Gloucestershire Paediatric Diabetes service - Poverty Proofing® Case Study with Natalie White and Samantha Adams

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Children North East

Because growing up can be hard

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Introduction

"I think every team in the country should do Poverty Proofing. It has had a really positive impact on our team."

The Gloucestershire Paediatric Diabetes Service provides care for children and young people across a large geographic area, operating from Gloucester Royal Hospital and Cheltenham General Hospital. While both sites offer outpatient clinics, inpatient care is only available at Gloucester Royal Hospital. Serving a catchment area that includes Cirencester, Stroud, the Forest of Dean, the Cotswolds, Bourton-on-the-Water, and Tewkesbury, the service manages approximately 290 patients under a single acute trust and one Integrated Care Board (ICB). Its multidisciplinary team of 19 staff—including consultants, nurses, dieticians, family support workers, administrators, and a psychologist—works collaboratively to deliver comprehensive diabetes care.

Recognising that socioeconomic factors can create barriers to healthcare access and outcomes, the service engaged with Children North East's Poverty Proofing initiative. This programme, building on work in Grimsby, Hull, and Gateshead, provides training, audits, and actionable recommendations to reduce inequities in healthcare. Participation enabled the team to critically examine its own practices, focusing on supporting equitable access to technology and improving clinical outcomes for all patients, regardless of socioeconomic status or ethnicity.

Gloucestershire Paediatric Diabetes Team

Between March and May 2024, Children North East trained 185 staff across the South West, both in person and virtually via Teams. In-person sessions were held in Exeter, Frome, Bristol, Gloucester, and Taunton, with multi-disciplinary teams encouraged to attend both general and diabetes-specific sessions. Virtual sessions focused solely on diabetes care.

This case study highlights the actions the Gloucestershire Paediatric Diabetes Service has taken in response to the Poverty Proofing audit, demonstrating how targeted interventions can improve equity in paediatric diabetes care. As health services increasingly focus on addressing health inequalities, this case study offers practical insight into how poverty-aware service design can be embedded within routine paediatric care.

Links between Diabetic Health and Poverty

Although Gloucestershire is often perceived as an affluent county, the service's data revealed a clear socioeconomic gradient in access to diabetes technologies such as insulin pumps and continuous glucose monitoring (CGM). Families from lower-income areas were less likely to use these devices, raising concerns that poverty-related barriers were influencing clinical outcomes.

> **"We recognised there was definitely a discrepancy in uptake of technology. Even though our area looks affluent on paper, the skew was still there – and quite significant."**

The team also became increasingly aware of the cumulative and often hidden costs associated with managing a child's diabetes. These included travel and parking expenses, electricity costs for charging devices, purchasing hypo treatments when prescriptions ran out, and missed free school meals due to clinic appointments.

> **"One of the biggest shocks for me was realising that children on free school meals were missing lunch because their appointments were over lunchtime – and that became another financial burden for families."**

Inequities in access to diabetes technologies and the hidden costs of care can have wide-ranging effects on health outcomes. Children who lack access to insulin pumps or continuous glucose monitoring may experience less stable blood glucose levels, increasing the risk of complications. Financial or logistical barriers can lead to missed appointments, gaps in care, or delayed treatment, which in turn can contribute to preventable hospital admissions. Beyond physical health, these inequities can affect psychosocial well-being, causing stress and anxiety for both children and their families, and potentially limiting children's participation in school and social activities. Overall, disparities in resources and support can significantly influence both the clinical and quality-of-life outcomes for young people with diabetes.

Poverty Proofing® Process

The service became involved after a regional call for paediatric diabetes teams to participate in Poverty Proofing, led by NHS England's South West Paediatric Diabetes Network.

"We applied as a team because we wanted to dig deeper into what was behind the inequalities we were seeing, and whether we were unintentionally perpetuating them."

Children North East facilitated a combination of group training and one-to-one staff consultations. Training sessions explored how socioeconomic factors can affect access to care, prompting staff to reflect on both clinical practices and the wider challenges families face. One participant said, "It was valuable to learn about the consequences of poverty and how it can impact on life in general," while another noted, **"This is such an important topic that I think is overlooked in clinical practice. I'm really looking forward to learning more."** Staff also gained practical knowledge, such as the availability of financial support schemes: **"It was really useful to learn about schemes which could provide financial support to families that are struggling - low income scheme & NHS travel costs scheme - I did not know about these!"**

"It was incredibly powerful just getting the whole team together in one room. That never happens – and it showed how invested people were."

The process surfaced strong emotional reactions, including surprise, discomfort, and reflection.

"It's hard to hear. There was shock, upset, and real introspection about whether some of our behaviours were making things worse."

The audit resulted in a structured set of recommendations, which were reviewed by the multidisciplinary team and prioritised through a service-wide action plan.

Addressing Barriers

The audit highlighted how well-intentioned clinical practices could unintentionally increase financial pressure.

"We realised that offering extra appointments to families who were struggling might actually be increasing their stress and costs."

In response, the team implemented and began developing a range of practical changes:

- Sharing clear information on cheaper parking and alternative parking locations near hospitals
- Providing guidance on affordable hypo treatments and local purchasing options
- Supporting access to phones for CGM and pump technology through charity partnerships
- Embedding earlier, open conversations about financial pressures at diagnosis
- Reviewing clinic scheduling and its impact on free school meals

"We used to think we were being helpful by adding more appointments. Now we ask whether we can support families in different ways that don't add to their burden."

The service also restructured how it allocates diabetes technology. Rather than offering pumps and CGM based on perceived 'readiness', the team introduced a fairer, cohort-wide approach.

"We had to confront our own anxieties about safety and risk. But poverty proofing gave us the confidence to say: we will work with every family to make technology starts as supported and safe as possible."

The audit strongly affirmed the value of the team's link worker role, which provides practical and emotional support beyond clinical care.

"She bridges the gap between families and clinicians. She helps with benefits forms, housing letters, school issues, and takes a huge burden off parents."

The link worker also standardised support across the caseload, ensuring fairness and consistency.

Other strengths highlighted included:

- One-to-one pump starts for families with complex needs
- Flexible use of interpreters
- Bespoke education
- Clear visual resources in clinics and use of DigiBete

- Proactive charity engagement to support digital access

While formal outcome data is still being collected, early indicators include increased confidence among staff in discussing financial pressures, more consistent access to diabetes technology across socioeconomic groups, and positive feedback from families.

Wider Reach

The lessons from Gloucestershire Paediatric Diabetes Service extend far beyond their team. Their approach to equitable technology allocation, early discussions about financial pressures, and proactive support for hidden costs provides a model other paediatric and specialist services can adopt. The strengthened link worker role shows how practical, consistent family support can reduce disparities, while the team's whole-service engagement demonstrates how training and reflection can drive lasting cultural change. Insights from this work are already influencing colleagues across the South West and offer a blueprint for embedding poverty-aware practice into routine care nationally.

Conclusion

The Poverty Proofing process has prompted meaningful practical and cultural change within the Gloucestershire Paediatric Diabetes Service. What began as an exploration of inequalities in access to technology evolved into a broader shift in how the team understands, discusses, and responds to the financial realities faced by families.

As a result of the audit, the service introduced clearer information on parking and travel, guidance on affordable hypo treatments, charity-supported digital access, and earlier conversations about financial pressures at diagnosis. The approach to offering diabetes technology has also been restructured to ensure more consistent and equitable allocation across the caseload. Alongside these operational changes, the link worker role has been strengthened as a central component of

equitable care, providing families with practical and social support that extends beyond clinical treatment.

Equally significant has been the cultural impact within the multidisciplinary team. Staff report increased confidence in raising financial concerns, fewer assumptions about families' circumstances, and a stronger shared responsibility for how service design influences equity and access. While some systemic changes remain in development, there is clear commitment to sustaining momentum and embedding poverty-aware practice into everyday care.

"It's reshaped our service for the better. We're more open, more honest, and more proactive about reducing barriers for families."

For paediatric and specialist services seeking to address health inequalities in a practical and sustainable way, Poverty Proofing offers a realistic and high-impact starting point for meaningful service improvement.