Children North East

Poverty Proofing® Health

Paediatric Diabetes National Roll-out

April 2026

children-ne.org.uk

Charity number: 222041

Contents

We are Children North East

Children North East is a large children's charity based in the North East of England, with work extending across the UK. Our mission is that all babies, children and young people are given the chance to grow up happy and healthy.

Children North East deliver services, support and initiatives that provide a platform for babies, children, young people and families to work through issues, take action and which gives them the tools to reach their full potential. We have a strong children's rights ethos and believe that real social change is achieved when those who are, or have, experienced issues lead the change, and so we campaign on issues and challenge those in positions of influence who make decisions affecting the lives of babies, children and young people.

Since 1891, we have worked to provide life-changing services for babies, children, young people and their families to thrive.

Poverty Proofing®

Children North East's Poverty Proofing® methodology is a nationally recognised tool which aims to address and challenge the hidden barriers that prevent people from being able to access education, healthcare, arts and culture and other settings.

We work with the people who access the setting, work there and the community to ensure we are listening to the voices of those with lived experience to shape the impact we have. By recognising the impacts of poverty, and uncovering financial barriers, we can support an equitable future and opportunities for all.

Poverty Proofing® Healthcare is designed to educate and enable health care professionals to identify, acknowledge, and reduce the impact of poverty, advocating for equality of access to healthcare, services and technologies that contribute to overall health outcomes experienced by those living in poverty.

We understand that minimising the impact of poverty on healthcare provision is key to breaking the link between an individual's income and their opportunity to live a long, healthy life.

The Poverty Proofing Ethos

No activity or planned activity should identify, exclude, treat differently or make assumptions about those whose household income or resources are lower than others.

Voice

The voice of those affected by poverty is central to understanding and overcoming the barriers that they face.

Place

We recognise that poverty impacts places differently, and so understanding place is vital in our response. Organisationally we also need to be clear about why and how decisions are made. This understanding of context is essential.

Structural inequalities

The root causes of poverty are structural. What structural changes can we make at an organisational level to eliminate the barriers that those in poverty may face.

Poverty and Paediatric Diabetes: The Wider Context

There are 173 Paediatric Diabetes Units in England and Wales

Children from poorer backgrounds are more likely to be diagnosed in diabetic ketoacidosis (DKA) a serious and potentially life-threatening condition

94% of children and young people with Type 2 Diabetes were experiencing overweight or obesity

33,478 (93.5%) of children in England and Wales receiving Diabetes treatment have Type 1 Diabetes

Children from more deprived backgrounds and minority ethnic groups experience poorer HbA1c outcomes and lower access to diabetes technology

77% of people with Type 1 diabetes say rising costs negatively affect their condition management

Paediatric diabetes care in England and Wales is delivered through 173 specialist units, supporting 35,801 children and young people with diabetes, according to the NPDA 2024/2025. These units form part of the National Children and Young People's Diabetes Network, which is organised into 11 regional networks.

Together, these networks work collaboratively to meet agreed standards of care, improve outcomes, and uphold robust quality assurance processes, with the shared ambition of delivering a world-class service for children and young people with Type 1 diabetes.

Each Paediatric Diabetes Unit participates in an annual audit, submitting data to the Royal College of Paediatrics and Child Health (RCPCH). The RCPCH collates and publishes these findings, providing national insight into performance, outcomes, and areas for improvement across the service.

Type 1 diabetes is a complex and lifelong condition that places significant physical, emotional, and financial demands on children, young people, and their families. While its incidence is not directly associated with socioeconomic status, the ability to manage the condition effectively is shaped by wider social determinants of health. Poverty can exacerbate the daily challenges of diabetes management, including access to healthy food, stable routines, parental support, and the ability to engage consistently with healthcare services. Consequently, children and young people from lower income households are more likely to experience poorer glycaemic control, higher rates of acute and long-term complications, and reduced life expectancy (Diabetes UK, 2023; Peters et al., 2021).

Advances in diabetes technology, such as continuous glucose monitoring (CGM), insulin pumps, and hybrid closed loop (HCL) systems, have transformed diabetes care, improving glycaemic outcomes and quality of life. However, access to these technologies has not been equitable. Previous National Paediatric Diabetes Audit (NPDA) reports have consistently demonstrated lower uptake among children and young people from the most deprived areas and from minority ethnic backgrounds, reflecting systemic inequalities in healthcare access, education, and support.

Although national policy and work done by the RCPCH has sought to address this gap, including NICE guidance issued in December 2023 recommending the use of hybrid closed loop systems for children and young people, the most recent NPDA report (2025) indicates that disparities remain. Children living in the most deprived areas and those from minority ethnic groups continue to have higher HbA1c levels and lower uptake of diabetes technologies.

This suggests that, despite improvements in overall availability, structural barriers linked to deprivation and ethnicity continue to limit equitable access to optimal diabetes care and outcomes.

Poverty Proofing Diabetic Care

Poverty Proofing® is a nationally recognised tool, designed to educate and enable health care professionals to identify, acknowledge, and reduce the impact of poverty, advocating for equality of access to healthcare, services and technologies that contribute to overall health outcomes experienced by those living in poverty. We understand that minimising the impact of poverty on healthcare provision is key to breaking the link between an individual's income and their opportunity to live a long, healthy life.

Children North East were commissioned to work with Gateshead Paediatric Diabetes service, the findings from this work highlighted significant inequalities and expenses families experiencing poverty were experiencing when managing their child's diabetes. Since then, the team have completed five further audits and produced a Common Themes document, Workforce Guide and Paediatric Diabetes Toolkit to further support diabetes services.

Findings from the work and consultations with families of children and young people with type 1 diabetes, found that many families face significant financial pressures in three areas.

1. Direct Costs:

While the NHS covers many essential aspects of diabetes care, such as insulin, certain treatments for hypoglycaemia, insulin pumps, continuous glucose monitors (CGMs), and hybrid closed-loop systems, families still report considerable out-of-pocket expenses. Parents frequently purchase additional hypoglycaemia treatments when their child's blood sugar drops, as well as up-to-date smartphones needed to operate and monitor diabetes technology. Other commonly bought items include waterproof sensor patches, pump bags, diabetes supply kits, low-carb or generally healthier foods, testing strips, insulin pen coolers, medical alert bracelets, Diawipes, finger-pricking devices, carb counting apps, and skin care products to help devices adhere properly or protect the skin. Many of these items are not available on prescription.

2. Indirect Costs:

In addition to direct spending, families incur indirect costs such as travel to medical appointments, time taken off work to attend those appointments or care for their child, and potential loss of income. There are also ongoing expenses linked to maintaining a suitable diet and supporting a healthy lifestyle for their child.

3. Impact of the Cost of Living:

Rising living costs have intensified these financial challenges. Many families report having to cut back on essentials such as food and energy, which can, in turn, affect diabetes management. For example, some may choose cheaper, less nutritious food options or limit cooking to save on energy bills, potentially compromising their child's health.

Paediatric Diabetes: The True Cost to Families

This represents the true cost to a families with a child living with Type 1 diabetes.

Food	£111.99
Digital	£97.94
Additional Medical Costs	£199.92
Hospital Appointment	£36
	£ 425.85

This does not include the general food shopping needed to feed a family for a month. In 2023, the average monthly spend was **£480**, however to live by the government Eatwell Diet these costs are around **£850 - £950** for a two adult, two child household.

Whilst some of these may be upfront or initial costs, families have to replace or replenish medical supplies often and with little notice, meaning an added strain on their finances each month.

Families can also face additional costs with travel to hospital appointments, such as taxi fare and fuel as well as needing to arrange additional childcare.

DLA (Disability Living Allowance) is meant to support a family to help care for a child aged under 16, however families must meet a set of eligibility standards and the current rates do not cover all costs.

Current average weekly DLA rates
- Low rate £30.30
- Middle rate £76.70
- High rate £ 114.60

The Poverty Proofing Paediatric Diabetes journey

April 2021 - April 2022
Children North East completed a full audit with Gateshead Paediatric Diabetes service, this was our first time working in this field.

July 2022
Following on from the success of the Gateshead audit, two further full audits for paediatric diabetes services in Yorkshire and Humber were completed.

October 2022 – January 2023
After this, Children North East delivered diabetes focused training in the NENC and Yorkshire and Humber CYP networks.

July 2023
A Common Themes document and a Workforce Guide were then created based on the voice that had been gathered from the previous audits.

April – October 2024
A further three audits in the were completed in the Paediatric Diabetes services in Salisbury, Gloucestershire and Airedale. Within the Airedale audit, there was a particular focus on the transition service.

December 2024
A Poverty Proofing Paediatric Diabetes Toolkit was developed as a practical guide for all services to access and become more poverty informed in their approach to care.

January 2025
Due to all of the previous Poverty Proofing® work completed in the Paediatric Diabetes field, the RCPCH funded a National training roll-out for all CYP diabetes network.

Poverty Proofing® Paediatric Diabetes National Roll-out

Children North East have been engaged in the Poverty Proofing ® Paediatric diabetes national roll-out of training across England and Wales from January 2025 – April 2026.

Children North East have delivered training across the 11 Children and Young People's (CYP) diabetes networks to a range of diabetes staff including; network leads, consultants, nurses, dieticians, managers, link workers, youth workers, staff from the Complications of Excess Weight (CEW) clinic, Diabetes UK staff and National Leads in Wales and staff from NHS England. In the sessions, we worked to identify the barriers and challenges faced by those accessing or attempting to access the service, and to agree the actions we can put in place to reduce them.

11 Children and Young People's (CYP) diabetes networks

- East Midlands
- East of England
- North East & North Cumbria
- North West
- South East Coast & London Partnership
- South West
- Thames Valley
- Wales / Cymru
- Wessex
- West Midlands
- Yorkshire & Humber

24 training workshops

925 members of staff

Section 1: Training content

The strength of the diabetes network has been instrumental in securing strong engagement throughout the workshops. Attendance has been consistently high, with over 925 trained across the network to date.

Strong communication links with network leads have also helped to streamline the complex logistics involved in delivering such an extensive programme. Their clear vision and commitment to the Poverty Proofing ethos has added real value to the work, supporting greater impact across services and ultimately improving access for families.

The network has also played a crucial role in the feedback and impact gathering process, actively encouraging members to complete surveys that provide vital insights into the steps services are taking to remove barriers.

Children North East created and delivered a bespoke training roll-out programme for paediatric diabetes networks based on agreed outcomes from the RCPCH.

Those outcomes included:

- Reduction in health inequalities through improved access to diabetes technology as evidenced through NPDA data.
- Reduction in healthcare unconscious bias, stigma and improved staff awareness as evidenced in training feedback data and project evaluation.
- Improved patient experience through removal of barriers and creating poverty informed environments that feel more welcoming and inclusive for families suffering the effects of poverty.

Training Offer

Children North East developed a tailored workshop offer, shaped by discussions with RCPCH and network leads, to support diabetes teams in becoming more poverty-informed and embedding this understanding into their practice.

The key objectives embedded into the workshop were to:

- Understand diabetes within the context of childhood poverty.
- Understand the ethos and principles behind Poverty Proofing© diabetes care.
- Workshop some of the most common themes and barriers to accessing diabetes care through a poverty lens.
- Begin to explore opening up conversations about barriers to access and financial circumstances.
- Identify key actions – what you can do now and what you can advocate for.
- Share promising practice, network and learn from others.

Based on these objectives, we delivered three hour workshops, both in person and online, to multidisciplinary paediatric diabetes teams. Each workshop was split into two parts: the first explored the impact of poverty within the context of diabetes, and the second focused on initiating conversations with patients about access barriers and developing actionable plans to improve services.

Training Feedback

A recurring theme in the training feedback was how much paediatric diabetes staff across the networks valued having dedicated time to talk with their peers and with colleagues from other areas about the challenges related to poverty.

"It was very interesting finding out what people do in different locations in the UK".

"Good to have the interactive elements even online and hear from lots of different services facing similar challenges".

"I really enjoyed the group activities as each member of the group shared a different perspective and understanding of poverty barriers in their area".

Wakefield workshop attendees (2025).

Birmingham workshop attendees (2025).

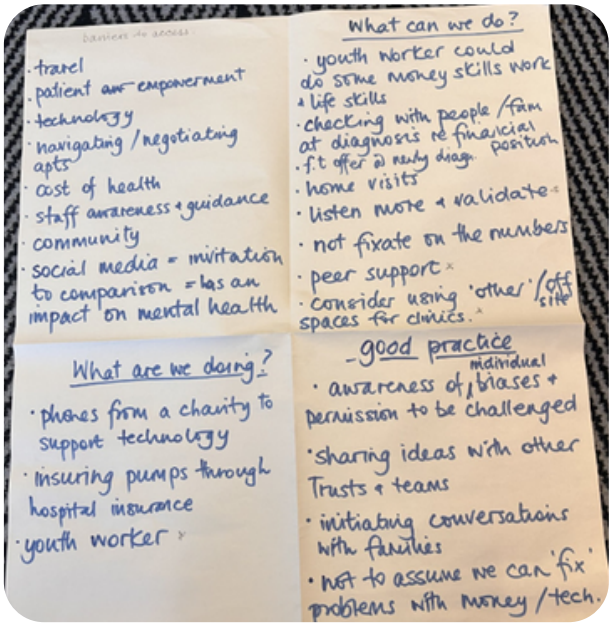
North West workshop attendees (2025).

Leicester workshop attendees (2025).

London workshop attendees (2025).

Section 2: Training outcomes

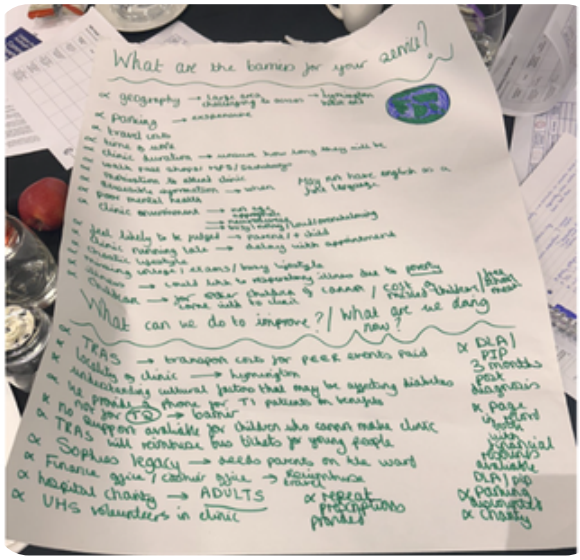
One of the main outcomes we wanted to achieve from the workshops was to allow diabetes staff to have the space to discuss how to embed Poverty Proofing ® and take a poverty informed approach to the care they provide. For this outcome, we asked attendees to create action plans.

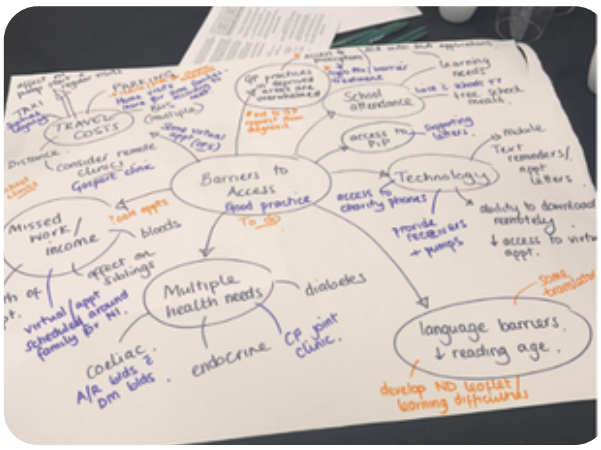


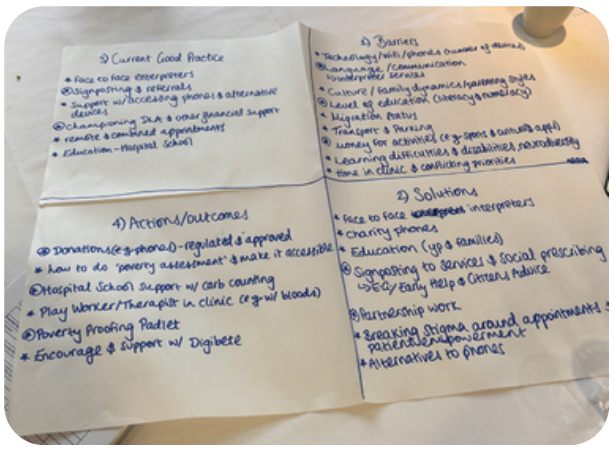
Action Plans

In the second half of the workshop, we shifted our focus to practical changes that services could introduce to become more poverty informed.

This led to the development of action plans, enabling teams to identify barriers, explore solutions, highlight good practice, and agree on concrete next steps. These plans were shaped through peer discussion and shared with the wider group.







Materials from action plan workshop.

Common themes from Action Plans across Networks

As a direct result of the action plans developed by the Paediatric Diabetes services in the workshops, we have been able to identify and collate common themes and barriers to access across all networks from a staff perspective.

Travel

Why this barrier matters

Travel remains a persistent barrier for patients across networks. Travel barriers can directly reduce clinic attendance, delay treatment, and disproportionately affect low income families. If patients cannot afford to travel or navigate reimbursement systems, they are more likely to disengage from care.

Recommendations

- Standardise travel reimbursement guidance across all Trusts in the network and create a document to explain it to patients.
- Train all staff to proactively inform families about travel reimbursement at appointment booking.
- Map local transport routes and parking options and share with families.
- Advocate collectively to Trust finance teams for same day reimbursement for low income families.
- Consider offering appointments at alternative, and more accessible, locations to the clinic where possible

Discussing Financial Barriers

Why this barrier matters

Conversations about money are essential for identifying hidden barriers to care. If staff avoid these discussions, families may miss out on support that could improve attendance, treatment adherence and wellbeing.

Recommendations

- Embed a short "financial check in" question into pre-assessment appointments, routine consultations or annual reviews.
- Provide staff with a simple script or prompt card to reduce discomfort.
- Build financial wellbeing into induction training for all new staff.

Unconscious Bias

Why this barrier matters

Unconscious bias can influence clinical decisions, communication and the quality of care. Increasing awareness helps ensure equitable treatment and reduces disparities across socioeconomic and ethnic groups.

Recommendations

- Encourage all staff to contact Children North East for their unconscious bias and stigma training refresher sessions.
- Encourage teams to review anonymised cases where bias may have influenced decisions.
- Add equity considerations to MDT discussions (e.g., "Are there social or cultural factors we may be overlooking?").

Signposting

Why this barrier matters

Effective signposting ensures families access essential support (e.g., food, housing, debt advice). Without it, unmet social needs can worsen health outcomes and reduce engagement with diabetes care.

Recommendations

- Develop a single, network-wide signposting directory updated quarterly.
- Assign one service per quarter to update a specific section (e.g., food support, housing).
- Create a laminated "quick signposting card" for clinics.
- Build signposting prompts into appointment templates.

Access to Mobile Phones

Why this barrier matters

Mobile phones are essential for diabetes management (e.g., apps, communication, appointment reminders). Lack of access widens inequalities and limits engagement with digital health tools.

Recommendations

- Compile a list of charities providing refurbished phones and share across the network.
- Work with Trust IT/charity teams to streamline referral for refurbished devices.

Staffing Levels

Why this barrier matters

Adequate staffing ensures holistic care. Without roles like social workers or family support workers, services struggle to address social needs that directly affect diabetes outcomes.

Recommendations

- Conduct a network-wide staffing audit to identify gaps and inequities.
- Develop a shared business case template for Trusts seeking additional posts.
- Explore cross Trust roles (e.g., shared social worker or family support worker).
- Use network meetings to share examples of successful staffing models.

Accessing Charity Funds

Why this barrier matters

Charity funds can provide rapid, flexible support for families in crisis. Administrative barriers slow down help and reduce the ability of staff to respond to urgent needs.

Recommendations

- Work with hospital charity teams to create a simplified, fast track process for urgent patient needs.
- Develop a network-wide "charity fund guidance sheet" explaining what can be funded and how.
- Nominate a charity liaison contact in each service.

Transition Pathways

Why this barrier matters

Poor transition processes lead to disengagement, which is strongly linked to deteriorating glycaemic control and increased hospital admissions. Consistent pathways protect continuity of care.

Recommendations

- Develop a network-wide transition protocol with minimum standards.
- Introduce joint paediatric–adult clinics where possible.
- The 'Ready, Steady, Go' programme for transitions could be introduced to all units to support young people.
- Track transition outcomes (attendance, HbA1c, disengagement) across the network.
- Provide young people with a transition checklist and named contact.

Advocacy for Disability Benefits

Why this barrier matters

Benefits like DLA and PIP provide crucial financial stability. Without advocacy, families may miss out on entitlements, increasing stress and reducing capacity to manage diabetes effectively.

Recommendations

- Create a standardised DLA/PIP information pack for families.
- Train one staff member per service as a benefits support lead.
- Partner with local welfare rights organisations for direct referral pathways.
- Offer group or virtual DLA/PIP workshops for families.

Type 2 Diabetes Children

Why this barrier matters

Rising rates of Type 2 diabetes in children reflect widening health inequalities. Understanding this trend is essential for planning future services and prevention strategies.

Recommendations

- Establish a network working group focused on paediatric Type 2 diabetes.
- Map current caseloads and identify hotspots.
- Share best practice models from London and West Midlands.
- Develop prevention and early intervention pathways with public health teams.

Section 3: Training feedback

To assess the impact of the training workshops, we asked attendees a series of questions and collected their responses both before and after the sessions.

As presented below, the shift in responses from before to after the training demonstrates the impact of the workshops, showing a clear increase in participants' knowledge and understanding of how poverty shapes the experiences of children and families living with diabetes.

99% of trainees had a good understanding of poverty after the training, vs **70%** before the training.

99% of trainees had confidence in opening up conversations with patients about financial barriers vs **36%** before the training.

99% of trainees had good understanding of the additional family expenses attached to managing diabetes, vs **67%** before the training.

97% of trainees had a good understanding of the consequences of poverty, vs **77%** before the training.

91% of trainees had a good understanding of poverty specifically in your local area, vs **61%** before the training.

"Really informative. Reflecting on MDT and clinics/ how to improve asking questions to families about potential barriers".

"This was excellent. Very knowledgeable and thought provoking. Definitely makes you want to help and make changes in our service".

"I feel this training would be beneficial to all health care workers, I feel lucky to have been able to access it".

"Could you approach whole trusts to get them to adopt this for everyone?"

"Excellent discussion and presentation, has really opened up so many things that I want to explore for my CYP and families and how we can help them".

"Great to know of the travel reimbursement scheme and other national charities".

Section 4: Further impact

Survey since training

Following the delivery of the workshops, we were keen to capture any insights into how staff were applying the learning within their services, and how the actions they had discussed were being implemented. In order to gather this data, we created a survey to be shared by network leads to all attendees. So far, we have had 58 responses from different diabetes services.

The below shows some examples of responses we have collected when asking attendees to give examples of the work they have been doing to embed their Poverty Proofing® learning and actions they have taken to do so.

Individual Level

Top 3 changes made by individuals

- Informing all families that they may be eligible for DLA.
- Asking families why they have missed an appointment.
- Thinking differently about poverty and access.

Service Level

Top 3 changes made by services

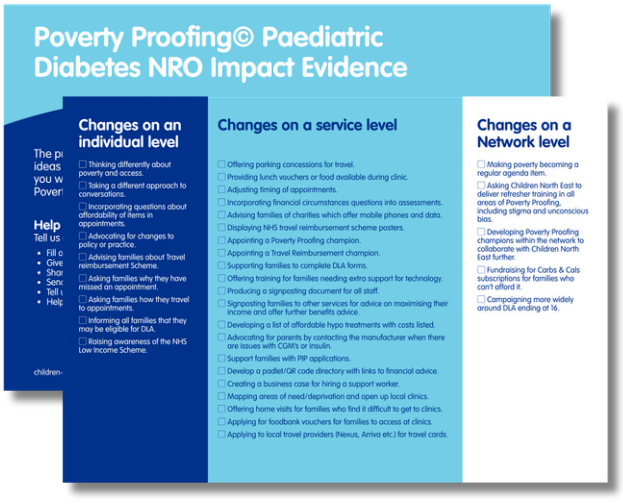
- Support to complete DLA forms
- Advising of charities for phones
- Support with PIP applications.

Trust Level

Top 3 changes made by trusts

- Making poverty becoming a regular agenda item
- Fundraising for Carbs & Cals subscriptions for families
- Asking Children North East to deliver refresher training

Alongside the survey, Children North East created a supporting 'cheat sheet' document (image below) based on the action plans as supportive document to engage and encourage attendees to think about changes they are beginning to make at an individual, service or network level.



Additional Comments

"I now ask every time I do an assessment with CYP and family not just in diabetes but also on other areas. We inform patients of the fact they could claim back travel expense and provide information on this. I sign post families to the community pantries in the area also explore apps like To Good to Go for supermarkets and also the local food bank hubs. We also explain that some families may be able to apply for hardship grants form government."

"We have made travel reimbursement as easy as we can by pre populating the forms and having them available at clinics. The whole team have become official referrers to food banks. We have created a poster which we display in clinics, with QR codes linking to useful services such as food banks etc. We have created a map of our patients and linked to DNA rates, and are hoping to do some outreach clinics closer to areas with high DNA rates."

"When booking clinic appointments will try to factor in time if they are relying on public transport and offering school clinics. The team have put together a poster with different forms of support with a QR code which have been emailed to all families and it is visible in the clinic. Team have also accessed local food bank information for families that need it."

"I had a case where we were struggling to get the family to engage in diabetes management and we discussed whether the financial impacts of travelling to clinic were a factor. We were able to offer support for travels costs, discussed financial pressures during clinic appointment and subsequently referred to local food bank, we also arrange for some reviews to take place at school. The PDSN's in the team are very good identifying the families who require access to a phone provided by the charity."

"Since our initial poverty proofing training (May 2024) our team has made a number of changes to our clinical and organisational practice. We have always run satellite clinics (reducing travel costs and time off work/school) but now offer evening clinic appointments at our main hospital site. We have asked GPs to prescribe hypoglycaemia treatments and adhesive removers and we also include these in our newly diagnosed bags. Our annual review process has the 3 poverty proofing questions. Our DSNs apply for local government household support funding on behalf of our patients and we use local charities to help fund mobile phones to ensure equitable access to technology for our patients. We also developed a Financial Support Leaflet for our patients."

"Ask about free school meals, can they afford the weekly food shop, have they reduced food intake to pay bills, are they in financial difficulties, can they afford the technology to support their diabetes. Show family free carb counting apps. Our local parent support group donate a Carbs and Cals book, bag full of hypo treatment to every child at diagnosis."

"I've always felt that growing up in a deprived area of Wales shaped my understanding of why deprivation needs to be considered across all public services. That's why it was so encouraging to see this training not only raise awareness of the issue, but also demonstrate practical, sensitive ways to incorporate these conversations without judgement or stigma. From the feedback I overheard, many attendees were left questioning assumptions they hadn't even realised they were making, which shows just how impactful the session was."

Training participant

Section 5: Real life examples
Staff case studies

As part of this national training roll-out programme, Children North East was keen to gather real life examples of impact. We worked collaboratively with diabetes colleagues to develop case studies to follow their journey after completing the training.

Simon Fountain-Polley (Wales)

We created a case study in collaboration with Simon Fountain-Polley who is a consultant paediatrician working with Hywel Dda University Health Board. He explained that by attending our workshops, he and his team gained a deeper awareness of poverty and the ways it can affect families coming to their clinics.

"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."

Making change
Within the workshop, Simon and his team identified key actions based on the barriers they discussed, which they wanted to target.

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

Since identifying actions in the training, Simon and his team have been proactive in making changes to make their service more accessible and continue to be more poverty informed in their approach to care.

Actions Implemented
- Expanding and Relocating Clinics
- Developing a 'Diagnosis Care Bundle'
- Asking the Questions
- Review DNA and 'could not attend' rates
- Gather patient feedback at annual reviews

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.

New clinics were established in Milford Haven (GP practice) and 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 community-based clinics were designed to reduce travel time and costs, early implementation showed that access barriers vary and solutions must stay flexible. Some families preferred central clinics because visits could be combined with school, shopping, or other essential activities, especially where specialist 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 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.

Lee Brookes (Stoke on Trent and Staffordshire)

We created a case study in collaboration with Lee Brookes who is a Paediatric Diabetes Specialist Nurse and Team Leader working across Stoke-on-Trent and Staffordshire. He explained that he came away enthused from the training and set up a working group to "do more" for the families they support.

He reflected on the importance of communication and shared the following insight:

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

He also highlighted the impact of financial barriers on families accessing care:

"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."

Making change

Within the training, Lee and his team identified key actions based on the barriers they discussed, which they wanted to target.

Actions Identified

- Asking consistent questions about families' circumstances
- Improving access to community and Family Hub support
- Reducing financial barriers to attending appointments
- Addressing digital exclusion in diabetes care

Since identifying actions in the training, Lee and his team have been proactive in making changes to make their service more accessible. They have implemented the actions listed below and continue to be more poverty informed in their approach to care.

Actions Implemented

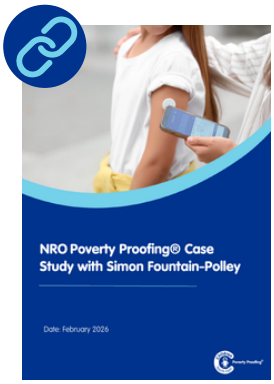
- Embedding socioeconomic questions into routine practice
- Strengthening links with community services
- Supporting families with travel costs
- Addressing digital exclusion

Embedding Socioeconomic Questions into Routine Practice

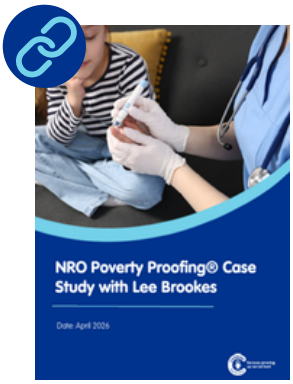
The team redesigned their admission document to include key socio-economic indicators. These questions are asked of all families at diagnosis, ensuring a universal and non-stigmatising approach.

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.

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



NRO Poverty Proofing® Case Study with Simon Fountain-Polley



NRO Poverty Proofing® Case Study with Lee Brookes

Section 6: Conclusion & Next Steps

Although the national roll-out of Poverty Proofing® Paediatric Diabetes is now complete, Children North East and RCPCH remain committed to keeping the momentum alive. It's essential that conversations about access barriers, poverty-informed care, and the realities families face continue to stay front and centre. One way to support this is by hosting quarterly online sessions with the network we've built, creating space to revisit learning, share impact, and strengthen connections across services.

This programme has enabled Children North East to build strong relationships with Networks across England and Wales and to open meaningful conversations about adopting a poverty-aware approach to care. We particularly valued the collaborative way we worked with Network Leads - their insight, enthusiasm, and support were central to the project's success. Through these partnerships, we gained a deeper understanding of diabetes care in different settings and were able to share promising practice across the network.

Personal Reflection from Beth Hetherington, Poverty Proofing Coordinator
I developed a strong interest in paediatric diabetes after completing a Poverty Proofing audit with a service in Airedale. Through the Poverty Proofing Paediatric Diabetes National Roll-Out project, I've had the opportunity to connect with Networks across the UK and Wales and begin meaningful conversations about adopting a poverty-aware care approach.

I particularly valued the collaborative way we were able to work with Network Leads, as well as their insight, enthusiasm, and support for the project.

One of the most rewarding aspects of delivering this work has been engaging in meaningful conversations with staff across multidisciplinary teams. Together, we've worked to identify barriers within their services that affect individuals experiencing poverty.

It's clear how deeply staff care about their patients, and witnessing those pivotal moments during training, when they begin to challenge their own biases and shift their perspectives, is incredibly powerful and thought-provoking.

Personal Reflection from Julie Pike, Poverty Proofing Coordinator
"Having previously completed Poverty Proofing audits in paediatric diabetes services, being involved in the national roll-out was a valuable opportunity to take this work further and see its impact on a much larger scale.

One of the highlights was the chance to work closely with network leads and teams across paediatric diabetes units in England and Wales. Through this, we were able to build relationships with staff, learn from their experiences, and gain a deeper understanding of the realities of delivering diabetes care in different settings.

Creating space for open and honest discussions allowed services to reflect on the challenges their patients face in a way that doesn't always happen in clinic.

Being part of these conversations and supporting services to develop their own action plans reinforced the importance of collaboration and shared understanding in driving meaningful change for families experiencing financial disadvantage.

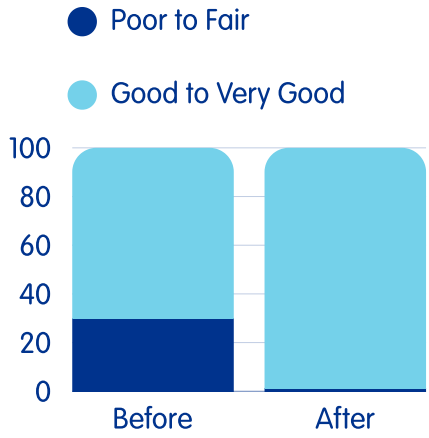
References

- Catherine J, Russell M, Peter C: The impact of race and socioeconomic factors on paediatric diabetes - eClinicalMedicine, 2021; 42
- rcpch_npda_summary_report_on_2025_data_r4_0.pdf
- 366_Tackling_Inequality_Commission_Report_DIGITAL (1).pdf

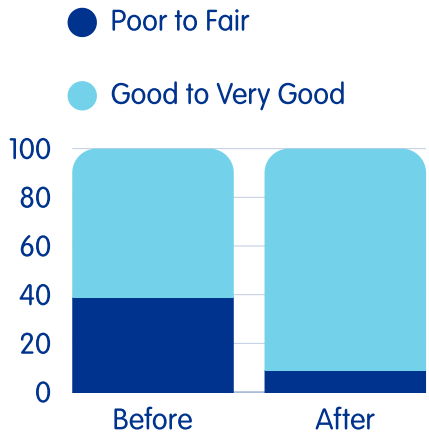
Appendix

Survey feedback:

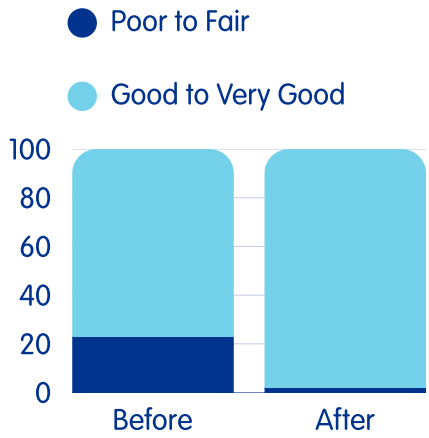
Q1. How well would you rate your understanding of poverty?



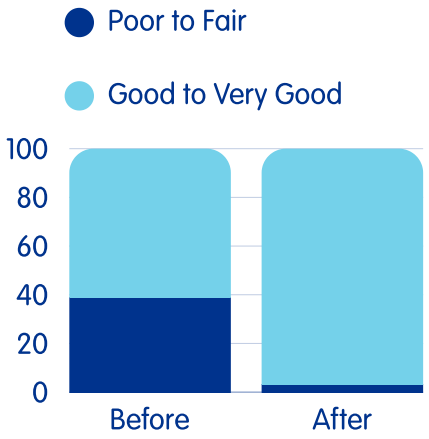
Q2. How would you rate your understanding of poverty specifically in your local area?



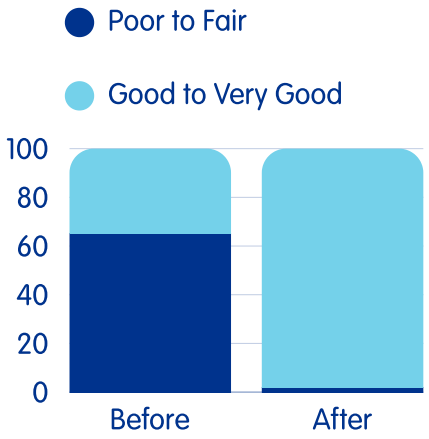
Q3. How do you rate your understanding of the consequences of poverty?



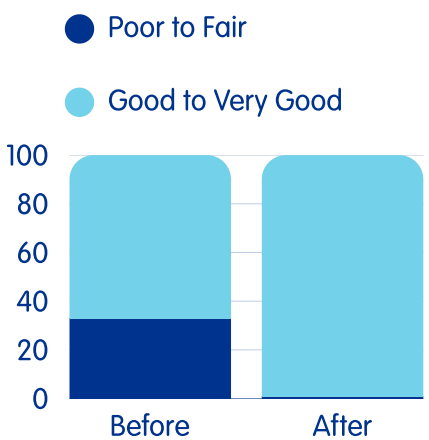
Q4. How confident are you in identifying barriers for low-income families?



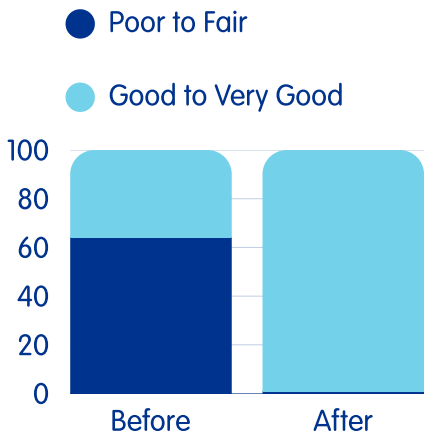
Q5. How would you rate your understanding of Poverty Proofing®?



Q6. Understanding of the additional family expenses attached to managing diabetes



Q7. Confidence in opening up conversations with patients about financial barriers

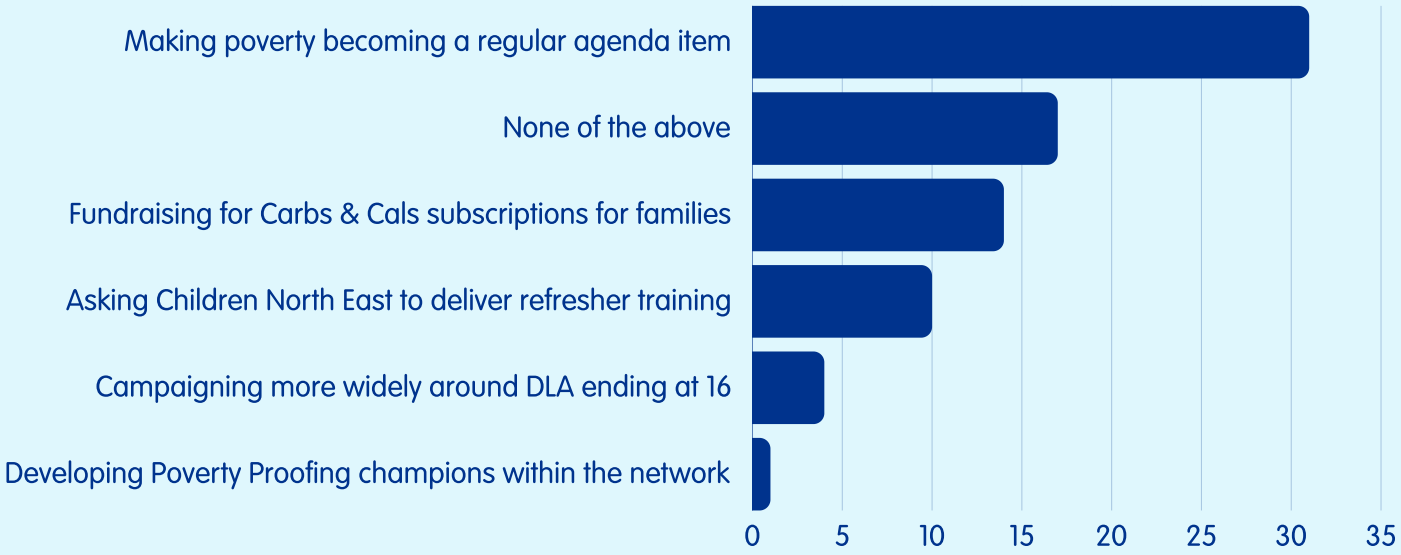


Service Level

Please tell us about any changes you are taking on an Service level to support those in poverty when accessing your service:

Network Level

Please tell us about any changes you are taking on an Network level to support those in poverty when accessing your service:



Further Quotes

"Really informative. Reflecting on MDT and clinics/ how to improve asking questions to families about potential barriers".

I thought the training was really engaging and a good mix of presentation and interactive group work".

"This was excellent. Very knowledgeable and thought provoking. Definitely makes you want to help and make changes in our service".

"Really good session. Taken a lot away from today and hope to put into practice. Interactive session really helpful".

"I feel this training would be beneficial to all health care workers, I feel lucky to have been able to access it".

"Could you approach whole trusts to get them to adopt this for everyone?"

"Excellent discussion and presentation, has really opened up so many things that I want to explore for my CYP and families and how we can help them".

"Great to know of the travel reimbursement scheme and other national charities".