was initially set up (again in England) by the National Diabetes Support Team after discussion between the English National Clinical Lead for Diabetes (Dr Sue Roberts, now succeeded by Dr R Hillson) and the Specialist Services Liaison Group chaired by Dr Jiten Vora with ABCD and DUK input. There are now a significant number of Consultant Diabetologists who have attended this residential course in Oxfordshire and hopefully they will have at least some of the required skills needed to adapt to this ever changing political landscape (ABCD has agreed to sponsor the same course for SpRs). As with all politics the answers will lie with us, as specialists, talking to people, pressing the flesh, and making our case. The days when we could, as consultants, bang the table, froth at the mouth and demand change have long since gone. However, the Consultant Diabetologist remains the obvious person to lead locally and to agitate and advocate for his/her patients. The Diabetes Network therefore simply facilitates networking and, if the commissioners attend the required networking can be done at these meetings, if not we will have to go to the mountain.

There is a lot happening in the National Health Service generally and in the world of diabetes in particular (see summaries of the situations in Wales and Northern Ireland on page 3). Whilst change is not only inevitable, but recurring, and indeed permanent, we should not be afraid of it. We should rise to the challenges and realise that our skills are indispensable. We should keep up to date and realise that until the cure for diabetes is found our jobs are secure and if any commissioner feels that we are not required they will surely have to reverse any decision made locally to be rid of any diabetes specialist(s) and will have to be reversed very much sooner rather than later. The light in the distance is hopefully the end of the tunnel.

ABCD committee update:

As retiring Chairman I am delighted to say that after competitive ballot Peter Winocour is to take over as new Chairman from the AGM. In view of the increasing workload it has been decided to split the secretarial activities into General Secretary and Conference Organiser, I am very pleased to indicate that Ian Gallen and Dinesh Nagi have been appointed into these posts respectively. We are currently balloting for committee members and will be seeking 5 members to include 2 consultants within 5 years from appointment as well as a Senior Academic. My personal thanks are given within the Chairman s Report.

CONTRIBUTE TO YOUR ABCD WEBSITE!

www.diabetologists.org.uk

Keep an eye on the notice board for the latest information. Powerpoint presentations from recent ABCD meetings can be downloaded from the members only, password protected, website. Any member can easily use the Sharepoint technology underpinning this area of the website to set up nationwide audits. There are ongoing discussions that we invite you to contribute to and new discussions can be easily be set up.

ABCD website officer, Bob Ryder, can supply user name and password for the members only website and also advise on the above.

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Commentaries on the status of diabetes within the NHS from Wales and Northern Ireland

Wales

The situation with respect to Diabetes Services in Wales differs somewhat from England. In Wales, we do not have PCTs but have an almost analogous situation called LHBs (Local Health Boards). Functionally they are almost the same. In Wales, the NHS is funded by the Welsh Assembly Government. The Minister of Health (Edwina Hart) therefore has a more hands on approach than Department of Health which is responsible for resourcing the NHS in England.

The policy for Chronic Disease Management is somewhat similar to that in England. The policy is that the overwhelming majority of people with diabetes should be managed in Primary Care. The Chairmen of the LHBs are actively trying to persuade Secondary Care to discharge suitable stable patients back to Primary Care.

Currently, as Chairman of the Welsh Endocrine and Diabetes Society we are in negotiations with Edwina Hart regarding the appropriate model of care that should be provided in the general practice setting. We have one registered GPSI in Diabetes who works in the Gwent area. In that locality, they provide an intermediate level of care whereby the GPSI in question (Dr. David Miller Jones) will assess difficult patients and either advise on their management as appropriate or advise referral for assessment at the local diabetes centre. This model seems to work very well. However, the level of expertise residing within primary care differs markedly in other parts of Wales. In more rural localities (e.g. Carmarthenshire) traditionally the GPs have looked after people with diabetes in the primary care setting. Many of them have postgraduate qualifications in diabetes (e.g. the Warwick Course). In other areas of Wales the situation is much more heterogeneous. The worry of course is that these patients will not be seen by the primary care physicians but by the practice nurse and there is concern generally within secondary care that as the management of people with type 2 diabetes becomes more complex (new agents = new problems!) this is precisely the time when patients are being discharged back to relatively inexperienced clinical personnel.

Recently, the Welsh Assembly Government have appointed a person designated to be responsible for Chronic Disease Management. This will include the management of people with diabetes, ischaemic heart disease and arthritis! The previous incumbent had sole responsibility for management of diabetes in Wales. You can therefore see how diabetes has been downgraded in importance.

With respect to postgraduate training in diabetes in Wales, a new Diabetes Diploma has been set up under the auspices of Cardiff University and the Welsh Endocrine and Diabetes Society. This is designed for the medical profession only Primary Care and SpRs.

Alan Rees

Northern Ireland

Health and Personal Social Services in Northern Ireland underwent yet another restructuring in 2007 under the Review of Public Administration, with the four existing Health Boards being replaced by a single new Multi-professional Regional Health and Social Care Board. This resulted in the amalgamation of trusts into five new Health and Social Care Trusts and the proposed establishment of five primary-care led Local Commissioning Groups

In the midst of all the changes, developments in diabetes services have been grindingly slow, and many of the recommendations from the CREST/Diabetes UK(NI) joint Task Force report of 2003 have yet to be implemented

There has been no commitment from the DHSSPSNI for a diabetes service framework for Northern Ireland despite strong lobbying by the diabetes consultants and Diabetes UK(NI). Diabetes has been included only as a section within the cardiovascular service framework which is totally unsatisfactory for such a prevalent disease.

A regional digital diabetic retinopathy screening service has been established, predominantly primary care based with central QA, and funding became available for structured patient education There has been some increase in clinical psychology, diabetes nursing and AHP staffing in the community but little increased funding for secondary care.

A few managed clinical networks for diabetes have been established but the lack of a comprehensive computer database with links between primary and secondary care inevitably limits their effectiveness.

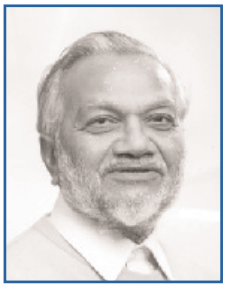
The prospect of secondary care input to the Local Commissioning Groups being set up is still being explored.

The NI Consultant Group in Diabetes and Endocrinology continues to lobby government on all these issues, but the voice of informed clinical opinion is frequently ignored..

Trevor Blair

Scottish commentary to come in the next issue

New Trustee



ABCD is delighted to announce that we have new Trustee, Lord Bhikhu Parekh. Educated at the Universities of Bombay and London, Bhikhu Parekh is a fellow of the Royal Society of Arts and of the Academy of the Learned Societies for Social Sciences and a Professor of Political Philosophy at the University of Westminster. Lord Parekh was chair of the Runnymede Commission on the Future of Multi-Ethnic Britain (1998-2000), whose report, The Future of Multi-Ethnic Britain, was published in 2000. He is vice-chairman of the Gandhi Foundation, a trustee of the Anne Frank Educational Trust, and a member of the National Commission on Equal Opportunity.

His main academic interests include political philosophy, the history of political thought, social theory, ancient and modern Indian political thought, and the philosophy of ethnic relations. Professor Parekh is the author of Rethinking Multiculturalism: Cultural Diversity and Political Theory (2000); Gandhi (2001); Colonialism, Tradition and Reform (1999); Gandhi's Political Philosophy (1989); Contemporary Political Thinkers (1982); Karl Marx's Theory of Ideology (1981); and Hannah Arendt and the Search for a New Political Philosophy (1981).

Highlights from the Autumn 2007 meeting of ABCD

Hotel Russell, London, 1st and 2nd November 2007

Over 100 members attended the Autumn 2007 Meeting ABCD to hear state of the art lectures on diabetes-related clinical topics and to debate the pros and cons of the Quality Outcomes Framework for Diabetes.

Current and future status of islet cell replacement strategies

Dr James Shaw, Senior Lecturer at the University of Newcastle.

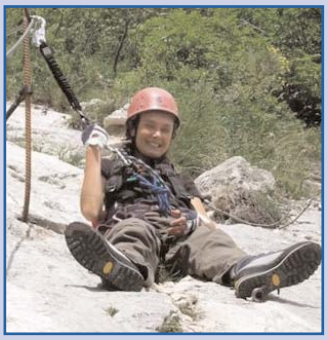
Transplantation of the whole pancreas could normalise glucose but there was a 20% re-operation rate, a 5% mortality rate in the first year after the transplant and lifelong immunosuppression. The success rate of the alternative of allotransplantation of pancreatic islet cells was a mere 7% until James Shapiro in Edmonton introduced more successful techniques in 2000. His main innovations were the use of new immunosuppressive drugs and the transplantation of larger quantities of islet cells. One of the important benefits of the new procedure was that there were no hypoglycaemic episodes.

A 5-year follow-up of the Edmonton Protocol demonstrated that 80% of patients were insulin-independent after one year but only 10% after five. However, patients were still C-peptide positive, were free of hypos and demonstrated a dramatically improved quality of life.

Islet cell transplantation was now being supported in the UK by Diabetes UK. A Consortium had been set up between six centres, two in London (Kings and the Royal Free), Newcastle, Bristol, Manchester and Oxford. Criteria for patient selection in the UK included established Type 1 diabetes for more than five years, recurrent severe hypoglycaemia, and sub-optimal control.

In plenary discussion, it was established that a priority of research was to get islet cells to replicate in culture. Using multiple donors increased the risk of autoimmune destruction of the beta cells. Could patients receive a top-up of islet cells after a few years? The answer was that this is not known. Could adult stem cell research be the long-term answer?

Meet the committee - Susannah Rowles



Qualifying in 1991 from Charing Cross and Westminster hospital medical schools I've been fortunate enough to have a taste of working as a junior doctor in central London, rural Gloucestershire and lively Newcastle before landing up in Manchester in 1994. I've rotated through the North West Deanery. In need of sunshine, and to experience a healthcare system different from the NHS I spend 18 fantastic months in Australia. Two years at the Christie Hospital as a Research Fellow has given me a special interest in acromegaly. Since starting out in medicine, I've continued to do "General Medicine" and as a result, the delights of "on call".

My first (and current) consultancy post has been at Fairfield Hospital, Bury, Pennine Acute Trust. At the time of appointment I was still doing ongoing research so my colleague and I have successfully piloted a "job-share" plan. In the time that I'm not employed by the Trust I work in Bury PCT both as a "hands-on" clinician in a Tier 2 diabetes service as well as having input in to service re design. Recently the PCT have identified the necessity for clinician input into future strategy and I now have an additional role as an Associate Member of the PEC (Professional Executive Committee) of the PCT, advising on long-term conditions.

The ABCD Debate

The QOF for Diabetes is the most important advance in diabetes care in the UK over the last decade

Chair: Patrick Sharp (Southampton)

Professor Kamlesh Khunti, from University of Leicester, proposing the motion, wanted to make it clear at the start that payments to GPs for the Quality Outcomes Framework for Diabetes (QOF) did not represent new or additional money. Secondly, he emphasised that diabetes represented only a part of QOF – a total of 99 out of a grand total of 1,050 points.

Professor Khunti said that QOF had led to undoubted improvements in care, for example beneficial changes in glycaemic and blood pressure (BP) control and lipid lowering. QOF had helped stimulate better systems for data collection and had encouraged the development of GPs specialising in diabetes. PC patient information systems in the UK were now the best in the world.

The median score for exception reporting from QOF in 2005 was only 6% and in 2006 a mere 4.7%.

Where money was concerned, it should be noted that only some targets attracted payment, eg. those for systolic and diastolic BP. However, Professor Khunti would not pretend that improvement in PC diabetes care was uniform. Larger practices were doing well, especially in deprived areas, but smaller practices were not doing so well. Critically, variations between practices in the quality of care were being reduced.

Speaking against the motion, Professor David Matthews, Director of the Oxford Centre for Diabetes, Endocrinology and Metabolism focused on two main points, first that QOF was primarily about money and, second, that the QOF statistics were highly suspect. He said that the title of QOF ought to be "Quality Income Framework" and described it as an apparatus designed by apparatchiks to pay GPs extra for things they should be doing anyway.

Professor Matthews pointed out that GPs were allowed as a matter of course to have up to 5% exception reporting in QOF. He compared the QOF figures with the much lower figures produced by the National Clinical Audit Support Programme.

In summary, QOF introduced the concept of medical practice by numbers and was rewarding activity, not care.

During plenary discussion and question and answer sessions, the following points were made. Many GPs were investing in

improvements to their practices. Exception reporting for diabetes in QOF was not radically different to that in other conditions.

Professor Khunti agreed that some patients - he estimated 5-10% - needed to have care delivered by specialists. He did not agree with the policy being adopted by some Trusts to shift all patients into PC. Professor Matthews agreed that clinical targets in PC were a good idea but thought that bringing money into the system was a great mistake. A former Chairman of ABCD was of the opinion that QOF had many faults but was still better than what was there before. But it was a great pity that ABCD had not been consulted over its introduction. Professor Khunti, in his closing remarks, pointed out that Professor Matthews had expressed the opinion previously in an article on behalf of the MODEL group that QOF was good for diabetes!

In the vote after the debate 37 voted for the motion and 52 against, with 3 not sure. This compared with 21 for and 54 against, with 4 not sure, in the vote before the debate. So, although Professor Matthews won the debate, Professor Khunti achieved the moral victory of persuading a number of delegates to change their vote in his favour.

OTHER PRESENTATIONS AT THE MEETING

Early effective treatment of type 2 diabetes
Professor Rury Holman, Professor of Diabetic Medicine, OCDEM, University of Oxford

The highs and lows of commissioning a diabetes service
Peter Bowker, Diabetes Network Manager, Hull & East Ridings PCT & Scarborough PCT

Role of the RAAS in treatment selection and target attainment in hypertensive diabetes
Professor Morris Brown, Professor of Clinical Pharmacology, University of Cambridge

Controversies in the management of paediatric diabetes
Dr Fiona Campbell, Consultant Paediatrician, St James University Hospital, Leeds

Provision of diabetes care for ethnic minorities in the UK – a special case?
Dr Tahseen Chowdhury, Consultant Diabetologist, The Royal Free Hospital, London

Note. The majority of the above presentations can be seen on the ABCD website: www.diabetologists.org.uk. Poster abstracts displayed at the meeting will be published in a future issue of Practical Diabetes International.

Conference Report: James Wroe

Young Diabetologists Forum Annual Day 2008... a great success!!!

The Young Diabetologists Forum (YDF) Annual Day took place on the 4th March 2008 in the Lomond Hall in the SECC- the day preceding the start of Diabetes UK APC. There were 115 SpRs who attended this event- making it easily the biggest gathering of Diabetes trainees in recent times.

The day was graced by a glittering array of speakers and the event started with Dr Partha Kar, YDF Chair, highlighting the changes that the YDF had undergone. This included moving to multiple sponsors, hosting the YDF day in the SECC apart from numerous other educational opportunities that the YDF had set out for its members. New members of the YDF Committee (Dr Marc Atkin; Dr Emma Wilmot; Dr Jyotish George; Dr Hermione Price; Dr Ragini Bhake and Dr Pratik Chowdhury) and their roles were introduced to the membership. The representation of the YDF in national organisations such as ABCD, JRCPTB, Society for Endocrinology was discussed. A special acknowledgement was made to ABCD for their help in setting up educational travel funds to EASD and agreeing to sponsor the upcoming ABCD Kings Fund SpR course.

This was followed by the keynote session. This looked at the possible role of diabetologists- both from an acute trust (Ursula Ward) and primary care perspective (Niti Pal). Needless to say, this created plenty of controversy, but what was encouraging was the wholehearted discussion which most of the delegates got involved in!

The next session was on the present controversy surrounding glitazones and Professor Christopher Byrne from Southampton gave a very balanced view of the studies done, the Nissen meta-analysis and on the future role of these products in the management of type 2 diabetes.

This was followed by the group breaking into several small workshops. The format was such that all got the opportunity to attend 4 workshops. The content of the workshop centred around varying topics such as research (Dr Irene Stratton), Management (Dr Mark Savage), Consultant interviews (Dr Gerry Rayman), motivational interviewing (Dr Tim Anstiss), antenatal diabetes (Professor Stephanie Amiel), paediatric diabetes (Dr Krystyna Matyka), pumps (Mrs Joan Everett) and obesity (Dr Simon Allwyn).

The final session of the day was a debate on which would have greater clinical use- DPP-4 inhibitors or GLP-1 agonists? Professor Stephen Gough highlighted the use of DPP-4 inhibitors while Professor David Mathews gave his view on GLP-1 agonists. This debate was chaired by Professor Stephanie Amiel and as expected was lively as well as entertaining! Professor Mathews won his side of the argument- thought Professor Gough managed to swing more voters to his side.

The day was wrapped up by Dr Partha Kar handing over the reins of the YDF Chair position to Dr Pratik Chowdhury. Dr Chowdhury thanked the sponsors of YDF 2008 (Glaxo Smith Kline; Novo Nordisk; Merck Sharpe and Dohme and Roche Diagnostics) for their contribution, while once again exhorting the membership to "spread the word" about the YDF and asking all to keep an eye on the website (www.youngdiabetologists.org.uk) for announcement of future courses.

In all, this day was a great success and appreciated by both the delegates and speakers. The YDF looks forward to the next year and hopes for further progress and development under the able stewardship of Dr Chowdhury!

Partha Kar

Chairman's Report

With some reflective sadness but balanced by increasing expectant relief, I put pen to my final Chairman's Report. Having recently perused rather nostalgically through the early ABCD archive files, when the initial "gang of three of us" set forth with determination and no little trepidation, I believe we can look with pride on the many achievements of the organisation over the last decade. It is time for the new generation to move forward and I have every confidence that the future of ABCD is in good hands, equipped to take on the huge challenges that are currently facing Consultant Diabetologists in our, as ever but seemingly rapidly changing, specialist world.

At an extraordinary meeting of committee last October members met to consider the role of Consultant Specialists within the changing NHS Models of Service Provision, the implications to recruitment and training of young doctors, and how ABCD should respond to these significant issues. All wanted to share a positive future vision, ensuring ABCDs essential contribution and responsibility for the promotion of professional diabetes speciality care within the NHS.

It is difficult to predict the precise way we will be working in the future – in reality there will be several different scenarios. However, as we await the Darzi Report on the way "Long-term Conditions" are to be managed, it is evident that the political direction of travel is for a significant proportion of specialist activity to shift into the community. Working with the NHS Alliance, ABCD has engaged in discussions around a Model of Integrated Working between Specialists and Primary Care, trying to move away from present activity–based accounting towards better systems of care. Whatever is ahead, we need to understand that the rules of engagement on the NHS Playing Field are changing and we need to ensure that we are still in the game. We face competitors from private providers waiting on the sidelines, but I believe we are still very much part of the future strategy and ABCD can help shape the way forward.

Having recently drafted a commissioned paper on contingency planning for diabetes services in the event of an influenza pandemic, it has become increasing apparent to me that integrated working and communication with primary care remains absolutely crucial. Contemplating the consequences of an influenza pandemic to our vulnerable population of diabetic patients is a matter of some concern – in fact quite frightening.

ABCD has continued to contribute to many professional activities over the year. ABCD representatives have provided expert advice to NICE both on specific topics as well as guideline development (including being prepared to disagree should the new type 2 guidelines fail to reflect the spectrum of current treatments available). ABCD now regularly meets with the Society of Endocrinology, discussing issues of training and education, and with Diabetes UK, encouraging patient advocacy of what best care should be expected. For example, such patient experience of care whilst in hospital underpins the much needed guidance on "Improving emergency and inpatient care for people with diabetes" a recently published report led by Mike Sampson on behalf of the NDST and endorsed by ABCD. Meanwhile "Ensuring Access to High Quality Care for all People with Diabetes" remains the paramount principle of our Joint Position Statement released this March in conjunction with Diabetes UK, the Primary Care Diabetes Society, The Royal College of Nursing Diabetes Forum and the Community Diabetes Consultants.

As I stand down from my term of office as Chairman, a privileged role I have much enjoyed but recognising how much more there is still to be done, I extend my grateful thanks to my many ABCD colleagues who have worked so hard on behalf of the organisation. Peter Winocour's tireless energy and enthusiasm is legend, and after 6 very productive years as Hon Secretary he takes over the mantle of Hon Chairman. Chris Walton clearly has financial aptitude and our accounts are now sufficiently healthy to enable us to extend our widening activities (supporting 20 SpRs to attend the King's Fund Course for example). Thanks to Anne Kilvert and Jiten Vora who also complete their term on the committee but both seek re-election and so there is every chance we will continue to benefit from their valued input. Particular thanks to Brian Frier who also stands down this time. Brian has been with us from the very beginning and I have been personally very appreciative of his sustained wise counsel.

At the time of writing we learn that Rowan Hillson is to be the next English Clinical Director for Diabetes and we congratulate her on this distinction, wishing her every success with the appointment. We hope she can continue as a committee member of ABCD but, if protocol prevents, our thanks also extend to you Rowan – well done indeed.

Final thanks must go to Elise Harvey and her staff at Gusto Events who have continued to provide a highly professional and effective administrative back up to ABCD. They have been tremendous. As for myself, I will take the opportunity of the "emeritus year" granted to the retiring Chairman and will continue to contribute where I best can. Having recently chaired the excellent meeting organised by Alan Sinclair at the RSM on "Diabetes in the Older Person", your retiring Chairman now knows the formula for long and healthy years ahead: to maintain a fast walking pace and to get a good nights sleep. Early nights from now on!

Professor Ken Shaw

MEMBERSHIP APPLICATION FORM FOR ABCD

Membership of ABCD is open to all Consultant Physicians with an interest in diabetes patient care in the NHS and all SpRs in Diabetes and Endocrinology. At present, the annual membership fee is £50.00. If you are interested in joining the Association, please fill in the application form below and return it to the ABCD Membership Secretariat at the following address:

Elise Harvey
ABCD Secretariat
Gusto Events Ltd
PO Box 2927
Malmesbury
SN16 0WZ
Tel: 07970 606962
email: elise@gustoevents.com

When your application has been approved, you will be sent a Standing Order Form for your annual subscription.

Membership Proposal Form

I wish to apply for membership of the Association of British Clinical Diabetologists.

Please use block capitals

Name (in full, please)

Professional Qualifications

Position held

Address

/ Post Code

Tel. No.

Fax No.

Email

Signed

Date