



# NRO Poverty Proofing® Case Study with Lee Brookes

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## Introduction

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Lee Brookes is a Paediatric Diabetes Specialist Nurse with nearly 30 years' experience working with children and over a decade specialising in diabetes care. As one of two nursing team leaders within the service, he brings extensive knowledge of the local community across Stoke-on-Trent and Staffordshire.

The service supports a large number of families from a wide range of backgrounds. While Type 1 diabetes affects all groups, the team recognises that the ability to manage the condition is often shaped by wider factors such as income, housing, access to food, and the cost of attending appointments.

As Lee reflects: **“Diabetes doesn't discriminate. We look after some really affluent families, but we look after families who are struggling as well.”**

Prior to engaging with Poverty Proofing, the team had already begun to explore inequalities in access to diabetes technology, particularly insulin pumps. However, reviewing local deprivation data highlighted the scale and concentration of disadvantage within their population, reinforcing the need for a more structured and consistent approach.

Following Poverty Proofing training, there was a clear shift from awareness to action. A multidisciplinary working group was established to embed learning into practice and ensure that the service responded more effectively to the needs of families experiencing financial hardship.

**“I came away from the training really enthused... it sowed that seed even further of we need to do something for these families.”**

## Awareness of Poverty

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The Poverty Proofing training strengthened the team's understanding of how poverty can impact every aspect of diabetes care. While staff were already aware of the challenges faced by some families, the training reinforced the importance of actively identifying and addressing these barriers.

A key learning point was the need to have open and confident conversations about financial circumstances. Staff recognised that concerns about causing offence or discomfort could prevent important issues from being explored. As a result, the

team began to reframe these conversations as a routine and necessary part of providing safe and effective care.

**“The biggest thing that I brought out of it was about having the conversations and having those difficult conversations.”**

This shift helped to normalise discussions around money, reduce stigma, and ensure that unmet needs were more consistently identified. It also encouraged greater professional curiosity, enabling staff to better understand the wider context of families’ lives. As Lee noted, **“I think the beauty of my team is that we are all from the local area so we know our demographics,”** which means staff are often familiar with the communities’ families come from - through local schools, GP practices, and neighbourhoods - supporting more informed and open conversations about financial circumstances.

## Actions Identified

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Through the working group, the team identified several priority areas for change:

- Introducing a consistent approach to capturing socioeconomic information
- Improving awareness of, and access to, local support services
- Reducing financial barriers to attending appointments
- Addressing digital exclusion in relation to diabetes technology
- Strengthening holistic support through multidisciplinary working

## Key Actions Implemented

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### 1. Embedding Socioeconomic Questions into Routine Practice

The team redesigned their admission documentation to include key socioeconomic indicators. These questions are asked of all families at diagnosis, ensuring a universal and non-stigmatising approach.

Information collected includes household composition, social worker involvement, free school meal eligibility, ethnicity, and parental employment. This enables the team to identify potential challenges early and tailor support accordingly.

By integrating these questions into routine processes, the service has moved from informal awareness to systematic identification of need.

**“We ask everybody these questions, we have a way of logging the information and then it can potentially lead somewhere else.”**

## **2. Strengthening Links with Community and Family Hub Services**

The team proactively developed relationships with local Family Hubs and community organisations. This has significantly improved their ability to signpost families to practical and social support.

Family Hubs provide a wide range of services, including parenting support, access to community groups, and assistance with essential household needs. Establishing direct links has enabled quicker and more effective referrals, ensuring families receive timely support.

This has also helped the team to better understand the wider support landscape and identify opportunities for collaboration.

## **3. Reducing Financial Barriers to Accessing Care**

The cost of attending appointments was identified as a key barrier for some families. Many were unaware of the NHS travel reimbursement scheme, resulting in missed appointments or financial strain.

The team has introduced a more proactive approach, supporting families to access reimbursement and guiding them through the process where needed.

“Even getting half of the cost back for travel is massive to some families. We’ve had plenty of families say they just can’t afford to come to clinic.”

## **4. Addressing Digital Exclusion**

Access to diabetes technology, including continuous glucose monitors, is dependent on access to suitable devices and connectivity. For some families, this presented a significant barrier.

Through partnership working with initiatives such as Digital Angels and national charities, the team has been able to provide mobile phones and SIM cards to families in need. This ensures that all patients can benefit from digital health technologies, regardless of their financial circumstances.

## 5. Enhancing Dietetic Support Through Home Visits

Home visits remain an important part of the service's approach, providing insight into families' living conditions and access to food. This allows dietetic advice to be tailored to what is realistic and achievable within each household.

The team is also exploring the use of charitable funding to provide essential equipment, such as digital kitchen scales, to support carbohydrate counting and diabetes management at home.

## 6. Integrating Youth Workers into the Service

Youth workers play a key role in engaging young people and building trusting relationships outside of clinical settings. Their work complements that of the clinical team, offering a different perspective and enabling them to identify issues that may not otherwise be disclosed.

They support young people through activities, group work, and opportunities that build confidence and reduce isolation. This includes facilitating experiences such as trips and peer engagement, which can have a significant impact on wellbeing and self-management.

**“Youth workers do a lot of unseen work—they build different relationships with young people, see sides we don't, and pick up on things we'd otherwise miss. They're a really valuable part of the team.”**

## Impact on Access and Outcomes

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### More Equitable Access to Diabetes Technology

By using deprivation data to inform service delivery, the team has prioritised access to insulin pumps and hybrid closed loop systems for families in the most deprived areas. As a result, the vast majority of eligible patients have now been offered this technology, reducing previous inequalities in access.

### Improved Engagement Through Flexible Delivery

The service has adapted its delivery model to better meet the needs of families. This includes offering education sessions in the home and tailoring approaches for those who may find traditional clinic settings challenging.

This flexibility has improved engagement, particularly among families who were previously considered underserved.

### More Targeted and Efficient Use of Resources

The team has shifted from a universal model of care to a more targeted approach, focusing resources on those with the greatest need. This has reduced unnecessary travel and enabled staff to deliver more focused, impactful interventions.

## Conclusion

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The implementation of Poverty Proofing within the Stoke-on-Trent and Staffordshire Paediatric Diabetes Service has led to a more equitable and responsive model of care.

**“Poverty Proofing is now a regular agenda item in our MDT meetings, helping keep it at the forefront, with most of the team trained in it.”**

The working group, led by Lee, has undertaken significant work to reduce barriers faced by families experiencing financial hardship. Through embedding poverty awareness into routine practice, strengthening community partnerships, and adapting service delivery, the team has enhanced access and improved outcomes for families.

This case study highlights the importance of understanding the wider context of patients' lives and demonstrates how relatively small, practical changes can have a significant impact on access, engagement, and outcomes.

At its core, this work reflects a commitment to ensuring that no child is disadvantaged in managing their diabetes due to poverty.

**“I really feel that Poverty Proofing and support for these families has been massively important and is much higher in our consciousness and workstream.”**