NRO Poverty Proofing® Case Study with Simon Fountain-Polley

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Children North East
Poverty Proofing®

Introduction

Simon Fountain-Polley is a Consultant Paediatrician working within Hywel Dda University Health Board, which covers the bottom quarter of Wales. The area includes Ceredigion, Pembrokeshire and Carmarthenshire, and presents a complex mix of rural geography, coastal communities, and pockets of urban deprivation. Simon is based in Carmarthen but travels extensively across West Wales to deliver clinics. Alongside acute paediatrics, he works in diabetes and rheumatology and now chairs the Wales Paediatric Diabetes Network.

The multidisciplinary diabetes team includes:

- Two paediatricians
- Five specialist nurses
- A dietitian
- Psychology input
- Administrative support

The service supports just over 200 children and young people with diabetes, spread across a large geographical area:

Aberystwyth (north): ~25–30 children

Pembrokeshire: ~60 children

Carmarthenshire / Carmarthen: ~110 children

While Aberystwyth is a university town, it serves a very rural surrounding population. Pembrokeshire includes both tourist areas and more deprived port communities, while Carmarthenshire includes former industrial towns and market towns.

"Our population is very spread out… there are these little pockets of towns where our kids with diabetes live."

The size and diversity of the region mean that families' ability to attend clinics, access technology, and engage consistently with care varies widely. Diabetes care requires frequent contact, digital monitoring, and sustained family involvement, making it particularly sensitive to barriers linked to poverty, geography, and digital exclusion. This case study explores how the paediatric diabetes service used Poverty Proofing to identify hidden barriers and implement practical changes to improve access and equity for children and young people across West Wales.

The Poverty Proofing Paediatric Diabetes Network Roll-out is a project developed at Children North East to equip diabetes healthcare professionals with a deeper understanding of how poverty affects children and families. Through a structured workshop model, it supported teams to become more poverty aware and to adapt their services so that paediatric diabetes care is genuinely accessible to all.

To date, the programme has delivered 20 workshops across the 11 CYP regional diabetes networks, reaching 736 diabetes professionals.

Awareness of Poverty

Before attending the Poverty Proofing workshops, the team already recognised that families faced different challenges, particularly around education, literacy, numeracy, and technology use — all of which are relevant in diabetes care.

However, the workshop helped surface how easily assumptions can be made.

"Most of the time in clinic, people put on their best faces… unless you ask, you don't necessarily pick up what's really going on."

One of the most impactful elements of the workshop was the monopoly exercise, which challenged assumptions and prompted reflection. Our Poverty Proofing Paediatric Diabetes game introduces how poverty can shape a family's budgeting and decision-making. It focuses on essential living costs and highlights the extra expenses faced by families of children with Type 1 diabetes, such as technology needs, additional hypo treatments, and the cost of attending appointments.

"Trying to live off benefits was one of the most useful things I did that day."
"We generally earn sufficient or more than sufficient and sometimes its easy to forget that."

The training helped the team reflect on unconscious bias, particularly around assumptions that benefits are "enough to get by".

"It's easy to fall into the trap of thinking 'surely you've got enough', but when you actually think about it, maybe that's not the case."

The training did not introduce new information so much as recalibrate existing knowledge, making clinicians more attentive to what is not immediately visible in clinic interactions.

Actions Identified

The workshops aim to give a broad understanding of diabetes within the context of childhood poverty, the ethos and principles behind Poverty Proofing and outlining the most common themes and barriers to accessing diabetes care through a poverty lens. The second half of the workshop focuses on practical steps services can take to ensure their service is accessible for all, by creating achievable actions and sharing promising practice amongst multi-disciplinary teams.

Following the workshop, the team focused on actions at service level, particularly around access and consistency.

Key actions identified included:

- Reducing travel burden for families
- Taking clinics closer to communities
- Embedding poverty awareness into service planning
- Asking consistent questions about resources and access

Actions Implemented

Expanding and Relocating Clinics

Recognising that it was easier for staff to be mobile than for families, the team have expanded the number of community-based clinics.

"It's easier for us to be mobile… bus services aren't great, so we decided to create more clinics."

New clinics were established in:

- Milford Haven (GP practice)
- Tenby (serving Pembroke and south-east Pembrokeshire)

Plans are underway for additional clinics in Ammanford / Cross Hands, targeting areas with higher need.

"We solidified the plan and started our peripheral clinics."

While the expansion of community-based clinics is intended to reduce travel distance, time, and associated transport costs for families, early implementation highlighted that access barriers are not uniform and that solutions need to remain flexible. Some families preferred to continue attending central clinics because appointments were combined with school attendance, shopping, or other essential activities, particularly where specialist schools or services were centrally located.

This learning reinforces that Poverty Proofing is not about a single solution fitting all families, but about offering choice and designing services that align with how families actually live their lives. It also emphasises that Poverty Proofing is an iterative process: anticipated benefits, such as reduced travel burden, need to be evaluated over time and services refined in response to family feedback and emerging patterns of need, rather than treated as a one-off fix.

Developing a Diagnosis Care Bundle

The team is developing a care bundle for children newly diagnosed with type 1 diabetes, building on existing education packages.

This includes:

- Consistent questions for all families
- Focus on access to digital technology
- Support for families who cannot afford a smartphone

"We try to get continuous glucose monitoring on at diagnosis — but that requires a phone."

The team sourced a charity that can provide reconditioned smartphones within 24 hours for families on Universal Credit, helping to reduce digital exclusion from the outset.

The development of a diagnosis care bundle highlighted how quickly digital exclusion can translate into clinical exclusion in modern diabetes care. Continuous glucose monitoring is now standard practice at diagnosis, offering significant clinical and educational benefits, but its use is dependent on access to a compatible smartphone. Without early intervention, families without access to suitable digital technology risk being disadvantaged from the outset of their diabetes journey. The transcript discussions reinforced the importance of speed at diagnosis: the first 24–48 hours are critical for education, engagement, and establishing effective glucose monitoring before discharge. By embedding consistent questions about digital access into the diagnosis pathway and

establishing rapid routes to source devices where needed, the service aimed to prevent inequity from becoming embedded at the point of diagnosis and to ensure that all families can access the same standard of care from the earliest stage.

Asking the questions

The workshop reinforced the importance of asking explicit, routine questions about families' circumstances, rather than relying on assumptions or outward presentation. Clinicians recognised that financial pressures, digital access, transport difficulties and competing priorities are often hidden unless deliberately explored. Embedding consistent questions into clinical pathways, particularly at diagnosis, created a more structured and equitable way to identify barriers early and offer timely support. As Simon reflected, **"unless you specifically dig a little, you don't pick up on certain things"**, and making this enquiry part of standard practice helped shift poverty awareness from an individual skill to a service-level approach.

Longer Term Plans

While it is still early to measure long-term outcomes, early feedback has been positive.

The team plans to:

- Review DNA and 'could not attend' rates
- Gather patient feedback at annual reviews

Learning from COVID also informed their approach:

"During COVID, our 'could not attend' rates improved when people could access clinics via Teams."

However, data showed that technology alone does not solve non-attendance, reinforcing the need to address wider barriers.

Experience from both the COVID period and early implementation of service changes reinforce that digital solutions alone do not address the underlying drivers of poverty-related non-attendance. While remote consultations and digital platforms improved access for some families, data and lived experience suggested

that the same families continued to disengage regardless of the modality offered, indicating that barriers such as financial insecurity, transport, competing priorities, and wider social pressures remain significant. In this context, community-based clinics are positioned not as a replacement for digital access, but as part of a broader, layered access strategy. By offering a combination of local face-to-face clinics, central hubs, and digital options, the service aims to provide flexible routes into care that reflect the diverse and complex circumstances of families, rather than relying on technology as a universal solution.

In addition, to support sustainability and ensure that learning translated into ongoing practice, a designated Poverty Proofing champion has been established within the diabetes nursing team. This role included summarising key learning from the Poverty Proofing workshop and sharing it with the wider multidisciplinary team, helping to maintain collective awareness and understanding. Acting as a deliberate "memory" mechanism, the lead ensures that considerations around poverty, access, and inequality are routinely revisited as services evolve, rather than being overlooked as pressures change. By embedding poverty considerations into the planning of new initiatives and service developments, this role helps prevent equity from becoming person-dependent and instead integrates Poverty Proofing into routine service design, supporting a more consistent and sustainable approach to equitable care.

Conclusion

This case study demonstrates how Poverty Proofing can move from awareness to action, even in complex, rural services - and how small, practical changes can make care more equitable. By bringing clinics closer to communities and addressing digital barriers at diagnosis, the service is taking tangible steps to reduce travel, improve access, and make care more equitable for children with diabetes in West Wales. Poverty Proofing has moved from awareness to action, with changes designed to fit the realities of families' lives. While longer-term outcomes will take time to measure, these community clinics represent a big step toward reducing inequality and ensuring that all families can access high-quality care, no matter where they live.