Interview

Neel Basudev

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Q1

With over 10 years of experience, what initially sparked your interest to pursue a career in the field of diabetes?

To be honest, my initial foray into the field of diabetes was by chance, as I took on the management of diabetes at the practice when I joined as a salaried general practitioner. I quickly grew to like diabetes as a specialty and found the clinical management fascinating. There was so much to learn and so many gaps in my knowledge that I started to read a bit more and do more specialist clinics to upskill myself. Things just snowballed from there and I started to enjoy healthcare provision and service transformation just as much as the clinical side of things; hence, the other diabetes-related roles that I now do.

Q2

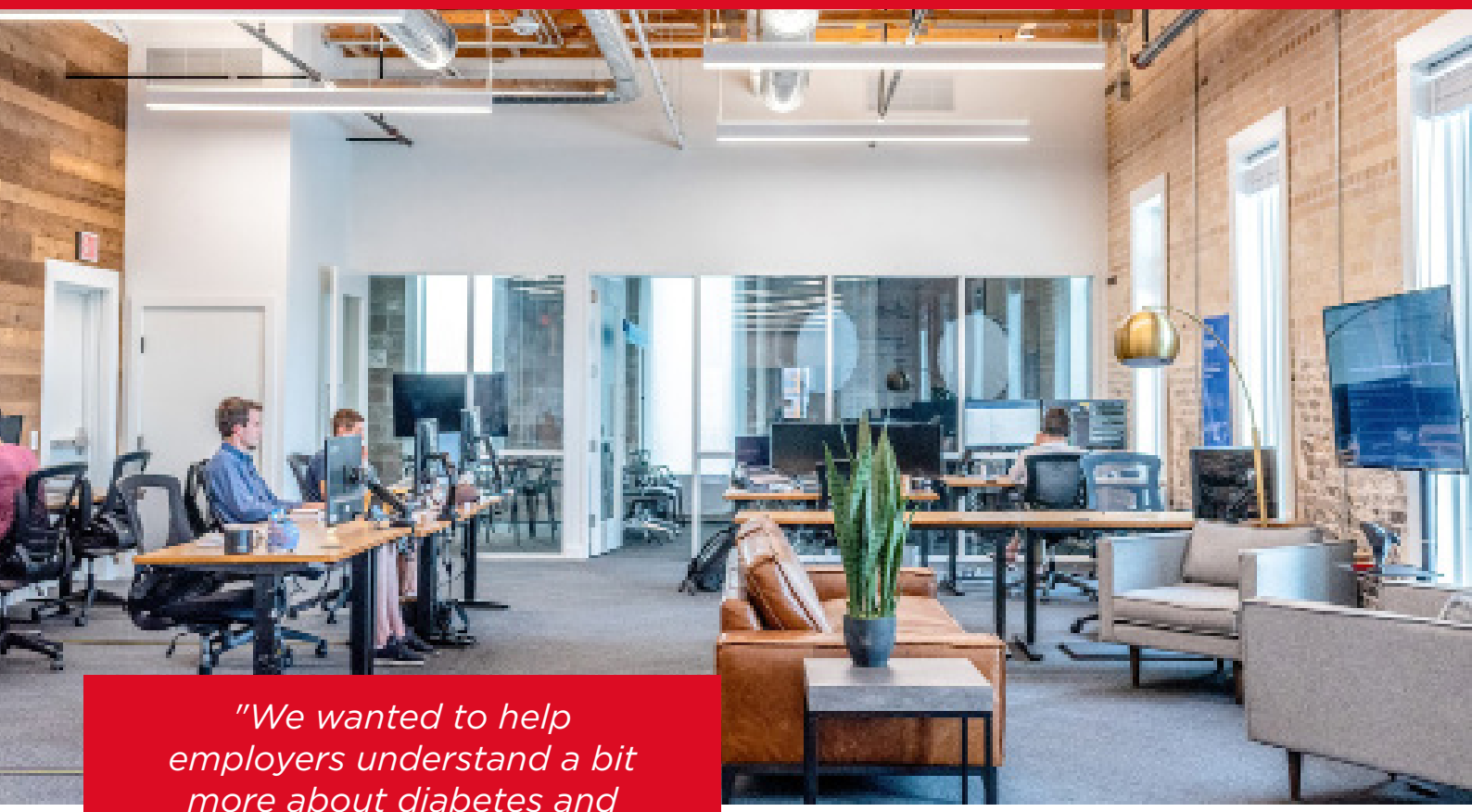
Earlier this year you contributed to a project on the topic of diabetes in the workplace. How important do you believe it is to educate employers on the disease and how would this impact patients in the workplace?

This project was part of an overarching aim to improve structured education provision and uptake for people with diabetes in South London, UK. We know that structured education uptake is generally low, and this is a particular problem for younger people of working age. Given their cumulative lifetime risk of complications, it is particularly important to support young adults with diabetes. Unfortunately, taking time off work to attend structured education is a very real barrier. We wanted to help employers understand a bit more about diabetes and the fact that keeping their workers healthy, ultimately, is better for their business. A small provision of time to access structured education can be a good thing in the long run.

Q3

With diabetes becoming an increasingly prevalent disease, have you seen much improvement in its treatment over the last few years?

That is a really difficult question to answer as it depends on how you define the words ‘improvement’ and ‘treatment’. If by ‘improvement’ you mean that there are more services available, more innovation, and more work happening on prevention as examples, then the answer is yes. There is certainly better recognition around diabetes, including the different types, early interventions, prevention, and weight management. I see all of these as improvements. Seeing a difference in numbers and metrics takes a bit more time, although



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recent reports suggest that we are much better at managing cardiovascular complications and that has led to a reduction in mortality. Similarly, the word 'treatment' is open to interpretation. To me, treatment does not just mean a medication. It means a whole system and way of working. A medication is only as good as someone taking it, consistently, day in and day out. I think we are on the right road in terms of better treatment in that context and reducing variation in care.

Q4

You have been involved in studying diabetes virtual clinics. Could you explain how these clinics work and the impact that they have on patients' quality of life?

A virtual clinic can mean a few different things. The definition here is one in which the person with diabetes is virtual. The clinic is actually more of a multidisciplinary meeting and case-based discussion bringing together diabetes specialists with the primary care team to discuss patient management in more detail. Each person brings their own expertise and perspective to help come up with workable therapeutic objectives for the patient. That then allows the primary care team to have a robust plan in place for onward discussion with the patient. These types of clinics have done very well locally and not only do they help with clinical management, but they also forge better relationships between primary, community, and secondary care colleagues, which also is an important driver of care quality.

Q5

One of your interests is in diabetes prevention and you currently Co-chair the South London Diabetes Prevention Programme, UK. Could you tell us a bit about the programme and the importance of focusing on the prevention of Type 2 diabetes mellitus (T2DM)?

It has taken a long time to make prevention of T2DM more prominent. It is inherently complex to do something like that at a local level as paying for such a programme and measuring outcomes would not match usual commissioning time frames. It required national set-up and input. The South London Diabetes Prevention Programme builds on a wealth of evidence that diet and lifestyle changes can greatly reduce the chance of someone developing T2DM. The programme is intentionally long, set at 9 months to try to maximise its potential effect. Given the increasing prevalence of T2DM, as well as the morbidity, mortality, and associated costs, it makes sense whatever way you look at it that any reduction in numbers of people with T2DM is vital.

Q6 What changes have you brought into effect since being appointed as Clinical Director for Diabetes at the Health Innovation Network (HIN), London, UK?

I work as part of a brilliant team and that makes things so much easier for me. The main thing that has changed since I started is perhaps that there is a greater focus on diabetes care, locally and nationally. Diabetes is, quite rightly, seen as a priority. This has meant more money in the system, so to speak. Our previous way of working was trying to bring innovation and best practice to people, which did not work so well in terms of traction and spread. Nowadays, we focus more on networking and building strong partnerships with our members and supporting and refining their offerings for diabetes care provision. By working together, projects are much more likely to move along at a steady pace and be sustainable.

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Q7 How have you seen the advancement of new technologies impact the field of diabetes?

Technology and diabetes go very well together. There are several reasons for that. The most obvious technology advancements involve the plethora of medications, medical devices, and disease monitoring tools now available to people and healthcare professionals. There have been huge strides, particularly for people with Type 1 diabetes mellitus, to make insulin administration and blood glucose checking safer, easier, and better. More recently, we have seen technology deployed and fast-tracked during the COVID-19 pandemic to support remote disease monitoring and management. Technology and innovation also support care delivery in the community, and so we are starting to see better ways to facilitate care and support planning using technology as an example of this.

Q8 You currently run a weekly diabetes community clinic at Springfield Medical Centre, London, UK. What was the mission you set out to achieve when you began these sessions?

This stemmed from my initial learning and trying to upskill myself in terms of diabetes management. I was very fortunate to have peers and mentors who supported me and taught me. The weekly community clinic remains a very active part of my job description as it not only allows me to keep on top of ever-changing diabetes clinical management, but it gives me a window into how general practice colleagues are managing people with diabetes and what issues they tend to get stuck with. This is helpful and informs some of my other work in terms of care delivery and variation in care. I feel that my clinical work in diabetes, but more so as a general practitioner, is what helps to keep me grounded and give me a sense of pragmatism when it comes to service delivery and design. ■