Salisbury Paediatric Diabetes Service Poverty Proofing® Case Study with Victoria Young

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Children North East Poverty Proofing©

Introduction

"It's changed the way we have our discussions. It's as essential as mandatory training."

Victoria Young (Advanced Dietetic Practitioner)

Children North East began the Poverty Proofing® audit with Salisbury Paediatric Service in April 2024, led by Victoria Young, Advanced Dietetic Practitioner and Laura Horne, PDSN. The Salisbury Paediatric Diabetes service covers a wide geographical area, including Salisbury, Devizes, Tidworth, Mere, parts of Dorset and Hampshire, and some patients from Warminster. At the time of the Poverty Proofing audit, the service comprised 11 staff - 2 consultants, 4 nurses, 1 dietitian, 1 psychologist, and 2 administrative staff - and was seeing 170 patients. Government data from 2020/21 to 2022/23 indicates that 19% of people in the South West were living in relative low income after housing costs, equating to over one million people. Action for Children (2024) reported 284,000 children living in poverty in the South West, including 40,000 children whose parents were working full-time. The Poverty Proofing work at Salisbury built on successful initiatives by Children North East in Grimsby, Hull, and Gateshead, which were positively evaluated and shared through Diabetes networks.

Children North East were commissioned by NHS England to deliver both universal and diabetes-focused Poverty Proofing training in the South West, as well as to complete two Poverty Proofing deep dives. Paediatric Diabetes services submitted expressions of interest to participate, and the Gloucestershire and Salisbury services were selected. The aim of the project was to support equitable access to technology and clinical outcomes for all patients across IMD quintiles and ethnicities.

The Salisbury Paediatric Diabetes team's engagement in Poverty Proofing was driven by a strong commitment to inclusivity and growing concern about inequalities affecting families. Early challenges emerged when families struggled to access diabetes technology following a shift from company-provided devices to phone-dependent systems, highlighting broader digital and financial exclusion. The team also observed increasing hardship among families attending clinic, particularly at key pressure points such as seasonal costs.

"It opened our eyes to the fact that this was more than just an issue around technology - it highlighted broader inequalities. We saw families struggling when coming to clinic and wanted to standardise our approach and address these challenges."

Links between Paediatric Diabetes and Poverty

In Salisbury and the wider Wiltshire area, overall child poverty rates are lower than the national average; however, significant pockets of deprivation persist, particularly in areas such as Bemerton, where more than 40% of children live in poverty after housing costs. Local public-health data highlight high levels of childhood overweight and obesity, with nearly one-third of 10–11-year-olds in the Salisbury community area classified as overweight or obese. National Paediatric Diabetes Audit data show a clear social gradient in paediatric diabetes, with children from more deprived backgrounds experiencing higher rates of Type 2 diabetes and poorer glycaemic outcomes. In this context, Salisbury reflects a broader national pattern in which socioeconomic deprivation, food insecurity, and limited access to health-promoting environments increase the risk of obesity-related Type 2 diabetes in children, reinforcing the link between poverty and paediatric diabetes vulnerability locally. In addition, poverty has a significant impact on the management of type 1 diabetes in children, affecting diet, education, and access to diabetes technology. Families experiencing financial hardship may struggle to provide consistent, healthy meals, which complicates insulin dosing and blood glucose control. Limited access to structured diabetes education and health literacy resources can reduce understanding of insulin management, carbohydrate counting, and lifestyle adjustments. Additionally, inequities in access to technologies such as insulin pumps and continuous glucose monitors can further hinder optimal diabetes management. Together, these factors increase the risk of poor glycaemic control and long-term complications, including heart, kidney, eye, and foot disease. Addressing these socioeconomic barriers is essential to improve outcomes and reduce health inequalities.

The Salisbury Paediatric Diabetes team has observed increasing financial hardship among families, evidenced by growing requests for food bank vouchers and challenges in attending clinic. Poverty Proofing helped shift staff perceptions away from assumptions about disengagement, prompting recognition of the practical barriers families face, including transport costs, childcare, digital access, and missed meals due to clinic timing. Appointment scheduling emerged as a significant barrier, particularly for working families and those managing multiple children.

Through the audit, the team began to see how poverty directly affected families' ability to manage diabetes. What might previously have been interpreted as a lack of engagement was often a consequence of practical challenges. For instance, children with mid-morning appointments could miss their free school meals, and many families were juggling multiple children, school runs, and other responsibilities, making clinic attendance and diabetes management more difficult. Victoria reflected, "**It would have been an automatic assumption that they didn't want to come - rather than actually recognising there's a barrier there."** She added, **"If a child had an 11:30 appointment, they might miss their free school meal, and for most families, it's not just one school pick-up to consider - many are managing multiple children and competing schedules."** These insights encouraged the team to adapt their approach, addressing practical barriers to better support families in managing paediatric diabetes.

Poverty Proofing® Process

"The training was very accessible… there was plenty of opportunity to do it."

Staff found the Poverty Proofing training accessible and flexible, with multiple face-to-face and online sessions offered over several months. While the process was detailed and time-intensive, it supported deeper understanding of poverty beyond assumptions about benefit entitlement. For staff who were already beginning this journey, the training broadened thinking and strengthened team-wide awareness.

A key challenge identified was staff confidence in initiating poverty-related conversations. While some roles (e.g. dietetics), naturally incorporate cost discussions, others required new skills and reassurance. Stigma, parental discomfort discussing finances in front of children, and how best to capture this information within clinical workflows were significant learning points. The introduction of discreet paper-based screening has helped to overcome these barriers.

"Having the confidence and skill set to open up the poverty conversation was one of our biggest team challenges."

Feedback from training:

> **"I think I had stereotyped people who are living with poverty and this has opened my eye about who might be living in poverty. This is something that is really going to help me to consider what more we could do to support people".**
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> **"Really good to have discussion around how this links to our practice. Learnt lots about poverty. Will be more conscious about patients in poverty and how it might impact care".**
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> **"I felt I had a good understanding of poverty pre session but was genuinely surprised how little I know". "Thank you – I genuinely feel you have impacted the teams thought and hopefully practices".**

Addressing Barriers

The advanced booking scheme was one of the real big positives. **"People were really pleased they could pick a time that suited them best."**

The audit highlighted several areas of strong existing practice, including the advanced booking system, which supports families to plan around work and school, and the approachable nature of the multidisciplinary team. Informal provision of mobile phones for families in acute need was also recognised, though the audit revealed this was often reactive rather than universal.

Following poverty proofing, the Paediatric Diabetes Service introduced a range of targeted changes to reduce financial, digital and access barriers for families. The team now routinely promotes the NHS Healthcare Travel Costs Scheme and provides claim forms to help offset transport costs. Appointment access has improved through the addition of an after-school clinic, reducing missed education and time off work. Financial screening questions are now embedded into annual reviews, enabling earlier identification of hardship and timely signposting to support, including food aid and benefits advice. Youth workers now provide wellbeing support and assist families with Disability Living Allowance (DLA) and Personal Independence Payment (PIP) applications. The service proactively contacts GPs to secure adequate hypo treatments, easing out-of-pocket costs. Patient voice is being strengthened through the planned introduction of structured feedback with psychology support. Work is also ongoing with local digital inclusion partners to address digital exclusion, despite challenges in sourcing suitable devices.

Significant practical changes have followed Poverty Proofing. These include a fully funded pilot to cover travel and parking costs for all diabetes patients, and partnerships with charities to provide mobile phones to families experiencing digital exclusion. While some delays have occurred due to wider trust pressures, funding has been secured and implementation is underway.

"We've reached out to several charities now that are able to provide us with phones."

Wider Reach

The most significant impact has been a cultural shift in how non-attendance and engagement are understood. Poverty is now considered as a first, rather than last, explanation for barriers to care. Improved recording systems help capture social reasons for missed appointments, including affordability and childcare responsibilities, enabling more responsive support.

Victoria strongly views equitable healthcare access as a core responsibility of the NHS, particularly in long-term conditions such as diabetes where outcomes are closely linked to consistent engagement and early intervention.

"Having equitable access to healthcare is going to change diabetes patient's long-term outcomes… it is basically the role of the healthcare system."

Victoria emphasised the importance of confidence, teamwork, and embedding Poverty Proofing into standard practice and professional training. She described it as transformative for both clinical discussions and service delivery.

"It completely changes the way that you run your practice."

Conclusion

Poverty Proofing has been a turning point for the Salisbury Paediatric Diabetes team. What started as concern about access to technology quickly became a much deeper understanding of the everyday financial, digital and practical barriers many families face. It has challenged assumptions about non-attendance and shifted conversations from "why didn't they come?" to "what got in the way?"

Most importantly, it has led to real, practical change. From travel and parking support, after-school clinics and routine financial screening, to stronger signposting, digital inclusion work and benefits support, the team has built equity into everyday practice. These changes are already making it easier for families to attend appointments, stay engaged and feel supported.

There has also been a powerful cultural shift. Poverty is now seen as everyone's business, not an uncomfortable side issue. Staff feel more confident having sensitive conversations and more connected as a team around a shared purpose.

The Salisbury experience shows how Poverty Proofing can reshape both thinking and practice. It demonstrates what's possible when a service truly commits to understanding families' realities and removing barriers, one practical change at a time.

References:

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