Australian Diabetes Educators Association

Annual Report 2010–11

The Australian Diabetes Educators Association is the leading organisation for health professionals providing diabetes education and care.

Vision

Optimal health and well being for all people affected by, and at risk of, diabetes.

Mission

To lead and advocate for best practice diabetes education and care.

To achieve this, ADEA will:

1. Support and promote the membership
2. Develop standards and best practice guidelines
3. Provide professional development and education opportunities
4. Promote the importance of diabetes education research
5. Advocate for equitable access to quality diabetes services
6. Liaise and collaborate with relevant bodies
7. Ensure good governance

Australian Diabetes Educators Association Annual Report 2010–2011

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ADEA Board

National Executive

PRESIDENT
Nuala Harkin RSCN NP RN CDE DipInfectionControl GradCert(DiabEd)

VICE PRESIDENT
Fiona McIver RN CDE BN GradCert(DiabEd)

FINANCE DIRECTOR
Tracy Aylen RN CDE

EXECUTIVE MEMBER
Giuliana Murfet RN CDE GradCert(DiabEd)

Other Board members

Carol de Groot RN CDE GradCert(DiabEd)

Cheryl Steele RM RN CDE GradCert(DiabEd)

Diana Sonnack RN CDE

Glynis Dent RN CDE GradCert(DiabEd) GradCertHumanNutrition

Jane Payne RN CDE NP GradCert(DiabEd)

Liz Powell APD CDE Bsc PostGradDipNutr&Diet GradCert(DiabEd)

Trish Roderick RN CDE

ADEA National Office staff

EXECUTIVE DIRECTOR
Clair Matthews

ADMINISTRATIVE ASSISTANT
Catherine Holland

ADMINISTRATION OFFICER
Aneesa Khan

CREDENTIALLING OFFICER AND NADC OFFICER
Gina Chen

FINANCE OFFICER
Megan Krajina

PROFESSIONAL OFFICER
Gil Cremer

RESEARCH OFFICER
Lhawang Ugyel

NDSS staff

STRATEGIES MANAGER
Bob Sims

ADMINISTRATIVE OFFICER
Aneesa Khan

FINANCE OFFICER
Megan Krajina

PROJECT OFFICERS
Geoff Murray-Prior *to September 2010*
Kerstin Weber *to August 2010*
Nithin Kolanu *to January 2011*
Graeme Wolfenden

National Office Staff
Back row L to R *Jessica Axelby, Aneesa Khan, Vicky Holland, Gina Chen, Catherine Holland*
Front row L to R *Bob Sims, Clair Matthews*

ADEA Board
From L to R *Glynis Dent, Giuliana Murfet, Fiona McIver, Liz Powell, Tracy Aylen, Cheryl Steele, Jane Payne, Carol de Groot, Trish Roderick, Nuala Harkin, Diana Sonnack.*

President's and Executive Director's report

It has been another busy year for the Australian Diabetes Educators Association (ADEA). One of the highlights of the year was planning the Strategic Direction of ADEA over the next 3–5 years.

The Strategic Planning Meeting was held in February 2011 and all members were well represented, with the attendance of the Branch Chairs, the Chair's of the ADEA Committees and Working Parties and all Board Directors. There were some lively discussions, and although there was agreement that ADEA is the leading organisation for health professionals providing diabetes education and care, there was a strong sense that the Vision and Mission should be more focused on our members. The key outcomes were an evolved Vision and Mission, and six clear focus areas.

Evolved Vision: Optimal diabetes education and care for all people affected by, and at risk of diabetes

Evolved Mission: To support and advocate for diabetes educators to deliver evidence based education and care

Six Focus Areas:

1 Communication, information and networking
2 Research and best practice
3 Advocacy
4 CDE credentialling, awareness and promotion
5 Professional development and support
6 Governance

The ADEA Board of Directors had hoped that the Strategic Plan would be completed, in time for the August edition of the Australian Diabetes Educator. However, it is a work in progress, and the completed document will be available as soon as possible.

The activities of this report are discussed under the 2008–11 Strategic Plan. Here are some highlights.

Support and Promote the Membership

ADEA membership continues to grow, and the current membership stands at 1746 members.

ADEA values its members and as such, will continue to improve and expand the services that benefit its members. ADEA needs to promote the CDE role, as one that has undertaken to set the benchmark for themselves, against the highest standards of diabetes self management education.

The development of the new membership form, will assist ADEA in gathering vital statistics that support the need for more Medicare rebates, and to justify the need for enhanced diabetes services in the primary and tertiary care sectors.

The *Australian Diabetes Educator (ADE)* continues to be a great source of information sharing, research, as well as keeping the membership updated with activities within ADEA. For some time, the Editorial Advisory Group had the goal, to commence a peer review section in the ADE. That came to fruition with the June 2011 edition.

The findings of the 2011 Member Survey are on the ADEA website. In the section 'Members perception of the ADEA Board', 77% of participants stated, that liaising with the members was one of the main functions of the ADEA Board of Directors. Respondents' preferred information sources about ADEA activities via member email (89%). The weekly email was reinstated as a result of the 2010 Member Survey.

The ADEA website database capacity has improved and will build with future stages of the website development. The Forums have been popular, however they are currently unavailable, while an online member declaration of acceptance of the terms and conditions of its use are developed. Further, the ADEA needs to source funding to remunerate experts who facilitate the forum topics.

Promotion of ADEA and our members has become an important focus. Clair and Bob have been busy developing media and marketing strategies with advertisements in consumer magazines, Nursing Review and on TV with the Rob Palmer diabetes nurse educator promotion; attendance at health professional conferences; development of the CDE brochure; and sourcing media presence at the ASM. ADEA is its members, and as such, endeavours to take every opportunity to put ADEA forward, and will always be on the lookout for new ways to raise the profile of the organisation and its members.

Develops Standards and Best Practice Guidelines

The Credentialling/Re-credentialling Review is on the website for member comment, and there is an opportunity for further input at a forum being held at the ASM. The Insulin Initiation documents have also been available for member comment and a workshop will be held at the ASM.

The Clinical Practice Committee continue to advise the ADEA Board on matters pertaining to diabetes education practice, researching current evidence, and presenting their findings to the Board of Directors, in line with our evolved Mission. A full report of their activities is presented further on in the Report.

The Course Accreditation and Standards of Practice committee continues to manage and advise

the ADEA Board on the ADEA Course Accreditation process. Judy Reinhardt has been the convenor, and involved with this Committee in its various formats for the best part of 20 years. Judy has recently resigned as Convenor. ADEA thanks Judy for her amazing commitment, and wish her well.

We know from the Member Survey, that 66% of members are interested in being involved in ADEA Committees or Working Parties. Thirty four percent of respondents have already participated, and to those participants, ADEA would like to say thank you for your commitment.

Provide professional development and education opportunities

The ADEA provides education opportunities for diabetes educators through the ASM, the Educators Day and Branch conferences and meetings. Some Branches offer teleconferencing facilities for members in rural and remote areas. We would like to thank the companies that have supported educators through sponsorship of registrations, provision of Scholarships to assist completion of post graduate qualifications, development of online courses, and mentoring of diabetes education in other countries.

Promote the importance of diabetes education research

'How does diabetes education add value to the health service, at all levels of the health care system?'

It has never been more important for ADEA to be able to answer this question, than in the present health climate, and the government's proposed plans and initiatives to care for people with diabetes. At the Strategic Planning Day in February 2011, there were some great discussions around this, and finding the answer will be a major focus of the next Strategic Plan.

Again, companies have been generous in their support of ADEA research opportunities.

Advocate for equitable access to quality diabetes services

From the Member Survey – 82% believed the function of the Board of Directors was to lobby Government. It is paramount that we continue to do so, both at local, state and National level. The Health Insurers and Private Practice (HIPP) Working Group has been very active in this regard, with the development of a kit to lobby private health funds.

The Department of Health and Ageing (DoHA), has sought ADEA's input into the National Diabetes Services Scheme to reach all people with diabetes throughout Australia.

ADEA is a member of the Diabetes Advisory Group. Over the past year there have been two face to face meetings, in which ADEA has been represented. Just to recap the Diabetes Advisory Group will play an important role in the design, implementation and evaluation of the Coordinated Care for Diabetes reform pilot, due to commence July 2011. Earlier this year there was a call for a tender regarding the pilot, and it was recently announced that a consortium led by McKinsey and Company would lead DoHA's pilot for the Coordinated Care of Diabetes. Clair Matthews and I will be meeting with members of the consortium in early August, to discuss ADEA's perspective and ideas in relation to the pilot. We will also be able to provide feedback on the proposed approach to the pilot, prior to the next Diabetes Advisory Group meeting, which is scheduled to take place on the 24th August in Canberra.

Liaise and collaborate with relevant bodies

ADEA will continue to liaise and collaborate with the relevant bodies, keeping in mind the strategic direction of the Company. The ADEA and the Australian Diabetes Society (ADS) as Australia's peak health professional bodies informing diabetes practice have regular ADEA/ADS Collaborative meetings. ADEA is involved in the National Association of Diabetes Centre's Steering Committee (NADC). ADEA is a member organisation of Diabetes Australia, Allied Health Professionals Australia, Medical Director and the Primary Health Care Network Partnership. ADEA has a representative on the DA Board.

ADEA is in a strong position to develop international partnerships, with the present International Diabetes Federation Vice Presidents, Trisha Dunning and Ruth Colagiuri, and the ADEA Western Pacific Region Representative, Trisha Dunning.

Ensure Good Governance

In order to have good governance it is critical to have the right mindset and culture, the right standards or principles, the right policies and procedures and the right training and understanding. With this in mind governance training will continue at both Board and Branch level.

As many of you will be aware, the proposed Constitutional Changes have been available on the ADEA website for some time. The ADEA Board of Directors has prepared a fact sheet and powerpoint presentation, and has encouraged all Branch chairs to discuss the proposed changes, at branch level.

From a corporate governance point of view, the suggested changes, if accepted, will move ADEA into more current governance arrangements.

Nuala Harkin
President

Clair Matthews
Executive Director

Finance Director's report

Another busy financial year has ended and the Annual General Meeting is fast approaching. The Finance and Audit committee (FAC) has met via six teleconferences and one meeting (held at the ASM). There are some new faces on the FAC this year; we welcomed Andrea Sanders (Branch Finance Officer – Queensland) and Edwin Pascoe (Branch Finance Officer – Victoria) for the 2010–2012 period. The National Finance Officer for the majority of this financial year, Megan Krajiina, took up a new position with a federal government department in Canberra and Gina Chen (former ADEA Credentialling Officer) has moved across to the finance role. Gina brings formal qualifications in finance to the position and has been orientated into her new role with support from the small National Office team. Martin Gordon continues to provide invaluable assistance and expertise as the Consultant Accountant for the committee.

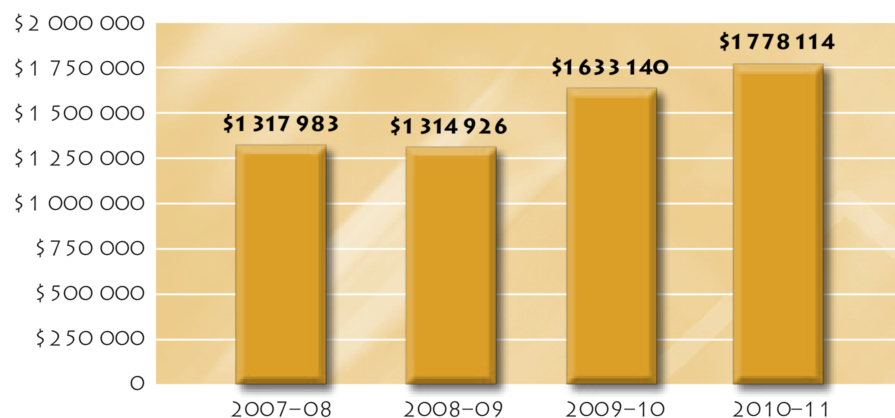
Members will have noted some new additions to the Australian Diabetes Educator. The most notable and exciting is the launch of a peer-reviewed section. Another new inclusion that the FAC is utilising to assist members is the series of articles 'Know your Professional Organisation'. As a previous Branch Chair in Victoria I recall trying to work out how the ADEA operated as a company, especially from a financial perspective. We hope you find the articles add to your knowledge about the organisation by providing concise information about finance operational processes. If you have any particular issues or questions you would like to see covered in future articles please send them to National Office to the attention of FAC.

During the year FAC activities included:

- Review of the committee terms of reference and updating the TOR to better reflect current practices, with the draft changes subsequently approved by the Board
- Teleconference with representatives of Diabetes Australia Limited regarding the restructure of DAL and any implications for member organisations
- Review of the investment strategy with our advisor
- Responding to specific members queries regarding fees and payment issues when requested
- Input to processes further aligning branch conference arrangements, including speaker payments, so that they are consistent across ADEA.

We encourage you to read through and familiarise yourself with the Financial Statements and accompanying Notes included in 2010–11 Annual Report. Overall ADEA continues the gradual increase in total equity (total equity is the difference between the assets and liabilities that the organisation holds). The audited reports show a comparison between the previous and current financial year. Below is a graph setting out the growth trend over the past four years.

Total equity 2008–2011



Last year's Finance report provided a comparison of income generated from membership fees (Full, Associate and Sustaining) against total revenue. Fee increases last year were based on generating sufficient income to cover the employment of a Professional Officer and to increase support to Credentialling. In 2009–10 membership fees comprised approximately 17% of total revenue. For the 2010–11 year membership fees amounted to $340 017 which covers 18% of total revenue. In comparison to total expenditure the membership fees covered only 20%. At ADEA, every year from its inception to the present, in order to meet the balance of funds required the CEO, National Office staff, Board, Branch Executives and general members are jointly working to raise the additional funds and limit costs. Project grants, Branch conferences, sponsorship of publications, advertising in the ADE and a number of other approaches help to bridge this funding gap.

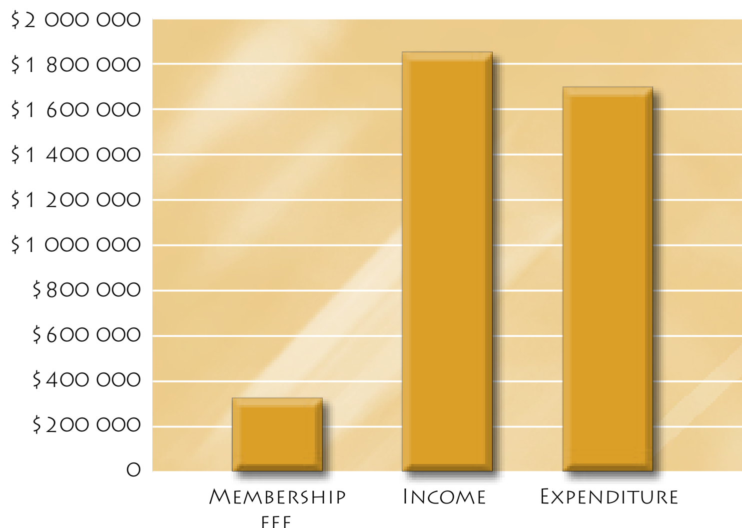
As mentioned above the investment portolio held by ADEA is reviewed at least annually to check our performance by comparison against average return on investments. Net return at the time of the review was 7.01% compared to 3.8% general market return. Allowing for maintenance of sufficient held funds in reserve (one year of operating costs) there is now some capacity to reinvest part of the interest received into member services. The Board supported the use $10,000 for research grants and will also fund activities arising from the review of the Strategic Plan. The conservative investment strategy will be maintained as the international financial situation currently remains unstable. At present ADEA holds 50% growth and 50%defensive position in investments.

Independent auditing of company accounts is a regulatory requirement. The company of appointed auditors for ADEA, Walter Turnbull, have merged with Price Waterhouse Cooper (PWC). At the AGM the Board will seek endorsement for continuation of PWC as the auditors for the 2011–12 financial year, and will consider the options for auditing services post 2012 over the next 12 months.

In conclusion, a big thank you is due to the National Office team for their efforts over the past twelve months and to Edwin, Andrea and Martin for their contributions.

Tracy Aylen
Finance Director

Annual membership income compared with total income and total expenditure



Industry partnerships

SUSTAINING MEMBERS

Our Sustaining Members make an important contribution to our ongoing growth. The payments assist the ADEA in pursuing its goal of achieving optimal health and well being for all people affected by, and at risk of, diabetes, through education, advocacy, support and research.

MERCK SHARP & DOHME

BUSINESS PARTNERS

ADEA's Business Partners make an invaluable contribution to ADEA and the programs it is able to provide to its membership. Over 2010–11, ADEA's Business Partners have supported a wide range of projects and activities including the provision of post graduate scholarships, on-line professional development, advocacy projects and support for ADEA marketing activities. We are grateful to them for their support.

PLATINUM BUSINESS PARTNERS

The Australian Diabetes Educators Association (ADEA) has used the education grant from ABBOTT DIABETES CARE, Abbott Australasia Pty Ltd to produce an online education program NEW TECHNOLOGIES for diabetes educators. These modules have been developed in collaboration with the Australian Diabetes Society (ADS) and are now available through the ADEA website. The topics covered include:

Glycaemia Matters

Blood Glucose Monitoring Systems

Insulin Pump Therapy

Continuous Glucose Monitoring Systems

Abbott Diabetes Care also funded:

Ten early bird registrations to the Annual Scientific Meeting (ASM) through the Annual Case Study Awards.

A Service Development Grant worth $5 000. The aim of this grant is to assist diabetes educators to undertake research in the workplace. This provides an opportunity for individuals to improve their research skills and competence, and supports the enhancement of the evidence base for diabetes education and management.

An interview with Rob Palmer of Dancing with the Stars fame. Rob was interviewed by Nuala Harkin, ADEA President, on managing his type 1 diabetes. The interview appeared in the March 2011 edition of the *Australian Diabetes Educator*.

Reprints of copies of the ADEA resource Feeling Sick? What to do – Information for people with type 1 diabetes.

The DIABETES MANAGEMENT IN THE PRIMARY CARE SETTING online education course for practice and enrolled nurses is now available through the Australian Practice Nurses Association website. This program was developed using an education grant from MERCK SHARP & DOHME. Merck Sharp & Dohme also developed and funded a campaign to advertise this course.

Merck Sharp & Dohme produced an advertisement highlighting the IMPORTANCE OF THE DIABETES EDUCATOR in diabetes management.

POST GRADUATE SCHOLARSHIPS PROGRAM

NOVO NORDISK has provided funding to support two ADEA members to attain Post-graduate Certificates in Diabetes Education.

AN INTEGRATED APPROACH TO DIABETES MANAGEMENT, EDUCATION AND CARE
A literature review on primary care diabetes service delivery models has been completed. These diabetes service delivery models have been aligned along a continuum of care to match the complexity of diabetes with the intensity of management required, for example Simple Intensity Model; Complex Intensity models; and Tertiary Diabetes Centres.

Focus groups have been conducted with general practitioners and practice nurses in metropolitan and regional Australia, to better understand scope of practice and referral patterns.

THE aims of the project are to:

- Identify and report on current diabetes education service delivery models, including an assessment of their strengths and weaknesses within the context in which services are provided.
- Identify the strength, role and scope of practice of:
  - diabetes education specialist practitioners (endocrinologists and Credentialled Diabetes Educators (CDEs)) in the tertiary health care sector;
  - diabetes education specialist practitioners (CDEs) in the primary health care sector; and
  - generalist practitioners (General Practitioners (GPs) and practice nurses) in the primary health care sector.
- Understand referral practices within primary care.

GOLD BUSINESS PARTNER

PHASE 3 of the Practice Development: Paediatric Insulin Pump Project was developed from the outputs of Phase 2 of this project using an education grant from MEDTRONIC. Two working groups were formed to review and make recommendations on 1) evaluation processes and 2) education resources, for insulin pump use and management in paediatrics. As part of this project, Medtronic funded a review of a Paediatric Insulin Pump Clinic using a multi-disciplinary approach to care.

Medtronic Diabetes International East established an EDUCATION FELLOWSHIP programme to provide two ADEA members with the opportunity to participate in a 12 month mentorship programme, mentoring diabetes educators who are based in India. The educators have met with diabetes educators working in an Indian Diabetes Clinic and will provide ongoing support on-line. A follow up visit is planned for later in 2011.

PARTNERS

ANNUAL Scientific Meeting: Best Poster Award

ANNUAL Scientific Meeting: Best Oral Presentation Award

BECTON DICKINSON PTY LTD has provided support in the review of needle injection techniques. Becton Dickinson is developing an online education program on injection techniques for diabetes educators, in conjunction with the ADEA.

ANNUAL Scientific Meeting: Best Novice Poster Award

ANNUAL Scientific Meeting: Best Novice Oral Presentation Award

ROCHE continue to fund the ADEA Roche Educators Day held the day before the Annual Scientific Meeting.

TOPICS covered at the August 2010 ASM were:

- Foot assessment and foot care for the non-podiatrist: what every educator should know
- Preventing and managing health professional burnout
- Brief solution focussed intervention for managing distress, anxiety and depression among people with diabetes
- Private practice – clinical issues to consider
- Accu-Chek Connect – tools that simplify diabetes management
- Educating people living with a mental illness and diabetes
- Bridging the diabetes education gap: nutrition education for diabetes educators
- To be or not to be – a mentor.

SPONSORSHIP of the ADEA CareSens SCHOLARSHIP to support an ADEA member working in rural/remote Australia to attend the 2011 Annual Scientific Meeting.

SPONSORSHIP of a media grant to engage the Media Relations Services of Ethical Strategies Pty Ltd for the ADS-ADEA Annual Scientific Meeting.

ESTABLISHMENT of an Expert Consultancy Council.

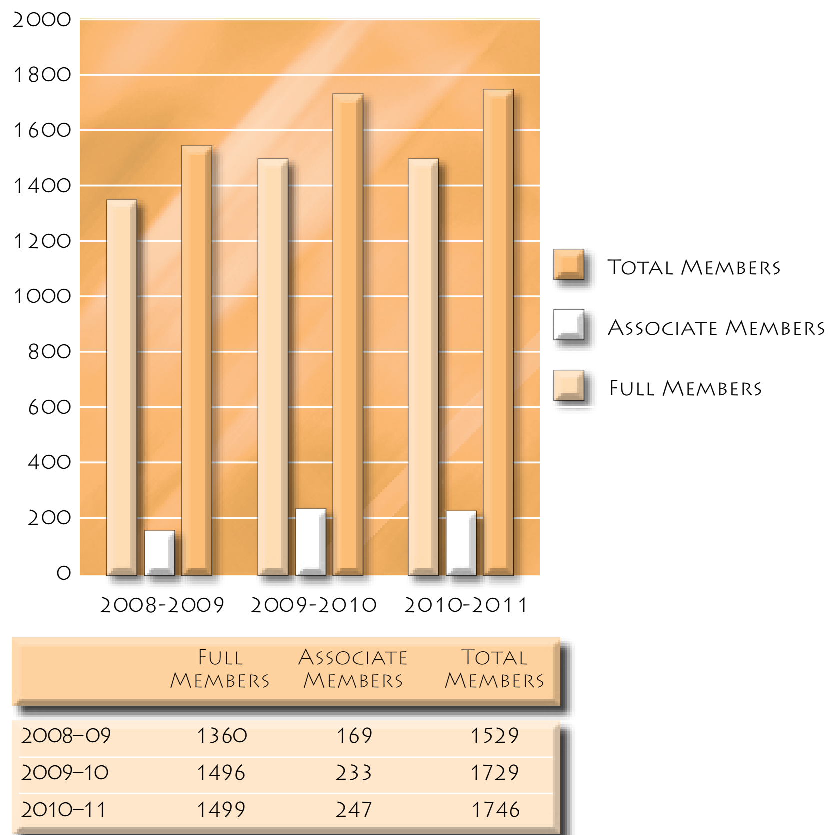
Membership and communications

Membership

The ADEA continues to experience an increase in the total membership with a small increase in numbers between 2009–10 and 2010–11. As indicated in Figure 1, the majority elect to become full members with only 14.2% electing to take up the option to become associate members.

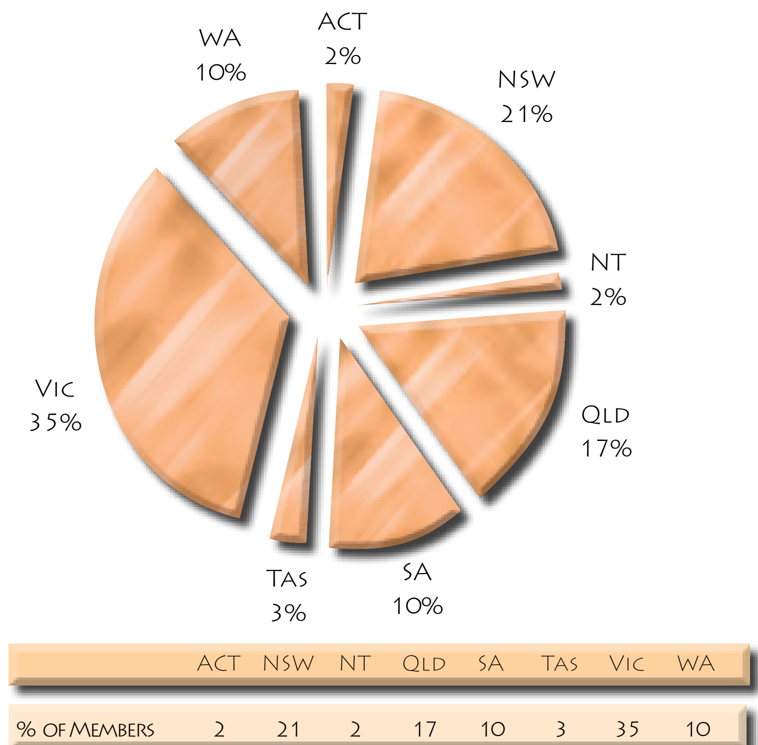
Currently, 35% of ADEA members come from Victoria (Figure 2). Furthermore, 20% and 17% of ADEA members live and work in New South Wales (NSW) and Queensland, respectively.

Figure 1: Annual membership for the period 2008–09 to 2010–11



	Full Members	Associate Members	Total Members
2008–09	1360	169	1529
2009–10	1496	233	1729
2010–11	1499	247	1746

Figure 2: ADEA membership by state/territory



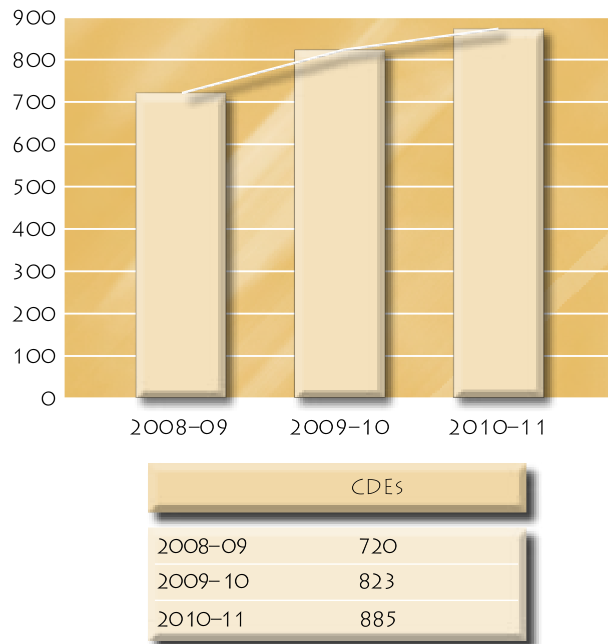
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
% of Members	2	21	2	17	10	3	35	10

The ADEA Credentialled Diabetes Educator

The number of ADEA members achieving recognition as CDEs increased from 823 to 885 between 1 July 2010 and 30 June 2011. This is a growth rate of 7.5% in the 2010–11 financial year. See Figure 3.

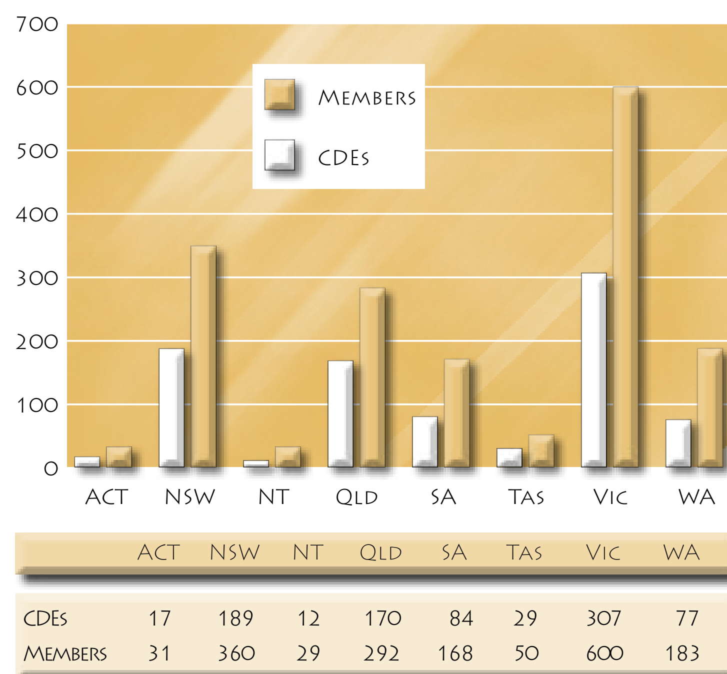
Similarly to the general ADEA membership, most CDEs live and work in Victoria and NSW. Figure 4 indicates there are 307 CDEs in Victoria. This is one third of the total number of CDEs in Australia. Six of the eight branches have 50% or more of their members credentialled, with Queensland and Tasmania having the highest proportion of members that are credentialled with 58.2 and 58%, respectively.

Figure 3: Number of CDEs by financial year



	CDEs
2008–09	720
2009–10	823
2010–11	885

Figure 4: Number of members and CDEs by state/territory



	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
CDEs	17	189	12	170	84	29	307	77
Members	31	360	29	292	168	50	600	183

Member Survey 2011

PRELIMINARY SUMMARY OF RESULTS

Introduction

The Australian Diabetes Educators Association (ADEA) Board commissioned a survey of ADEA members. A researcher, independent of the ADEA, placed the questionnaire on Survey Monkey and the ADEA National Office informed members about the survey. The survey was conducted for a month over March/April, 2011. The researcher downloaded the completed questionnaires, analysed the data and prepared the report.

Respondents

- A total of 427 ADEA members completed the survey, a response rate of 25%. The largest proportion of respondents indicated they are employed in a hospital (39%) followed by community health (27%).
- Seventy-four per cent of respondents were aged between 41 and 59 years and the primary qualification of the majority of respondents was nursing (92%).

ADEA membership

- Most respondents were full ADEA members (96%), and 43% of respondents have been a member for more than eight years.

- The most frequently cited reason for joining ADEA was the credentialling process (82%) followed by networking opportunities (68%), the professional development program (55%), the conference (54%) and access to the *Australian Diabetes Educator* (53%).

Insulin dose adjustment

Three hundred and forty-four (81%) respondents indicated insulin dose adjustment is part of their clinical work. Of these, 157 (46%) had training in delegated authority in a hospital setting, 114 (33%) had training in patient specific medication authority, 46 (13%) had no training in this advanced practice and 27 did not answer the question about training.

ADEA projects

The current ADEA project most important to respondents was the credentialling review (79%), followed by the sick day guidelines review (55%) and Consumer Fact Sheets (52%).

ADEA website

Most respondents reported accessing the ADEA website 2–3 times per month (32%) or weekly (29%), followed by monthly (23%). The aspects of the website of most interest to respondents were: updates (79%), conference information (78%) and the member's only section (60%).

Membership renewal

Three hundred and fifty-two respondents (82%) had renewed their membership since the 1st of April 2010. Of these, 232 (66%) rated the membership renewal process via the website as 'good' and 23% as 'very good'.

Communication from National Office

Almost half (61%) of respondents rated the quality of communication from the National Office as 'good' and a further 25% as 'very good'. Only 10% rated it as 'poor' and 2% as 'very poor'.

Credentialling

- The majority of respondents were credentialled (n = 319, 75%). Most of these 319 respondents rated the quality of administration of their initial credentialling as 'good' (54%) or 'very good' (30%).
- Of the 262 members who responded to the question about the re-credentialling process, most rated it as 'good' (54%) or 'very good' (38%).

ADEA events

- Almost all (n = 395, 93%) respondents had attended an ADEA event. Events attended by these respondents were: Branch conference (88%), ASM (76%), and Branch seminar (49%).
- Of the 395 respondents who had attended an ADEA event, 97% indicated they 'provided good networking opportunities', 95% indicated they 'improved your knowledge' and 85% rated them as 'value for money'.

ADEA Committee or Working Party membership

- One hundred and forty-seven (34%) respondents had ever served on an ADEA Committee or Working Party.
- Sixty-six per cent indicated they would be interested in serving on a Committee or Working Party in the future.

Perceptions of the function of the ADEA Board

When asked about the functions of the ADEA Board, the functions most frequently selected by respondents were: lobbying government (82%); ensuring the financial health and sustainability of the company (82%); setting the strategic direction of the company (79%); implementing the ADEA strategic plan (75%); and liaising with the membership (77%).

ADEA Branches

- Over 85% of respondents perceived each of the following were functions of their ADEA Branch: networking opportunities (88%); opportunity to raise and discuss issues (87%); professional development (85%); and local conference (84%).
- Forty-two per cent of respondents had attended one to two Branch Meetings in the past 12 months, 24% had attended three to four Branch Meetings, and 26% had attended no Branch Meetings in the past 12 months.

Special Interest Groups

- The largest proportion of respondents who were members of any Special Interest Group (SIG) were members of the Private Practice SIG (15%). A further 6% were members of the Nurse Practitioner SIG, the Paediatric SIG (6%) and the High Risk Foot SIG (5%).
- Respondents indicated the function of their SIG as information sharing (50%), identifying professional issues (49%), networking opportunities (46%), professional development (45%) and mentoring (38%).

Information sources and ADEA publications

- Respondents' preferred information sources about ADEA activities were member email (89%), ADEA website (68%) and the *Australian Diabetes Educator* (57%).

- The quality of the *Australian Diabetes Educator* was rated as 'good' by 51% and 'very good' by 40% of respondents.
- Publications used by the greatest proportion of respondents were *National Core Competencies for CDEs* (81%), *The CDE in Australia* (76%), *Code of Conduct* (67%) and *National Standards for Diabetes Education Programs* (59%).

Recommending the ADEA to others

- The majority of respondents (89%) would recommend ADEA membership to their colleagues, 5% would not recommend ADEA membership, and 5% did not respond to the question.

Difference in responses to 2010 survey

In general the responses were quite similar to the responses to the 2010 survey. One clear difference was that the ratings of communication from the National Office were substantially more positive in the current survey compared to the 2010 Member Survey. The percentage of respondents rating communication as 'Good' or 'Very good' increased from 60% in 2010 to 86% in 2011.

The response rate was also higher in 2011.

Branch activities

The ADEA branch activities continue to provide support and professional development opportunities to members. Teleconferencing continues to be offered as a mechanism of offering rural and remote members an opportunity to participate in events and engage with peers and colleagues.

Videoconferencing is used by some branches to assist those in rural and remote areas to participate in branch meetings and activities.

Branches continue to hold highly successful conferences and workshops. These are generally annual one to two day events and are increasingly attracting registrants from other health professionals outside the ADEA membership. The branches are also hosting a range of other professional development activities and events often focusing on specific professional issues.

The ADEA Board and the National Office commend the contribution and dedication of the Branch Executives and other members participating in the development of the learning objectives and planning of these events.

The ADEA acknowledges the contribution of the many Companies, who support Branch conferences and events and the significant role this sponsorship plays in the success of Branch activities.

The ADEA President has attended the New South Wales, Queensland and Victorian Branch conferences. The June ADEA Board meeting was held at a venue near the Victoria Branch conference. This allowed some ADEA Board Directors to participate, albeit in a small way, in the Victorian Branch conference.

The opportunity for the President, and Executive Director, to meet with the ADEA membership continues to be a highly valued activity.

ACT Branch

Terri Berenguer Branch Chair

During the 2010–11 period the ADEA ACT Branch held four meetings in September, November, February and May.

On September 16, 16 attendees had a presentation on a new class of oral hypoglycaemic agents. 'The use of gliptins in type 2 diabetes mellitus' was delivered by Associate Professor Christopher Nolan.

On November 26, endocrinologist Dr Caroline Droste presented to 14 attendees on 'Diabetic ketoacidosis'. Dr Droste was very interactive in her presentation and engaged throughout with the audience sharing experiences locally as well as from South Africa. Attendees became more familiar with the term 'ketosis prone' in a population of African origin.

Our ADEA National Board Representative member, Trish Roderick, kindly attended this meeting and presented her National Board Report. Trish stayed on after the dinner meeting to further get to know local members, which was very welcome.

On February 19, with 14 attendees, the meeting was conducted prior to the second day of the ACT Branch conference workshop, which was delivered over two days – Friday18 and Saturday 19 February.

On May 26 with 15 attendees, Bob Sims (ADEA National Diabetes Service Scheme (NDSS) Strategies Manager) and Gina Chen (ADEA Credentialling Officer) attended the meeting to answer questions from members related to the NDSS and credentialling.

In addition, information on 'Updating the Constitution – What you need to know' was also provided with copies of the associated fact sheets on display.

Our Branch Conference

for 2011 was presented as a workshop to support education on mental health. The Mental Health First Aid Workshop was held on February 18–19. This award winning course developed in 2001 was attended by 20 participants. The maximum number of participants able to attend the course was 21, however there was a late withdrawal due to that member re-locating inter-state. The workshop with a diabetes theme was delivered over 14 hours with an aim to improve mental health literacy, assist in early intervention and supportive action. At the completion of the course attendees received a certificate of attainment, the 'Mental First Aid Manual', and a broad range of other relevant resources.

ACT Branch members Vicky Mahood and Nola McFarlane attended the Novartis education day in Melbourne and Helen Rojas attended the Novartis education day in Sydney and reports were presented at the following branch meeting. Jennifer Gallagher received funding for the ADS–ADEA National Conference in Sydney in August 2010 and presented her report at a Branch meeting also.

NSW Branch

Marlene Payk Branch Chair

The NSW ADEA Branch has just had another successful annual conference held on the 20th and 21st May 2011 at Rydges Parramatta. The theme this year was 'A collection of interesting particulars' with a variety of topics to interest all members.

We began on the Friday afternoon with concurrent sessions offering members the choice of the 'Accu-chek Connect Workshop' or 'Straight from the hip. . . what's going on with the feet?' presented by podiatrist Chris Scanlon.

Roche presented two free registrations for the ADS-ADEA Annual Scientific Meeting to be held in Perth to two lucky attendees of the Accu-Chek Connect Workshop.

Speakers on the Saturday of our Conference included Neroli Armstrong presenting 'The role of the diabetes case manager', Louise Brown on 'Health coaching', Leanne Gregory on 'Food for thought', Chris Zingle updated us on the latest 'Injection techniques', Simon Rosenbaum on 'How to *stretch* the most out of activity' and Laura Toose NSWNA 'Legal issues relating to diabetes educators'.

Our panel discussion this year was on 'Scope of practice: who does what?' The panel was represented by nurse practitioners, a private CDE and a practice nurse, evoking very topical discussions.

Jenny Kinsella (Matron) again entertained the audience with her role chairing The Great Debate – 'Wearing a uniform benefits diabetes education'. On the affirmative we had Kirsty Boltong and Kathy Grudzinskas both dressed in their work uniforms arguing their point but 'The Matron' was unimpressed with this modern day uniform! On the negative, we had Debbie Scadden and Kris Heels the winning team for their humour and ability to give even 'The Matron' a laugh.

The conference was attended by 76 delegates from both rural and metropolitan regions.

With support from the 14 companies who sponsored our conference we were able to present four registrations for this year's ADS–ADEA Annual Scientific Meeting in Perth. Successful members receiving these registrations were: Catherine Wilson, Debra Sadie, Ivy Semple and Yvonne Peisley.

We continued our Branch meetings, holding four over the past 12 months in various Diabetes Centres around Sydney with excellent guest speakers at each of these.

Our September meeting was held at Prince of Wales Hospital and we had an extremely interesting presentation by Professor Bernie Tuck titled 'Diabetes stem cell research update' with 18 members participating.

In December we met at Nepean Hospital where our presenter was Dr Ivan Kuo updating us on 'New therapies in diabetes' and a new version of the *Twelve days of Christmas* that all 20 participants sang along to. For anyone interested in looking at this presentation or any of our presentations they are available in the NSW Branch archives.

In February we had 30 members attending our meeting at Westmead Hospital and our presentation was by Dr Connie Yap 'Randomised trial of vitamin D supplement in pregnancy'.

The NSW Branch Executive would like to thank all the diabetes centres and their staff for hosting our meetings throughout the year and organising such informative topics and presenters. Thank you also to the companies who sponsored these education sessions and the members for their support in attending the meetings.

NT Branch

Michelle Walding Branch Chair and *Melissa Tait* Branch Finance Officer

The ADEA Northern Territory Branch teleconferences five

Branch meetings a year.

As well as discussing general items, we have a rotating roster for presentations for our continuing professional development, including topics such as gastric paresis, and for networking.

Our membership is slowly growing, and includes nurses, pharmacists, dietitians and an aboriginal health worker. Our skill mix is wide and varied, with some of our membership working in and travelling to remote communities for outreach clinics, either as sole practitioners or accompanying adult and paediatric endocrinologists. These outreach clinics help improve communication between major hospitals and remote communities.

Our members are spread out from Alice Springs to Katherine to Darwin and over to Gove while covering all communities over the NT in between. As we are all in different areas it is great to hear what services and programs are being provided in the variety of health care settings, including Baker IDI now located in Alice Springs with two of our members working there.

As we are a small (but resourceful) Branch, we only hold our Branch Conferences biannually. Our last branch conference was held in Darwin in 2010, with our next one to be held in Alice Springs in 2012. ADEA NT will also be behind our Aboriginal Health Worker to become the first to be credentialled in Australia, as she has just completed her Graduate Certificate in Diabetes Education.

Queensland Branch

Denise Bennetts Branch Chair

The year 2010–2011 has been a prosperous and exciting year for the Queensland Branch. The Queensland State Conference was held on the 3rd and 4th June in Brisbane and was well attended by 120 delegates. The theme of the conference was 'Partnerships in Care'.

Conference Keynote speaker Kate Gilbert, who works for Victorian Government Department of Health, inspired everyone with discussion of *The Type 1 Diabetes Network* which she established 13 years ago and her innate knowledge of how health professionals can best support people with type 1 diabetes.

It was fantastic to have the ADEA President, Nuala Harkin, and Vice President, Fiona McIver, in attendance this year at the Queensland state conference. The conference was a great success and enjoyed by all that attended.

The executive have held four branch meetings in the past year. A survey of Queensland members was conducted by the Executive in an attempt to invoke more support and attendance at Branch meetings. This resulted in the inclusion of more dinner meetings with a professional development component. Psychologist Stan Steindl delivered an enjoyable, lively and interactive presentation on 'Motivational interviewing' at the Christmas dinner meeting. The March dinner meeting provided the opportunity for members to telephone link into the meeting.

Membership of ADEA has increased in Queensland to 259 full members and 33 associates. Queensland now enjoys welcoming 20 more Credentialled Diabetes Educators this year, with a total number of 167.

Non-ADEA initiated professional development opportunities continued during the year, including the 'Partnership Weekend' which was pharmaceutical company sponsored and attracted 113 attendees. Several Company sponsored breakfast and dinner seminars were also offered throughout the year.

Award Winners

Congratulations to the following Queensland members who have received awards for their dedication and effort.

Deb Foskett was awarded the 2010 JDRF Diabetes Educator of the Year award for her dedication and effort.

Helen D'Emden was awarded ADEA – Eli Lilly Best Novice Presenter at the ADEA/ADS 2010 ASM.

Janelle Anderson and Kathleen Harrison were winners of ADEA – Abbott Diabetes Care 2010 Case Study Award.

SA Branch

No report provided.

Tasmania Branch

No report provided.

Victorian Branch

Cassie Cheeseman Branch Chair

The Victorian Branch Executive is comprised of:
Chair Cassie Cheesman
Secretary Coralie Cross
Finance Officer Edwin Pascoe
Board Director Cheryl Steele

The Victorian Branch has 599 members of whom 284 are Credentialled Diabetes Educators.

Branch Meetings: The Victorian Branch in total held four meetings over the last financial year.

1 30th September 2010, at Royal Women's Hospital: Attendees 57 Apologies 29

2 2nd December 2010, at St Vincent's Hospital: Attendees 58 Apologies 30

3 3rd February 2011, at Western Hospital, Footscray: Attendees 44 Apologies 28

4 5th May 2011, Baker International Diabetes Institute: Attendees 47 Apologies 24

Meetings of the Victorian Executive:

25th November at Western Hospital Footscray

6th January at Western Hospital Footscray

31st March at Western Hospital Footscray

Seminars/Workshops

9th March 2011 – 'Preparing an abstract for presentation at a scientific conference': Presented by Professor Trisha Dunning: – 13 signed attendees – Thankyou to Elizabeth Obersteller and Gillian Cranzin for organising.

17th June 2011 – Pre conference Workshop – 'Conversational maps'. Sponsored by Eli Lilly, organised by the LOC/POC 2011.

17th June 2011 – Pre Conference Workshop – 'Accuchek Connect'. Sponsored by Roche organised by the LOC/POC 2011.

Victorian Branch Conference:

This will be held on the 18th of June 2011 at the Darebin Arts and Entertainment Centre, Cnr Bell Street and St Georges Road Preston from 8.30am. Registrations have now closed and we have 183 registrants.

The theme of this year's conference is 'Diabetes – head to toe'. The topics covered are:

Diabetes and eye disease – 'Eye disease and vision loss in people with diabetes is increasing; between 25–45% of people with diabetes will have some form of eye disease'.

Speaker: Dr Sanj Wickremasinghe – Ophthalmologist from Victorian Eye and Ear hospital.

Diabetes and the gastrointestinal tract – 'Gastroparesis, mortality and diabetes – the links'.

Speaker: Dr Christopher Rayner MBBS PHD FRACP – Consultant Gastroenterologist Royal Adelaide Hospital.

Diabetes and Vitamin D – 'The links'.

Speaker: Professor Peter Ebeling: Endocrinologist, The Western Hospital.

Diabetes, Kidney disease and Heart disease – 'The links'.

Speaker: Barbara Harvie, Nurse Practitioner, ACT Health

'Neuropathies and other pathologies of the feet'.

Speaker: Jane Tennant, Lead Podiatrist High Risk Foot Service Western Health.

A different idea we have engaged this year is to use an MC to run the day i.e., timekeeping and keeping the audience engaged to mimimise people leaving early.

We have also arranged a post conference social gathering at the local RSL as a chance for people to network and catch up in a relaxing atmosphere.

Conference photos/highlights and a conference report will be submitted post the conference.

Grants and Scholarships

Professor George Jerums, The Austin Hospital, Order of Australia 26/01/2011

Professor T. Dunning, 'Outstanding Achievement Award'.

Michelle Robins, 'The 2010 Jan Baldwin Award'.

Nicole Duggan, 'ADEA – Eli Lilly Best Novice Poster Presenter' at the ADEA/ADS 2010 ASM.

Trisha Dunning: ADEA – Becton Dickinson 'Best Poster Presenter' at the ADEA/ADS 2010 ASM

ADEA – Abbott Diabetes Care 2010 Case Study Awards: Sue Redden, Kathleen Steele, Gail Schuler, Elly Kenyon, Mary Gilligan

Other News:

Special Interest Group minutes are now tabled as received at each State Branch Meeting and appendixed to the Meeting Minutes.

Thankyou to the Vic Branch Executive, Cheryl Steele, Coralie Cross and Edwin Pascoe for your support, dedication and commitment to the executive. It is greatly appreciated and valued. I thank you personally and from the Victorian ADEA Members.

WA Branch

Wendy-Lee Pittick Branch Chair

General meetings and In-services

Meeting attendance in the city remains consistent with a very gradual increase in rural sites accessing via the videoconferencing facility.

One of the Executive goals has been to increase the rural member participation in attendance at ADEA functions along with increased access via videoconferencing to the Branch meetings. The Professional Development Committee and Executive surveyed the rural members in the hope of identifying barriers and enablers experienced when accessing the ADEA events

by videoconference. Despite the very low return rate from ten members the survey did identify some structured feedback to work with. The survey will be repeated in twelve months to assess members' response to changes.

The following meetings were held in 2010–11.

The August 2010 meeting was attended by 46 members and four members from two videoconference sites. Guest Speaker Judi Moylan MP and Chair of the Parliamentary Diabetes Support Group, a bipartisan group that raises diabetes related issues, spoke to this meeting. Judi has also worked towards the UN Declaration for Diabetes.

Members recommended that Judi be invited to present at the ADS–ADEA Annual Scientific Meeting in Perth to provide members with the opportunity to gain a greater insight into the Parliamentary Diabetes Support Group. Judi recommended and encouraged educators to lobby local politicians for change.

Following the meeting members enjoyed a delightful meal sponsored by Abbott Diabetes Care.

The November 2010 meeting was attended by 41 members and five members from three videoconference sites. The guest speaker was Dr Liz Davis, a paediatric endocrinologist at Prince Margaret Hospital.

The meeting was sponsored by Johnson & Johnson.

The February 2011 meeting was attended by 39 members and eight members at five videoconference sites. Guest Speaker Professor John Newnham, the head of the Women and Infants Research Foundation and sub Dean of Medicine at the University of Western Australia and also a Maternal Foetal Medicine Specialist at King Edward Memorial Hospital, presented on the topic 'The origins of disease and health – inter-uterine environment and how this sets a child up for life', namely talking about the risk of heart disease and diabetes.

The meeting was sponsored by Animas Insulin Pumps.

The May 2011 meeting was attended by 31 members and six members at four videoconferencing sites. The guest speaker Mary King, Clinical Nurse Consultant and Nurse Practitioner at the Urology/Continence Unit, Sir Charles Gairdner Hospital spoke on 'Urinary and bowel dysfunction related to diabetes'.

The meeting was sponsored by Roche Diagnostics.

No Branch Conference was held in 2011 conference due to the ADS–ADEA Annual Scientific Meeting being held in Perth this year.

The next Branch conference will be in Albany in 2012.

Workshops:

Sponsorship from both Novartis and Novo Nordisk facilitated two very successful study days held throughout the year. This was the culmination of efforts from the Professional Development Committee working with our local Company representatives.

The Professional Development Committee has been very active in securing a variety of exceptional guest speakers for each Branch meeting and are working with sponsors towards facilitating further regional based workshops in 2012.

Grants:

Travel Grants: were awarded to two members to assist with costs to attend the 2010 ADS–ADEA Annual Scientific Meeting in Sydney. Applications are currently being processed to assist ten members to attend the 2011 ADS–ADEA Annual Scientific Meeting being held in Perth in August/September of this year.

Committees, Working Groups:

Many members continue to generously contribute their time and expertise to a representation on committees, working groups and ADEA projects. All representations are a regular item on the Branch meeting agenda and representatives report back to members both verbally and with a written report. These include:

ADEA WA Branch professional development committee

WA Health Endocrine Network

WA State GDM Reference Group

ADEA Credentialling Committee*

Diabetes Australia Health Care and Education Committee*

ADEA Clinical Practice Committee*

Curtin-Course Advisory Committee Robert Ian Harmer*

NADC Steering Committee*

2011 ADS-ADEA Annual Scientific Meeting – Program and Local Organising Committees*

ADEA WA Branch Conference Organising Committee

**Indicates ADEA representation*

Denise Smith, Carol De Groot and myself joined other Board Directors, the Executive Director, Branch, Committee

and Working Group Chairs and the immediate past President on Saturday February 26 in Sydney to plan the Strategic Direction for ADEA over the next three years. Many exciting ideas were put forward to enhance the work of ADEA and its national profile.

Finally, my two year term has come to an end and I wish to acknowledge the support from our Branch Secretary Lauren Cotter and Finance Officer Pica Ellis. I wish them and the incoming Chair a successful future.

Member communication

Website access

Australians have made a mammoth 2 640 028 hits on the ADEA website between July 1 2010 and the end of May 2011, averaging 240 002 hits a month. People living in new Zealand and India are the next two most frequent visitors with 11 864 and 5 422 hits, respectively, during that same period.

The average time spent on the website was just under eight minutes. The popular page visits were the 'Find a CDE', followed closely by the section 'For Diabetes Educators'. See Figure 5.

This year online registration was available for all Branch conferences. Coming soon, online membership and membership renewal.

The Australian Diabetes Educator

The *Australian Diabetes Educator* (*ADE*) continues as a quarterly publication and is provided free of charge to all members. The production of the *ADE* continues to be completed by a small dedicated team, namely the Editorial Advisory Group (EAG). Members of EAG comprise ADEA members who volunteer their time and National Office staff.

Writing for the *ADE* is one way of sharing experiences of diabetes education with your peers. This year has seen articles covering a range of diabetes topics including:

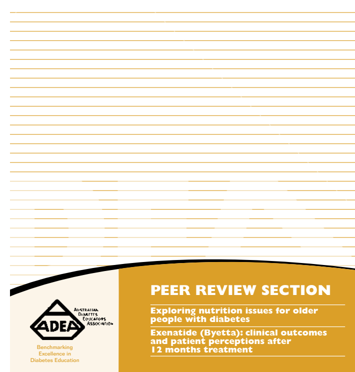
Foot care;

Sharps disposal;

Haemochromatosis;

Non-alcoholic fatty liver disease;

Prebiotics, inflammation and insulin resistance;



Diabesity drivers;

Managing glycaemia;

Diabetes education in General Practice; and

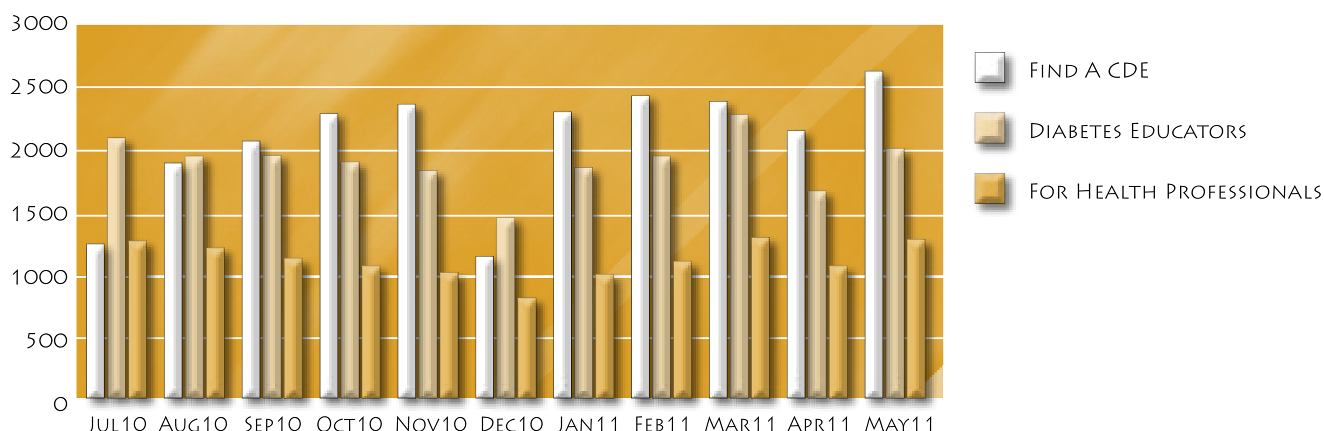
Indigenous matters – with two articles, one on building capacity in Aboriginal Health and another on Koori diabetes education graduates.

This is supplemented by the occasional item from the person with diabetes, which provides a window into living with diabetes through the sharing of personal experiences.

The article by Melissa Giles and her venture into Ecuador as an exchange student is an example. The Juvenile Diabetes Research Foundation also provides regular stories with a personal perspective.

There are also regular features on select topics throughout the year. March 2011 saw the completion of the series on

Figure 5: Popular page visits 1 July 2010 to 30 May 2011



‘Diabetes and Exercise’ written by Allan Bolton.

March heralded the commencement of a new series by author, Dr Lisa Engel, writing on ‘Mindful Eating’.

Jan Alford answered your ‘Frequently Asked Questions’ on credentialling and re-credentialling processes.

Professor Trisha Dunning continued her series on ‘Complementary Medicine’ with articles on ‘Momordica Charantra’ and ‘Fenugreek’. In 2011, Professor Dunning has been setting the scene for the use of complementary therapies in health care practice, starting with an article on ‘Complementary medicines (CAM) use in hospitals’ followed by an article on ‘Integrative medicine’.

The full series of Professor Dunning’s work on complementary medicines, from 2006 to now is available from the ADEA website. The earlier work has been reviewed and updated to contain the latest evidence.

Dr Pat Phillips has provided insight into tests and what the results really tell you through his series on ‘Testing Tests’.

Michelle Robins has kept us up-to-date with the latest research with snippets from a range of journals in ‘Research Insights’.

The *ADE* also provides an avenue to keep members updated with activities within ADEA, at the National and Branch level. All ADEA Position Statements and Updates are published in the ADE as they are produced. In 2010–11, the ADEA Position Statement on HbA_{1c} Reporting and the ADS–ADEA Updates on Avandia were published.

EAG’s main goal for this year was to commence a peer review section in the *ADE*. The first manuscripts are to be published in the June edition of the *ADE*.

One is a commissioned report ‘Exploring nutrition issues for older people with diabetes’ and the other is research into ‘Exenatide (Byetta): clinical outcomes and patient perceptions after 12 months treatment’.

Establishing the peer review process has required the development of a large number of support documents to guide the process, both for the Editorial Office, the authors and the peer reviewers. These documents include:

Instructions for Authors.

Personal Information Cover Sheet.

Conflict of Interest Policy.

Conflict of Interest Statement (and associated policy) and

Consent and Copyright form.

ADE Reviewer Feedback forms (Commissioned Reports and Research).

Photograph Consent form.

Colour Printing Approval form.

ADE Editorial Review form.

Checklist for Authors.

Checklist for Editorial Office.

These documents are available on the ADEA website.

ADE administrative functions have been allocated to an Administrative Assistant within National Office.

EAG has two main aims for 2011-12. One is to conduct a survey of ADEA members to ascertain satisfaction with the *ADE* and to gain ideas on the topics members would like to see covered in the *ADE*. The second, whilst commencing this year, is a longer term aim, to market the peer review section of the *ADE*.

I would like to thank all our authors for their time and commitment to writing and submitting an article for the *ADE* and would like to encourage you all, if you have not already done so, to start writing.

ADEA Special Interest Groups

The ADEA Special Interest Groups (SIGs) provide a Community of Practice (CoP) where members can share knowledge, experience and expertise within a specific field of practice or area of professional interest. Currently, ADEA has four SIGs.

The HIGH RISK FOOT IN DIABETES (HRFD) SIG was chaired by Emma Holland to March 2011. The new Chair is Thyra Bolton.

The main outcomes from this Group are:

The development of a draft Self Care Management Checklist. The Checklist is being reviewed by the Australian Diabetes Society, prior to being made available for member comment.

Feedback on the National Health and Medical Research Council’s ‘National Evidence Based Guideline on Prevention, Identification and Management of Foot Complications in Diabetes’.

Development of a draft research proposal ‘What is the diabetic foot – shape and size – Footwear?’ which aims to pilot ten people at each diabetes centre.

A survey of HRFD members on current and future direction and activities of the SIG has

been conducted using Survey Monkey.

Input was provided into possible data collection from diabetes centres involved in ANDIAB 2011 on the high risk foot. However, the data collection items were closed prior to the receipt of the input.

The CHI Diabetic Foot Working Party has:

- Developed new data collection forms, which include data on ulcers and time to heal.
- Developed new clinical indicators.
- Collected statistics regarding amputations in the district from 2010.

Michelle Robins was the Chair of the NURSE PRACTITIONER SPECIAL INTEREST GROUP (NPSIG) up until February 2011.

On November 1st 2010 legislation was enacted allowing endorsed/authorised Nurse Practitioners (NPs) to apply for a PBS Prescriber number and a Medicare Provider number. Several NP diabetes members attended a forum in Canberra with 250 other NPs to be informed on the changes and how to implement them within the role.

Endorsed NPs who are employed in both the private and public sector (provided the latter is employed in a health service that is part of the Pharmaceutical Reform Agreement) are eligible to apply for a PBS Prescriber Number.

Currently NPs in NSW cannot apply for a prescriber number as the state has not signed to the Pharmaceutical Reform Agreement. However, there are additional layers to having authorisation to prescribe PBS medications determined by the Pharmaceutical Benefits Advisory Committee. Under the General Schedule – Section 85, there are four sections applicable to NPs: unrestricted, continued therapy only model, shared care model and no access at this time.

Also NPs employed within the public sector cannot apply for a Medicare Provider number – only those endorsed NPs working in the private sector, private practice or a non-Government Organisation (NGO). This means that the majority of NPs cannot order pathology and diagnostics, make medical specialist referrals or charge a Medicare fee. Four fees exist and are based on the duration of the consultation. Yet despite these difficulties more and more nurses are committed to undertake the study and the role of Nurse Practitioner Diabetes.

At last year's ASM 21 NPs and candidates attended a face to face meeting.

In February 2011 Michelle Robins stepped down as convener – a position held since the establishment of the special interest group four years previous. Despite a membership of 30 people, no one nominated to convene the group and the Nurse Practitioner Special Interest Group was disbanded in April 2011.

Michelle Woods is the Tasmanian representative for the Australian College of Nurse Practitioners.

Karen Jameson is the Chair of the PAEDIATRIC SPECIAL INTEREST GROUP (PSIG)

School issues have been a concern for the members of the PSIG. Members have provided statistics on the number of school visits they are doing each year. This is still yet to be analysed and we can see if the number of diagnosis each year is matched with the number of school visits being done. This may provide research opportunities.

The next meeting will be at the ADS–ADEA Annual Scientific Meeting in Perth.

The PRIVATE PRACTICE SPECIAL INTEREST GROUP

NO REPORT PROVIDED.

Find a CDE

Improving access to a qualified diabetes health professional for people with diabetes and their families is one of the ADEA's key objectives. Similarly, increasing the visibility of CDEs and their services is one of the strategies employed to achieve this objective.

Therefore, the ADEA web page has a dedicated search engine which people with diabetes and their health care professionals can use to find a CDE in their local community.

The 'Find a CDE' search function has been updated. It includes a search by distance from the person requesting the information, a search by specialty area of practice and a search by language spoken by the CDE.

ADEA continues to promote the Credentialled Diabetes Educator. Merck Sharp & Dohme generously produced an advertisement on the Credentialled Diabetes Educator. This has been published in: two editions of Diabetic Living and Nursing Review; Burke's Backyard; Good Health, preceding their diabetes health handbook; and on the outside back cover of the *Australian Diabetes Educator*.

The 'Find a CDE' promotional material has been distributed at conferences attended by ADEA as an exhibitor. The ADEA NDSS Strategies Manager and the ADEA Credentialling Officer attended the 11th National Rural Health Alliance Conference in Perth in March 2011, the Australian Practice Nurses Association's National Conference in Sydney in April and a GP Super Clinics Conference in Brisbane in May. Credentialled Diabetes Educators are responsible for more than 60% of registrations to the National Diabetes Services Scheme and as such are key referral points along the continuum of diabetes care.

On all occasions ADEA's attendance was warmly received and the opportunity was taken, to not only inform attendees of the role of the CDE, but to also promote ADEA and its work in advocating for equitable access to quality diabetes services.

Attendance at conferences such as these is something relatively new for ADEA. The response has been positive. It is hoped this type of exposure can be continued.

ADEA and it members must never lose an opportunity to put ADEA forward and should always be on the lookout for new ways to raise the profile of our organisation and its members.

Professional Indemnity Insurance for Credentialled Diabetes Educators

The Guild provides a range of insurance products for CDEs. The premiums are comparable to what is available for other allied health professionals from other insurers. These insurance products may also be applicable for CDEs not in private practice, for example professional indemnity, products liability and public liability insurance.

The ADEA would like to remind CDEs to check that the insurance offered through their employer schemes adequately covers the range of services they provide and activities they undertake.

Equitable access to diabetes self management education

Developing a model for delivery of diabetes education in conjunction with general practice

Phase three of the National Diabetes Services Scheme, Strategic Development Grant (Project 84), is now complete. The final product in this phase is the development of the document 'The Economics of Financing Primary Health Care for People with Diabetes'.

In review:

Phase one saw the development of the *Diabetes Self Management Education* package. This comprised an initial one hour individual assessment, five two hour group education sessions and a final half hour individual discharge/review appointment.

Tools used included the Brief Case Find for Depression (BCD), Problem Areas in Diabetes (PAID), Diabetes Empowerment Scale – Short Form (DES-SF), Summary Diabetes Self Care Activities (SDSCA), Personalised Assessment Tool (PAT-Treonic) and the Partners in Health Scale (PIH).

Phase two saw the implementation of the Education package in two Divisions of General Practice.

Clinical and other data collected using the tools outlined in the preceding paragraph were entered into a database by the Credentialled Diabetes Educators employed by each Division of General Practice. The database was specially designed for this project.

A report on the analysis of this data completed this phase of the project. In summary, those participating in the program showed improvement in psychosocial self-efficacy (DES-SF), reduction in diabetes-specific emotional distress (PAID) and increase in average number of days consuming a good diet, exercising, testing blood glucose, caring for feet and complying with medication.

The program had 17 deliverables ranging from reduction of anxiety and stress to motivating blood glucose monitoring to reduce risks of complications. Just under 70% of participants felt that these were achieved very well, particularly with respect to those centred around understanding, decision making and healthcare interaction.

The report from phase three, 'The Economics of Financing Primary Health Care for People with Diabetes' was commissioned by ADEA to detail a range of options and potential funding sources for sustainable delivery of *Diabetes Self Management Education* to people newly diagnosed with type 2 diabetes.

The report uses a model which considers diabetes on a needs basis in four different situations – type 1 simple, type 1 complex, type 2 simple and type 2 complex. The requirements of each situation are then considered in the first year of diagnosis and in subsequent years, giving rise to eight different, distinct scenarios. These scenarios are then analysed and costed according to different levels of care which could be provided, for example general practitioner alone, nurse led clinic, multidisciplinary team or Tertiary Diabetes Centre.

At the same time, focus is placed on the role of the Credentialled Diabetes Educator (CDE) in providing and coordinating care for those with diabetes, the implication of recent Commonwealth government policy changes for the CDE workforce, how CDEs fit into these new policies and the nature of the role of CDEs working in general practice or primary care.

The model then considers the framework of the then-proposed new Commonwealth funding for care of people with diabetes wherein it is suggested that GPs will hold a budget of $1 200 per patient with diabetes, who elects to enrol with a nominated, registered practice.

Having brought all of these considerations together, four recommendations are made to underpin a proposal for the ongoing financing of primary healthcare for people with diabetes.

1. At a minimum, requirements for referral to CDEs, that ensure access for all people with complex diabetes care needs, is an annual CDE consultation. This consultation would be used for assessment and advice regarding diabetes self-management practice.
2. Increased infrastructure is required for Tertiary Diabetes Centres and nurse-led diabetes clinics in primary care. This would maximise access to cost-effective healthcare services for people with simple diabetes care requirements as well as for those with complex care requirements.
3. A commitment is needed to a 'Five year CDE workforce expansion plan'. There is an identified need to increase the CDE workforce to ensure access to best practice care for all people with diabetes. Current CDE numbers can provide an initial consultation to only 57% of all people with diabetes.
4. An increased number of practice nurses trained in providing diabetes information and care in general practice. Appropriately qualified practice nurses can provide case management and allied health referral and also triage people with diabetes according to their care needs.

This project was funded by the Department of Health and Ageing, via a Diabetes Australia Strategic Development Grant.

The outcomes of this project provided the impetus to apply for funding through the Australian Primary Health Care Research Institute (APHCRI) to expand the model. ADEA, in partnership with Baker IDI, were successful in receipt of funds to assess 'Will

voluntary patient registration, performance incentives plus capitated payments to general practice for care for people with diabetes result in improved access, coordination and outcomes?'

Diabetes Referral Map across Primary Care and between Primary and Tertiary Care

This study aims to develop a framework that will serve as a guide for inter-professional diabetes education specialist referrals and for cross-referrals between primary and tertiary care.

A literature review on primary care diabetes service delivery models has been completed.

Focus groups have been conducted with general practitioners (GPs) and practice nurses (PNs) in metropolitan and regional Australia to identify their:

1. current practice in diabetes management
2. awareness of the role of the Credentialled Diabetes Educator (CDE) in diabetes management
3. practice in referring to CDEs, that is, their referral triggers and patterns.

Further focus groups are planned, with additional focus groups to be conducted in regional centres. A survey is planned for diabetes educators.

This project is being generously funded by an education grant from Novo Nordisk.

Diabetes Education for Aboriginal and Torres Strait Islander Community and Health Workers

The 'Diabetes Education for Aboriginal and Torres Strait Islander Community and Health Workers' project aims to develop a diabetes education program incorporating a curriculum specifically designed for Aboriginal and Torres Strait Islander Health and Community Workers.

The education is directed to Aboriginal and Torres Strait Islander people who have an interest in becoming health workers or who have recently been employed as health workers and require some formal knowledge of diabetes. The course content recognises that many of the participants do not have undergraduate nursing or health training. The focus is on Aboriginal and Torres Strait Islanders employed, or aiming to be employed, in metropolitan Australia.

The online learning course comprises 26 hours of learning. The topics covered include a general introduction to diabetes, chronic complications, managing diabetes, medicines and insulin, self monitoring, lifestyle issues, acute complications, support and practice, and the diabetes team. The course uses storytelling with three fictitious scenarios to place the learning into a familiar context.

The course is designed to be conducted with a facilitator who monitors and contributes to discussion board activities and answer questions about diabetes and assessment items. It is recommended that the teacher/facilitator has at least a teaching qualification of Certificate IV or above and a relevant diabetes qualification.

A CD version of the course and a paper based workbook has also been developed to be used by people in metropolitan areas who have limited access to a computer and/or the internet.

This project has been funded by the Department of Health and Ageing through a National Diabetes Services Scheme Strategic Development Grant.

Medicare

Overall at a national level and in most states and territories there continues to be a steady increase in the uptake of diabetes education health services provided through the Medicare Benefits Scheme (MBS). See Figure 6. The uptake, hence overall expenditure, is particularly low in the ACT, Northern Territory and Tasmania.

Keeping in mind the small population numbers in these Territories and State, analysing the MBS service provided per 100 000 population, as shown in Figure 7, highlights the Northern Territory and Tasmania do well in providing services to the population, at times almost equalling the services per 100 000 population in Victoria.

Figure 8 shows the attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) for the preparation of a GP Management Plan (GPMP) for a patient, or Item 721.

The number of MBS services for item 721continues to be low in the Northern Territory and Tasmania, with a slight improvement over the past four quarters, namely 2010 Q1 to 2011 Q1. When this is viewed as MBS services per 100 000 population, as in Figure 9, Tasmania and the Northern Territory again do well.

The need for CDEs practising in the primary care sector remains strong and continues to grow with the Commonwealth Government's focus on primary care and the increasing incidence and prevalence of type 2 diabetes.

CDEs practising in the primary care sector have a variety of permanent and contract employment arrangements with state and territory health organisations and general practices, as well as being employed as independent practitioners.

Maintaining a strong focus on matters pertinent to CDEs working in the primary care setting remains an integral

Figure 6: Total MBS services for item 10951 by state, quarterly

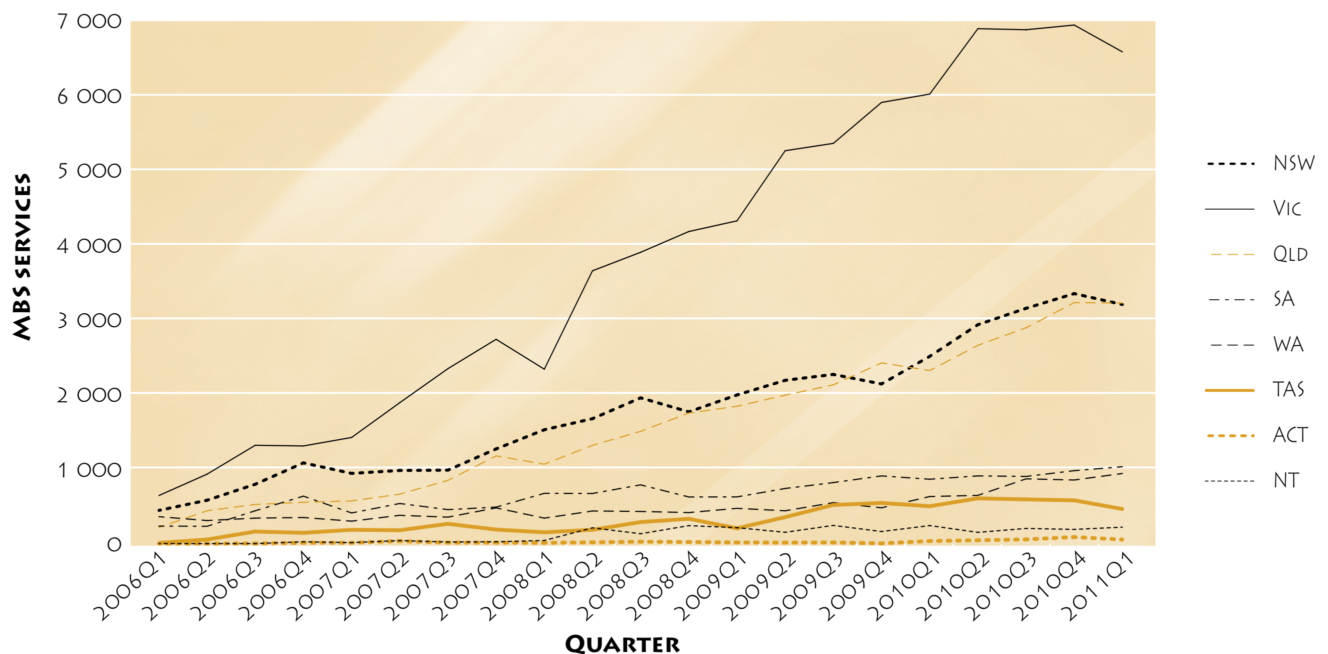
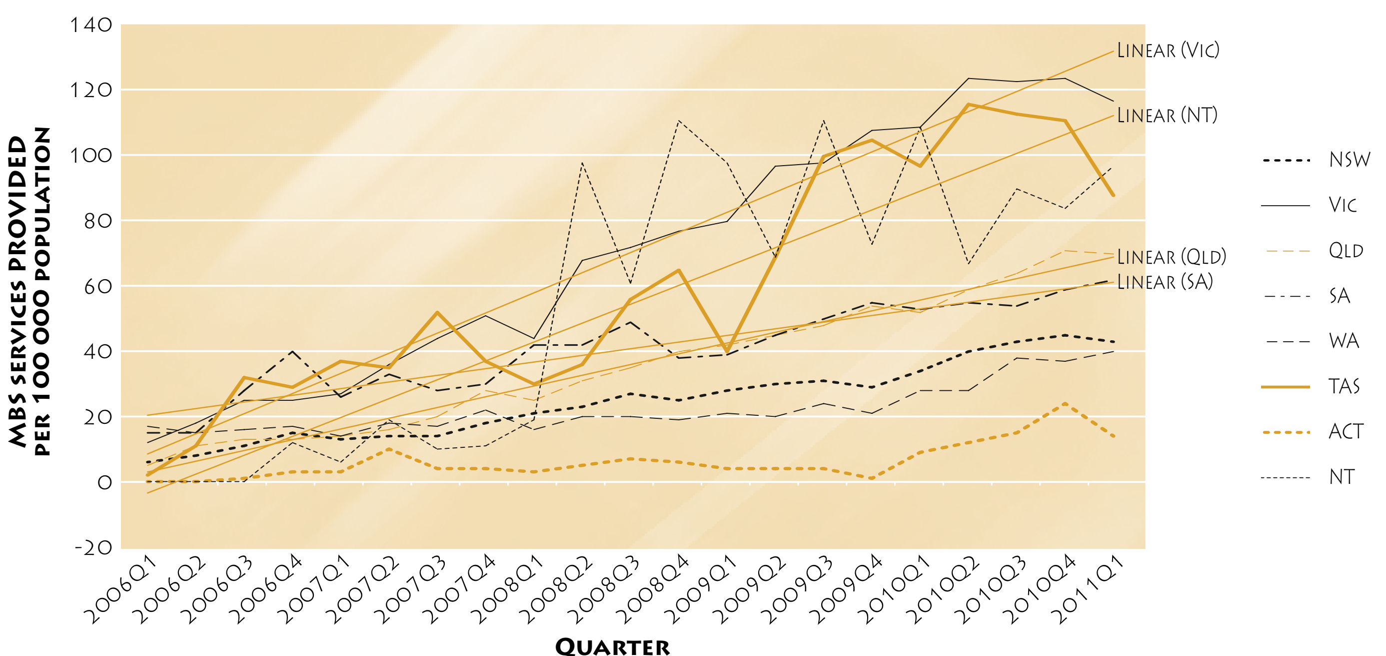


Figure 7: MBS services per 100 000 population for item 10951 by state, quarlerly



part of ADEA's core business. Limited access to rebates for diabetes education under Medicare continues to be a central theme in ADEA's engagement with the Department of Health and Ageing and the Minister's Office.

Allied Health Professions Australia (AHPA) and the National Primary Health Care Partnership (NPHCP) continue to support efforts to increase the number of consultations available to health professionals.

In addition, the HIPP Working Group has launched its campaign to lobby the private health insurance industry and Government. More information on the lobbying strategy is provided on page 35 and is available through the ADEA website.

Figure 8: Total MBS services for item 721 by state, quarterly

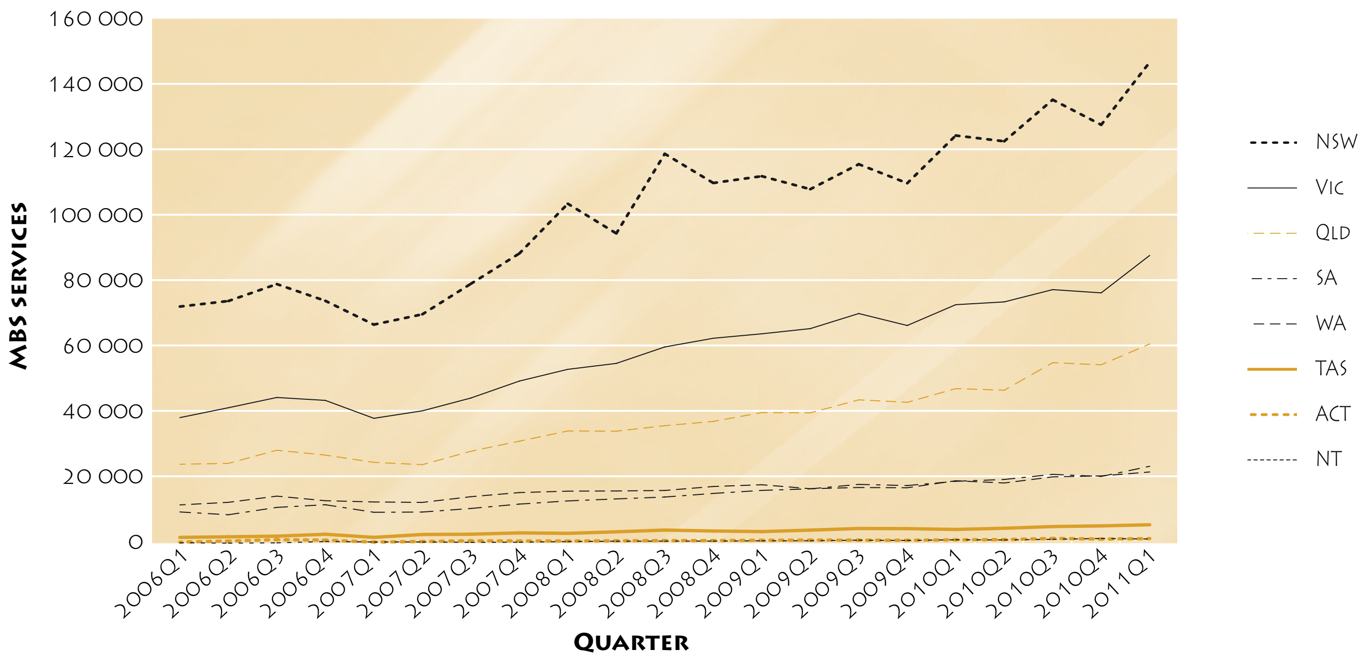
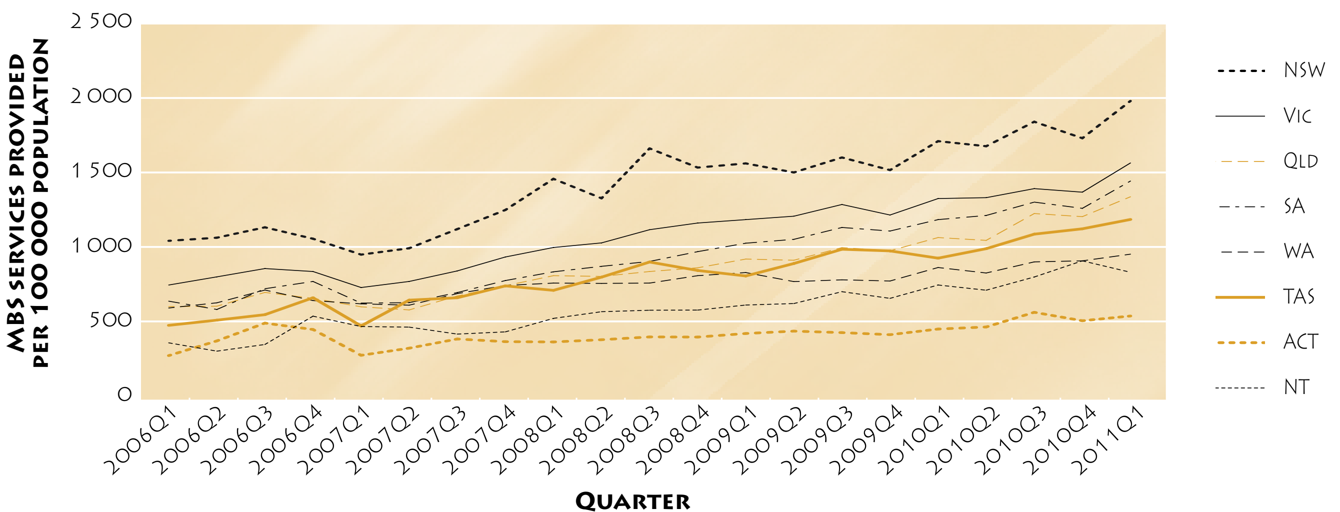


Figure 9: MBS services per 100 000 for item 721 by state, quarterly



Excellence in professional practice

Audio and online continuing education

ADEA has developed its LEARNING MANAGEMENT SYSTEM using a generous education grant from Abbott Diabetes Care.

The online course, NEW TECHNOLOGIES, comprises four modules.

Module 1: GLYCAEMIA MATTERS

The first module of the New Technologies eLearning program, Glycaemia Matters, includes the following topics:

- What is normoglycaemia?
- Diagnosis of pre-diabetes
- Why is the diagnosis of type 2 diabetes important?
- Epidemiology of type 1 diabetes
- OGTT in Pregnancy

The learning outcomes include:

- Have challenged previously held assumptions relating to glycaemic control in your patients with diabetes.
- More critically appraise the benefits and limitations of diagnostic tools.
- Better understand the benefits and limitations of glycaemic monitoring tools.
- Critically reflect on your own practice in relation to diabetes in special circumstances

Module 2: SELF MONITORING BLOOD GLUCOSE (SMBG)

The second module of the New Technologies eLearning program, SMBG, includes the following topics:

- Who is SMBG recommended for?
- The frequency of SMBG
- Monitors available in Australia
- Factors affecting choice of monitors
- Strip technology and lancing devices
- Interactive computer-based patient education

The learning outcomes include:

- Describe diagnostic criteria for diabetes mellitus
- Identify SMBG as one component of comprehensive diabetes self management education
- Be familiar with all aspects of a blood glucose meter
- Discuss the benefits of SMBG with a patient / client
- Understand how to access products for SMBG
- Be confident in the recommendation of the most appropriate meter for a client
- Advise the client on how to contact diagnostic companies
- Understand the psychological aspects surrounding SMBG

Module 3: INSULIN PUMP THERAPY (IPT)

The third module of the New Technologies eLearning program, IPT, includes the following topics:

- Severe hypoglycaemia with loss of consciousness or fitting
- Financial considerations for pump therapy
- Pregnancy
- Augmented pumping

The learning outcomes include:

- Able to discuss the principles of pump therapy
- Identify and discuss the features of different pumps on the market
- Recognise the difference in pump canulae and when to recommend the correct choice for different patient types
- Identify which health care professionals (HCPs) should be involved in initiation of pump therapy
- To identify the roles of each of the HCPs involved in pump therapy
- To identify the steps involved in initiation of pump therapy
- To understand how initial rates are calculated for a pump start
- To understand how to verify rates
- To identify issues associated with travelling when using an insulin pump
- Know what advice to give a patient using a pump when planning to travel
- Understand how to calculate a back-up dose in case of pump failure

Module 4: CONTINUOUS GLUCOSE MONITORING (CGM)

The fourth module of the New Technologies eLearning program, CGM, includes the

following topics:

- What are Continuous Glucose Monitors, what types are available, and how does it work?
- Potential uses
- Costs
- Patterns related to insulin pump usage

The learning outcomes include:

- Knowing practical aspects of CGM
- Knowing potential indications and practical aspects of its use
- Knowing how to interpret CGM data

PRIMARY CARE AND DIABETES EDUCATION

The 'Diabetes Management in the Primary Care Setting' online education course, developed in collaboration with the Australian Practice Nurses Association (APNA) with a funding grant from Merck Sharp and Dohme, was launched in April at APNA's Annual Conference.

The aim of the course is to promote best practice diabetes education by improving the knowledge and understanding of diabetes among registered and enrolled nurses currently providing diabetes care and management in the primary care setting.

The course material was developed by Dr Kate Marsh with content review from practice nurses to ensure it is grounded in the practice context experienced by nurses in the primary care setting.

The online education program comprises two units, with each unit consisting of six modules.

Unit one provides an INTRODUCTION TO DIABETES.

It has been designed for those who aim to update or increase their basic diabetes and diabetes management knowledge. This unit will provide the learner with a basic understanding of the disease and its impact on patients and the community.

It will also provide an understanding of the diabetes specific knowledge needed to deliver quality care to diabetes patients and their carers as well as identify when to refer patients with more complex diabetes care requirements.

Unit two looks at SUPPORTING PEOPLE LIVING WITH DIABETES.

It has been designed to provide more detailed knowledge about specific situations and individual circumstances that influence diabetes care and management goals for a range of population groups.

This unit is aimed at those who have an active role in the diabetes care team and provides knowledge on how to individualise basic diabetes care and management.

Referral to specialised diabetes care underpins this unit.

The course is now available to registered nurses and practice nurses and will take approximately 20–25 hours to complete.

A comprehensive promotional campaign was delivered by Merck Sharp & Dohme in collaboration with ADEA and APNA. Articles were published in Medical Observer – Primary Care Nurse, Nursing Review, APNA e-news, Australian Hospital and Healthcare Bulletin, Australian Nursing Journal and by many Divisions of General Practice.

CHRONIC KIDNEY DISEASE AND DIABETES

The Chronic Kidney Disease online course has been developed by Kidney Australia in collaboration with ADEA.

This project has been funded by the Department of Health and Ageing National Diabetes Services Scheme through Diabetes Australia.

DIABETES AND AGED CARE

Three online courses have been produced on diabetes and Aged Care, each course being developed for a different target audience, namely diabetes educators, aged care workers, and registered nurses. The content was developed by Professor Trisha Dunning.

This project has been funded by the Department of Health and Ageing National Diabetes Services Scheme through Diabetes Australia.

Mentoring program

The ADEA Mentoring Program was introduced in 2008. The Program supports members' delivery of best practice in diabetes education and care not only for entry level practitioners, but also for experienced practitioners during career or role transition. Participation in a formal registered partnership with the ADEA Mentoring Program became a mandatory category for initial credentialling in March 2009.

The total number of members registered as available to be a mentor has increased from 80 to 109 in the one year period 2009–10 to 2010–11.

In Victoria, 42 CDEs have registered as available mentors. This is closely followed by NSW where 22 CDEs have

volunteered to act as mentors in the Mentoring Program. See Figure 10.

At 9 June 2011, 412 mentoring partnerships had been registered with the ADEA Mentoring Program. Of these, 157 have been completed and another 189 are still in progress. For the ongoing mentoring partnerships, 95% of participants are working towards achieving initial credentialling (see Figure 11). Five mentoring partnerships have been withdrawn within this same period.

Furthermore, almost two-thirds of all active mentoring partnerships were entered into by Victorian and NSW members (see Figure 12).

ADEA committees

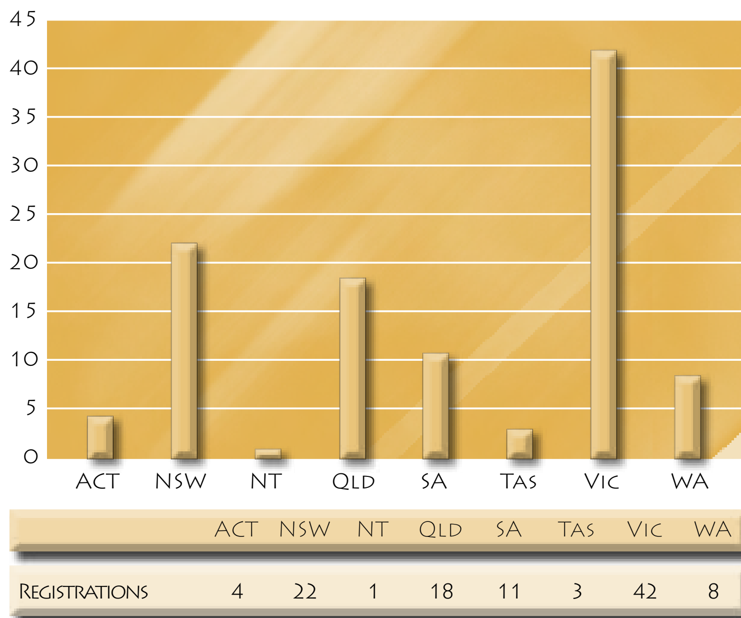
ADEA supports excellence in professional practice through the accreditation of university courses in diabetes education and management, credentialling of diabetes educators, the development of standards and guidelines and by providing continuing education. Much of this work is completed through ADEA's committee structure, which includes: the Course Accreditation and Standards of Practice committee; the Credentialling committee; the Clinical Practice committee; and the Program and Local Organising committees for the ASM.

Clinical Practice Committee

Michelle Robins

The Clinical Practice Committee (CPC) has seen a change in membership over the past year and welcomes Lyndon Homeming CDE and

Figure 10: Registrations as Available Mentors by State/Territory, 2010–11



	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
REGISTRATIONS	4	22	1	18	11	3	42	8

Figure 11: Nature of Mentoring Partnership

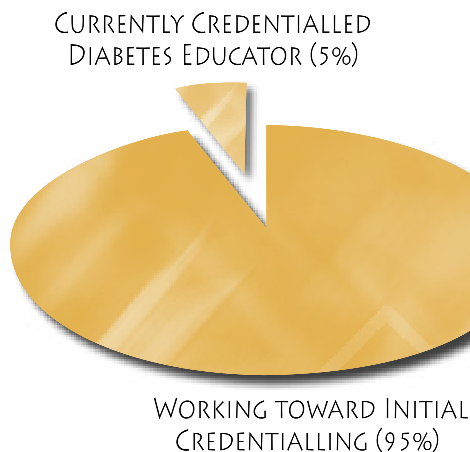
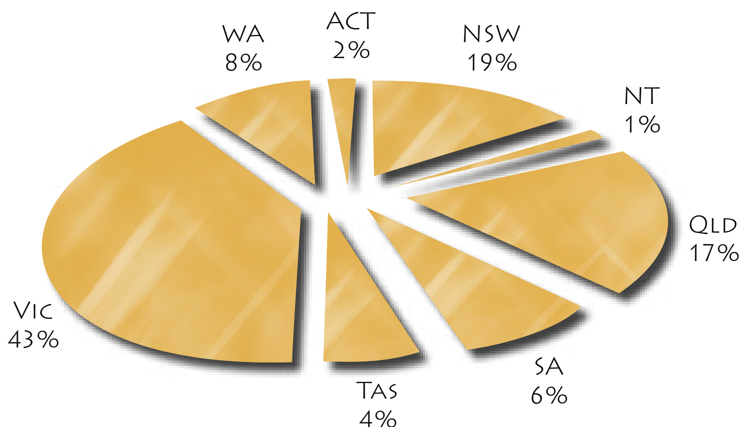


Figure 12: Ongoing Mentoring Partnerships by Branch



podiatrist and Carol De Groot CDE and Nurse Practitioner Candidate to the team that includes CDE/dietitians Melissa Armstrong and Denise Smith, CDE/RN Wendy Bryant and Michelle Robins (Convener) and Mark Coles CDE/pharmacist.

Activities completed this year have included:

Recommending ADEA endorsement of the Guidelines for Managing Diabetes at the End of Life

Recommending ADEA endorsement of the National Evidence-Based Guideline on Prevention, Identification and Management of Foot Complications in Diabetes

ADEA Clinical Recommendations for Subcutaneous Injection Technique for insulin and Glucagon-Like Peptide 1

ADEA Position Statement for The effectiveness and appropriateness of educational components and strategies associated with insulin pump therapy (ITP)

ADEA Position Statement for The effectiveness, appropriateness and meaningfulness of self-monitoring blood glucose (SMBG) in type 2 diabetes

The CPC is currently working on a number of revisions and work on new documents that provide clinical guidance to diabetes educators. The CPC will continue to review existing guidelines from other bodies to determine whether such guidelines meet the needs of diabetes educators and can be ADEA endorsed. The CPC also hopes to introduce a new type of document currently used by the American Association of Diabetes Educators: 'Practice Advisories' – short documents providing precise clinical information to diabetes educators.

The CPC plans to introduce, on the ADEA website, a vehicle by which ADEA members could propose in writing an area of practice that may require review and useful documented clinical direction.

I would like to thank Rachel Stoney, retiring CPC member 2010 for all the work she contributed to the team for several years and Gil Cremer as the team's Secretariat.

Complaints Committee

Fiona McIver

The aim of the Complaints Committee is to maintain the credibility of ADEA and ADEA diabetes educators and protect the recognition of the Credentialled Diabetes Educators as the appropriately qualified health care professionals to be providing diabetes education.

The complaints committee membership was renewed after the endorsement of the new Terms of Reference in 2010. The members of the committee are: Denise Smith, Carol De Groot, Neroli Price, Cathy Carty, Amanda Bartlett (all ADEA members) as well as two external participants, Jo Mazengarb and Barbara Campbell.

There has been little activity in the past 12 months, with only one complaint received since my commencement as the chair of this committee in September 2010, which achieved a satisfactory outcome.

Course Accreditation and Standards of Practice (CASP) Committee.

Judy Reinhardt

Members: Judy Reinhardt (Chair), Jan Alford, Trish Dunning, Karen Crawford, Pauline Hill, Sara Jones, Rhonda Griffiths.
Reference Group: Pamela Sessions, Bodil Rasmussen, Rebecca Munt, Michelle McAllister, Ian Harmer.

During the past year regular meetings have been held between the CASP Committee and the Reference Group composed of Co-ordinators of the ADEA accredited courses. During 2008 ADEA accredited tertiary institutions received a further five year accreditation for their diabetes education and care courses at Graduate Certificate level.

Mid-term reports are due to be sent to ADEA in June. The idea behind these reports is that it is an opportunity for Co-ordinators of ADEA accredited reports to provide information to ADEA of any changes to their courses or to their allocated resources that have occurred or may occur in the remaining period of accreditation.

The online self management chronic disease course being developed in Curtin University in conjunction with ADEA is nearing completion and will soon be available to all diabetes educators to gain credentialling points.

Judy Reinhardt has resigned from this Committee following retirement from her diabetes position.

Credentialling Committee

Jan Alford

The Committee members are: Jan Alford (Chair), Diane Bond, Lauren Botting, Wendy

Bryant, Glynis Dent, Lisa Grice, Maggie Lasdouskas, Chris Lester, Liz Oberstellar, Helen Phelan, Lois Rowan, Lyn Randall and Maxine Schlaeppi.

There are currently 889 (as at 02/06/2011) members credentialled.

2011 has seen the long awaited credentialling review undertaken by Trisha Dunning and we await the final report which is with the Board for consideration of its recommendations. The credentialling process may require some adjustments to meet those recommendations adopted.

The Local Organising Committee (LOC)

Elise Ritchie

ADEA members: Elise Ritchie (Chair), Jillian Loveday, Marina Mickleson, Denise Smith, Clair Matthews (ADEA Executive Director),
ADS members: Jenny Gunton (Chair), Kim Cheng, Wendy Davis, Suzie Neylon (ADS Executive Officer).

The LOC is organising the social functions and entertainment for the 2011 ADS–ADEA ASM in Perth (31st August - 2nd September). The theme is 'Rock Star'.

All room bookings have been finalised at the venue and correspondence continues with the trade sponsors. The onsite review of the venue was held on the 9th June with ASN Events.

National Association of Diabetes Centres (NADC)

Jane Payne

Membership: 68 members

Steering committee:
ADS members: Wah Cheung, Frank Alford, Sophia Zoungas;
ADEA members: Rosemary Marco, Cheryl Steele and Jane Payne (Chair).

Main achievements 2010-2011

The newly developed *NADC Accreditation program* has been piloted and will be introduced, with some minor changes, in 2011-2012.
The aim of the accreditation program is to establish national standards for Diabetes Centers and to demonstrate that our members operate as Centers of Excellence with best practice in diabetes care.

The inaugural *NADC Best Practice in Diabetes Centre symposium*, 'Multicultural food: practical advice for diabetes health professionals' was held at the September 2010 ASM. It was well received by all participants who attended. We would like to thank Eli Lilly for their ongoing support of NADC educational activities.

ANDIAB 2 data collection has been completed in 2010. A total of 28 centers took part in the data collection. The complete report is available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/diabetes-pubs-andiab210.

ANDIAB data collection for 2011 is completed and reports will be available later in the year.

The *Work Survey* provided valuable information from the membership regarding staffing levels; types of patients seen; and other clinical activities. The data has been used by both ADS and ADEA in their discussions with the Department of Health and Ageing.

NADC are planning the biannual *BPDC* meeting to be held in early July 2011. The themes for the sessions include

'Lifelong diabetes care' and 'Evaluating diabetes care'. The second *NADC Best Practice in Diabetes Centers symposium*: 'Diabetes and pregnancy: beyond glucose control' is being planned for the 2011 ASM in Perth.

I would like to thank all members of the steering committee, Suzie Neylon and Clair Matthews for their support during the last year.

A special vote of thanks goes to Gina Chen for outstanding support of NADC.

Program Organising Committee (POC)

Denise Smith

The current committee, chaired by Denise Smith, was convened in November/December 2011 to organise the 2011 and 2012 ADS-ADEA Annual Scientific Meetings. Working closely with the official conference organiser, ASN Events, the LOC, chaired by Elise Ritchie, and the Australian Diabetes Society (ADS) POC, chaired by Dr Jenny Gunton, the POC has kept to deadlines and is on target to deliver a varied and exciting program in Perth.

Registration numbers for the 2010 ADS–ADEA Annual Scientific Meeting in Sydney were very healthy with 1514 registrants, an increase of approximately 12% from the ASM held in Adelaide in 2009.

Seventeen percent of ADS and ADEA registrants responded to the 2010 ASM Satisfaction

Survey. Eighty percent evaluated the Overall Program as either 'Excellent' or 'Very Good'; 82% rated the Program Standard as either 'Excellent' or 'Very Good'; 83% rated the Program Content either 'Excellent' or 'Very Good' and 82% rated the Program Relevance either 'Excellent' or 'Very Good'.

The Plenary Speaker for the 2011 ADS–ADEA ASM, sponsored by Abbott Diabetes Care, is Dr Barbara Anderson from Department of Paediatrics, Baylor College of Medicine in Houston, Texas. Dr Anderson is a behavioural scientist and licensed clinical psychologist with 25 years of experience in diabetes research as well as in clinical work with youth with diabetes and their families.

The Educator's Day will again be supported by Roche and will continue in the format of workshops.

A broad selection of abstracts has been received and currently they are being assessed against ADEA criteria. Early bird registration closes at the beginning of July and there has already been a keen number of members taking advantage of the reduced registration rate. There has also been a favourable response to trade exhibition with all spaces now allocated.

This year we will be trialling electronic abstracts with computer terminals being placed amongst the trade exhibitors. This is an exciting opportunity to move forward in the electronic world.

The Committee thanks the outgoing Chair, Melissa Armstrong, for her time and dedication in handing over the previous two scientific meetings. Her excellent organisational skills see this Committee equipped with detailed electronic processes to guide program development and organisation of the ASM.

Sponsorship Committee

Fiona McIver

Members: George Barker and Clair Matthews

The Terms of Reference of this Committee were reviewed in 2010.

Governance

New premises

In May and June of 2010, ADEA moved its National Office to more spacious rooms within the Chifley Health and Wellbeing Hub. This has provided space for a reception area, three individual offices and a separate area for the running of the National Diabetes Services Scheme.

There has been a few minor technical hitches that come with the refurbishment of an old building, for example false fire alarms, leaking roof, however overall, the move has been a more than positive one.

Communication from National Office

Improving communication from National Office was a major goal set by the ADEA Board for this financial year. It was, therefore, pleasing to compare the results of this year's member survey with the member satisfaction survey conducted the previous year. A 16% increase in members rating communication from National Office as 'Very good' or 'Good' was heartening and provides a new target to better in the next survey.

This improvement is likely to have been assisted by the new website and its capacity to send a weekly email to members and the increase in administrative staff time dedicated to member matters.

The Board has approved further improvements to the website with online membership becoming available early in the 2011–12 financial year.

Professional Officer

This year was the first year of employing against the professional officer position after a two year vacancy.

The Professional officer has been responsible for:

Developing diabetes messages for clients of optometrists

Writing an article 'Monitoring Blood Glucose Levels' for healthy&HEARTWISE

Drafting a submission to Health Workforce Australia on their 'National Health Workforce Innovation and Reform Strategic Framework for Action'

Writing a presentation about ADEA for Directors

Writing a presentation about CDEs for Directors

Developing items for the ADEA website on CDEs and ADEA

Scripting the 'Diabetes Management in the Primary Care Setting' modules to be available as an online course for practice nurses

Developing the assessment modules for the 'Diabetes Management in the Primary Care Setting' course

Participation in the Insulin Initiation Working Party including:

Drafting an updated 'Standards for Initiating Insulin in Ambulatory Care Settings'

Writing parts of the 'Managing Insulin in Primary Care Settings: A Quality Use of Medicines Strategy'

And

Answering member questions on professional matters.

Ensuring clinical governance

The ADEA Board remains committed to ensuring high standards of clinical practice.

Guidelines/Recommendations

The Board has endorsed three sets of Guidelines/ Recommendations:

NHMRC 'National Evidence-Based Guideline: Prevention, Identification and Management of Foot Complications in Diabetes'

'Guidelines for Managing Diabetes at the End of Life' and 'A Document to Accompany the Guidelines'

'ADEA Clinical Recommendations for Subcutaneous Injection Technique for Insulin and Glucagon-like Peptide 1'

ADEA has also been involved in development of the recently NHMRC endorsed 'National Evidence Based Clinical Care Guidelines for Type 1 Diabetes in Children, Adolescents and Adults'.

Terms of Reference

The following Terms of Reference have been reviewed and set by the Board.

Clinical Practice Committee

Course Accreditation and Standards of Practice Committee

Credentialling Committee

Finance and Audit Committee

Health Insurers and Private Practice Working Group

Local Organising Committee

Program Organising Committee

Sponsorship Committee

Networking Group Guidelines (newly developed)

Special Interest Group Guidelines

Building organisational capacity for sound governance

The Board has again reviewed the ADEA Constitution and proposed changes in order to align ADEA with current governance standards. As many of you will be aware, the proposed Constitutional changes have been available on the ADEA website, along with fact sheets and powerpoint presentation. The Board directors have presented the changes at their respective Branch meetings and encouraged discussion of the proposed changes, at Branch level.

Leadership and collaboration

Australian Diabetes Society / Australian Diabetes Educators Association Collaborative

Heather Hart

Members: ADEA Heather Hart (to September 2), Nuala Harkin, Fiona McIver (from September 2), Clair Matthews, ADS Stephen Twigg (to September 2), Wah Cheung, Jenny Gunton (from September 2), Suzie Neylon.

The Australian Diabetes Society (ADS) and the Australian Diabetes Educators Association (ADEA) are the peak health professional bodies in Australia representing a national perspective on medical, scientific and educational issues relating to diabetes.

While ADS and ADEA have separate functions, those functions are related in their common wish to better serve and assist people with diabetes. ADS and ADEA will from time to time work collaboratively on the same project, or on closely related projects, or will sponsor the National Association of Diabetes Centres (NADC) in the execution of specific projects.

The Collaborative met quarterly by teleconference and face to face at the 2010 ASM. The Chair role rotates between the ADS and ADEA President.

Key areas of collaboration include the Annual Scientific Meeting (ASM), NADC activities such ANDIAB and the Work Survey, which is conducted to gather data from diabetes services who are members of NADC, to assist particularly in discussions with the Department of Health and Ageing regarding current and future diabetes funding and planning. National Diabetes Services Scheme projects are conducted individually by ADEA and jointly with ADS.

Australian Diabetes Foot Network

Jan Alford

ADEA Representatives: Jan Alford and Emma Holland

The network has representation from ADS, ADEA and APodC and is funded through ADS from NDSS funding. The key focus for this year has been to finalise a series of articles for submission to the Medical Journal Australia (MJA). These articles focus on:

1. A follow up article reviewing the progress in the management of the High Risk Foot since the last ADS Position Statement in 2005.
2. A Position Statement on wound management – written with a focus on general practitioners and others providing various levels of care to people with diabetes who might be at high risk of developing lesions.
3. A Position Statement on appropriate footwear for people with diabetes at high risk of developing lesions.

They are currently with the MJA for consideration after content approval from various bodies, including ADEA.

Driving and Diabetes Working Party Report

Victoria Stevenson

I sincerely hope that by the time you read this report, you will have used some of the resources produced by the ADS Driving and Diabetes Working Party and found them to be useful in your practice.

The Driving and Diabetes project commenced in 2008 and its members comprise Professor Stephen Twigg (Chair), Associate Professor Maarten Kamp, Clinical Professor John Carter, Dr Bruce Hocking, Dr Peter Abernathy, Dr Seham Girgis, Mr Daniel Davies, Ms Suzie Neylon and ADEA representative Ms Victoria Stevenson.

We are pleased to report on these finalised documents which are the:

Systematic Literature Review. This has been completed and has informed the Working Party in the development of the following publications.

- Assessing Fitness to Drive Book. The diabetes section has been thoroughly revised by the Working Party and the full book will available later this year.
- Driving and a recent severe

hypoglycaemia sheet. This has been developed for diabetes health professionals when seeing a patient who is known to have experienced a recent episode of severe hypoglycaemia. This information sheet may also be filed in a patient's medical record.

Diabetes and Driving in Australia booklet. This has primarily been developed for the consumer and is an educational tool for health professionals. The booklet includes a key message to 'Stay Above 5 to Drive', how to avoid hypoglycaemia whilst driving, managing a hypo, hypoglycaemic unawareness, associated conditions that may affect driving, legal responsibilities and websites of State and Territory licensing authorities.

The above information will be available through the NDSS, DA, ADS and ADEA websites with associated links.

We acknowledge and thank ADEA and ADS members for voicing their concerns and comments about driving and diabetes. We also acknowledge and thank Diabetes Australia and the Type 1 Diabetes Network for conducting the focus groups and for providing invaluable feedback from its members.

Funding for this project was made possible through the Department of Health and Ageing's National Diabetes Services Scheme.

The HbA_{1c} Reporting Working Party (HbA_{1c} RWP)

George Barker

The HbA_{1c} RWP (WP) was formed in mid 2009 with representatives of Royal College of Pathologists Australia (RCPA), Australasian Association of Clinical Biochemists (AACB), Australian Diabetes Society (ADS) and ADEA. The aim of the WP is to determine how HbA_{1c} results will be reported in Australia in the future, together with consideration of other relevant issues.

The International Federation of Clinical Chemistry (IFCC) has developed a new standardised and accurate method for assaying and reporting HbA_{1c} results. These are known as Systeme International (SI) units (mmol/mol, also known as IFCC units).

All participating WP organisations have formally confirmed their support of the introduction of the new IFCC units. The ADEA position statement was published in the ADE in the August 2010 edition along with a supporting article.

A position statement has been prepared by all members of the WP for publication in the Medical Journal of Australia.

This position statement supports the introduction of dual reporting in the current units (%) and SI units (mmol/mol) as an interim measure leading towards the use of SI units only after a two year transition period.

A formal date for the adoption of the new reporting system is not confirmed but will coincide with the publication of this position statement in the MJA. At this stage it will be most likely mid–late 2011.

A powerpoint presentation has been prepared for the use of ADEA members to help colleagues understand the proposed changes. This presentation is posted on the ADEA website.

The WP strongly agrees that routine reporting of Estimated Average Glucose (eAG) with all requests for HbA_{1c} is not appropriate. The eAG may, and will, be used at the discretion of individual clinicians as an educational tool. This information should be provided by an informed clinician who can assist the patient to understand the significance and limitations of the result.

Recent international guidelines are supporting the use of HbA_{1c} for diagnosis of diabetes mellitus. The use of HbA_{1c} for diagnosis is being considered by the WP but currently the use of HbA_{1c} is not approved by Medicare for this purpose.

Issues regarding assay precision and between laboratory bias will also need to be addressed if HbA_{1c} is to be used as a diagnostic test.

Health Insurers and Private Practice Working Group (HIPP WG)

Deb Foskett

MEMBERS: Deb Foskett (Chair), Tracy Aylen, Annabelle Thurlow, Leigh Spokes, Judy Tod, Carolien van Geloven, Marilyn Burgess.

To have health funds acknowledge diabetes educators service to their members by way of better recognition and reimbursement to their members.

Development of the lobby kit has been the major focus of HIPP activities. The lobby kit was made available to all ADEA members via the website for four months, from February to mid June. The Lobby Kit comprised a guideline on the aim and process, sample client letters and petitions to lobby members of parliament and health funds.

In response to emails from some members, the HIPP WG has replied to any queries regarding the lobbying and added a generic letter and petition to the web based documents, as there are reports of clients wanting to participate who are not in the targeted Private Health Insurer groups.

A short letter to Conquest from a concerned person with diabetes has been published, and responded to by Professor Dunning. In her response, Prof Dunning suggested the correspondent contact the Diabetes Australia representative organisation in their state to raise the issue and gain some support.

The next stage in this campaign is to broaden the lobbying effort.

Insulin Initiation Working Party

Trisha Dunning

Members: Trisha Dunning (Chair), Professor Andrew McLachlan, Ms Lyn Weeks, Dr. Linda Mann, Ms Heather Hart, Ms Fiona McIver, Ms Julie Bligh, Dr Ashim Sinha, Ms Gil Cremer.

The Insulin Initiation Working Party was formed in late 2009 in response to concerns members raised regarding insulin initiation and scope of practice. The working party has developed two draft documents addressing these and related issues.

These are:

Managing Insulin in Primary Care Settings: A Quality Use of Medicines Strategy; and

Standards for Initiating Insulin in Ambulatory Care Settings.

Once completed the Board will review the document prior to their placement on the ADEA website for member comment.

Medtronic International Diabetes Fellowship 2011

Dorothy Thomas and Rachael Critchell

Dorothy Thomas RN CDE and Rachael Critchell RN CDE were the recipients of the inaugural Medtronic International Diabetes Fellowship for 2011. The fellowship is aimed at providing mentoring to diabetes educators in a developing country via two site visits and ongoing mentoring via WebEx.

The initial visit to the Apollo Gleneagles Hospital Diabetes Clinic, a private healthcare provider, in Kolkata, India, occurred in March.

With rapid economic growth India has an increasing middle class with diabetes becoming a major problem. The Apollo Gleneagles Hospital is part of the first large scale initiative to train and educate health care professionals in India about diabetes. This project has been implemented by Health Opportunities for People Everywhere (HOPE), an international health education and humanitarian aid organisation, in conjunction with the International Diabetes Federation (IDF), which has adapted the teaching program specifically for the Indian population.

Many clients access healthcare late in the disease process due predominantly to economic factors. Therefore client needs are often complex and are guided by deeply held religious and cultural beliefs. This high cost of healthcare has promoted a medical driven service with minimal multidisciplinary team input and minimal ongoing therapeutic client relationships with other health care providers.

Many lifestyle compliance issues are the same as in Australia, although exacerbated in India by the high cost of medications and diabetes supplies. Most clients do not use blood glucose monitors due to ongoing costs, and minimal availability of teaching resources.

The Australian team spent five days observing clinic practices, discussing differences between the Australian and Indian health care systems and attending client consultations.

A forum was held for the Australian team and 28 HOPE trained nurses and dietitians to discuss the differences in health services between the two countries, the role of diabetes educators in Australia, management and self-care education strategies used in Australia and the role of ADEA as a professional body.

Diabetes education is a new concept in India, and it is not yet a recognised profession. Diabetes educators in India require ongoing support, mentoring and sharing, and educational opportunities. The development of a professional network would enable further ongoing professional development and creditability.

Minister's Diabetes Advisory Group — Coordinated Care for Diabetes pilot

ADEA President, Nuala Harkin, is the ADEA representative on the Minister for Health and Ageing's Diabetes Advisory Group. This membership ensures ADEA involvement in the oversight of the design, implementation and evaluation of the Coordinated Care for Diabetes pilot. The Request for Tender to finalise the design of, and implement, manage and evaluate this pilot has now closed. At the time of reading this, the pilot group is likely to have been selected and the pilot underway.

National Diabetes Services Scheme

ADEA continues to develop and implement its annual NDSS Services Plan as part of its commitment under the NDSS Services Agreement (Agreement). The ADEA has recruited a dedicated NDSS Project Team to manage the various activities funded under the Agreement.

Some of these activities are single entity projects completed within a financial year, but the majority are developed and undertaken in stages where one project informs the development of future projects that may be undertaken and completed within the timeframe of the Agreement.

The main achievements for this year are reported throughout this Report.

In summary these include:

Marketing of the role of the Credentialled Diabetes Educator (CDE) at conferences throughout Australia and in consumer and nursing focussed magazines.

Update of the 'Find a CDE' search function on the ADEA website.

A literature review on primary care diabetes service delivery models and review of current models of care that are being adopted in Chronic Disease Management.

Alignment of these models along a continuum of care, such as Simple Intensity Model – Diabetes Management by GPs; Complex Intensity Model, for example nurse-led clinics and multidisciplinary teams; and tertiary diabetes centres, for use in its assessment of workforce requirements for diabetes educators.

Development of best practice models of care for people with diabetes by CDE's for eight diabetes scenarios – those with type 1 diabetes who have simple or complex care needs and by duration of diagnosis, within the first year and thereafter; and those with type 2 diabetes who have simple or complex care needs and by duration of diagnosis, within the first year and thereafter.

Workforce projections for diabetes educators to meet the needs of people with diabetes according to these best practice principles.

Update on literature reviews for the 'Systematic Review of the Effectiveness, Appropriateness and Meaningfulness of Self-monitoring Blood Glucose in People with Non-insulin Treated Type 2 Diabetes', the 'Effectiveness and Appropriateness of Educational Components and Strategies Associated with Insulin Pump Therapy' and 'Mangaging Sick Day Guidelines' in order to produce Position Statements on these topics.

Feasibility pilot of collecting outcomes and indicators of diabetes education from Credentialled Diabetes Educators.

Development of an online education course on Kidney Disease and Diabetes.

Development of online education courses on Diabetes and Aged Care. This comprises three courses aimed at different target audiences working in Aged Care, namely diabetes educators, aged care workers and registered nurses.

Development of an online diabetes education course for Aboriginal and Torres Strait Islander Community and Health Workers.

Paediatric Insulin Pump Project

Clair Matthews

Phase 3 of the Paediatric Insulin Pump project has been conducted between July and December 2010. Two Paediatric Insulin Pump Project (PIPP) Working Groups were established comprising volunteer diabetes educators from nursing and dietetic backgrounds. Phase 3 also sought and achieved representation from the Australian Paediatric Endocrine Group (APEG).

PIPP Working Group 1 reviewed evaluation tools that are recommended for use in paediatric insulin pump initiation; how to build the use of these tools into patient assessment processes; and considered recommendation of an auditing process to verify

the effect of the use of the tools.

PIPP Working Group 2 worked to collate existing resources available to nurses and dietitians, to develop a framework to evaluate the collated resources and to identify and recommend the best practice resources for use in an insulin pump program.

Both Groups identified recommendations for the ADEA Board to consider in the advancement of best practice paediatric insulin pump use.

PIPP 1 Evaluation

1. Develop a national paediatric database for service level indicator data, including insulin pump programs.
2. Develop Australian paediatric validated evaluation tools.
3. Electronic download of insulin pumps should become part of routine follow-up.

PIPP 2 Education Resources

1. Ensure consumer input into the development of pump education resources.
2. Consider low literacy and numeracy skills in the development of these National, standardised paediatric pump education resources.
3. Gain health care practitioner consensus on the paediatric pump education required.
4. Gain agreement on a standard method of scoring resources against resource assessment criteria.

The report from this project is now available on the ADEA website.

I would like to thank Diabetes Medtronic Australasia for their support of this project.

Review of the Credentialling and Re-credentialling process

Trisha Dunning

The review of ADEA's current credentialling and re-credentialling programs was commissioned by immediate past president, Heather Hart.

At the time of reading this, you will have had the opportunity to participate in providing feedback on the key recommendations from this review.

The process, which commenced late 2010, has included:

A structured literature review.

A comparison of the ADEA Credentialling process with other continuing professional development processes, specifically AADE, CDA and UK processes because these countries most closely resemble Australian processes.

Receipt of ethics from Barwon Health Human Research Ethics Committee.

Results from a convenience sample of ADEA members attending the annual conference in Sydney in September. This helped to identify key issues to include in a questionnaire distributed via the ADEA website to ADEA members.

Other questionnaires were developed and used to assess key issues for:

- Graduate Certificate of Diabetes Education Course conveners.
- Students currently undertaking or who just completed the graduate Certificate.
- Randomly selected health care organisations likely to employ diabetes educators.

Analysis of 367 completed responses from ADEA members to the survey available on the ADEA website between 22nd November to 8th December.

Conduct of a discussion group with representatives from key organisations whose membership comprises health professionals who are eligible for credentialling.

Input from members of the ADEA Credentialling Committee.

Development of draft documents ready for comment.

Strategic Plan

The Strategic Planning Meeting was held in February 2011 and members were well represented, with the attendance of the Branch Chairs, and the Chairs of ADEA Committees and Working Groups. There was lively discussions, and the key outcomes of the Strategic Planning Day are a revised Vision and Mission, and six clear focus areas. The Strategic Plan is a work in progress at this time and will be launched later in the year.

Type 1 Diabetes Guidelines Expert Panel Working Group

Heather Hart

Membership: ADEA Nuala Harkin and Heather Hart as part of a composite group of diabetes health professionals drawn from paediatric and adult areas of practice.

The Australasian Paediatric Endocrine Group (APEG) and the Australian Diabetes Society (ADS) have been contracted by the Department of Health and Ageing (DoHA) to review and update the Type 1 Diabetes Guidelines in Paediatrics and Adolescence and to extend them into adulthood.

The Expert Panel Working Group was formed in July 2009 to work over an 18 month period, setting topics and key questions to be addressed, enabling a systematic review process followed by public consultation.

Dissemination and distribution strategies for the final guideline, including how to make them accessible to health professionals, has also been discussed. The revised guideline, has now been endorsed by the National Health and Medical Research Council and are due for release in 2011.

It has been interesting to collaborate and discuss clinical issues with very experienced and senior diabetes health professionals, across a broad spectrum of clinical practice and research. Lack of high grade evidence in some very fundamental diabetes clinical areas highlights that further research is needed to expand our knowledge to continue to improve patient care.

ADEA leaders

Branch executives as at May 2011

ACT

Terri Berenguer (Chair)
Elaine Slater (Secretary)
Wendy Mossman (Finance Officer)

NSW

Marlene Payk (Chair)
Gillian Walker (Secretary)
Anne Wansbrough (Finance Officer)

NT

Michelle Walding (Chair)
Jan Stevenson (Secretary)
Melissa Tait (Finance Officer)

Qld

Denise Bennetts (Chair)
Yvonne Elliot-Kemp (Secretary)
Andrea Sanders (Finance Officer)

SA

Tess Reynolds (Chair)
Lynn Rollbusch (Secretary)
Rhonda Rowe (Finance Officer)

Tas

Joanne Saunders (Chair)
Joan Hamon (Secretary)
Fiona Swinton (Finance Officer)

WA

Wendy Lee Pittick (Chair)
Lauren Cotter (Secretary)
Pica Ellis (Finance Officer)

Vic

Cassie Cheeseman (Chair)
Coralie Cross (Secretary)
Edwin Pascoe (Finance Officer)

Committees, Working Groups and Special Interest Groups

Complaints Committee

Fiona McIver (Chair)
Denise Smith
Carol de Groot
Neroli Price
Cathy Carty
Amanda Bartlett
Jo Mazengarb
Barbara Campbell

Conference Program Organising Committee

Denise Smith (Chair)
Deborah Grant
Annette Hart
Estelle Hayler
Gladys Hitchen
Linda Hop
Kylie Mahony
Rebecca Munt
Liz Powell
Trish Roderick
Mark Shah

Conference Local Organising Committee

Elise Richie (Chair)
Jillian Loveday
Marina Mickleson

Course Accreditation and Standards Of Practice Committee

Judy Reinhardt (Chair)
Jan Alford
Karen Crawford
Trisha Dunning

Rhonda Griffiths
Pauline Hill
Sara Jones

Credentialling Committee and Reviewers

Jan Alford (Chair)
Diane Bond
Lauren Botting
Wendy Bryant
Glynis Dent
Lisa Grice
Maggie Lasdauskas
Chris Lester
Elizabeth Obersteller
Helen Phelan
Lynnette Randall
Lois Rowan
Maxine Schlaeppi

Finance and Audit Committee

Tracy Aylen (Chair)
Martin Gordin
Megan Krajina
Clair Matthews
Edwin Pascoe
Andrea Sanders
Trish Roderick

Sponsorship Committee

Fiona McIver (Chair)
George Barker
Clair Matthews

Editorial Advisory Group

Clair Matthews (Chair)
George Barker
Glynis Dent
Kate Marsh
Michelle Robins

Clinical Practice Guideline Committee

Michelle Robins (Chair)
Melissa Armstrong
Wendy Bryant
Mark Coles
Carol de Groot
Lyndon Homeming
Denise Smith

Special Interest Groups

NURSE PRACTITIONER
Michelle Robins (Convenor)
PAEDIATRIC
Karen Jameson (Convenor)
PRIVATE PRACTICE
Lesley Wilcox (Convenor)
HIGH RISK FOOT
Emma Holland (Convenor)

ADEA Representation

ADS/ADEA Collaborative

Nuala Harkin
Fiona McIver
Clair Matthews

ADS/APEG Type 1 Diabetes Guidelines in Paediatrics and Adolescence

Heather Hart
Nuala Harkin

Australian Diabetes Foot Network

Emma Holland
Jan Alford

Coalition of National Nurses Organisation

Jane Payne/Tracy Aylen

Conquest

Trisha Dunning

DA Mental Health Expert Panel

Pam Grierson

Diabetes and Driving

Victoria Stevenson

Diabetes Australia Board

Tracy Aylen

Diabetes Management Journal

Kate Marsh

Health Care and Education

Shirley Cornelius – up to February 2011
Diana Sonnack

IDF-WPR Council

Trisha Dunning

Medical Education and Scientific Council

Fiona McIver
Giuliana Murfet

NHMRC Type 2 Diabetes Guidelines Review and Update Advisory Committee

Clair Matthews

Working Party on HbA_{1c} Reporting

George Barker

Life members

Professor Trisha Dunning
Gloria Kilmartin
Ann Morris
Jan Alford
Ruth Colagiuri
Lesley Cusworth
Rhonda Griffiths
David Irvine
Edwina Macoun
Judy Reinhardt
Coral Shankley
Helen Turley
Erica Wright
Kaye Neylon
Maureen Unsworth
Gillian Harris

Congratulatio ns to our 2010 award winners

Jan Baldwin Award

Michelle Robins (Vic)

Abbott Diabetes Care Service Development Grant

Nicole Samara (Tas)

ADEA – Abbott Diabetes Care Case Study Awards

Janelle Anderson (Qld)
Kirrily Chambers (SA)
Mary Gilligan (Vic)
Kathleen Harrison (Qld)
Vicki Hewett (SA)
Elly Kenyon (Vic)
Anne Marks (NSW)
Sue Redden (Vic),
Gail Schuler (Vic)
Kathleen Steele (Vic)

Becton Dickinson Best Oral Presentation ADEA–ADS ASM 2010

Robyn Gray (NSW)

Becton Dickinson Best Poster Presentation ADEA–ADS ASM 2010

Trisha Dunning (Vic)

Eli Lilly Best New Oral Presentation ADEA–ADS ASM 2010

Helen D'Emden (Qld)

Eli Lilly Best New Posterl Presentation ADEA–ADS ASM 2010

Nicole Duggan (Vic)

FINANCIAL REPORT

For the year ended 30 June 2011

ACN 008 656 522

AUSTRALIAN DIABETES EDUCATORS' ASSOCIATION LIMITED
ABN 65 008 656 522

DIRECTOR'S REPORT

Your directors present this report on the Company for the financial year ended 30 June 2011

Directors

The names and particulars of each person who has been a director during the year and to the date of this report are:

Nuala Harkin
RN RSCN NP CDE Dip(InfectionControl) GradCert(DiabEd)

Tracy Aylen
RN CDE BHSc(Nursing) GradCert(DiabEd) GradCert(HSM)

Fiona McIver
RN CDE BN GradCert(DiabEd)

Jane Payne
RN CDE GradCert(DiabEd)

Glynis Dent
RN CDE GradCert(DiabEd) GradCert(HumanNutrition) Dip(Nursing)

Cheryl Steele
RN RM CDE GradCert(DiabEd)

Carol de Groot
RN CDE GradCert(DiabEd)

Giuliana Murfet
RN CDE NP MSc(Diabetes) MNg(Nursing)

Trish Roderick
RN CDE

Liz Powell
APD CDE Bsc PostGradDipNutr&Diet GradCert(DiabEd)

Diana Sonnack
RN CDE

Heather Hart (to 2 September 2010)
RN CDE

Neroli Price (to 2 September 2010)
RN CDE

Directors have been in office since the start of the financial year to the date of this report unless otherwise stated

AUSTRALIAN DIABETES EDUCATORS' ASSOCIATION LIMITED
ABN 65 008 656 522

DIRECTORS' REPORT (CONTINUED)

Meetings of Directors

	DIRECTOR'S MEETINGS	
	Number eligible to attend	Meetings attended
Heather Hart	2	2
Nuala Harkin	6	6
Tracy Aylen	6	6
Fiona McIver	6	5
Glynis Dent	6	6
Jane Payne	6	6
Giuliana Murfet	6	6 (1 by teleconference)
Neroli Price	2	2
Cheryl Steele	6	6 (1 by teleconference)
Carol de Groot	6	5
Trish Roderick	6	6
Diana Sonnack	4	3
Liz Powell	4	3

Principal Activities

The principle activities of the Company during the financial year were to promote best practice in diabetes education and care.

No significant changes in the nature of the Company's activities occurred during the financial year.

Operating Results

The profit of the Company amounted to $126,613.

Dividends Paid or Recommended

No dividends were paid or declared since the start of the financial year. No recommendation for payment of dividends has been made.

Review of Operations

A review of operations of the Company during the financial year indicated that the poor performance of investment markets and interest rates led to a decrease in income for the financial year.

Significant Changes in State of Affairs

No significant changes in the Company's state of affairs occurred during the financial year.

DIRECTORS' REPORT (CONTINUED)

After Balance Date Events

No matter or circumstances have arisen since the end of the financial year which significantly affected or may significantly affect the operations of the Company, the results of those operations or the state of affairs of the Company in future financial years.

Future Developments

The Company expects to maintain the present status and level of operations and hence there are no likely developments in the Company's operations.

Environmental Issues

The Company's operations are not regulated by any significant environmental regulations under the law of the commonwealth or of a state or territory.

Options

No options over issued shares or interests in the Company were granted during or since the end of the financial year and there were no options outstanding at the date of this report.

Indemnifying Officers or Auditor

No indemnities have been given or insurance premiums paid , during or since the end of the financial year, for any person who is or has been an officer or auditor of the Company.

Proceedings on Behalf of the Company

No person has applied for leave of Court to bring proceedings on behalf of the Company or intervene in any proceedings to which the Company is a party for the purpose of talking responsibility on behalf of the Company for all any part of those proceedings

The Company was not a party to any such proceedings during the year

Auditor's Independence Declaration

The lead auditor's independence declaration for the year ended 30 June 2011 has been received and can be found on page 4 of this financial report

Signed in accordance with a resolution of the Board of Directors.

Tracy Aylen, Director

Dated this 15th day of August 2011

Australian Diabetes Educators' Association Limited

ABN 65 008 656 522

Annual report for the year ended 30 June 2011

Australian Diabetes Educators' Association Limited ABN 65 008 656 522
Annual report - 30 June 2011

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These financial statements are the financial statements of Australian Diabetes Educators' Association Limited as an individual entity. The financial statements are presented in the Australian currency.

Australian Diabetes Educators' Association Limited is a company limited by guarantee, incorporated and domiciled in Australia. Its registered office and principal place of business is:

Australian Diabetes Educators' Association Limited
Chifley Community Park
Corner of Eggleston and Maclaurin Crescents
Chifley ACT 2606

The financial statements were authorised for issue by the directors on 15 August 2011. The directors have the power to amend and reissue the financial statements.

Australian Diabetes Educators' Association Limited
Statement of comprehensive income
For the year ended 30 June 2011

	Notes	2011 $	2010 $
Revenue from continuing operations	4	**1,846,184**	1,463,010
Staff costs		**(229,516)**	(234,899)
Operating expenses		**(139,150)**	(56,063)
Move to new premises		**(3,717)**	(20,634)
ADEA products and general expenses		**(111,968)**	(72,026)
Meetings and travel		**(105,737)**	(111,363)
Branch meeting expenses		**(14,039)**	(7,084)
Branch conference costs		**(107,382)**	(126,532)
Branch travel grants		**(5,000)**	(4,240)
Financial and legal		**(77,763)**	(26,331)
Awards and travel support		**(39,667)**	(6,203)
Subscription memberships		**(16,004)**	(14,586)
NDSS expenses		**(684,312)**	(384,119)
Project expenses		**(185,316)**	(80,716)
Profit for the year		**126,613**	318,214
Other comprehensive income for the year		**-**	-
Total comprehensive income for the year		**126,613**	318,214
Total comprehensive income for the year is attributable to:			
Members of Australian Diabetes Educators' Association Limited		**126,613**	318,214

The above statement of comprehensive income should be read in conjunction with the accompanying notes.

Australian Diabetes Educators' Association Limited
Statement of financial position
As at 30 June 2011

	Notes	**2011 $**	2010 $
ASSETS			
Current assets			
Cash and cash equivalents	6	**1,306,277**	1,191,326
Trade and other receivables	7	**89,699**	114,268
Other current assets	8	**6,559**	9,154
Other financial assets	9	**798,886**	750,647
Total current assets		**2,201,421**	2,065,395
Non-current assets			
Property, plant and equipment	10	**28,691**	38,716
Total non-current assets		**28,691**	38,716
Total assets		**2,230,112**	2,104,111
LIABILITIES			
Current liabilities			
Trade and other payables	11	**135,911**	102,094
Other current liabilities	12	**327,936**	367,752
Total current liabilities		**463,847**	469,846
Non-current liabilities			
Provisions	13	**6,512**	1,125
Total non-current liabilities		**6,512**	1,125
Total liabilities		**470,359**	470,971
Net assets		**1,759,753**	1,633,140
EQUITY			
Retained earnings		**1,759,753**	1,633,140
Total equity		**1,759,753**	1,633,140

The above statement of financial position should be read in conjunction with the accompanying notes.

Australian Diabetes Educators' Association Limited
Statement of changes in equity
For the year ended 30 June 2011

	Retained earnings $	Total equity $
Balance at 1 July 2009	**1,314,926**	**1,314,926**
Total comprehensive income for the year	318,214	318,214
Balance at 30 June 2010	**1,633,140**	**1,633,140**
Total comprehensive income for the year	126,613	126,613
Balance at 30 June 2011	**1,759,753**	**1,759,753**

The above statement of changes in equity should be read in conjunction with the accompanying notes.

Australian Diabetes Educators' Association Limited
Statement of cash flows
For the year ended 30 June 2011

	Notes	2011 $	2010 $
Cash flows from operating activities			
Receipts from members and customers		**1,938,892**	1,406,626
Interest received		**106,910**	35,724
Payments to suppliers and employees		**(1,878,741)**	(1,275,459)
Net cash inflow from operating activities	20	**167,061**	166,891
Cash flows from investing activities			
Payments for property, plant and equipment	10	**(3,871)**	(32,258)
Payments for available-for-sale financial assets		**(46,438)**	-
Payments for held-to-maturity investments		**(1,801)**	-
Net cash (outflow) from investing activities		**(52,110)**	(32,258)
Net increase (decrease) in cash and cash equivalents		**114,951**	134,633
Cash at the beginning of the financial year		**1,191,326**	1,056,693
Cash and cash equivalents at end of year	6	**1,306,277**	1,191,326

The above statement of cash flows should be read in conjunction with the accompanying notes.

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1 Summary of significant accounting policies

The principal accounting policies adopted in the preparation of the financial report are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated.

(a) Basis of preparation

These general purpose financial statements have been prepared in accordance with Australian Accounting Standards, other authoritative pronouncements of the Australian Accounting Standards Board, Urgent Issues Group Interpretations and the *Corporations Act 2001*.

Historical cost convention

These financial statements have been prepared under the historical cost convention, as modified by the revaluation of available-for-sale financial assets, financial assets and liabilities (including derivative instruments) at fair value through profit or loss, certain classes of property, plant and equipment and investment property.

Critical accounting estimates

The preparation of financial statements requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Company's accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the financial statements, are disclosed in note 3.

(b) Revenue recognition

Grant revenue is recognised in profit or loss when the Company obtains control of the grant and it is probable that the economic benefits gained from the grant will flow to the Company and the amount of the grant can be measured reliably.

If conditions are attached to the grant which must be satisfied before the Company is eligible to receive the contribution, the recognition of the grant as revenue will be deferred until those conditions are satisfied.

When grant revenue is received whereby the Company incurs an obligation to deliver economic value directly back to the contributor, this is considered a reciprocal transaction and the grant revenue is recognised in the statement of financial position as a liability until the service has been delivered to the contributor, otherwise the grant is recognised as income on receipt.

Interest revenue is recognised using the effective interest rate method, which for floating rate financial assets is the rate inherent in the instrument.

Revenue from the rendering of a service is recognised upon the delivery of the service to the customers.

All revenue is stated net of the amount of goods and services tax (GST).

(c) Income tax

No provision for income tax has been raised as the Company is exempt from income tax under Division 50 of the *Income Tax Assessment Act 1997.*

(d) Leases

Lease payments for operating leases, where substantially all the risks and benefits remain with the lessor, are charged as expenses on a straight-line basis over the lease term.

(e) Impairment of assets

At each reporting date, the Company reviews the carrying values of its tangible and intangible assets to determine whether there is any indication that those assets have been impaired. If such an indication exists, the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, is compared to the asset's carrying value. Any excess of the asset's carrying value over its recoverable amount is expensed to profit or loss.

Where the future economic benefits of the asset are not primarily dependent upon the asset's ability to generate net cash inflows and when the Company would, if deprived of the asset, replace its remaining future economic benefits, value in use is determined as the depreciated replacement cost of an asset.

Where it is not possible to estimate the recoverable amount of an assets class, the Company estimates the recoverable amount of the cash-generating unit to which the class of assets belong.

1 Summary of significant accounting policies (continued)

(f) Cash and cash equivalents

Cash and cash equivalents include cash on hand, deposits held at-call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts.

(g) Property, plant and equipment

Each class of property, plant and equipment is carried at cost or fair values as indicated, less, where applicable, accumulated depreciation and impairment losses.

Plant and Equipment

Plant and equipment are measured on the cost basis less depreciation and impairment losses.

The carrying amount of plant and equipment is reviewed annually by directors to ensure it is not in excess of the recoverable amount from these assets. The recoverable amount is assessed on the basis of the expected net cash flows that will be received from the assets employment and subsequent disposal. The expected net cash flows have been discounted to their present values in determining recoverable amounts.

Depreciation

The depreciable amount of all fixed assets is depreciated on a straight-line basis over the asset's useful life to the Company commencing from the time the asset is held ready for use.

The depreciation rates used for depreciable assets are 10 – 33%.

The assets' residual values and useful lives are reviewed, and adjusted if appropriate, at each balance date.

Asset classes carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount.

Gains and losses on disposals are determined by comparing proceeds with the carrying amount. These gains or losses are included in the statement of comprehensive income.

(h) Trade and other payables

These amounts represent liabilities for goods and services provided to the Company prior to the end of financial year which are unpaid. The amounts are unsecured and are usually paid within 30 days of recognition. Trade and other payables are presented as current liabilities unless payment is not due within 12 months from the reporting date. They are recognised initially at their fair value and subsequently measured at amortised cost using the effective interest method.

(i) Provisions

Provisions are recognised when the Company has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result and that outflow can be reliably measured. Provisions recognised represent the best estimate of the amounts required to settle the obligation at reporting date.

(j) Employee benefits

Provision is made for the Company's liability for employee benefits arising from services rendered by employees to balance date. Employee benefits expected to be settled within one year together with benefits arising from wages, salaries and annual leave which may be settled after one year, have been measured at the amounts expected to be paid when the liability is settled. Other employee benefits payable later than one year have been measured at the net present value.

Contributions are made by the Company to an employee superannuation fund and are charged as expenses when incurred.

1 Summary of significant accounting policies (continued)

(k) Financial instruments

Initial Recognition and Measurement

Financial assets and financial liabilities are recognised when the Company becomes a party to the contractual provisions to the instrument. For financial assets, this is equivalent to the date that the Company commits itself to either purchase or sell the asset (ie trade date accounting is adopted). Financial instruments are initially measured at fair value plus transactions costs except where the instrument is classified 'at fair value through profit or loss' in which case transaction costs are expensed to profit or loss immediately.

Classification and Subsequent Measurement

Financial instruments are subsequently measured at either fair value, amortised cost using the effective interest rate method or cost. Fair value represents the amount for which an asset could be exchanged or a liability settled, between knowledgeable, willing parties. Where available, quoted prices in an active market are used to determine fair value. In other circumstances, valuation techniques are adopted.

Amortised cost is calculated as:

(i) the amount at which the financial asset or financial liability is measured at initial recognition;

(ii) less principal repayments;

(iii) plus or minus the cumulative amortisation of the difference, if any, between the amount initially recognised and the maturity amount calculated using the effective interest method; and

(iv) less any reduction for impairment.

The effective interest method is used to allocate interest income or interest expense over the relevant period and is equivalent to the rate that exactly discounts estimated future cash payments or receipts (including fees, transaction costs and other premiums or discounts) through the expected life (or when this cannot be reliably predicted, the contractual term) of the financial instrument to the net carrying amount of the financial asset or financial liability. Revisions to expected future net cash flows will necessitate an adjustment to the carrying value with a consequential recognition of an income or expense in profit or loss.

Financial assets at fair value through profit or loss

Financial assets are classified at 'fair value through profit or loss' when they are held for trading for the purpose of short-term profit taking, or where they are derivatives not held for hedging purposes, or when they are designated as such to avoid an accounting mismatch or to enable performance evaluation where a group of financial assets is managed by key management personnel on a fair value basis in accordance with a documented risk management or investment strategy. Such assets are subsequently measured at fair value with changes in carrying value being included in profit or loss.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market and are subsequently measured at amortised cost.

Held-to-maturity investments

Held-to-maturity investments are non-derivative financial assets that have fixed maturities and fixed or determinable payments, and it is the Company's intention to hold these investments to maturity. They are subsequently measured at amortised cost.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets that are either not capable of being classified into other categories of financial assets due to their nature, or they are designated as such by management. They comprise investments in the equity of other entities where there is neither a fixed maturity nor fixed or determinable payments.

Financial Liabilities

Non-derivative financial liabilities (excluding financial guarantees) are subsequently measured at amortised cost.

1 Summary of significant accounting policies (continued)

Fair Value

Fair value is determined based on current bid prices for all quoted investments. Valuation techniques are applied to determine the fair value for all unlisted securities, including recent arm's length transactions, reference to similar instruments and option pricing models.

Impairment

At each reporting date, the Company assesses whether there is objective evidence that a financial instrument has been impaired. In the case of available-for-sale financial instruments, a prolonged decline in the value of the instrument is considered to determine whether an impairment has arisen. Impairment losses are recognised in profit or loss.

Derecognition

Financial assets are derecognised where the contractual rights to receipt of cash flows expires or the asset is transferred to another party whereby the Company no longer has any significant continuing involvement in the risks and benefits associated with the asset. Financial liabilities are derecognised where the related obligations are either discharged, cancelled or expired. The difference between the carrying value of the financial liability, which is extinguished or transferred to another party and the fair value of consideration paid, including the transfer of non-cash assets or liabilities assumed, is recognised in profit or loss.

(l) Goods and Services Tax (GST)

Revenues, expenses and assets are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Australian Taxation Office. In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of an item of expense. Receivables and payables in the statement of financial position are shown inclusive of GST.

Cash flows are presented in the statement of cash flows on a gross basis, except for the GST component of investing and financing activities, which are disclosed as operating cash flows.

(m) New accounting standards and interpretations

The Australian Accounting Standards Board has issued new, revised and amended standards and interpretations that have mandatory application dates for future reporting periods. The Company has decided against early adoption of these standards and does not expect them to have a material effect on the Company's financial statements.

(n) Comparative Figures

Where required by Accounting Standards comparative figures have been adjusted to conform with changes in presentation for the current financial year.

(o) Members' guarantee

The Company is incorporated under the *Corporations Act 2001* and is a company limited by guarantee. On the winding up of the Company the constitution states that each member of the Company is required to contribute to the company's assets an amount not exceeding fifty dollars while that person is a member and for a period of one year afterwards.

At 30 June 2011 the number of members was 1744.

2 Financial risk management

The Company's financial instruments consist mainly of deposits with banks, local money market instruments, short-term investments, accounts receivable and payable.

The carrying amounts for each category of financial instruments, measured in accordance with AASB 139 as detailed in the accounting policies to these financial statements, are as follows:

	Notes	**2011** $	2010 $
Financial assets			
Cash and cash equivalents	6	**1,306,277**	1,191,326
Financial assets at fair value through profit or loss	9	**571,521**	525,083
Held-to-maturity investments	9	**227,365**	225,564
Loans and receivables	7	**108,061**	114,268
		2,213,224	2,056,241
Financial liabilities			
Trade creditors and accruals	11	**102,894**	75,907
		102,894	75,907

Financial Risk Management Policies

The Board of Directors' overall risk management strategy seeks to assist the Company in meeting its financial targets, whilst minimising potential adverse effects of financial performance. Risk management policies are approved and reviewed by the Board on a regular basis. These include credit risk policies and future cash flow requirements.

Specific Financial Risk Exposures and Management

The main risks the Company is exposed to through its financial instruments are interest rate risk, liquidity risk, credit risk and equity price risk.

(a) Credit risk

Exposure to credit risk relating to financial assets arises from the potential non-performance by counter parties of contract obligations that could lead to a financial loss to the Company.

Credit risk is managed through the monitoring of payment histories of customers for aged receivables.

Risk is also minimised through investing surplus funds in financial institutions that the directors have assessed as being financially sound.

Credit risk exposures

The maximum exposure to credit risk by class of recognised financial assets at balance date is equivalent to the carrying value and classification of those financial assets (net of any provisions) as presented in the statement of financial position.

Trade and other receivables that are neither past due or impaired are considered to be of high credit quality.

The Company's credit risk is concentrated with the financial institution with which the Company deposits its surplus funds.

(b) Liquidity risk

Liquidity risk arises from the possibility that the Company might encounter difficulty in settling its debts or otherwise meeting its obligations related to financial liabilities. The Company manages this risk through the following mechanisms:

- Preparing forward looking cash flow analysis in relation to its operational and investing activities;
- Managing credit risk related to financial assets; and
- Investing significantly in surplus cash with major financial institutions.

The tables below reflect an undiscounted contractual maturity analysis for financial liabilities.

2 Financial risk management (continued)

Cash flows realised from financial assets reflect management's expectation as to the timing of realisation. Actual timing may therefore differ from that disclosed. The timing of cash flows presented in the table to settle financial liabilities reflects the earliest contractual settlement dates.

Financial liability and financial asset maturity analysis:

At 30 June 2011	**Within 1 Year $**	**1 to 5 Years $**	**Over 5 Years $**	**Total $**
Financial liabilities due for payment				
Trade creditors and accruals	102,894	-	-	102,894
Total expected outflows	102,894	-	-	102,894
Financial assets - cash flows realisable				
Cash and cash equivalents	1,306,277	-	-	1,306,277
Trade and other receivables	108,061	-	-	108,061
Other investments	798,886	-	-	798,886
Total anticipated inflows	2,213,224	-	-	2,213,224
Net inflow on financial instruments	2,110,330	-	-	2,110,330

At 30 June 2010	Within 1 Year $	1 to 5 Years $	Over 5 Years $	Total $
Financial liablities due for payment				
Trade creditors and accruals	75,907	-	-	75,907
Total expected outflows	75,907	-	-	75,907
Financial assets - cash flows realisable				
Cash and cash equivalents	1,191,326	-	-	1,191,326
Trade and other receivables	114,268	-	-	114,268
Other investments	750,647	-	-	750,647
Total anticipated inflows	2,056,241	-	-	2,056,241
Net inflow on financial instruments	1,980,334	-	-	1,980,334

(c) Price risk

Price risk relates to the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices largely due to demand and supply factors for commodities.

The Company is exposed to securities price risk on financial assets classified as at fair value through profit or loss. Such risk is managed through diversification of investments across industries.

(d) Fair value measurements

The fair values of all financial assets and financial liabilities approximate their carrying values as presented in the statement of financial position. Fair values are those amounts at which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arm's length transaction.

2 Financial risk management (continued)

Fair values derived may be based on information that is estimated or subject to judgement, where changes in assumptions may have a material impact on the amounts estimated. Areas of judgement and the assumptions have been detailed below. Where possible, valuation information used to calculate fair value is extracted from the market, with more reliable information available from markets that are actively traded. In this regard, fair values for listed securities are obtained from quoted market bid prices. Where securities are unlisted and no market quotes are available, fair value is obtained using discounted cash flow analysis and other valuation techniques commonly used by market participants.

Differences between fair values and carrying values of financial instruments with fixed interest rates are due to the change in discount rates being applied by the market since their initial recognition by the Company. Most of these instruments which are carried at amortised cost are to be held until maturity and therefore the net fair value figures calculated bear little relevance to the Company.

The fair values of financial instruments have been determined based on the following methodologies:

(i) Cash and cash equivalents, trade and other receivables and trade and other payables are short-term instruments in nature whose carrying value is equivalent to fair value. Trade and other payables exclude amounts provided for relating to annual leave and deferred income which is not considered a financial instrument.

(ii) For listed held-for-trading financial assets, closing quoted bid prices at reporting date are used.

(iii) Fair values of held to maturity investments are based on quoted market prices at reporting date.

(e) Interest Rate Risk

Exposure to interest rate risk arises on financial assets and financial liabilities recognised at reporting date whereby a future change in interest rates will affect future cash flows or the fair value of fixed rate financial instruments.

Interest rate risk on financial assets is managed by depositing some surplus funds with financial institutions on terms with fixed interest rates. Interest rate risk on financial liabilities is managed by ensuring that the Company does not have any material interest bearing debt.

Sensitivity analysis

The following table illustrates sensitivities to the Company's exposure to changes in interest rates and equity prices. The table indicates the impact on how profit and equity values reported at balance date would have been affected by changes in the relevant risk variable that management considers to be reasonable possible. Theses sensitivities assume that the movement in a particular variable is independent of other variables.

The below sensitivity analysis has been performed on the assumption that all other variables remain unchanged.

No sensitivity analysis has been performed on foreign exchange risk as the Company is not exposed to foreign currency fluctuations.

	Interest rate risk				**Other price risk**			
	-2%		**+2%**		**-10%**		**+10%**	
30 June 2011	**Profit $**	**Equity $**	**Profit $**	**Equity $**	**Profit $**	**Equity $**	**Profit $**	**Equity $**
Total increase / (decrease)	**(24,976)**	**-**	**24,976**	**-**	**(54,830)**	**-**	**54,830**	**-**

	Interest rate risk				Other price risk			
	-2%		+2%		-10%		+10%	
30 June 2010	Profit $	Equity $	Profit $	Equity $	Profit $	Equity $	Profit $	Equity $
Total increase / (decrease)	(23,813)	-	23,813	-	(52,508)	-	52,508	-

3 Critical accounting estimates and judgements

Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that may have a financial impact on the entity and that are believed to be reasonable under the circumstances.

(a) Critical accounting estimates and assumptions

(i) Estimated impairment

The Company assesses impairment at each reporting date by evaluation of conditions and events specific to the Company that may be indicative of impairment triggers. Recoverable amounts of relevant assets are assessed using value-in-use calculations which incorporate various key assumptions.

(b) Critical judgements in applying the entity's accounting policies

(i) Valuation of Aged Receivables

Included in trade and other receivables at 30 June 2011 are receivables over ninety days past due amounting to $24,411 (2010: $19,786). The Company considers that a portion of these are uncollectible and therefore a provision for impairment of $18,362 has been made at 30 June 2011.

4 Revenue

	2011 $	2010 $
From continuing operations		
Memberships	**340,018**	245,596
Credentialing	**54,713**	14,089
NDSS allocation	**662,283**	392,235
Interest and investment income	**106,910**	69,101
Conference ASM	**196,151**	197,685
Branch revenue	**163,366**	239,458
Awards, grants and sponsorships	**4,277**	71,979
Magazine, publications and advertising	**192,527**	110,922
Project income	**113,039**	115,022
Other revenue	**12,900**	6,923
	1,846,184	1,463,010

5 Expenses

	2011 $	2010 $
Profit before income tax includes the following specific expenses:		
Depreciation		
Plant and equipment	**13,896**	8,160
Total depreciation	**13,896**	8,160
Rental expense relating to operating leases		
Minimum lease payments	**-**	7,964
Total rental expense relating to operating leases	**-**	7,964
Total employee benefits expense	**680,766**	396,370

6 Current assets - Cash and cash equivalents

	2011 **$**	2010 $
Cash on hand	-	700
Cash at bank	**1,306,277**	1,190,626
	1,306,277	1,191,326

(a) Risk exposure

The Company's exposure to interest rate risk is discussed in note 2. The maximum exposure to credit risk at the end of the reporting period is the carrying amount of each class of cash and cash equivalents mentioned above.

7 Current assets - Trade and other receivables

	2011 **$**	2010 $
Net trade receivables		
Trade receivables	**108,061**	111,052
Provision for impairment of receivables ((a))	**(18,362)**	-
	89,699	111,052
Other receivables	-	3,216
	89,699	114,268

(a) Provision for impairment of receivables

Current trade receivables are generally due within 30 days after the end of the month. These receivables are assessed for recoverability and a provision for impairment is recognised when there is objective evidence that an individual trade receivable is impaired. These amounts have been included in financial and legal expenses.

Movements in the provision for impairment of receivables are as follows:

	2011 **$**	2010 $
At 1 July	-	-
Provision for impairment recognised during the year	**18,362**	150
Receivables written off during the year as uncollectible	-	(150)
Provision for impairment at the end of the year	**18,362**	-

The creation and release of the provision for impaired receivables has been included in 'financial and legal' in the statement of comprehensive income. Amounts charged to the allowance account are generally written off when there is no expectation of recovering additional cash.

7 Current assets - Trade and other receivables (continued)

(b) Past due but not impaired

The Company does not have any material credit risk exposure to any single receivable or group of receivables.

The following table details the Company's trade and other receivables exposed to credit risk with ageing analysis. Amounts are considered as 'past due' when the debt has not been settled within the terms and conditions agreed between the Company and the customer or counter party to the transaction. Receivables that are past due are assessed for impairment by considering the past payment history of the debtors and are provided for where there are specific circumstances indicating that the debt may not be fully repaid to the Company.

As at 30 June 2011, trade receivables of $26,006 (2010: $43,764) were past due but not impaired. These relate to number of independent customers for whom there is no recent history of default. The ageing analysis of these trade receivables is as follows:

	2011 **$**	2010 $
Up to 30 days (not past due)	**63,693**	70,504
31 - 60 days	**13,695**	15,336
61 - 90 days	**6,262**	8,642
Over 90 days	**6,049**	19,786
Total	**89,699**	114,268

The other classes within trade and other receivables do not contain impaired assets and are not past due. The balances of receivables that remain within initial trade terms (as detailed in the table) are considered to be of high credit quality. The Company does not hold any financial assets whose terms have been renegotiated, but which would otherwise be past due or impaired.

8 Current assets - Other current assets

	2011 **$**	2010 $
Prepayments	**6,559**	9,154
	6,559	9,154

9 Current assets - Other financial assets

	2011 **$**	2010 $
Held-to-maturity investments	**227,365**	225,564
Financial assets at fair value through profit or loss	**571,521**	525,083
	798,886	750,647

Held-to-maturity investments comprise bank term deposits.

Financial assets at fair value through profit or loss comprise managed investments.

10 Non-current assets - Property, plant and equipment

	Plant and equipment $	Total $
At 1 July 2009		
Cost or fair value	26,423	26,423
Accumulated depreciation	(11,805)	(11,805)
Net book amount	14,618	14,618
Year ended 30 June 2010		
Opening net book amount	14,618	14,618
Additions	32,258	32,258
Depreciation charge	(8,160)	(8,160)
Closing net book amount	38,716	38,716
At 30 June 2010		
Cost or fair value	58,681	58,681
Accumulated depreciation	(19,965)	(19,965)
Net book amount	38,716	38,716

	Plant and equipment $	Total $
Year ended 30 June 2011		
Opening net book amount	38,716	38,716
Additions	3,871	3,871
Depreciation charge	(13,896)	(13,896)
Closing net book amount	28,691	28,691
At 30 June 2011		
Cost or fair value	56,530	56,530
Accumulated depreciation	(27,839)	(27,839)
Net book amount	28,691	28,691

11 Current liabilities - Trade and other payables

	2011 $	2010 $
Trade creditors and accruals	102,894	75,907
Provision for annual leave	33,017	26,187
	135,911	102,094

12 Current liabilities - Other liabilities

	2011 $	2010 $
Membership fees received in advanced	198,626	129,147
Unexpended grants	129,310	238,605
	327,936	367,752

13 Non-current liabilities - Provisions

	2011 $	2010 $
Employee benefits - long service leave	6,512	1,125
	6,512	1,125

(a) Movements in provisions

Movements in each class of provision during the financial year, other than employee benefits, are set out below:

	Employee benefits - long service leave $	Total $
At 30 June 2011		
Non-current		
Carrying amount at start of year	1,125	1,125
- additional provisions recognised	5,387	5,387
Amounts used during the period	-	-
Carrying amount at end of year	6,512	6,512

Provision for Long-term Employee Benefits

A provision has been recognised for employee entitlements relating to long service leave. In calculating the present value of future cash flows in respect of long service leave, the probability of long service leave being taken is based on historical data. The measurement and recognition criteria relating to employee benefits have been included in Note 1(j) to these financial statements.

14 Key management personnel compensation

(a) Key management personnel compensation

	2011 **$**	2010 $
Short-term employee benefits	**117,447**	106,528
Post-employment benefits	**10,570**	9,921
	128,017	116,449

Any person having authority and responsibility for planning, directing and controlling the activities of the Company, directly or indirectly, is considerd key management personnel.

15 Remuneration of auditors

During the year the following fees were paid or payable for services provided by the auditor, its related practices and non-related audit firms:

	2011 **$**	2010 $
(a) WalterTurnbull		
Audit and other assurance services		
Audit and review of financial statements	**8,400**	8,000
Other audit services	**-**	1,500
Total remuneration for audit and other assurance services	**8,400**	9,500
Other services	**8,000**	1,000
Total remuneration of WalterTurnbull	**16,400**	10,500

16 Contingencies

As at balance date there were no known contingent liabilities or contingent assets.

17 Commitments

As at balance date there were no known commitments

(i) Operating lease commitments

	2011 **$**	2010 $
Commitments for minimum lease payments in relation to non-cancellable operating leases are payable as follows:		
- not later than 12 months	**-**	8,760
- later than 12 months but not later than 5 years	**-**	17,553
	-	26,313

The property lease commitments are non-cancellable operating leases contracted for but not capitalised in the financial statements with a five-year term. Increase in lease commitments occur at a rate of 3% per annum. The above amounts are reported inclusive of GST.

During the year ended 30 June 2010, the Company reached an agreement with the lessor to surrender the property lease.

18 Related party transactions

The Company transacts with the National Association of Diabetes Centres (NADC), a related entity of the Company.

NADC reimburses the Company for costs incurred in the ordinary course of business. As at 30 June 2011, the balance receivable from NADC was $4,238 (2010: $20,473).

Transactions with related parties are on normal commerical terms and conditions no more favourable than those available to other persons unless otherwise stated.

19 Events occurring after the reporting period

There were no events subsequent to the balance sheet date that require disclosure.

20 Reconciliation of profit after income tax to net cash inflow from operating activities

	2011	2010
	$	$
Profit for the year	**126,613**	318,214
Non-Cash Flows		
Depreciation and amortisation	**13,896**	8,160
Bad debts expense	**27,852**	-
Change in operating assets and liabilities:		
Decrease / (Increase) in financial assets	**-**	(40,014)
Decrease / (Increase) in trade receivables	**6,207**	8,993
Decrease / (Increase) decrease in other current assets	**2,595**	(4,944)
(Decrease) / Increase in trade and other payables	**24,327**	(30,726)
(Decrease) / Increase in other current liabilities	**(34,429)**	(92,792)
Net cash inflow (outflow) from operating activities	**167,061**	166,891

In the directors' opinion:

(a) the financial statements and notes set out on pages 1 to 20 are in accordance with the *Corporations Act 2001*, including:

  (i) complying with Accounting Standards, the *Corporations Regulations 2001* and other mandatory professional reporting requirements, and

  (ii) giving a true and fair view of the company's financial position as at 30 June 2011 and of its performance for the financial year ended on that date, and

(b) there are reasonable grounds to believe that the Company will be able to pay its debts as and when they become due and payable.

This declaration is made in accordance with a resolution of the directors.

Tracy Aylen, Director

Dated: 15 August 2011

WALTER TURNBULL
your extra asset

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BUSINESS ADVISORY SERVICES
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FINANCIAL PLANNING
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ACCOUNTING SOLUTIONS

Auditor's independence declaration under section 307C of the Corporations Act 2001 to the directors of Australian Diabetes Educators' Association Limited

As lead auditor for the audit of Australian Diabetes Educators' Association Limited for the year ended 30 June 2011, I declare that, to the best of my knowledge and belief, there have been:

a. no contraventions of the auditor independence requirements of the *Corporations Act 2001* in relation to the audit; and
b. no contraventions of any applicable code of professional conduct in relation to the audit.

This declaration is in respect of Australian Diabetes Educators' Association Limited during the period.

Shane Bellchambers
Partner
WalterTurnbull

Canberra
15 August 2011

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Independent auditor's report to the members of Australian Diabetes Educators Association Limited

Report on the financial report

We have audited the accompanying financial report of Australian Diabetes Educators Association Limited (the company), which comprises the statement of financial position as at 30 June 2011, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and the directors' declaration.

Directors' responsibility for the financial report

The directors of the company are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the *Corporations Act 2001* and for such internal control as the directors determine is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. Those standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation of the financial report that gives a true and fair view in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Independence

In conducting our audit, we have complied with the independence requirements of the *Corporations Act 2001*.

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ACCOUNTING SOLUTIONS

Independent auditor's report to the members of Australian Diabetes Educators Association Limited (continued)

Auditor's opinion

In our opinion the financial report of Australian Diabetes Educators Association Limited is in accordance with the *Corporations Act 2001*, including:

(a) giving a true and fair view of the company's financial position as at 30 June 2011 and of its performance for the year ended on that date; and

(b) complying with Australian Accounting Standards and the *Corporations Regulations 2001.*

Matters relating to the electronic presentation of the audited financial report

This auditor's report relates to the financial report of Australian Diabetes Educators Association Limited (the company) for the year ended 30 June 2011 included on the Australian Diabetes Educators Association Limited web site. The company's directors are responsible for the integrity of the Australian Diabetes Educators Association Limited web site. We have not been engaged to report on the integrity of this web site. The auditor's report refers only to the financial report named above. It does not provide an opinion on any other information which may have been hyperlinked to/from the financial report. If users of this report are concerned with the inherent risks arising from electronic data communications they are advised to refer to the hard copy of the audited financial report to confirm the information included in the audited financial report presented on this web site.

Shane Bellchambers, CA
Partner
PricewaterhouseCoopers

Canberra
August 2011

Liability limited by a scheme approved under Professional Standards Legislation.

Australian Diabetes Educators Association

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Australian Diabetes Educators Association

ADEA

What is diabetes self management education?

Diabetes self management education (DSME) is a specialty area of practice requiring advanced knowledge of diabetes management, counselling and teaching skills. DSME is a therapeutic, as well as an educational intervention, integrating clinical care and comprehensive self management education and support.

What is diabetes education?

All members of the multidisciplinary diabetes team provide discipline-specific diabetes education to support their clinical intervention. Diabetes education is provided by a wide range of health care providers including general practitioners, psychologists, practice and other generalist nurse, dietitians, podiatrists, aboriginal health workers and other allied health professionals.

ADEA welcomes all of these health profssionals as members.

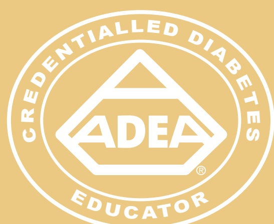
Who is a Credentialled Diabetes Educator?

Credentialled Diabetes Educators (CDEs) are authorised to practice in an eligible health discipline and have:

- completed an ADEA Accredited Graduate Certificate course in diabetes education and care
- completed 1800 hours clinical practice
- been mentored and peer reviewed
- maintained continuing professional development; and
- abide by the ADEA Code of Conduct for Diabetes Educators.

A CDE must be a Registered Nurse (in Victoria, a Division One Registered Nurse), Accredited Practicing Dietitian, Registered Podiatrist, Registered Pharmacist accredited to conduct medication management reviews, or a Medical Practitioner.

CDEs are the recognised providers of DSME by Medicare, the Department of Veterans Affairs and private health funds.



Choose a Credentialled Diabetes Educator for the delivery of expert diabetes self management education services. Look for the CDE symbol.