

INCLUSION HEALTH NEEDS ASSESSMENT II

Community Engagement and Lived Experience Insights Report

March 2026

East Riding of Yorkshire

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Acknowledgements

This report was shaped by the contribution and personal stories of many people across the East Riding. We would like to thank all those who have been a part of the development of this report. In particular, we are grateful to individuals with lived experience who generously shared their time, insights, and perspectives, ensuring this work is grounded in real-world experience. We also thank community and voluntary sector for their involvement, and professionals across health, local government, and partner organisations for their contributions, engagement, and support throughout the process.

Executive Summary

This report presents the findings of a comprehensive consultation into the health and social care needs of socially excluded groups in the East Riding of Yorkshire. Grounded in the voices of people with lived experience and the insights of practitioners, the assessment explores the barriers, enablers, and opportunities for improving inclusion health outcomes across the region.

Key Findings

Evidence from practitioners, VCSE partners, and people with lived experience gathered through this consultation indicates that, for socially excluded residents in the East Riding, the quality and continuity of human relationships, including trusted outreach, peer support, community hubs and effective multi-agency coordination, are the most salient drivers of engagement with services and continuity of care for inclusion health populations observed in this consultation. While wider socioeconomic determinants such as poverty, housing insecurity, and structural inequality remain fundamental to long term health outcomes, the findings here consistently show that rigid, digital-first, and fragmented systems undermine engagement, particularly for people experiencing trauma, instability, or mistrust of statutory services. In contrast, relational, low barrier approaches delivered through community based, peer informed, and coordinated models enable people with inclusion health needs to access support, sustain involvement, and re-engage following periods of disengagement.

Across contexts, individuals face a combination of emotional (stigma, trauma, mistrust), identity-related (experiences linked to substance use, neurodiversity, veteran status, or criminal justice involvement), practical (digital exclusion, limited transport, housing instability), and systemic (fragmented pathways, bureaucracy, digital-first models, rigid appointment structures) barriers. Evidence throughout this report demonstrates that these systemic features are not neutral, but actively drive exclusion for inclusion health populations, particularly where rigid eligibility thresholds, inconsistent referral pathways, and inflexible service models disrupt trust and continuity. Social isolation is exacerbated by trauma, rurality, stigma, and lack of family support, and emerges as a major risk factor for crisis and disengagement. These barriers are often cumulative and self-reinforcing, disrupting prescriptions, referrals, and care continuity for those in temporary or unstable accommodation, and leaving people with the greatest needs at heightened risk of exclusion unless there is proactive advocacy and supported engagement.

Integrated, multi-agency collaboration and relationship-based practice are therefore vital for reducing exclusion and improving recovery pathways. The quality of engagement is a key predictor of its continuity: when relational continuity, emotional safety, and trust are present, people feel “seen,” understood, and supported. These conditions enable meaningful engagement with services and the rebuilding of lives. Conversely, fragmented systems and

inconsistent processes undermine these protective factors, with bureaucratic complexity and inflexible access models creating both practical and emotional barriers that deter participation.

Finally, there are acknowledged insight gaps regarding the experiences of specific groups, including sex workers, Gypsy, Roma and Traveller communities, and vulnerable migrants. Efforts are underway to strengthen engagement and address these gaps through targeted outreach, investment in relationship-building, and co-production with people with lived experience, ensuring that learning and service improvements are grounded in the realities of those most affected.

Implications

Relational continuity, emotional safety, and trust are critical for enabling engagement and supporting recovery. Fragmented systems, digital-first models, and rigid appointment structures create practical and emotional barriers, while housing instability, rural transport limitations, and financial hardship further disrupt continuity of care and increase vulnerability. For many, these barriers are cyclical and mutually reinforcing, highlighting the need for proactive advocacy and supported engagement.

Recommendations

To address these challenges and build on existing strengths, the report proposes a series of targeted and universal recommendations. These are summarised as:

Targeted Recommendations: Focus on underrepresented groups and areas where engagement and insight are most limited, including strengthening connections with professionals and communities, and building relationships within VCSE and community settings.

Universal Recommendations: Embed inclusion health within population health approaches, enhance policies and processes, and strengthen communications and engagement across the system.

It is proposed that these specific recommendations are established or formalised as workstreams alongside system-wide actions to invest in trauma-informed, relationship-based, and community-led models; improve service coordination and access options; and embed advocacy and peer support throughout pathways.

Conclusion

Building engagement with individuals who have lived experience of multiple unmet needs, alongside the professionals who support them, is fundamental to achieving meaningful change. Strengthening relational, trauma-informed, and coordinated approaches is essential for reducing exclusion, improving recovery pathways, and supporting long-term resilience across inclusion health populations in the East Riding.

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Glossary of Acronyms and Services

ERP	East Riding Partnership	The East Riding Partnership provides integrated drug and alcohol support across East Riding, offering clinical treatment, community rehabilitation, outreach, and family services, with specialised programs for young people and people who use performance-enhancing drugs.
ERYC	East Riding of Yorkshire Council ('the Council')	The local authority responsible for governance in the East Riding of Yorkshire.
ICB	Integrated Care Board	Humber and North Yorkshire (HNY) ICB is a statutory NHS body serving 1.7 million people across Humber and North Yorkshire. It plans and funds health services, integrates care with partners, tackles health inequalities, and drives population health improvement. Its priorities include prevention, equity, sustainability, and collaborative delivery through six place-based partnerships.
IHS	Inclusion Health Service	Aims to make healthcare inclusive and accessible for every resident of the East Riding regardless of their situation by removing the barriers people may face. The Inclusion Health Vehicle is a mobile service targeting both those in Inclusion Health Groups and universally. In partnership with ERYC, Homelessness Navigators also provide holistic support and intensive engagement with service users referred by the Rough Sleeper Team.
MAPPA	Multi-Agency Public Protection Arrangements	MAPPA is a statutory arrangement in England and Wales for assessing and managing the risk posed by certain sexual and violent offenders. It brings together the Police, Probation and Prison Services, with other agencies (such as local authorities, NHS and housing providers) under a duty to co-operate. MAPPA aims to protect the public through information sharing, joint risk assessment and coordinated management plans. Offenders are managed under three categories (sexual, violent, and other dangerous individuals) and at three levels, ranging from single-agency oversight to senior multi-agency panels for the highest-risk cases.
Nacro		Nacro provides integrated clinical and psychosocial support for people using substances and involved with or at risk of criminal justice. Services include assessment, care planning, medication-assisted treatment, detoxification, and outreach. Working with partner agencies, NACRO ensures continuity across custody and community, supports rehabilitation, safeguards, and reduces substance-related crime through multi-agency collaboration and training.
NHP	Neighbourhood Health Partnership	Neighbourhood Health Partnerships bring local health, care and VCSE organisations together to understand community needs, plan strategically and deliver collectively where a shared response is required. They work at neighbourhood level because most people access services close to home, and this is where health inequalities are most visible and can be tackled effectively.
PH	Public Health	ERYC team responsible for health improvement, health protection, and health intelligence.
RSMHWS	Rough Sleepers Mental Health and Wellbeing Service ('The Hub')	Provides vital support to rough sleepers and those at risk of homelessness in East Riding, offering crisis stabilisation, mental health and addiction support, access to healthcare, and practical help. The service removes barriers to essential services, promotes recovery, and fosters healthier, safer communities.

I. Introduction

Inclusion health refers to the health and social care needs of people who are socially excluded. These individuals often experience multiple, overlapping risk factors for poor health, such as poverty, violence, and complex trauma, and face stigma and discrimination. As a result, they can face additional challenges to accessing healthcare, leading to poorer health outcomes and significant health inequalities compared to the general population. These inequalities can contribute to a lower average age of death. The NHS identifies certain populations as ‘inclusion health groups’, which are characterised by these challenges:

- People who experience homelessness
- People with drug and alcohol dependence
- Vulnerable migrants and refugees
- Gypsy, Roma, and Traveller communities
- People in contact with the justice system
- Victims of modern slavery
- Sex workers
- Other marginalised groups

Challenges in accessing healthcare and subsequent health inequalities often arise from three interconnected factors: how individuals are connected with their peers and communities, their past and present experiences of engaging with services, and the barriers they encounter when seeking support. A critical principle underpinning this document is that these inclusion health needs are not confined to those within predefined groups; they can affect anyone at any point in life. Furthermore, these groups are not mutually exclusive – individuals may often belong to more than one, such as a person experiencing homelessness who may also be managing substance use and mental health issues. This can create overlapping disadvantages and intersecting forms of discrimination, compounding barriers to health and wellbeing.

Building on the findings of the Inclusion Health Needs Assessment (2024), this document shares insights into these challenges voiced by people with inclusion health needs, alongside perspectives from professionals working closely with them. These lived experiences have shaped key themes that form an evidence base for change. Moving beyond the 2024 recommendations, this document sets out specific targeted and universal recommendations designed to enable actionable, impactful, and sustainable change.

2. Approach, ethics, and ethos

A flexible, informal consultation approach was led by community-facing professionals across the East Riding. Recognising the ethical principles from patient and public involvement and engagement (PPIE) practices, and the challenges of engaging typically underrepresented inclusion health groups, the involvement of partners from across health and community settings was vital to ensure insights were captured respectfully and safely. This approach aimed to simultaneously strengthen relationships and build rapport, acknowledging that meaningful engagement requires time and trust rather than simply collecting information and moving on.

Conversations involved open, neutral prompts focused on three themes: connections (links to peers and communities), engagement (experiences with services), and barriers (obstacles to accessing support). Informed consent was given by participants being clearly told the purpose of the consultation,

assured of anonymity, and reminded that their involvement was voluntary. Insights were recorded by practitioners using narrative collection sheets which were then collated and thematically analysed to produce this report. Additional engagement methods included service-specific interviews, community events, and detailed case studies from service performance monitoring reports.

3. Groups engaged with

Given the informal consultation approach used, it is not possible to ascertain the exact number of individuals engaged. Appendix A contains a summary of the groups engaged with, defined according to the [NHS Inclusion Health Framework \(2023\)](#), using rough estimates of numbers based on the returned narrative collection sheets. It also contains a summary of all the case studies either directly referenced or used to inform this document.

4. Key themes and case studies

The following section highlights key themes which emerged during the consultation approach, linked to connections, engagement, and barriers.

4.1. Connections

Across the East Riding, evidence consistently highlights that meaningful connection to people, services, and places supports recovery, resilience, and engagement. Fragmented or inconsistent support undermines trust and continuity, leaving individuals reliant on professionals rather than empowered through community.

4.1.1. Fragmented support:

The experience of fragmented, inconsistent support across different agencies was commonly described as disrupting continuity and undermining connection and trust. Variability in care quality and differing processes creates confusion, whilst practical obstacles and bureaucratic “red tape” were described as making accessing routine help difficult. Many individuals rely heavily on professionals because their personal networks are limited, and delays in assessments or case transfers reduce engagement and increase risk of deterioration.

“There is also ‘ridiculous red tape’ around daily tasks that don’t make any sense to him, i.e., he has two care companies involved in his care plan, as one cannot fulfil his full requirements, and both have different stipulations around daily chores. There doesn’t seem to be any standardisation across providers.” – CHCP, Case Study 9

“Regular moves have made it difficult to manage mental health medication and support as [my client] has needed to keep changing GP. There was no onwards referral process from prison to community. ... Dental treatment has been unavailable to [my client] as he has moved so many times and will need to move again when his contract on his current room ends in January.” – Nacro Recovery Practitioner, Case Study 6

4.1.2. The importance of the VCSE: community groups, local support networks, and social connections

Isolation from family, partners, or the wider community significantly increases vulnerability, with a lack of informal networks leading to greater reliance on professionals, heightened emotional distress, and an increased risk of exploitation or crisis. Emotional distress is often linked to separation from children, partners, or extended family, while housing instability makes it difficult to form or maintain

relationships. Some individuals have no informal networks at all and depend solely on services for connection.

Community-based settings such as cafés, warm spaces, and wellbeing hubs, were frequently described as trusted and familiar spaces that foster engagement through informality, accessibility, and peer support. These hubs act as low-barrier entry points into care and wellbeing, offering informal and welcoming environments that contrast with the formality of statutory offices. People reported how these spaces felt more comfortable, being “safe” and “non-judgemental”.

“It’s easier to talk here. You’re not filling out forms; you’re having a cuppa.” (Service user, VCSE community hub)

Case Study 3 describes the Warm Welcome sessions at The Hinge in Bridlington, highlighted as a space where people could access social connection, food, and conversation without fear of judgment. This has helped reduce isolation and anxiety around help-seeking, creating structure and relational connection. The informal conversations people can have with staff and volunteers there, and their consistent presence, has fostered trust and engagement. This has been particularly vital for isolated people, supporting a sense of belonging, social connection, and purpose, helping to stop issues from escalating to crisis.

“The hub provides food, a place to charge devices, and most importantly, social contact and community” (Case Study 4: Rough Sleepers - describing the RSMHWS)

“Staff and volunteers at The Hinge are highly committed to go above and beyond for the community” (HEY Smile VCSE Inclusion Health Worker)

4.1.3. Integrated, multi-agency support and protective factors

When professionals collaborate, crises are prevented or deescalated, risk is reduced, and duplication is avoided. Individuals described how 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.

“Professionals’ meetings were held with the council and health teams to ensure all agencies were clear on their role in supporting her resettlement.” (Inclusion Health Service)

Stories from across case studies and lived experiences demonstrate how coordinated practice, accessible support models, and trusted relationships become a protective system. Integrated approaches only improve outcomes, creating the conditions for individuals to build resilience, regain control and sustain their long-term engagement and wellbeing. Safe, trusted relationships formed in community spaces are reinforced through coordinated support, becoming a critical buffer against harm, exploitation, relapse, and risk. Case Study 4 shows the impact this had in WA’s experience, a vulnerable adult with learning difficulties who was found sleeping rough in a churchyard, experiencing psychosis, untreated cancer, and deep mistrust of services and health care. Building a relationship with him and coordinating support between the GP, mental health team, church, housing providers, and Inclusion Health Service has now enabled supported living, with benefits in place, a local GP, and independently accessing health services.

“There is a need for ongoing, person-centred support. WA’s story underscores the importance of consistent, person-centred relationships and the role of the hub in providing a stable, supportive network that helps reduce isolation and build resilience”. (Case Study 4: Rough Sleepers)

4.1.4. Trust, safety and trauma-informed relationships

Trusted relationships were identified as critical to effective engagement, particularly given the challenges professionals encounter when supporting individuals who mistrust statutory services. Particularly, trust is fundamental for people with trauma histories, substance use challenges, or unstable living situations, as relational continuity and emotional safety are key to enabling engagement and supporting recovery. People value and respond best to services that offer consistent relationships, while peer-led models help reduce shame and increase credibility. Veterans and trauma survivors in particular often prefer to engage in non-statutory spaces.

Case Study 5 illustrates the impact of this in TR’s experience, a vulnerable adult with a history of homelessness, substance use, exploitation, and psychosis. He received integrated, person-centred support from staff at the Bridlington Homeless Hub and other agencies to address his communication needs and build trust, accompanying him to appointments and supporting with budgeting. With this in place, his health outcomes improved, enabling him to continue to engage with services and offering him stability in his life. For TR and others who have received similar types of 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.

“TR has developed a strong, trusting relationship with staff at the Rough Sleepers Mental Health and Wellbeing Service (RSMHWS) and Mind support workers. These connections are central to his willingness to engage and accept support, in contrast to his wariness of statutory services.” (Case Study 5)

4.1.5. Peer support and lived experience

Peer support was conveyed as a critical dimension to building trust with people, playing a crucial role in building confidence and a sense of belonging, particularly for people who have felt misunderstood, judged, or stigmatised. Evidence from across substance use treatment and recovery settings, mental health support, veterans’ services, and community hubs shows people engage well in peer-led groups. People report feeling more open, understood, and motivated when supported by peers, with shared experience helping to reduce shame and increase hope.

Case study 6 describes the difference this has made for DS, who faced numerous barriers to accessing services and support upon leaving prison, including discrimination, isolation, lack of onwards referral from prison to community treatment settings, access to technology, and difficulties securing housing. The opportunity to connect with a Nacro keyworker reframed how he thought of his lived experience:

“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 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.”

4.1.6. Practitioners’ insights: connections

Practitioners reported that fragmented, siloed systems absorb significant time and energy, drawing them away from direct support and often pushing them beyond their professional remit. As one Inclusion Health Practitioner explained, *“the system works in silos, if you don’t know how to navigate it, you fall between the gaps.”* Others echoed the difficulty of unclear pathways, with a Homeless Navigator noting clients have *“difficulty knowing which service to contact for which need.”* These challenges, combined with delays or limited responses from statutory services, frequently required organisations like Nacro and Inclusion Health to step in to bridge gaps: *“there have been delays and pushback in statutory service responses, requiring Nacro and Inclusion Health to step in beyond their usual remit.”*

Across the system, practitioners spoke highly of the value of VCSE and community settings as vital spaces for engagement, trust-building, and early intervention. They described these environments as protective and stabilising, being places where people can form connections, feel emotionally safe, and rebuild confidence. HEY Smile Foundation’s VCS Inclusion Health Worker highlighted the importance of such community hubs: *“my time at The Hinge has been invaluable for building trust and understanding the community’s health and wellbeing needs... Staff and volunteers are a significant asset, but greater capacity and funding would allow The Hinge to reach more people.”* Community spaces were seen as especially important for individuals arriving in an area without existing networks, offering multiple entry points into formal support and helping people regain independence and wellbeing.

Trauma and stigma were consistently identified as major barriers to engagement, reinforcing the need for flexible, trauma-informed, person-centred approaches. As Nacro put it, *“overall, barriers are compounded by trauma, stigma, and the need for services to be flexible, trauma-informed, and person-centred.”* Trust-building was seen as central to helping individuals overcome fear, shame, or prior negative experiences.

Peer support emerged as a particularly effective tool in sustaining engagement and breaking down barriers, especially where people feared judgment. A staff member from The Hepatitis C Trust described how lived-experience workers make a meaningful difference: *“Most of our staff and volunteers have experience with Hep C... Peer-led support is also important in breaking down some of the barriers to treatment. The nursing teams I work alongside have a great rapport with our client group who can often feel judged and discriminated against.”*

Overall, practitioners emphasised that strong partnership working, greater investment in community-based organisations, and consistent trauma-informed practice are essential for improving engagement and outcomes within inclusion health.

4.2. Engagement

Engagement with health and social care services is shaped by a complex interplay of emotional, practical, relational, and identity-based factors. For individuals experiencing multiple vulnerabilities

such as homelessness, trauma, addiction, or social isolation, barriers are often cumulative, cyclical, and mutually reinforcing. Evidence gathered through the Inclusion Health Service, VCSE partners, and people with lived experience reveals consistent themes about what helps, what hinders, and what sustains engagement.

4.2.1. Relationship-based, person-centred engagement

Engagement improves when relationships are prioritised and support is delivered in personalised, informal, and empathetic ways. A critical aspect of this is recognising and respecting people as individuals; identity-related factors such as neurodiversity, veteran status, LGBTQ+ identity, and criminal justice history were often mentioned as impacting the way that people experienced, such as how culturally-insensitive, tailored responses to very specific components of people's identity had created negative experiences and fostered disengagement. Examples include neurodiverse individuals who had reported services not being communication or sensory-friendly, people who have histories of trauma avoiding formal spaces because they feel intimidating and/or authoritarian, and veterans who described feeling invisible within civilian systems and under-identified services.

Engagement improved when services demonstrate adaptation to individual needs, for example in Case Study 7:

NB, an older woman and carer with multiple physical health concerns, found it difficult to access GP appointments and felt anxious about structured support. A referral to Social Prescribing enabled home visits using a 'walk and talk' approach, which felt less rigid than traditional counselling and made her more comfortable. Over several months, she began to look forward to her appointments, regained motivation, and re-engaged with activities that improved her wellbeing. (Inclusion Health Service, Case Study 7)

Another key factor for sustaining engagement was the continuity of relationships, particularly amongst individuals with complex trauma, who repeatedly cited trust and familiarity as essential to accessing ongoing support.

"I only felt able to engage because the staff were consistent, empathetic, and treated me without judgement, they really focused on what mattered to me." (About the RSMHWS, Case study 5)

4.2.2. Supported engagement and outreach as an enabler

Many individuals need supported assistance, accompaniment, or reassurance, especially when managing unmet needs. Outreach workers play a vital role in bridging the gap between people and formal services, being a lifeline for people disconnected from mainstream systems. Practical measures such as transport, reminders, and physically accompanying individuals to appointments improve attendance and follow-through, particularly for those with anxiety, trauma, or cognitive difficulties. Initial joint attendance and advocacy are often critical for accessing GPs, housing offices, and mental health services. Peer-led outreach teams are especially important for individuals unable to attend structured appointments or engage digitally, often due to chaotic lifestyles, homelessness, or substance use. Repeated, predictable contact helps stabilise people in crisis and prevent escalation, building trust through consistency, persistence, and presence. Outreach is frequently the first step into treatment, housing, or health engagement, with teams offering practical support such as harm reduction, testing, and linkage to services. Peer-led models are particularly effective because shared lived experience fosters rapport and reduces stigma, enabling people to accept help in non-judgmental environments.

“[The service user] prefers to attend groups and appointments with their support worker present, as this provides reassurance. They enjoy group sessions when supported but lack the confidence to attend alone. They disclosed difficulties managing appointments and knowing who to contact for what.” (Homeless Navigator, Inclusion Health Service)

“If someone comes with me, I can do it. If I have to go alone, I just don’t.” (Service User, Inclusion Health Service)

In Case Study 8, outreach workers from The Hepatitis 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 this outreach, workers were able to establish a trusted relationship, providing welfare checks and food to a man experiencing homelessness, helping him to restart his prescription, re-engage with substance use treatment, and access hepatitis C medication directly. With this support, GH was able to stabilise his health and begin reconnecting with wider services.

4.2.3. Motivation and re-engagement

Engagement fluctuates according to stability, environment, and readiness. People often cycle between connection and withdrawal, depending on life circumstances. In particular, people’s conditions of living can strongly detract from their willingness, motivation, and ability to engage with services. For example, individuals living in unstable accommodation or experiencing active addiction often disengage temporarily but re-engage when their housing situation or mental health improves. Supportive networks, practical progress, and relational continuity all were described as significantly enhancing re-engagement, giving people stability and building connection.

“After being rehoused, she engaged well with support, regained motivation, and became largely independent. She expressed that she feels she has ‘gained back all the motivation’ she had previously lost.” (Inclusion Health Service, Case Study 2)

4.2.4. Practitioners’ insights: engagement

Practitioners highlighted that internalised stigma, fear of judgement, and previous negative experiences significantly reduce individuals’ willingness to engage with health services. As one Homeless Navigator noted, *“[people] often feel judged or dismissed by health services, as if their lifestyle has directly caused their health issues.”*

Respect for cultural context, identity, lived experience, and personal connection was viewed as fundamental to person-centred care. Practitioners stressed that culturally informed, insight-led practice helps avoid assumptions and build trust, as reflected in one Nacro practitioner’s question: *“we discussed culture, particularly in Goole. What do we know or find out, before making judgements?”* Many provided examples where flexible, trauma-informed approaches had been key to positive outcomes. In Case Study 2, practitioners from the Inclusion Health Service described how, *“building trust and confidence through in-person support and ensuring all agencies understood their roles made a significant difference... she regained her independence and motivation, demonstrating the value of tailored, compassionate intervention for those with complex inclusion health needs.”*

Outreach was repeatedly identified as essential for engaging people who may mistrust, avoid, or be unaware of available services. Practitioners described physically accompanying individuals to statutory appointments to reduce anxiety, support communication, and build confidence. As Inclusion Health

Service staff described in Case Study 4, “staff often physically accompanied him to the GP, housing office, and community hubs... Once introduced to people face-to-face, he was able to return independently, but the initial support was critical.” Such approaches were seen as vital not only for health engagement but also for building bridges to housing and other key services.

Practitioners also observed that people’s ability to engage is shaped by unstable living conditions, competing priorities, and the cumulative impact of stigma and exclusion. These circumstances often create additional barriers and, over time, lead to despondency or withdrawal from support. This reinforced the importance of flexible, holistic, person-centred approaches that recognise the broader context of people’s lives and the emotional toll of persistent barriers.

4.3. Barriers

Barriers to inclusion health access are multi-layered, interconnected, and often self-reinforcing. For many individuals experiencing homelessness, trauma, substance use, or poverty, these barriers exist across physical, digital, emotional, and systemic dimensions.

4.3.1. Emotional barriers: stigma, shame, mistrust, judgement, and trauma

Individuals frequently report feeling judged, undervalued or ignored, which undermines confidence and motivation to engage with services. Many people described this as stemming from previous experiences of stigma or dismissal, particularly within clinical environments such as A&E or primary care. This had reinforced feelings of shame and being perceived as a ‘problem’ or ‘burden’, which were described as significant barriers to help-seeking, often leading individuals to withdraw from statutory systems. Many people described how stigma relating to substance use, homelessness, criminal history, or identity had caused profound emotional impact and worsened their needs.

“He feels he is a burden on society and doesn’t want to cause a fuss” (CHCP practitioner, describing client)

“I stopped going to appointments because I felt like I wasn’t being listened to. It’s easier not to ask for help than to be judged again.” (Service user, RSMHWS)

This stigma was often reinforced by assumptions about people’s lifestyle or reliability, for example, individuals reported feeling judged or dismissed by health services, as if their health issues were solely the result of their lifestyle choices and described staff attitudes as uncomfortable or unwelcoming. Such experiences erode confidence and trust, making it less likely that people will seek support or engage with services. Mistrust of authorities, fear of compulsory treatment, and previous negative experiences were also highlighted as discouraging engagement, emphasising the need for trauma informed, non-judgmental, and person-centred approaches to reduce these barriers and foster genuine connection and support.

I think being able to listen is a big thing. Not being judged is a big thing. Let them know it's not all just about passing a drug test, that you're more than that!! My keyworker has been there for me and that definitely helped me!!!” (Nacro Client)

“DS says he has felt discriminated against, dismissed and is judged by what is on paper about him. He gave an example of visit to the Jobcentre. He has to use the “Red room” due to previous behaviour, but his 16 months of recovery have been disregarded, so he remains being treated differently.” (Case study 6)

Case study I shows the impact this had on FN's health outcomes, 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 misuse, 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. (Case Study I)

4.3.2. Practical barriers: digital exclusion, language, transport, housing instability, isolation, and cost of living

“Jargon can become a barrier, different areas use different words for the same things, drugs might be referred to in different ways. Literacy can be a problem. Keeping forms short and simple instead of complicated like they are now. For those who work access to services and prescribing can be hard. For those who live in outlying areas just getting to an appointment can take the best part of the day. We have had cases where people have been stranded in a small village as there were no buses for 6 weeks. Some prison leavers don't know how to use the latest phones and services have an expectation that everyone will be able to use the systems. A person who cannot read and write may have to be taught to use a phone or voice control on a phone. Can they afford a smart phone?” (Nacro Recovery Practitioner)

Integrated support depends on practical accessibility; difficulties with managing appointments, travelling between locations, and navigating multiple services were highlighted as making services feel inaccessible and exclusive. Digital technologies and digital-first systems risk isolating those who do not have access or capacity to use them.

Housing instability is a major barrier to accessing assessments, continuity of care, and safe environments. Frequent moves, time spent in emergency accommodation, and insecure tenancies disrupt relationships with professionals and break care pathways. This can also complicate support being provided and compound poor health outcomes, for example homeless individuals being 'not eligible' for Care Act assessments, as in the case of Case Study 4. Housing instability can also disrupt continuity of care, for example GP registration. Housing is framed as a barrier to assessment rather than a priority for intervention.

Rural geography and limited transport options can further add complexity and restrict access to healthcare, community groups, and essential services, heightening social isolation. Community transport services face long waits and limited routes.

“For those who live in outlying areas just getting to an appointment can take the best part of the day. We have had cases where people have been stranded in a small village as there were no buses for 6 weeks.” (Nacro Recovery Practitioner)

Often compounding the difficulties of rurality and transport, financial hardship significantly limits access to services and exacerbate isolation, both socially and digitally, by forcing people to choose between essentials like food, heating, exercise, technology, social activities, and healthcare.

In case study 7, NB experienced multiple physical health issues and anxiety around formal support, alongside difficulties accessing timely GP appointments. A referral to social prescribing enabled home visits using a relaxed ‘walk and talk’ approach, which she found less rigid than traditional counselling and more accessible. Over time, NB became more receptive to support, regained motivation, and re-engaged with activities that improved her wellbeing. She felt this flexible approach, particularly home visits, easier booking, and non-standard hours, removed barriers she had previously faced such as digital exclusion, difficult appointment bookings and hours, which had made the service feel confusing and ostracising.

4.3.3. Systemic barriers: fragmented pathways, bureaucracy, rigidity, and disconnect

Health and social care systems are confusing and inconsistent, with unclear communication, duplicated processes, and fragmented referral routes that leave many people unsure who to contact. Rigid, appointment-based systems are often incompatible with the realities of instability, crisis, and cycles of substance use. Missed appointments are common due to unpredictable circumstances. Policies that remove individuals from services following non-attendance can disproportionately exclude people with chaotic lifestyles and unmet needs from accessing services. Lack of flexible, assertive outreach and harm reduction options leaves many at risk of deteriorating health and ongoing exclusion.

“Without intervention, he would not have coped and would have remained homeless.” (Case Study 11)

Poor information-sharing and outdated or inaccessible materials further hinder access, particularly for new residents, veterans, digitally excluded people, and those with learning needs, many of whom are unaware of available support or entitlements.

4.3.4. Practitioners’ insights: barriers

“Services do not offer unsociable hours appointments for those who work 9-5. Technology is advancing too quickly. Everything, including accessing medical records is a tedious online process which can involve QR codes, online forms and identity checks. It’s not accessible to everyone and can leave certain groups feeling ostracised and discouraged from seeking support from various services.” (Inclusion Health Practitioner)

Practitioners were frustrated by the impact of practical barriers and repeatedly highlighted that simplified, co-located, ‘one-stop’ hubs could significantly reduce practical barriers to engagement and offer a safe, predictable environment. This could foster trusting, supportive relationships and overcome some of the emotional barriers people face.

“[My client] would prefer services to be delivered in one place, so that updates are shared across professionals. [We] discussed the idea of a ‘one-stop’ centre, e.g. the Jean Bishop Centre in Hull, where they could see different specialists in a single visit and get referrals on the day.” (Homeless Navigator)

“[My client] finds it hard to maintain appointments with GP, talking therapy, and homeless navigator. Prefers to attend groups and appointments with support worker present, as this provides reassurance. Would prefer services to be delivered in one place, so that updates are shared across professionals.” (Homeless Navigator)

“We don’t start with services; we start with trust. Once that’s there, everything else follows.” (Outreach Practitioner, The Hepatitis Hep C Trust)

Importance was placed on outreach, in facilitating engagement for individuals who have chaotic lifestyles and may struggle to attend structured appointments. Flexibility and peer-led support are essential to ensure these individuals are not isolated further.

“Patients I engage with live chaotic lifestyles so struggle to attend structured appointments. Outreach to these patients is essential... The nursing teams I work alongside have a great rapport with our client group who can often feel judged and discriminated against. Peer led support is also important in breaking down some of the barriers to treatment.” (The Hepatitis C Trust)

5. Perspectives from key inclusion health services

5.1. Inclusion Health Service

Connections

Practitioners praised East Riding’s social prescribing and community hubs such as The Hinge, Mind Hub, Hope Hub, and Bridlington Christchurch for providing welcoming, non-judgemental spaces that help people build trust and confidence. These settings act as gateways to services like GPs and Job Centres that individuals may previously have avoided. Many clients see them as the only places where they can simply be themselves without pressure to “give anything back”.

An ideal model was described as similar to Hull’s Jean Bishop Centre, bringing multiple services together in one place. Advocacy and chaperoning were seen as central to their service, helping clients gain confidence until they can engage independently, with practitioners’ core skill lying in gradually empowering people through trusted relationships.

Engagement

Engagement with the Inclusion Health Service varies widely and is shaped by each person’s circumstances. Some clients struggle to recognise their own progress, which can lead to frustration and a belief that “nothing has helped,” especially when they expect quick results despite the slow and complex nature of recovery.

The service supports many people with high levels of neurodiversity, often undiagnosed due to long waits or misdiagnosis linked to addiction and mental health needs. Practitioners frequently observe rejection sensitivity and behaviours associated with undiagnosed conditions, highlighting the need for earlier intervention for children and young people.

Public mistrust of local-authority-linked services also affects engagement with the service. Branding of the Inclusion Health vehicle and the presence of council logos can create misconceptions or deter some groups. Staff felt that a clearer, distinct Inclusion Health identity would improve trust and encourage interaction with the health team onboard.

There are strong examples of inclusion-aware practice in the community, such as staff at Bridlington Yorkshire Building Society identifying financial abuse through relationship-building. However, this case also illustrated ongoing system inconsistency, with other involved services failing to share concerns.

Barriers

Staff reported that limited time and capacity make it difficult to offer reflective conversations, as appointments often become “firefighting” due to the complexity of clients’ needs and extensive paperwork. Many clients also experience apathy and hopelessness after feeling repeatedly let down by services, which undermines trust and makes engagement harder. Low confidence and difficulty navigating complex systems mean people often give up when faced with confusing processes.

“Apathy is a problem. The people we work with are on the fringes of society, feeling that they have been let down, that nothing is going to happen or change, so why bother?”

Trust, once established, is fragile. Several clients built up courage to seek help but felt dismissed or misinformed, leading to humiliation and withdrawal. Fear of being directed back to the same negative experiences further contributes to reluctance to re-engage.

Digital exclusion remains a major issue, especially for older people and those without devices or skills. The shift to online systems, multi-step authentication, and automated phone lines makes essential services feel inaccessible, reinforcing inequalities.

Transport barriers also limit engagement, particularly in areas like Bridlington where hospital appointments require long journeys. While support schemes exist, low awareness and unclear eligibility add to the challenge. Occasional taxi funding helps only a few, leaving many without workable options.

Confusion about what services offer and how to access them is widespread. Even professionals struggle to keep up with changing referral routes and benefit processes. Many clients do not realise that organisations like CAB can support with complex forms, leading to missed opportunities and increased vulnerability. Staff highlighted how issues such as debt, housing, benefits, and mental health interlink, and suggested adopting preventative models, such as CAB’s ‘Breathing Space’, to give people time to stabilise.

Service continuity remains a challenge, with many health services operating strictly 9-5. This excludes people who cannot take time off work or whose lifestyles don’t fit traditional service patterns. Outreach and late-night clinics are more accessible, though home visits are rare due to safety assessments, limiting options for those unable to travel.

5.2. Nacro

Connections

Individuals leaving prison often become isolated when placed out of area, losing contact with family and familiar services. This increases vulnerability and makes it harder to attend essential appointments. Support workers play a key role in bridging these gaps through advocacy, practical help, and trust-building. Low confidence and fear of stigma frequently deter people from engaging with services, and many feel unworthy or unsure where to start. Nacro’s person-centred approach focuses on meeting basic needs first, offering informal support, and reducing stigma through strong, supportive relationships.

Engagement

Engagement with key statutory services is often blocked or disjointed by unclear thresholds and poor communication, leaving people without support. Statutory services are seen as inconsistent, while voluntary organisations take a more proactive, person-centred role. Nacro frequently ends up coordinating care and driving multi-agency work due to limited responses from statutory partners.

Progress often depends on individual advocates rather than system processes. Co-located and integrated service hubs are viewed as more effective for improving access.

Barriers

Barriers to engagement are wide-ranging. Language difficulties persist for ethnic minority groups, as jargon and complex terms remain hard to navigate even with interpreters. Prison leavers face gaps in mental health care, stigma, and a lack of resources, leaving many excluded from essential services. Support workers play a crucial role but are limited by restrictive policies and insufficient practical support.

Digital exclusion affects those without phones or internet, while transport issues and geographic boundaries further limit access. Low literacy, bureaucracy, and criminal justice histories deter people from engaging and contribute to unmet needs. Mental health services often exclude people with dual diagnoses, and housing instability reinforces cycles of homelessness. Discriminatory attitudes, particularly toward those with substance use issues or criminal records, further undermine access to support.

5.3. MAPPA social work team: perspectives from working within prisons and with prison leavers

In prison, healthcare is delivered more consistently, but significant gaps appear when people move into the community. Mental health and long-term condition needs are often unmet on release, contributing to mistrust and disengagement.

A major issue is the way mental health cases are closed immediately if someone declines support, even temporarily. Because capacity assessments are not undertaken in custody and waiting lists are long, many individuals reach support too late and feel let down.

“[Mental health support is] a system which closes people down if they change their minds.”

Poor communication between prison and community services further disrupts continuity, with slow or incomplete information sharing and unclear referral routes. Examples included prison leavers receiving crisis numbers rather than proper mental health support after moving areas. These experiences leave people feeling abandoned and unsure why they should re-engage. MAPPA professionals described this as a wider loss of confidence in services.

Practitioners noted that the current “first refusal close” approach reinforces disengagement. Instead, they emphasised the value of returning to check on someone and exercising professional curiosity as an approach that often rebuilds trust and reopens access to support.

“We need safe services and boots on the ground.”

MAPPA staff stressed that embedding this proactive, relationship-based approach into system processes instead of relying on individual workers would help prevent premature case closures and ensure people feel heard and supported. They also highlighted the importance of early education about available support to build confidence long before individuals reach crisis.

6. System level recommendations and practical implications

This report highlights lived experience, furthering insights from the Inclusion Health Needs Assessment (2024) to present refined recommendations aimed at informing current and future system-level workstreams. Engaging with people who have lived experience is fundamental to each of these recommendations and how we drive action toward meaningful change.

It is proposed that the following recommendations be established, or formalised where activity is already underway, into structured workstreams to deliver on these recommendations and act in response to the insights and gaps in this report. Overall portfolio accountability and governance for the Inclusion Health Needs Assessment will be held by East Riding of Yorkshire Council Public Health, in line with its statutory responsibilities. Delivery oversight and system coordination will be aligned to current Health and Care Committee and Inclusion Health Sub-Group arrangements, with the Needs Assessment remaining under East Riding of Yorkshire Council's Public Health Inclusion Health portfolio regardless of any future ICB or Health and Care Committee structural changes.

6.1. Targeted recommendations

While the themes in this report are not explicitly linked to specific individuals or inclusion health groups, there are notable gaps in the representation of certain recognised groups, particularly people engaged in sex work, Gypsy, Roma and Traveller communities, and vulnerable migrants. These gaps highlight the need to strengthen connections with professionals who work closely with these populations, invest time in building relationships within VCSE and community settings, and address barriers that currently hinder engagement.

The Inclusion Health Needs Assessment (2024) set out a comprehensive range of recommendations for each Inclusion Health group. The recommendations outlined below have been developed to focus on areas where engagement and insight are currently most limited, representing priority actions to address the most significant gaps. In doing so, we also acknowledge the vital role of other service areas that work with these groups and will ensure their contributions and perspectives inform this process. While these recommendations target immediate priorities, all other recommendations remain important and will continue to shape future planning and service development.

Proposed targeted recommendations

Gypsy, Roma and Travellers

1. Establish a targeted workstream in partnership with site staff, VCSE partners, and Gypsy, Roma and Traveller communities to strengthen relationships and improve understanding of local health and wellbeing needs.
2. Prioritise relational engagement and trust-building approaches to support the inclusion of lived experience insight within wider system planning and service design.

Vulnerable Migrants

1. Strengthen connections with professionals, VCSE organisations, and community groups working with vulnerable migrant populations to improve insight into access barriers and unmet need.

2. Review learning and effective practice from other areas to inform local approaches.
3. Support and build on existing local initiatives, including the Moorlands project in Goole, to enhance relational engagement and continuity of support.

Sexual Health and Sex Work

1. Build engagement and insight with people who have lived experience of sex working, recognising the additional barriers created by stigma, safety concerns, and mistrust of statutory services.
2. Work collaboratively with professionals and people with lived experience from Hull and East Riding to evolve the Hull and East Riding Inclusion Health / Sexual Health Workshop into a delivery-focused group that supports shared learning, relationship-based practice, and improved coordination.

Children, Families, and Care Experience

1. Strengthen partnership working between social care teams and Public Health to share insight on health needs, learning, and emerging risks for children, families, and care-experienced people.
2. Build opportunities to incorporate lived experience insight from care-experienced people into relevant inclusion health activity.
3. Embed inclusion health principles and frameworks within existing work relating to children, young people, and families, ensuring alignment with broader population health and prevention approaches.

6.2. Universal recommendations

In acknowledgement of the findings and general recommendations of the Inclusion Health Needs Assessment (2024) and of this report, the following ‘universal’ recommendations are proposed. This report identifies systemic barriers that contribute to widening health inequalities for people experiencing social exclusion, indicating a need for universal, system-level action on inclusion health to address barriers and support outcomes. The adoption of a Health in All Policies (HiAP) approach is positioned as a core element of this system-level response, supporting the routine consideration of potential impacts on people experiencing social exclusion within existing policy development, strategic planning, and partnership decision-making across health, care, housing, transport, and wider public services. This supports the framing of inclusion health on a strategic level as a cross-cutting lens that informs priorities, reduces unintended exclusion, and supports alignment across place-based and population health activity. Broader system change is therefore understood to be enabled primarily through policy alignment, partnership governance, and shared accountability.

Within this approach, East Riding of Yorkshire Council Public Health will retain portfolio accountability for Inclusion Health, while delivery will be driven through collective action across health, care, local authority, VCSE, and wider system partners. Governance will remain aligned to existing statutory and partnership arrangements, irrespective of wider structural change.

Population health: embedding inclusion health within population health approaches on a local and regional level

Evidence from this assessment highlights that inclusion health needs are experienced unevenly across places, shaped by local service configuration, access to community assets, and the strength of multi-agency coordination. Protective factors identified through the consultation, including trusted community hubs, outreach, and relationship-based practice, align strongly with a population health and place-based approach, particularly at neighbourhood level through Neighbourhood Health Partnerships (NHPs).

Embedding inclusion health within population health approaches supports equity by ensuring that people experiencing social exclusion are visible within local intelligence, planning, and delivery, rather than relying on reactive or service-specific responses. This approach reflects the finding that inclusion health is not confined to specific groups, but emerges where systems, environments, and access models fail to accommodate complexity, trauma, or instability.

Implications for population health:

The findings of this needs assessment highlight that embedding Inclusion Health within population health approaches should prioritise the following system-level considerations:

- Enable local flexibility to respond to unmet need, particularly in areas with limited transport, digital exclusion, or sparse service provision
- Support co-located, outreach-based, and extended-hours access models, recognising that standardised 9–5, appointment-led services disproportionately exclude inclusion health populations
- Strengthen minimum access expectations across neighbourhoods, reducing unwarranted variation in availability, continuity, and quality of support
- Build shared understanding of inclusion health across partners, ensuring that population health activity consistently considers people at risk of exclusion
- Invest in workforce capability and local intelligence, combining quantitative data with lived experience insight to understand who is missing from services and why

Policy and process: enhancing inclusion health outcomes through policies and processes

This assessment demonstrates that policies, processes, and system conditions play a critical role in shaping access, engagement, and continuity of care for people with inclusion health needs. Rigid pathways, fragmented referral routes, digital-first defaults, and inflexible attendance policies are shown to act as drivers of exclusion, particularly for people experiencing trauma, housing instability, substance use, or involvement with the criminal justice system.

Within the scope of this consultation, the evidence indicates that relational approaches are most effective where policy and process create the conditions for trust, flexibility, and continuity, rather than constraining practice through bureaucratic or risk-averse design.

The findings suggest that strengthening inclusion health outcomes requires a shift from service-specific or programme-based responses toward a system-wide lens. A Health in All Policies (HiAP) approach enables inclusion health considerations to inform decision-making across policy development, service design, access models, and operating procedures.

Implications for policy and process across the system:

- Apply inclusion health as a cross-cutting consideration within needs assessment, population segmentation, service design, and evaluation
- Ensure policy decisions are informed by co-production with people who have lived experience, alongside joined-up qualitative and quantitative insight
- Embed prevention across service design and access pathways to address system-level barriers.
- Maintain clear and stable governance for inclusion health, with Public Health holding portfolio accountability regardless of wider system or structural change

Communication and engagement: strengthening connections, engagement, and communication around inclusion health

Evidence from this assessment demonstrates that effective engagement with people who have inclusion health needs is built on trusted relationships, welcoming environments, and communication approaches that are tailored to individual contexts. The consultation highlights that trust, familiarity, and relational safety are central to whether people feel able to approach, engage with, and remain connected to services.

The findings also show that communication is not neutral. Branding, language, visibility of statutory organisations, and the way information is shared can either enable engagement or act as a barrier, particularly for people with previous experiences of stigma, trauma, or exclusion. Where communication feels formal, inconsistent, or disconnected from lived realities, individuals are less likely to engage, even when support is available.

Community and VCSE organisations play a critical role in bridging this gap. They are often trusted first points of contact, translating system messages into accessible, relational engagement and providing insight into what works locally. However, this relational role is frequently under-recognised within system communication and engagement approaches.

Implications for communication and engagement across the system:

The evidence indicates that strengthening inclusion health outcomes requires communication and engagement to be treated as a system function, not solely a messaging activity. Effective approaches are those that:

- Are co-produced with people who have lived experience, ensuring language, branding, and information reflect how services are actually perceived and accessed
- Support ongoing relationship-building and outreach, recognising that engagement is often gradual, non-linear, and dependent on trust over time

- Recognise and invest in the role of VCSE organisations as trusted connectors, knowledge holders, and engagement partners for inclusion health populations
- Enable shared learning and feedback loops across partners, so insight from lived experience and frontline practice informs continuous improvement rather than being captured once and lost

7. Conclusion

This Inclusion Health Needs Assessment (IHNA) is grounded in the voices of people experiencing social exclusion and health inequalities in the East Riding, alongside insights from professionals working closely with them. However, it also highlights that engagement with people who have lived experience remains uneven, with some populations and perspectives under-represented within current intelligence. Addressing these gaps is both a key finding of this assessment and central to the purpose of the proposed recommendations that follow.

Evidence from local consultation, case studies, and professional reflection indicates that people with the greatest health and social care needs frequently face the greatest difficulty accessing, navigating, and sustaining support. Within the scope of this consultation, lived experience and practitioner insight consistently show that relational continuity, trust, and emotional safety are the most salient drivers of engagement with services and continuity of care for inclusion health populations observed in this assessment. These findings sit alongside, and do not replace, the well-established role of wider socioeconomic determinants such as poverty, housing insecurity, and structural inequality in shaping long-term health outcomes. Instead, the evidence demonstrates that system design, access models, and service processes often determine whether people experiencing social exclusion are able to engage with support at all and therefore mediate the impact of those wider determinants.

This can be summarised through the following key principles, which describe the inclusion health needs and system pressures identified through this assessment, and which should underpin future health and social care activity, both targeted and universal, across the East Riding.

1. Relationship-based practice and relational continuity

The assessment identifies that the quality and continuity of relationships, rather than the number of services involved, is a critical predictor of engagement, continuity of care, and recovery for inclusion health populations observed in this consultation. Where trust, emotional safety, and consistent relationships are present, people are more likely to engage, re-engage, and sustain involvement with support. Conversely, fragmented pathways, frequent staff changes, and transactional service models undermine these protective factors and increase disengagement.

2. Community and peer-led support as protective factors

Community-based settings and peer-led approaches are consistently identified as low-barrier entry points into support for people who may mistrust or avoid statutory services. These spaces provide social connection, advocacy, and a sense of belonging, particularly for people experiencing isolation, stigma, or trauma. The assessment highlights a reliance on these models to carry relational engagement, alongside a system risk where their capacity and sustainability are not consistently secured.

3. Addressing social isolation and emotional barriers

Social isolation emerges as a significant risk factor for crisis, disengagement, and worsening health outcomes. Trauma, stigma, shame, and previous negative experiences with services compound this isolation and reduce help-seeking. The assessment identifies a need for early identification of isolation, routine consideration of social networks, and approaches that actively reduce stigma and judgement within service environments.

4. Integrated, multi-agency collaboration

Fragmented systems, unclear pathways, and poor continuity between services, particularly at transition points such as release from custody or changes in accommodation, are identified as drivers of exclusion. The assessment demonstrates that integrated, multi-agency working, supported by shared understanding and coordinated planning, reduces duplication, strengthens continuity, and improves people's experience of care.

5. Flexible, person-centered engagement

Rigid, appointment-led, and digital-first access models are shown to disproportionately exclude people experiencing instability, trauma, or chaotic circumstances. The assessment identifies a need for flexible access routes, including outreach, supported engagement, and non-punitive responses to missed appointments, recognising that engagement is often non-linear and shaped by people's wider living conditions.

6. Tackling practical barriers: transport, housing, and financial hardship

Practical barriers such as transport limitations, housing instability, digital exclusion, and financial hardship significantly disrupt continuity of care and access to support. These barriers are cumulative and self-reinforcing, particularly in rural areas. The assessment highlights the need for system responses that maintain continuity of care regardless of accommodation status and reduce reliance on individuals' capacity to navigate complex systems.

7. Trauma-informed, compassionate practice

Trust and safety are critical for sustained involvement. All services should embed trauma-informed, compassionate approaches, with staff trained to recognise trauma impacts. Peer mentors and stable relationships help bridge gaps and reduce fragmentation.