Appendix: Summary of engagement sample and case studies

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Table 1 - *Summary of engagement sample, aligned to NHS Inclusion Health Framework (2023)*

Inclusion Health Group*	Examples from engagement	Estimated number engaged
People who experience homelessness	People sleeping rough or accessing the RSMHWS	~45+
People with drug and alcohol dependence	People supported for substance use, such as those engaged with the Hep C trust or East Riding Partnership	~10+
People in contact with the justice system	People who are prison leavers, have experienced recent arrest, or been engaged with NACRO or MAPPA	~3+
Other marginalised groups	Veterans, LGBTQ+, people who are care experienced, people who are neurodiverse, people who have disabilities and/or sensory impairments, people experiencing social isolation	~50+
Vulnerable migrants and refugees	Not explicitly documented	0
Gypsy, Roma, and Traveller communities	Not explicitly documented	0
People who are victims of modern slavery	Not explicitly documented	0
People with experience of sex working	Not explicitly documented	0

*NHS Inclusion Health Framework definition.
Source: NHS England (2023) *A national framework for NHS action on inclusion health*. 9 October 2023. Available at: https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/

Table 2 - Summary of case studies

Case Study No.	Source	Summary	Identified factors creating inclusion health needs
1	Nacro	Male veteran with history of binge drinking, alcohol dependency, and suspected alcohol-related cognitive impairment. Experienced trauma during military service, has no local family support, recently arrested for assault (does not recall due to alcohol use), ongoing involvement with NACRO due to wellbeing concerns.	Substance use, trauma, social isolation and lack of family support, contact with the criminal justice system
2	Inclusion Health Service	Woman placed in emergency B&B for over nine months after losing her home following a hospital admission under the Mental Health Act, triggered by significant trauma. Has high anxiety, lack of motivation, limited engagement and unclear wider support needs.	Homelessness, mental health, trauma, need for stable housing and support, instability.
3	VCS Inclusion Health Connect Worker	Warm Welcome sessions at The Hinge in Bridlington regularly attract around 40 attendees, many of whom have experienced homelessness, substance use, and social isolation. Mainly attended by males over 50, with some women. Individuals described the sessions as providing routine, social connection, and a sense of safety.	Community connection, inclusion, warmth, safety, routine
4	Inclusion Health Service	Vulnerable adult with learning difficulties found sleeping rough, multi-agency support enabled him to access accommodation and health services.	Vulnerable adult, homelessness, learning difficulties
5	RSMHWS (Bridlington Homeless Hub)	Individual with history of homelessness, living temporarily in a caravan after previously living in a tent. History of substance use, exploitation, and contact with CJS, experiences psychosis but mistrusts authorities and rejects mental health support due to previous experience of compulsory mental health treatment. A recent incoming payment has increased vulnerability to financial exploitation. Practical needs, safeguarding, and community connection are supported by the RSMHWS.	Homelessness, substance use, psychosis, exploitation
6	Nacro	Middle-aged individual who has spent most of their adult life in prison, has used substances since age 14. Released from prison, resettled twice in five months, feels alone and isolated but determined to stay drug free and sober. Seeks a new start, but faces stigma, instability, and past trauma.	Prison leaver, substance use, social isolation, housing instability, resettlement support, social reintegration, trauma, recovery
7	Inclusion Health Service	Woman referred to social prescribing. Previously cared for her mother and husband with Alzheimer's. Has faced multiple bereavements, physical health concerns, and now social isolation challenges.	Social isolation, bereavement and mental health support, physical health, carer support
8	Hepatitis C Trust	Two males occupying a property usually used for supported housing. One was in distress after falling off methadone prescription and using various substances, presenting with leg ulcers. Was supported to by the Hep C Trust to access drug services, wound care, and harm reduction supplies, with ongoing welfare checks arranged.	Homelessness, substance use, harm reduction, physical health deterioration, outreach.
9	City Health Care Partnership (CHCP)	Elderly man with unmet needs due to complex and conflicting care pathways, processes, and packages, compounded by digital exclusion.	Digital exclusion, complex pathways, fragmentation.

10	RWMHWS (Bridlington Homeless Hub)	Client sleeping in van following relationship breakdown and mental health crisis, supported by The Hinge, Bridlington Homeless Hub, and the Inclusion Health Service to access health care, secure accommodation and support decision-making.	Homelessness, suicide prevention, mental health
11	RSMHWS (Bridlington Homeless Hub)	Male with history of homelessness and alcohol dependency returned to rough sleeping when funding for temporary accommodation ended. Basic needs and recovery support were facilitated by the Bridlington Homeless Hub, enabling referral to Nacro Homes.	Homelessness, recovery, multi-agency collaboration, building trust.

Case Study 1: Trauma, chronic alcohol use, and complex needs

FN is a 58-year-old veteran with a long history of binge drinking and alcohol dependency, suspected cognitive impairment, trauma, and profound social isolation. He is now highly vulnerable with complex physical and social health needs and self-neglect. After leaving the army in his twenties, he struggled with trauma and developed chronic alcohol use, which has persisted throughout his adult life. He has repeatedly been hospitalised for alcohol use and feels he has been dismissed by health services particularly when his health concerns were attributable to his lifestyle. He therefore withdrew from GP appointments and other clinical care, his health needs worsening as he described feeling judged, undervalued, and like a burden, which eroded his confidence and motivation to seek help. He has no local family support and relies entirely on professionals and carers for his wellbeing.

FN's engagement with health and social care services has been repeatedly undermined by system complexity, fragmented processes, and unclear responsibilities between agencies. Despite abstaining from alcohol for several weeks, his care plan was delayed due to conflicting requirements across health and social care. Missed appointments, lack of reasonable adjustments, and poor communication compounded these issues, leaving his health needs unmanaged and resulting in repeated hospitalisations. He often felt dismissed and misunderstood by statutory services, which deepened his mistrust and reluctance to seek help, increasing his risk of self-neglect and relapse.

NACRO and Inclusion Health practitioners intervened intensively to stabilise his situation. Their approach was trauma-informed and person-centred, focusing on rebuilding trust and ensuring FN's care needs were met. This included advocating for urgent assessments, coordinating multi-agency professionals, and providing consistent, empathetic engagement. Daily welfare checks were arranged to safeguard his wellbeing, and referrals were made for occupational therapy and fire safety assessments to address risks in his home environment.

This case illustrates how stigma, system complexity, and fragmented support can lead to exclusion and deteriorating health for vulnerable individuals. FN's experience underscores the critical importance of proactive, relationship-based practice and effective multi-agency collaboration. Without the intervention of NACRO and Inclusion Health, FN would have remained at high risk of harm. The case highlights that addressing such complex needs requires strong advocacy, coordinated care pathways, and a commitment to trauma-informed, compassionate practice to prevent individuals from falling through the cracks of disconnected systems.

Case Study 2: Mental health crisis and housing support

A woman lived in a B&B for over nine months after losing her home following a hospital admission under the Mental Health Act. She became isolated from her family and described feeling 'frozen,' with her life on hold. Advocacy with the council and collaboration with Emmaus enabled her to be rehoused in Cottingham. Staff physically accompanied her to GP and dental appointments, helped furnish her home, and supported her confidence. Since moving, she has engaged well, regained motivation, and is confident in her independence.

This case highlights the importance of holistic, person-centred support for people in emergency accommodation, especially following trauma and mental health crises. Direct advocacy, practical help with resettlement, and coordinated multi-agency working were key to her successful transition. Building trust and confidence through in-person support and ensuring all agencies understood their roles made a significant difference. With the right support, she has regained her independence and

motivation, demonstrating the value of tailored, compassionate intervention for those with complex inclusion health needs. (Source Inclusion Health Service)

Case Study 3: Warm Welcome sessions at The Hinge in Bridlington

Warm Welcome sessions at The Hinge in Bridlington regularly attract around 40 attendees, many of whom have experienced homelessness, substance use, or social isolation. The demographic is predominantly men over 50. These sessions provide more than tea and toast they offer routine, informal conversation, and a sense of safety and belonging. Staff and volunteers go above and beyond to create a welcoming environment, and service users report that attending Warm Welcome reduces anxiety and improves engagement with healthcare. This case demonstrates how community hubs act as protective factors against isolation and provide low-threshold engagement points for people with complex needs. (Source: Dan Rothery, Hey Smile Foundation, The Hinge, Bridlington)

This highlights the critical role of community hubs in promoting wellbeing and inclusion. By offering relational safety and trust-building, these spaces create an environment where individuals feel valued and understood. The routine and informal nature of engagement helps reduce isolation, providing a sense of stability and belonging that formal services often cannot achieve. Furthermore, community hubs act as early intervention spaces, enabling people to access support before issues escalate into crisis, reinforcing their importance as a cornerstone of preventative and person-centred care.

The value of these informal, relational environments becomes even more evident when considering individuals who arrive in the area with no existing connections. In such circumstances, the presence of multiple community touchpoints breakfast clubs, hubs, walking groups, and meal providers creates a safety net that can catch people before they fall into deeper crisis.

Case Study 4: Homelessness, mental health support, and complex needs

WA is a vulnerable adult with learning difficulties was found sleeping rough in a bush in a churchyard garden. He was not initially considered a priority need by the council housing team as he held a tenancy in Kent, though he was unwilling to return there. He was experiencing psychosis and hallucinations and in need of social care, yet his homelessness prevented a Care Act assessment from being completed. Health checks later revealed a cancer diagnosis, which he declined treatment for, believing supernatural forces would heal him. His case required urgent mental health involvement to assess capacity around medical decision-making.

WA received coordinated support through professionals' meetings involving the GP, the mental health team, the church, and housing providers. Staff physically accompanied him to appointments and community hubs, addressing his communication needs and building trust. In doing so, he was later able to return independently and continue to engage.

Flexible budgeting provided essentials, and ongoing collaboration enabled a successful transition to supported living with benefits in place, a local GP, and access to health services. This case demonstrates how integrated, person-centered support and trusted relationships act as protective factors, enabling engagement, stability, and improved health outcomes.

This case study illustrates effective integrated working across agencies creates clarity, consistency, and shared purpose for individuals who often navigate complex systems. When professionals collaborate, crises are prevented or de-escalated, risk is reduced, and duplication is avoided. Evidence shows that coordinated multi-agency meetings have resolved acute issues, stabilised individuals, and supported successful resettlement, while joint planning strengthens accountability

and reduces service fragmentation. For the people receiving support, this level of coordination is visible and meaningful; individuals report feeling "seen" and understood when services communicate appropriately and work together around their needs.

Case Study 5: Homelessness and vulnerability

TR is a male experiencing homelessness, currently living in a caravan in Bridlington. Before this, he lived in a tent and accessed support through the Bridlington Homeless Hub. His history includes substance use and episodes of psychosis, and past experiences with compulsory mental health treatment have led to a deep mistrust of local authorities and mainstream health services. These experiences have shaped his reluctance to engage with statutory services and created significant barriers to wider connection and support.

Despite these challenges, TR has built strong, trusting relationships with staff at the Rough Sleepers Mental Health and Wellbeing Service (RSMHWS) and Mind support workers. These relationships have been central to his willingness to accept help, contrasting sharply with his wariness of statutory services. The Bridlington Homeless Hub plays a vital role in his life, offering more than just practical support. It provides food, a safe space to charge devices, and, most importantly, social contact and community. For TR, the hub represents a source of belonging and safety – a place that feels like 'home' in the absence of stable housing. This sense of connection helps reduce isolation and fosters resilience.

TR's story also highlights ongoing risks and vulnerabilities. He has a history of exploitation within the community, particularly linked to substance use, which has made him cautious about forming new connections. At the same time, he demonstrates self-awareness and autonomy, choosing to move to a caravan to gain greater independence and distance from negative influences. He actively makes decisions about his mental health care, showing a desire for control over his life despite significant challenges.

A recent development added complexity to his situation: TR received a backdated Personal Independence Payment (PIP) award totalling £10,000. Mind support workers recognised that this sudden access to funds could place him at risk – both from associates who might take advantage and from lifestyle choices linked to past substance use. Through open and honest conversations, support workers encouraged TR to reflect on potential risks while also helping him see this as an opportunity for positive change.

TR made a positive initial decision by purchasing a six-berth caravan and securing a pitch on a local caravan park, paying site fees in advance. However, when it became clear that the caravan park would close seasonally, Mind support workers collaborated with the East Riding Homeless Team to explore sustainable, year-round housing options. They supported TR in applying for a permanent pitch on an East Riding Travellers Caravan Site, aiming to provide stable accommodation and reduce risks associated with homelessness and financial vulnerability.

This case demonstrates the importance of consistent, trauma-informed, person-centred engagement and the value of partnership working with local agencies. By framing the challenges associated with sudden financial gain as opportunities for growth, the support team empowered TR to make informed decisions and take ownership of his choices. Ultimately, these interventions fostered hope, encouraged positive steps toward stability, and reduced vulnerability to exploitation – underscoring the power of trusted relationships and empowerment in promoting long-term wellbeing.

Case Study 6: Prison to community transitions, recovery, and mental health

DS is a 44-year-old man who spent most of his adult life in prison and struggled with substance use since his early teens. Upon release in February 2025, he knew that returning to his old environment would jeopardize his recovery, so he chose to relocate to a new area, despite the challenges of isolation and starting over. In just five months, DS moved twice, each time having to rebuild his support network from scratch. He chose to change everything: "I just got up one morning and said 'that's it, I've had enough. I am now nearly 16 months clean, I changed everything – the people in my life, where I live, how I react, and have spent a lot of time reflecting about how I have behaved in the past, people I have hurt, especially my family and myself, and for what?".

Regular moves have made it difficult to access dental treatment and to manage mental health medication and support, as DS has needed to keep changing GP. There was no onwards referral process from prison to community, making mental health services very difficult to access. This is compounded by access to phones, which are required for mental health phone assessments and risk the referral being closed if the phone is not answered.

DS has also struggled with housing and been at risk of homelessness as private accommodation to rent will not take people who cannot get a guarantor. DS was supported to access CAS3 accommodation (temporary accommodation for people leaving prison) however then given only 6 days to find new accommodation. This was stressful and strained his ability to keep going in his recovery. DS says he felt discriminated against, dismissed, and judged by what was on paper about him, for example how he had to use the 'red room' at the Jobcentre due to previous behaviour, disregarding his 16 months of recovery.

What made the difference for DS was the opportunity to connect with a keyworker who encouraged him to use his lived experience as a force for good. Through open conversations, DS reflected, "You have to know when to talk and when to listen for people to open up. They really want to speak to someone who's been there and felt that hopelessness and that feeling of dread you get when you think there's no way out. By talking and opening up, feeling safe, heard, included, I believe a new life is there if you want it!"

With ongoing encouragement, DS began to see his past as a stepping stone to better things. He started to believe in his ability to help others and expressed a desire to become a peer mentor or volunteer. "My keyworker has encouraged me to think about how I can use my past as a power for good and I have started to believe I have far more to offer than I ever thought I would. I want to get involved and help other people. I know I have lots to learn. I feel safe in myself and emotionally strong but this is not always easy and is harder some days than others."

DS' story highlights the transformative impact of peer support and the importance of being understood by someone with shared experience. It demonstrates how lived experience can be harnessed to build hope, confidence, and a sense of belonging for people facing social exclusion and recovery challenges.

Case Study 7: Social prescribing and person-centred engagement

An older woman, NB, was referred to the local Social Prescribing Service by her GP while struggling with stress and physical health issues. She was previously a carer for her husband with Alzheimer's and her unwell mother, and received valuable support from the Alzheimer's Society.

NB has had multiple physical health concerns herself and has found it difficult to access timely GP appointments and felt anxious about structured, formal support. A referral to social prescribing by the GP enabled her to receive home visits and took a 'walk and talk' approach, with social

prescribers meeting her in a relaxed, informal way. She described these sessions as feeling much less rigid than traditional counselling, which made her more comfortable and receptive to support. Over several months, she began to look forward to her appointments, regained motivation, and re-engaged with activities that improved her wellbeing. She recognised that this approach had made the service far more accessible to her and wished this flexibility, i.e., access in unsociable hours, easy appointment bookings, home visits etc., were available for more service to make them accessible to everyone. For NB, each of these elements had previously been a barrier to accessing health services, with technological advances in particular causing health care access to be confusing and ostracising.

This case illustrates how relationship-based, person-centred engagement delivered through informal, empathetic contact can reduce anxiety and build trust, especially for those who may feel overwhelmed or alienated by formal systems. The continuity and flexibility of support enabled her to feel safe, heard, and included, ultimately leading to improved confidence and positive outcomes. It highlights the value of VCSE and community settings in providing a sense of belonging and safety, and demonstrates that informal, consistent engagement is a key predictor of sustained involvement for people who might otherwise avoid critical services due to mistrust or previous trauma.

Case Study 8: Homelessness, substance use, and physical health support

An outreach worker from the Hep C Trust established regular contact with a man, GH, living in a property used for squatting, who was in distress after falling off his methadone prescription, using multiple substances, and presenting with ulcers on his legs. Through daily welfare checks, provision of food, and informal conversation, trust was gradually built. The outreach team supported GH to re-engage with his local drug service, restart his prescription, and access hepatitis C medication directly from the nurse. They also ensured he had access to clean injecting equipment and arranged for follow-up welfare checks, wound care, and naloxone supply. This consistent, practical support enabled GH to stabilise his health and begin reconnecting with wider services. This case illustrates the importance of outreach teams, which GH discussed as needing more of due to too much emphasis being placed on service users to attend a service and not all being able to.

Case Study 9: Complex care pathways and isolated older individuals

A man in his 90s, living at home and receiving regular care visits from two different care companies, faced significant barriers due to system complexity and lack of standardisation. His care plan was determined more by what the companies could provide than by his actual needs. There were not enough carers to cover all shifts, and the quality of care varied depending on the caregiver. He described "ridiculous red tape" around daily tasks, with each company having different stipulations for chores, and no standardisation across providers. This led to confusion, frustration, and unmet needs, as well as a sense of being managed by bureaucracy rather than supported as an individual. Due to his limited mobility, dexterity, and technological understanding, he is unable to use email and other online systems, being reliant on letters and phone calls.

This case directly demonstrates how fragmented systems, inconsistent communication, and bureaucratic processes can make it extremely difficult for older adults and those with complex needs to access and coordinate appropriate care. It highlights the urgent need for simplified, standardised processes and better communication between providers to ensure that care is truly person-centred.

Case study 10: Crisis support, homelessness, and conditions of living.

WA was referred to the Inclusion Health Service after being found homeless and living in his van, following a traumatic relationship breakdown. He had attempted to end his life and was working up to 20 hours a day, sleeping for only four hours a night, leading to exhaustion and collapse. He had given up his properties and was admitted to hospital under the Mental Health Act due to his suicide plans. WA was discharged weeks later without being considered a priority for emergency accommodation by their home council. With no stable housing, the client began sleeping in their van in Bridlington. Through a referral from The Hinge, the client started attending the Bridlington Homeless Hub daily, where Mind support workers provided trauma-informed, holistic support. This included liaising with the Job Centre for benefits, negotiating with a storage company to access belongings, drafting letters to creditors, and working with the East Riding Homeless Team to progress housing applications. He is now highly independent but calls the Inclusion Health Service for reassurance he was "doing the right things" in his decision-making.

All support was delivered using a trauma-informed approach, prioritising practical solutions and emotional support to build trust and stability. Mind support workers accompanied the client to meetings with housing managers and navigators, resulting in him securing temporary accommodation at a local B&B and, eventually, viewing and preparing to move into a council flat. Ongoing support was offered through the Hub, and partnership with Emmaus was arranged to recover stored belongings. WA has reflected that the Bridlington area has provided the best support of all the places he has lived and that he would not be in a stable position today without the teamwork across agencies.

This case highlights the essential role of trauma-informed, consistent, and empowering engagement in supporting clients during times of crisis. By addressing immediate barriers such as storage arrears, access to food, and travel practitioners were able to reduce the client's stress and create the stability needed for recovery. The outcome also demonstrates the value of partnership working, with collaborative efforts between support workers, housing teams, and other agencies ensuring coordinated and effective housing solutions. Ultimately, it was the blend of emotional support, advocacy, and practical problem-solving that enabled the client to move from a state of crisis to one of increasing stability and independence.

Case Study 11: Recovery and housing support

A male client with a history of homelessness and alcohol dependency was placed in temporary accommodation, but when funding ended, he returned to rough sleeping. The Hub staff provided daily support, food, clothing, showers, and emotional encouragement while building trust and understanding his needs. Recognising the need for permanent housing, staff referred him to NACRO, a supported housing provider, and encouraged engagement with Becca House (alcohol support service).

Through rapid, multi-agency partnership and the client's willingness to engage, he was assessed in person, agreed to address his alcohol use, and was ultimately accepted for a two-bedroom NACRO flat. The Hub's ongoing support was crucial in preparing him for this transition and maintaining his commitment to recovery.

This case highlights the critical importance of early intervention and continuous engagement by homelessness support staff, demonstrating how sustained, person-centred involvement can help individuals navigate complex challenges. It also underscores the value of multi-agency collaboration

bringing together council housing teams, addiction services, and supported housing providers to create coordinated, effective pathways out of homelessness. The client's progress illustrates how trust, respect, and appropriate support can foster a genuine willingness to change, even in the face of longstanding barriers such as alcohol dependency. Finally, the case reveals the inherent instability of temporary accommodation solutions when they are not paired with structured follow-up and advocacy, reinforcing the need for ongoing, holistic support to achieve lasting positive outcomes.