INCLUSION HEALTH NEEDS ASSESSMENT

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East Riding of Yorkshire

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EAST RIDING
OF YORKSHIRE COUNCIL

Executive Summary and Recommendations

Inclusion health refers to the recognition across the health care system of the additional, and often complex, health needs of certain marginalised groups of the population, who may face multiple systemic barriers to health care and are at an increased risk of poorer health outcomes compared to the general population. This includes people who are rough sleeping or at risk of rough sleeping, vulnerable migrants, Gypsy, Roma & Traveller populations, Veterans, Care Leavers, people who engage in sex work, people who are sexually exploited and victims of modern slavery, prison leavers, LGBTQIA+ groups, and people who are dependent on substance use.

Though national research evidences that there are health inequalities and heightened vulnerabilities amongst socially excluded groups, the unmet needs within the East Riding have not yet been comprehensively assessed. The present needs assessment forms an evidence base of the engagement and unmet needs of inclusion health groups in the East Riding. This assimilates quantitative performance and engagement data from health and care services across the authority along with research findings and national trends, qualitative insights from those working most closely with these populations, and the perspectives of people involved in the voluntary, community, and social enterprise (VCSE) network.

Quantitative data repeatedly demonstrates that health inequalities in the East Riding are linked first and foremost to social deprivation, which individuals who are marginalised and underserved in our societies are most at risk of. Communities in the East Riding with the greatest level of deprivation also have the lowest life expectancies, the greatest numbers of preventable deaths, and the worst health outcomes The poorest physical health is seen amongst our most deprived communities, with the greatest rates of obesity, disability, and long-term chronic conditions experienced by those who also face the most adversity such as inadequate accommodation, increased unemployment, and poorer educational attainment. The intersection and influence of these conditions of living on health outcomes is a clear demonstration of how inclusion health needs must be considered across the system of public services beyond health settings alone.

Data, and an absence of data, from services engaging with inclusion health groups has highlighted several areas where actions need to be targeted in order to reduce unmet needs. An example is the experience of care leavers, who have not been typically considered an inclusion health group but for whom the experience of many barriers in the health system including stigmatisation has links to poor mental health outcomes and a failure to present at a service until at crisis point. Identity has also been a barrier for veterans, amongst whom many have not felt aware of the support offers available to them or have felt they do not fit the target group of the service.

Service performance has also been an indication of areas of best practice, whereby a collaboration of voluntary and community groups along with local authority and NHS leads has led to the creation of safe spaces that holistically address health outcomes and facilitate pathways to other services. Bridlington's Wellington Road Community Hub, run by HEY Mind, is an exemplar multidisciplinary service that is continuously increasing its engagement with people sleeping rough and managing their complex substance use and mental health treatment needs alongside supporting access to other health services

Consultation with those working closest to inclusion health groups has been key to informing this needs assessment, and recognises the existing trusting relationships and best practice happening in communities. Professionals have been clear in conveying how better engagement with inclusion health groups will come from services being more flexible and improving accessibility by embedding a person-centred approach in their delivery. Flexible appointment times, increased multidisciplinary collaboration, and improved data sharing will aid professionals to improve their understanding of inclusion health groups and better meet their complex needs. Representatives from the VCSE sector consistently spoke of the need for increased training and awareness around inclusion health, and how this will help to build local intelligence in order to aid responsive service design and delivery.

As this workstream now moves into its second phase of consultation with communities, it is intended that the perspectives of those who are part of inclusion health groups themselves will be increasingly incorporated into this intelligence and used to inform the changes made going forward. It is hoped that strong, trusting, and lasting relationships will be made with inclusion health communities, helping to remove the barriers faced and respond effectively to trends in health and care needs if we are to create sustained reductions in health inequalities.

1. General recommendations for the advancement of inclusion health

I. **Deliver services flexibly**
   - Options such online video appointments, evening and weekend options, ability to reschedule and Did Not Attend policies can help to overcome barriers to accessing services

II. **Increase shared learning, shared best practice, and adaptability**
   - Learn from the parts of the system which are working well in terms of engaging with inclusion health groups and improving health outcomes.

III. **Develop the workforce and improve awareness of inclusion health**
   - Health care professionals and those working with inclusion health groups should be trained to recognise and address inclusion health needs, including cultural competency and education around the wider determinants of health.
   - Targeted awareness campaigns, training programmes should be implemented, with leadership championing these initiatives

IV. **Increase collaboration and partnership working across the conditions of living**
   - Holistic approaches to health using multidisciplinary teams and sharing expertise across the system should be implemented where possible.

V. **Support and develop VCSE networks linked with inclusion health groups**
   - Increase awareness and understanding across the VCSE sector of the nature of inclusion health and the importance of inclusion health work. Continue to support with the development of training and education for VCSE networks.
   - Improve collaboration between VCSE groups, local authority, and local health and care providers, increasing VCSE representation in multidisciplinary meetings and strategic-level influence.
   - Support capacity-building across the VCSE, commissioning into the VCSE where there are existing trusting relationships where possible.

2. Targeted recommendations for services working with inclusion health groups

Vulnerable migrants

Language barriers and a lack of information can prevent migrants from accessing local services. Yet there are strong, trusted connections across the VCSE which are helping to connect and empower these communities. Work needs to build on these connection to ensure that we are maximising the potential points of engagement with the capability to meet the unmet needs identified amongst these groups.

- Ensure services include tailored outreach, accommodating for language, literacy, and digital exclusion needs. Incorporate lived experience and peer-support to guide these where possible.
- Build capacity within the VCSE and support the VCSE to continue their vital work with migrants, empowering migrant communities to be informed and manage their health needs
  - Share learning and best practice from the VCSE
  - Ensure local services such as the Inclusion Health Service are informed about the work happening by VCSE groups engaged with migrant communities, and can connect in where possible.
  - Include VCSE groups who are working with migrants in decision-making and service design, sharing expertise

People who are rough sleeping

There is a lot of work concentrated around people who are homeless, rough sleeping, or at risk of rough sleeping in the East Riding. This is exemplar partnership working, demonstrating how improvements to physical and mental health have been made when tailored services have capacity to manage complex and comorbid needs. It would be beneficial to scale up this work and implement it across the East Riding, in response to the growing number of people rough sleeping and at risk of homelessness. Stronger partnership connections between housing teams, health services, social care, and VCSE organisations would support the holistic management of health needs in relation supporting individuals' conditions of living.

- Expand multidisciplinary partnership working such as Homeless Hub site in Bridlington in order to continue to build trust with rough sleepers and holistically address health needs whilst managing conditions of living.

Gypsy, Roma, and Traveller Communities

There are strong cultural beliefs around health amongst Gypsy, Roma, and Traveller (GRT) communities which can act as a barrier to individuals accessing health care, creating stigma within the community and a lack of awareness of the services or health needs themselves. Overcoming these barriers will be helped by increasing the engagement of health services with these communities, in partnership with, and informed by, the experiences and voices of those working closely within GRT communities who already have trusted relationships.

- Strengthen the connection between professionals who have expertise and trusting rapport with GRT populations with health services
    - Liaise with Gypsy and Traveller Officers who have contact with these communities to direct lived experience consultation and how best to engage
- Improve the connection of GRT populations with health services and education services
    - Ensure professionals are educated and informed about specific needs and identities of this population
    - Work with PCNs to ensure access to GPs and pathways across the health care system are being facilitated
- Improve education, understanding, and awareness of health issues amongst GRT communities, particularly regarding sexual health and mental health
    - Co-produce an education strategy for GRT communities in order to reduce the stigma surrounding mental health and sexual health needs, in order to increase engagement in services and the opportunity for preventative work.

Veterans

Veterans form a large and diverse group, with many differing needs and levels of access to health care. Differences in veterans' identities, such as their generation and recency of being discharged from the Armed Forces, have led to distinct health needs, attitudes, and cultures. Professionals have explained that working with veterans to understand identity is key to increasing engagement through encouraging peer support and improving understanding of the offers available. Services need to understand these nuances to increase engagement and build trust with this community. Incorporating lived experience, sharing best practice, and working with those who have influence amongst this group such as peer mentors would help to ensure services are accessible and appropriate to veterans. The health needs of those supporting veterans and impacted by the veteran lifestyle must also be accounted for, recognising the health inequalities experienced by veterans' families and children that demonstrate the necessity for person-centred, holistic support to be implemented in all services where possible.

- Reduce the inequalities in mental health outcomes by ensuring services can cope with complex needs; investigate gender-specific pathways and targeted mental health outreach for veterans.
- Investigate opportunities to improve physical activity and access to gyms, physical activity clubs, green spaces.
- Develop evidence of substance use needs and drinking culture amongst older veterans

    - Work with East Riding Drugs Partnership Leadership to ensure coordinated and targeted response to potentially-identified unmet treatment needs amongst this cohort, including referral, harm-reduction, and preventative education.
- Ensure access to available services is maximised by working with the veteran community to challenge negative stereotypes, inform and educate, and build relationships.
    - Increase signposting to veterans, improving awareness of the available services and offers
        - Ensure that people are aware of the veteran-specific support available and that they may have to explicitly identify as a veteran in order to access services.
        - Work with PCNs to increase the number of veterans registering with GPs and ensure GPs are 'veteran friendly'
    - Implement assertive outreach of services among veteran communities
    - Build on areas of good practice such as peer-support initiatives amongst veterans
- Ensure services facilitate a person-centred approach and have wrap-around care accounting for the impact on families and children
- Consult further with the veteran community to understand the specific identities, perceptions, and attitudes amongst veteran groups, and how this links to how best to engage with them as well as their support needs.

<u>Care leavers</u>
Care leavers have not traditionally been recognised as an inclusion health group, but professionals working in the local area have identified there are numerous barriers faced by this group when accessing health care and clear inequalities in the health outcomes they experience. These are particularly linked to the conditions of living, with health sometimes having to be the last priority after ensuring basic food, accommodation, and travel needs can be met. Health services must be adaptable and flexible in accommodating people's access needs, embedding lived experience of people who are care leavers into their engagement and outreach strategies.

- Increased data collection at points of contact with care leavers
    - Particularly across mental health services in order to tailor preventative mental health work to this group
- Work with social care colleagues to investigate the experiences of care leavers across public services
    - Understand the experience of care leavers across the health system, including where they face stigma.
    - Investigate the experience of care leavers in maternity services

<u>People who engage in sex work</u>
In the East Riding, the physical and mental health needs of sex workers are relatively unknown due to there being very little opportunity to specifically identify people who are sex working. Stigma surrounding sex working has meant that people often withhold this identity and may not feel comfortable engaging with health services. A key priority is to increase the engagement and intelligence with this group, to destigmatise sex working and improve health outcomes.

- Identify people who sex work when they come into contact with relevant services, such as sexual health.
    - Work with sexual health leads to support the development of a sexual health needs assessment investigating unmet sexual health needs and the demographics of this population
    - Work with sexual health leads to support sexual health needs assessment recommendations and ensure that sexual health services are safe, destigmatised, and accessible to sex workers

    - Increase partnership working between the Inclusion Health Service and sexual health services
- Improve education around sex working amongst professionals, and awareness of the potential health needs and comorbidities

Prison leavers

Prison leavers face a lot of stigma within society and the transition to community health services can be complex. Best practice transitions where there is coordination between prisons, probation, and health services, such as the continuity of care pathway managing the transition to community substance use treatment settings, provide good opportunities for further learning. Embedding this service design and staff expertise into similar contexts where prison leavers are likely to need to transition into community health services will help to strengthen pathways across the system, supporting prison leavers' health outcomes.

LGBTQIA+ groups

More work is needed to analyse available data such as that from the Census, Health & Wellbeing Survey, and Pride events, as well as connecting with LGBTQIA+ - specific spaces led by the VCSE to understand more of people's lived experiences. Across the health system, language has been highlighted as a key barrier for LGBTQIA+ groups, particularly for trans people, who felt that inconsistent and often incorrect language created stigma around their identity and preventing services from feeling inclusive.

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- Ensure service staff are trained and comfortable in using the correct and preferred terminology, as well as aware of possible LGBTQIA+ specific health needs.
    - Work with primary care networks (PCNs) to ensure this training is available for GPs
- Build on best practice in parts of the system where there are strong connections with LGBTQIA+ groups, such as involvement of the Inclusion Health Service in local Pride events and LGBTQIA+ VSCE groups.
- Investigate health protection needs including sexual health and HIV

Contents

1 Introduction

Inclusion health describes health and social needs for people who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence, and complex trauma), and experience stigma and discrimination. This can often lead to barriers in access to healthcare and poor health outcomes, causing health inequalities across the general population, and this can ultimately lead to a lower average age of death. Typically, these barriers include a lower level of engagement with services, difficulty accessing services due to transport or technology requirements, difficulty understanding and navigating the healthcare system, feeling stigmatised within the healthcare system and having negative past experiences, and not speaking the language or being able to read or write.

Inclusion health groups may include people who experience homelessness, people with drug and alcohol dependency, vulnerable migrants and refugees, Gypsy, Roma, and Traveller communities, people in contact with the justice system, victims of modern slavery, people who sex work, members of the LGBTQIA+ community, and other marginalised groups. The NHS England (2023) definition recognises how these individuals often share common experiences such as discrimination and stigma, violence and trauma, poverty, and invisibility in health datasets. These experiences can result in insecure and inadequate housing, very poor access to healthcare services due to service design, and poor experiences with public services. Each of these can be a risk factor for poor health, and typically amongst inclusion health groups it is the interaction of these factors that lead these groups to have poorer health outcomes and even early death compared to other social groups.

The present report uses the term ‘inclusion health’ in reference to actions and services which specifically aim to increase these groups’ engagement with health services and improve their health outcomes to reduce these inequalities.

Inclusion health is not just about health care alone, however. Our health systems need to be inclusive (Marmot., 2010), providing the right conditions for individuals to exhibit positive health behaviours and pro-actively engage with services. This includes having the right pathways in place for people to transition through the system and be signposted to the services they need, ensuring they are accessible to everybody. Understanding how this works and feels like for staff and people engaged with services is the first step to recognising the gaps in need, enabling us to take responsive action to promote inclusion health.

The present needs assessment does this in two ways;

- Firstly, by assessing the quantitative evidence available on the status of inclusion health groups in the East Riding
- Secondly by incorporating qualitative insights from professionals on their work with inclusion health groups and the barriers they face.

This evidence has been gathered through semi-structured interviews with professionals across the East Riding, with the intention of also strengthening relationships and using their knowledge to help guide our approach to working with those who have inclusion health needs. The needs assessment is an iterative process and following its initial publication, a phase of consultation and relationship building with people with lived experience will be undertaken. These insights will help to develop an action plan around the recommendations in order to accurately understand and comprehensively address unmet needs.

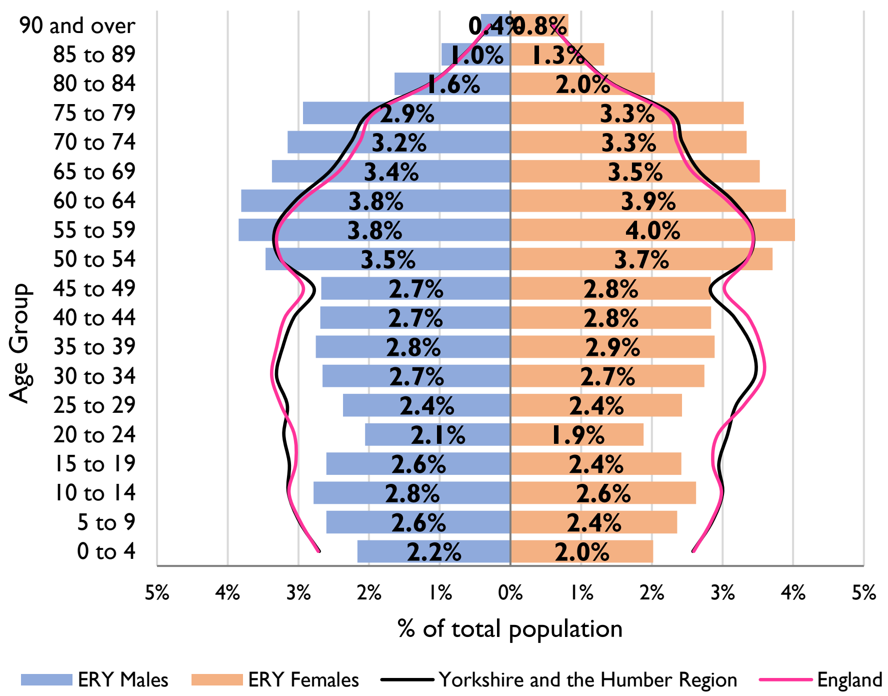
2 Inclusion health in the East Riding

2.1 East Riding demographics

2.1.1 Population overview

The East Riding local authority area covers approximately 930 square miles, making it one of the largest unitary authorities in the country. The 2021 Census estimates the total population within the East Riding to be 342,215 and reported that the East Riding population has a higher proportion of older age groups than both the region and England overall. East Riding residents aged 50 and over made up 49% of the population (region and England were 39% and 38% respectively), whilst residents aged 65 years comprised 26% (19% and 18% respectively for region and England). A population pyramid for the East Riding can be viewed in Figure 2.1.

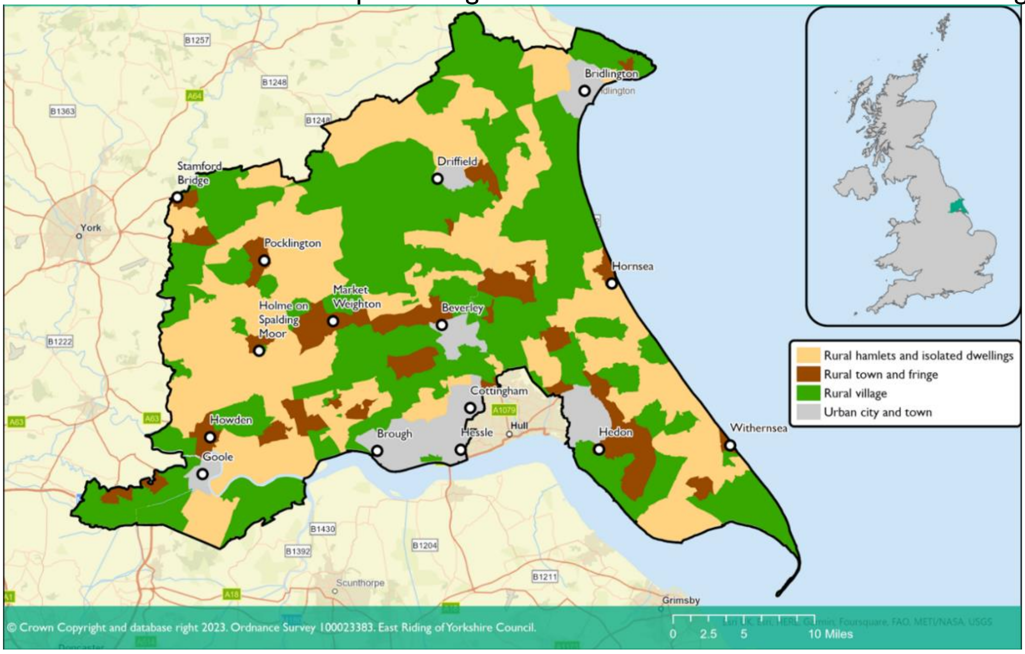
Figure 2.1 - Population pyramid for East Riding of Yorkshire, showing the proportion of each age group split by sex, 2023



Source: Data sourced from Census 2021. East Riding of Yorkshire Council Public Health Intelligence Team, 2024.

2.1.2 Urban, rural and coastal areas

In 2011, the ONS classified the East Riding as being 93% rural by area and 44% rural by population. This results in a low population density of approximately 1.4 people per hectare. According to the Census 2021 population figures, 43.7% (149,683) residents lived in rural areas, while 56.7% (192,535) were urban residents. A map showing urban and rural areas within the East Riding is displayed in



The East Riding also has one of the longest coastlines of any local authority area in England, spanning 52 miles (84.5km) from Flamborough's chalk headland, across the Holderness plain, to the Humber Estuary. Unlike urban and rural areas, there is no specific ONS classification as to what are considered coastal communities.

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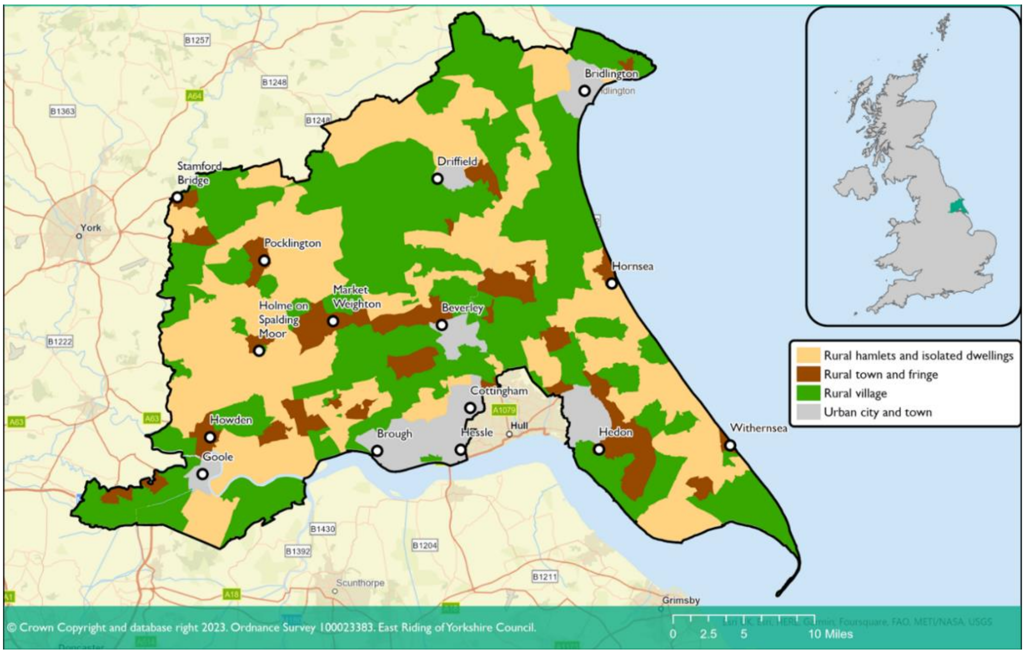
Figure 2.2 - East Riding rural and urban areas, based on 2011 urban/rural classification



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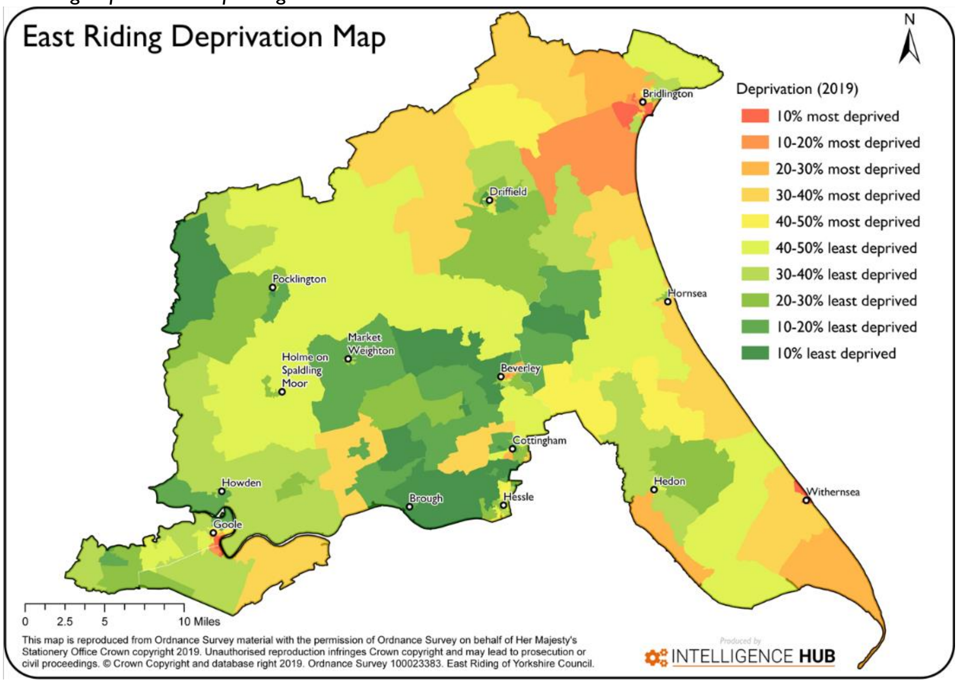
2.1.3 Deprivation

Overall, the East Riding is generally considered to be an affluent area, however, there are substantial variations in deprivation levels within the local authority area. Small geographic areas (known as Lower Super Output Areas, 'LSOAs') within the East Riding are allocated a deprivation decile (or quintile) based on their 2019 index of multiple deprivation (IMD) score and how they compare to other LSOAs nationally. Figure 2.3 displays LSOA areas of the East Riding as deprivation deciles, with the more deprived areas coloured red or dark orange. Coastal areas such as Bridlington and Withernsea both contain communities which are not only some of the most deprived in the East Riding and also within England overall. An interactive map can be accessed from this link: Intelligence Hub.

Figure 2.3 - East Riding deprivation map using IMD 2019



Source: East Riding of Yorkshire Council Intelligence Hub, 2024.

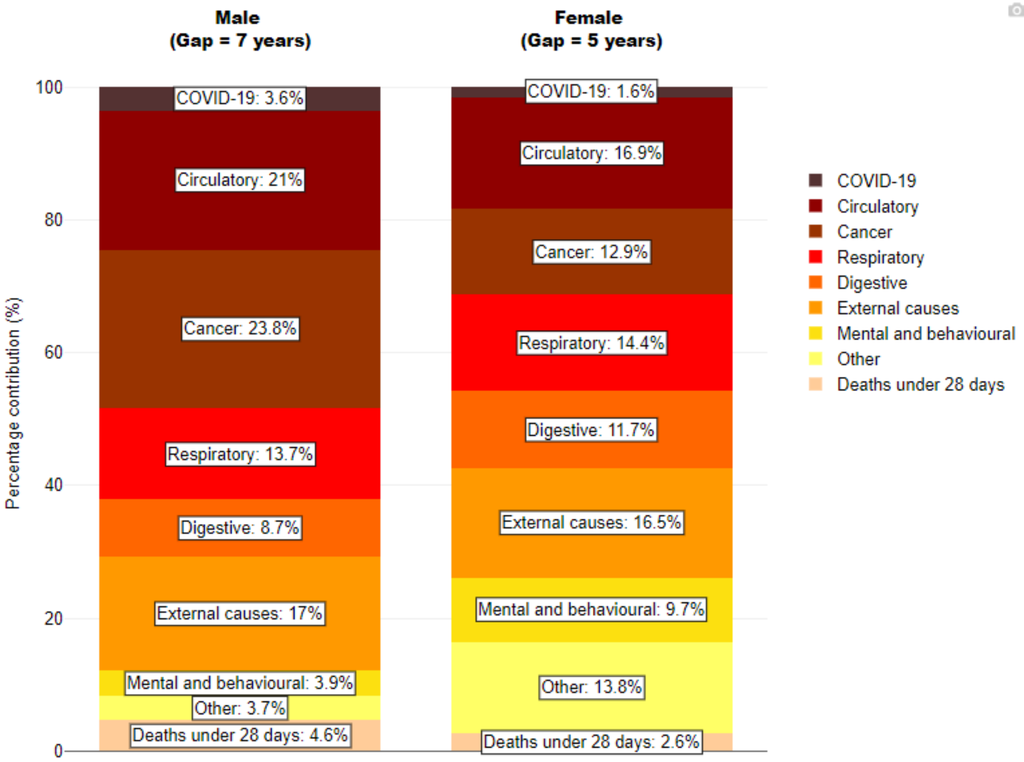
2.2 Health Inequalities across the East Riding

2.2.1 Life expectancy and mortality

Life expectancy is most often used as a measure to examine and quantify health inequalities, as it is closely related to people's health outcomes and socio-economic circumstances (Williams, et al., 2022).

The OHID 'Segment Tool' examines the causes of death and the specific age groups which contribute to the inequalities in life expectancy, within England and local authorities individually. Figure 2.4 highlights the diseases which have contributed to inequality within the East Riding for males and females. For males, the largest contributor to mortality inequality was cancer (23.8%), and for females it was circulatory diseases (16.9%).

Figure 2.4 - Breakdown of the life expectancy gap between the most and least deprived quintiles of East Riding of Yorkshire by cause of death, 2020 to 2021.



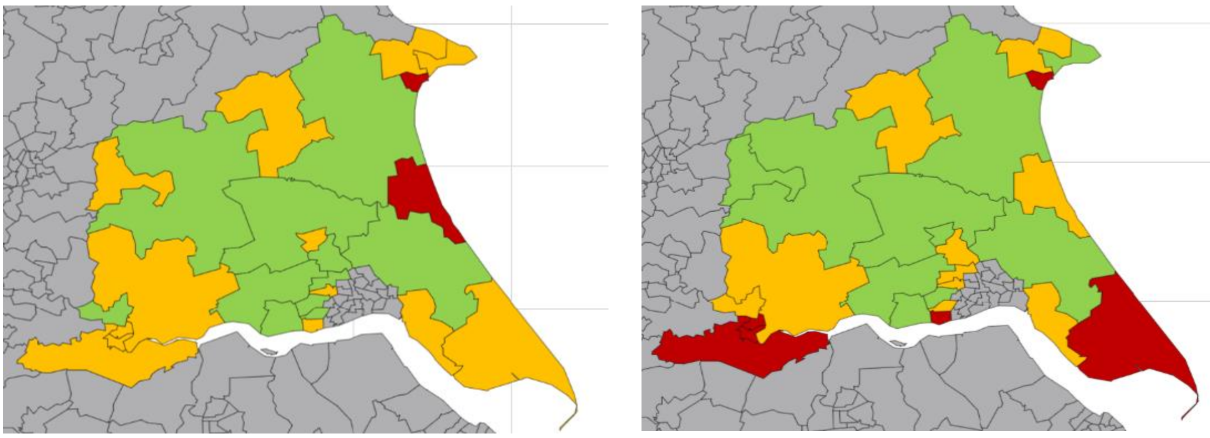
Source: OHID., 2024. Segment tool. Available online at: https://analytics.phe.gov.uk/apps/segment-tool/

Figure 2.5 below highlights how life expectancy differs across the geographies of the East Riding for males and females. The lowest life expectancies occur in coastal communities such as the areas of Withernsea, Hornsea and Bridlington, as well as Goole and surrounding area.

Figure 2.5 - Male and female life expectancy at birth across all East Riding wards

Male

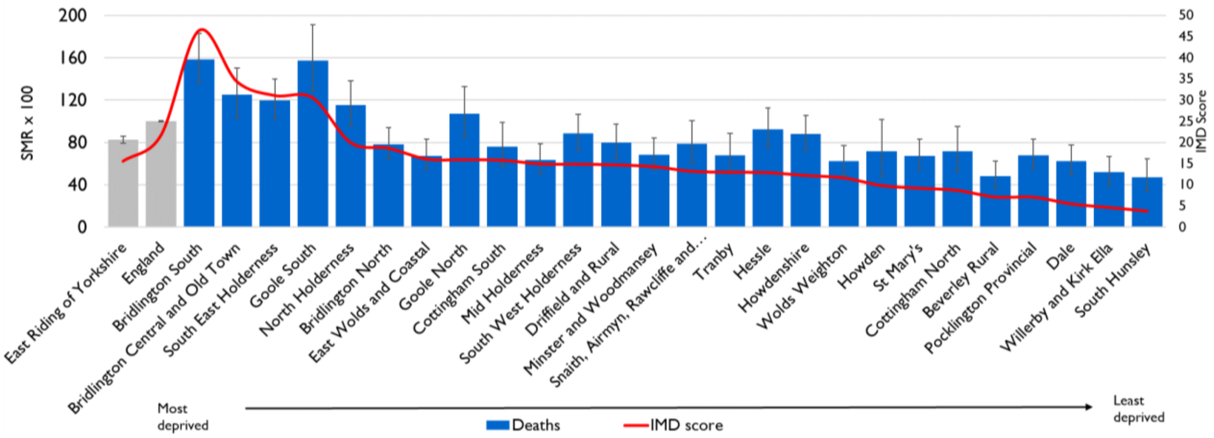
Female



N.B. Areas shaded in red denote wards with a significantly higher life expectancy than the East Riding average. Yellow shading denotes no significant difference to the East Riding average, and green shows wards where it is significantly lower than the East Riding average.

Figure 5.1 and Figure 5.2 (within Appendix B) illustrate how the inequalities in health outcomes are linked to deprivation, to the extent that the lowest life expectancies within the East Riding are seen in the most deprived wards. This matches national trends, where research has demonstrated that living in a different postcode can change healthy life expectancy (Lov-Koh et al., 2015). For example, in the East Riding, Bridlington South (the most deprived ward) records the lowest life expectancy of all wards in the county for both males and females (73.6 years and 80.4 years respectively). This is in contrast to South Hunsley (the least deprived ward) where life expectancy is calculated to be almost 10 years higher for males (at 82.3 years) and 6 years higher for females (85.9 years).

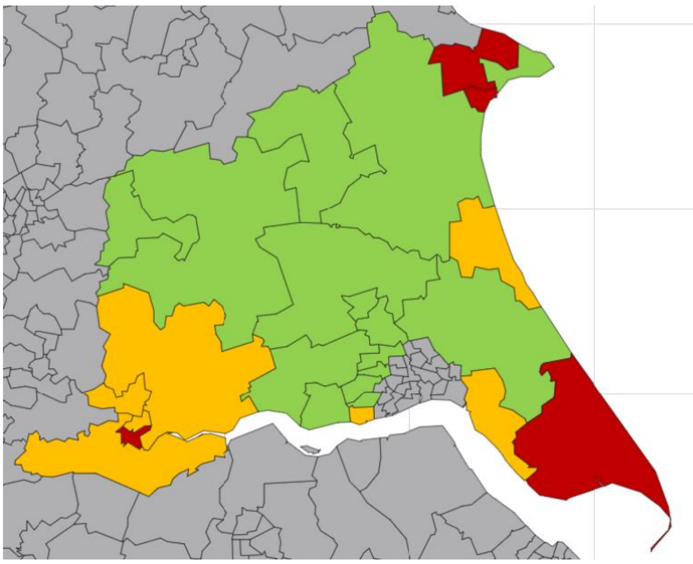
Figure 2.6 - Deaths from all causes considered preventable amongst those under 75 years in East Riding wards, standardised mortality ratio, 2016-20



Source: PHE Fingertips (2024)

Figures 2.6 and 20.7 show the geographic differences in preventable mortality across the East Riding, again showing inequalities linked to deprivation with the highest rates occurring in wards in the Withernsea, Goole, and Bridlington areas. The concept of preventable, or avoidable, mortality is recognised as an indicator of how population health is amenable to the quality of health care, access to health care, and other systemic barriers including wider conditions of living that are faced by a population (Nolte & McKee., 2004).

Figure 2.7 - Deaths from causes considered preventable, <75 years, for East Riding Wards. Standardised mortality ratio, 2016-20.



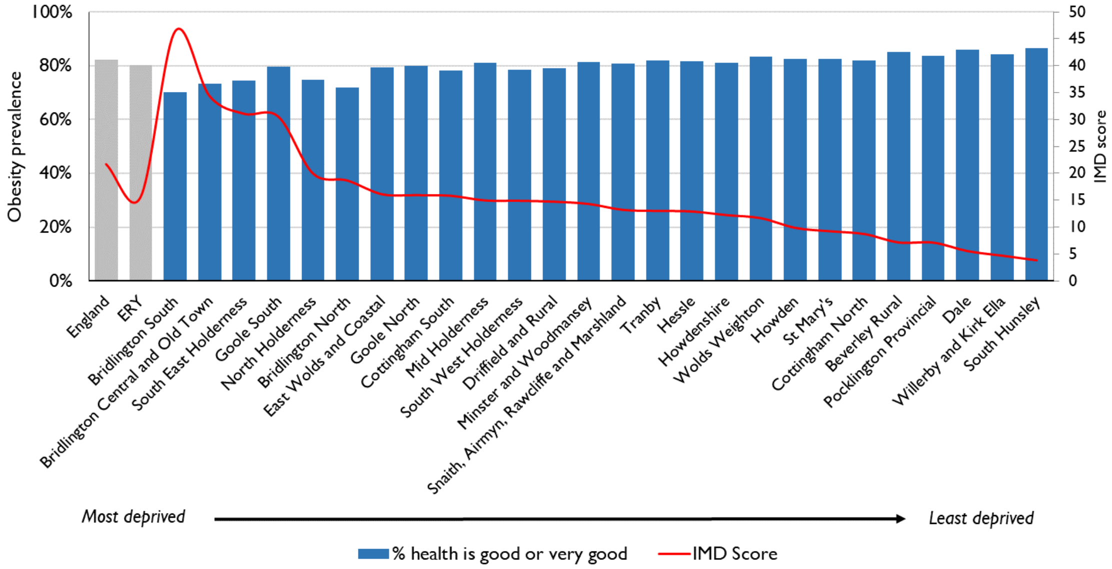
N.b. Red is significantly higher than England, amber is similar, green is significantly lower.

2.2.2 Health outcomes

The 2021 Census reported that, nationally, a lower proportion of people in the most-deprived areas stated that they were in very good health when compared with the least-deprived areas and that a higher proportion living in deprived areas assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses (a definition of a disability in line with the Equality Act, 2010.

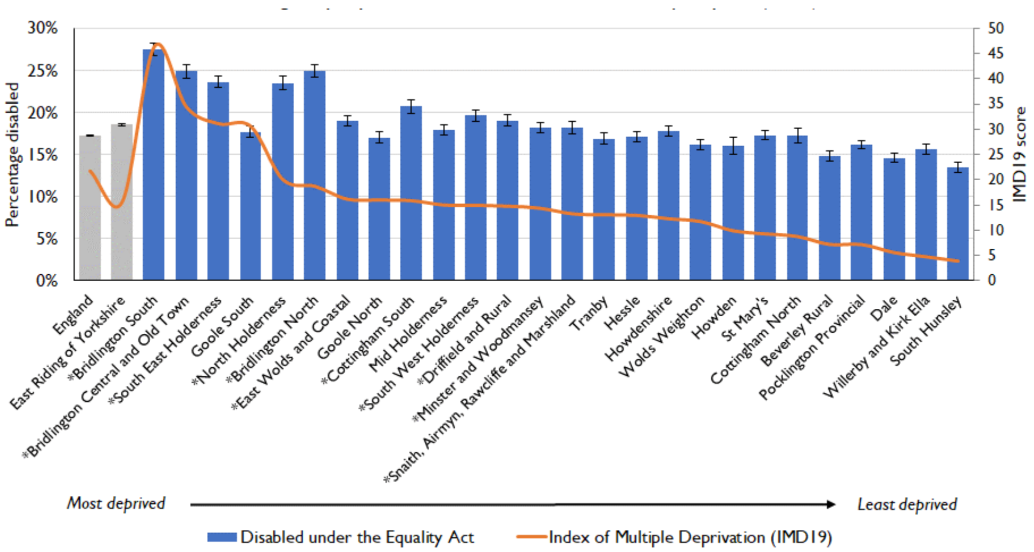
This was also recorded in the East Riding. Figure 2.8 shows that a lower proportion of residents in more deprived wards reported their health to be good or very good (e.g. 70.2% in Bridlington South) compared with least deprived wards (e.g. 86.6% in South Hunsley). Regarding disability, there was a higher prevalence within the more deprived wards (28.6% in Bridlington South) compared to the least deprived (14.8% in South Hunsley). Figure 2.9 displays the East Riding ward prevalence of disability.

Figure 2.8 - Percentage of population in good or very good health, East Riding wards.



Source: East Riding of Yorkshire Council Rural and Coastal Needs Assessment., 2024. Data sourced from Census 2021.

Figure 2.9 - Percentage of population assessing day-to-day activities as limited by long-term conditions or illnesses, East Riding of Yorkshire, 2021.

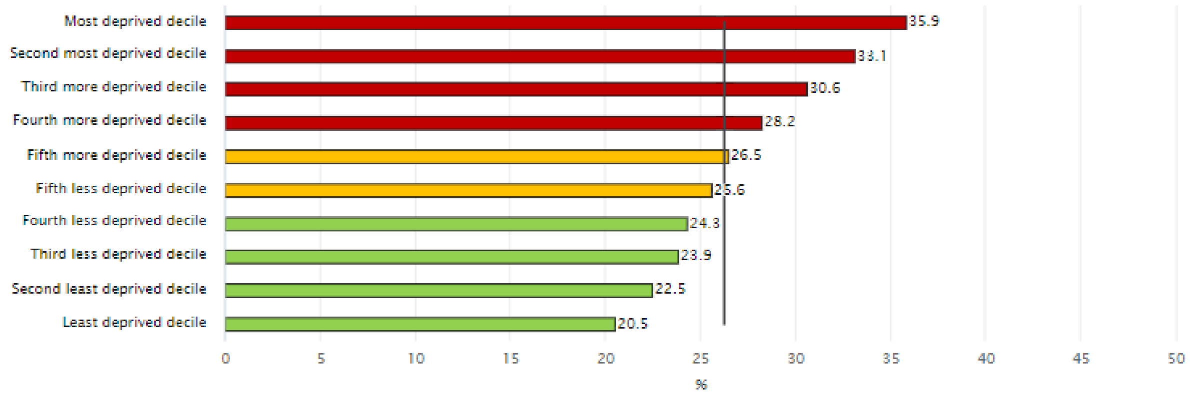


Source: Census 2021. ** Denotes significantly higher than the England average.*

Obesity

Obesity is associated with a wide range of health risks, including type 2 diabetes, cardiovascular diseases, certain types of cancer, and respiratory problems. Obesity can also lead to musculoskeletal disorders, such as osteoarthritis, and has been linked to mental health issues, including depression and anxiety. Over a quarter of adults (aged 18+ years) were recorded obese in 2022/23 (PHE., 2024) and the prevalence has been steadily climbing in recent years, rising from 22.6% in 2015/16 to 26.2% in 2022/23. In England obesity is starkly more prevalent in more deprived areas as illustrated in Figure 2.10. The 4 most deprived deciles are all significantly higher than the England average, with a contrast in obesity prevalence in the most and least deprived deciles of 35.9% and 20.5% respectively. In the East Riding adult obesity was at 27.7% in 2022/23 and the prevalence has not varied significantly since 2015/16. There was no deprivation analysis available for East Riding adult obesity.

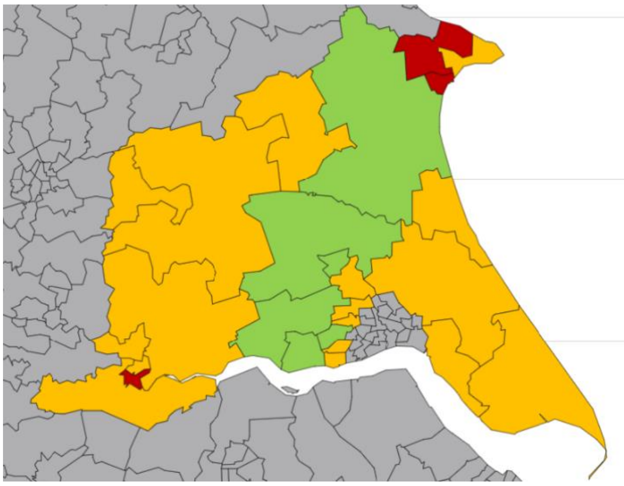
Figure 2.10 - Obesity prevalence in adults (18+ years), England overall, IMD 2019 deprivation deciles, 2022/23. Grey vertical line shows England average.



Source: OHID Fingertips., 2024

Obesity in East Riding Year 6*[1]children has increased in the 5 year period between 2017/18 and 2022/23, from 15.5% to 21.4%, however it was within the most deprived communities that a higher prevalence was recorded. Figure 2.11 highlights in red, the wards with a significantly higher prevalence than England average, which are also the 3 most deprived Eat Riding wards. Bridlington Central and Old Town (2nd most deprived East Riding ward) recorded a 30% obesity prevalence, in comparison with South Hunsley (least deprived ward) at 13.1%.

Figure 2.11 – Prevalence of obesity across the East Riding, 2020/21-22/23.



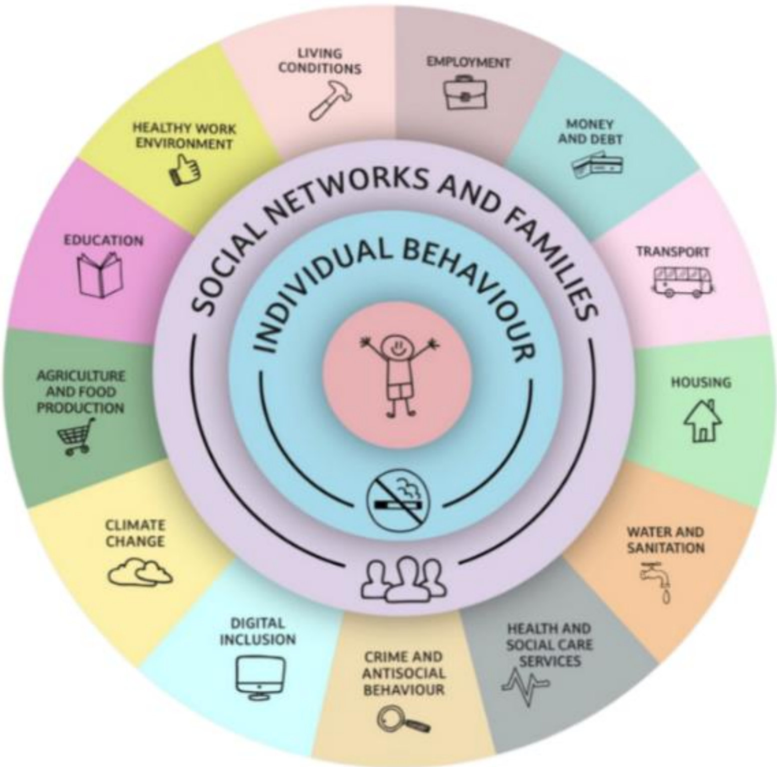
Source: OHID Fingertips., 2024

*Children in year 6 and reception are weighed and measured annually as part of the National Child Measurement Programme and from which weight categories are calculated to each cohort.

2.3 Wider determinants

There are clear health inequalities across the East Riding, demonstrating the impact that wider determinants such as housing, literacy, conditions of living etc. associated with deprivation can have on health outcomes. Figure 2.1 shows how these 'conditions of living' are considered determinants of health along with social networks and families and individuals' own behaviours. Whilst anybody may have an inclusion health need, the evidence is clear that the people who are most at risk of ill-health are those who are exposed to detrimental conditions of living and may therefore have more complex needs, which is consistently those living in the most deprived areas of the East Riding.

Figure 2.12 – Conditions of Living Wheel



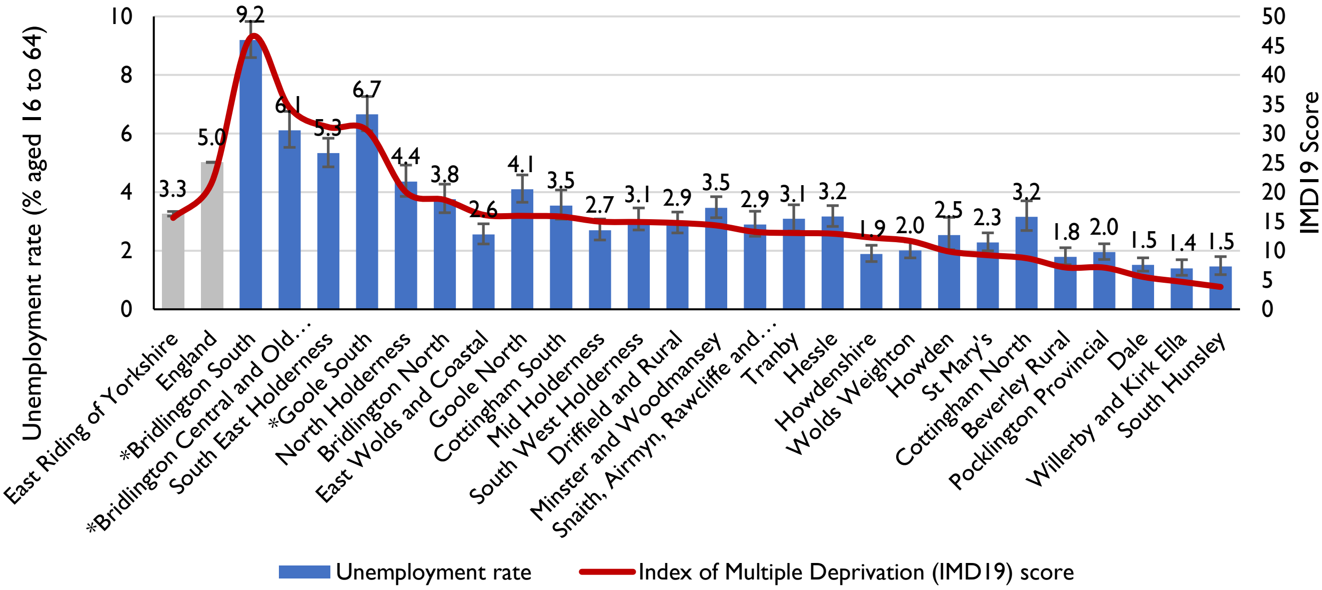
Deprivation can be measured using the Index of Multiple Deprivation scale, 'IMD19'. The following section highlights certain conditions of living such as employment and accommodation, and overlays the deprivation score to demonstrate how we consistently see the worst outcomes (such as the highest figures for unemployment or bedroom occupancy) amongst the most deprived compared to the least deprived populations of the East Riding.

This highlights why deprivation, as a result of the combination of our conditions of living, predicts greater risk of poor health outcomes, and why we therefore see health inequalities between our most and least deprived populations. Inclusion health populations may not necessarily be the most deprived; however, marginalisation across these conditions of living is another reason their risk of poor health is increased.

2.3.1 Employment

Employment is a cornerstone of economic stability and personal well-being. However, in the UK, significant disparities exist in employment opportunities and outcomes between those living in the most and least deprived areas. These disparities perpetuate cycles of poverty and social inequality, affecting not only individuals but also society as a whole. The unemployment rates within the wards of the East Riding during 2021/22 are illustrated in Figure 2.13, which highlights that the most deprived communities of the county have higher rates of unemployment. For example, Bridlington South, the ward with the highest IMD score (i.e. the most deprived) in the East Riding recorded 9.2% in this period over 6 times higher than the rate in the least deprived ward (South Hunsley) at 1.5%.

Figure 2.13 - Comparison of unemployment rates (% aged 16-64) and deprivation scores across ER Wards (2021-22)



N.b. *Denotes unemployment rate is significantly greater than England rate. Primary axis shows unemployment, as percentage of the working age population (aged 16-64) claiming out-of-work benefit in England, 2020-2021, overlaid with Index of Multiple Deprivation (IMD19) score for each electoral ward on secondary axis. A higher deprivation score equates to a more deprived area. Source: OHID Fingertips (2023). Public health profiles, indicator 93097.

2.3.2 Income

The IMD 2019 features two specific domains relating to income deprivation and gives an income deprivation score to each LSOA of the East Riding, for each domain.

- Income Deprivation Affecting Children Index (IDACI): estimates the proportion of children aged 0 to 15 years living in income-deprived families (as defined by receipt of various benefits or tax credits with an income below 60% of the national median before housing costs).

- Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of all those aged 60 or over, who experience income deprivation.

Both indicators highlighted areas of Bridlington, Withernsea, Goole and Swinemoor (Beverley) within the East Riding, as being within the 10% or 20% most deprived areas of England.

An interactive IMD 2019 map can be accessed from this link: Intelligence Hub.

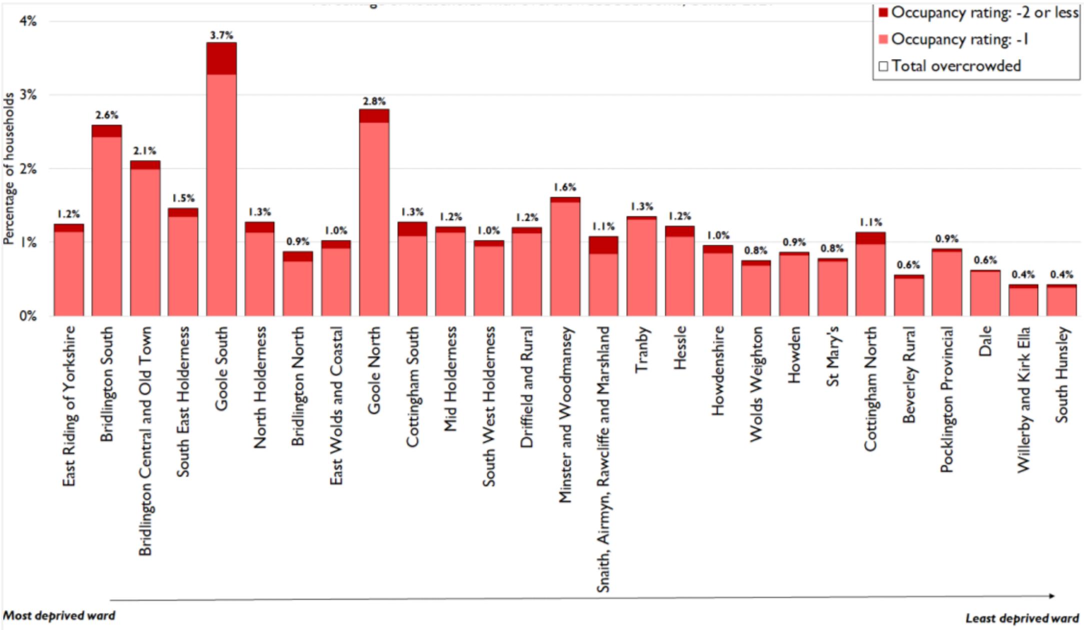
2.3.3 Housing and living environment

Part of the 2021 Census focussed on households and it enabled identification of those which were overcrowded based on overall room occupancy levels.Whether a household's accommodation is overcrowded, ideally occupied or under-occupied is calculated by comparing the number of bedrooms the household requires to the number of available bedrooms. A negative occupancy rating implies that a household's accommodation has fewer bedrooms than required and is considered overcrowded, with a rating of -1 meaning the household has one fewer bedroom than would be required, and a rating of -2 or less has two (or more) fewer bedrooms than is required.

In 2021, 1.2% of all households in East Riding of Yorkshire were rated as being overcrowded, however, Minster and Woodmansey, Bridlington Central and Old Town, Bridlington South, Goole North, and

Goole South had significantly higher proportions than this. Also, 0.4% of households in Goole South have two (or more) fewer bedrooms than required, which is four times higher than is seen across the whole of East Riding of Yorkshire.

Figure 2.14 - Households with overcrowded bedrooms by wards and occupancy rating, 2021



Source: TS052: Occupancy rating for bedrooms, Census 2021

2.3.4 Ethnicity and language

The 2021 Census provided data about the main language spoken within the East Riding overall and the communities. Table 2.1 displays the top 10 main languages spoken within the East Riding, with almost 98% of residents stating that English was their main language. Of other languages, Polish was the most commonly spoken.

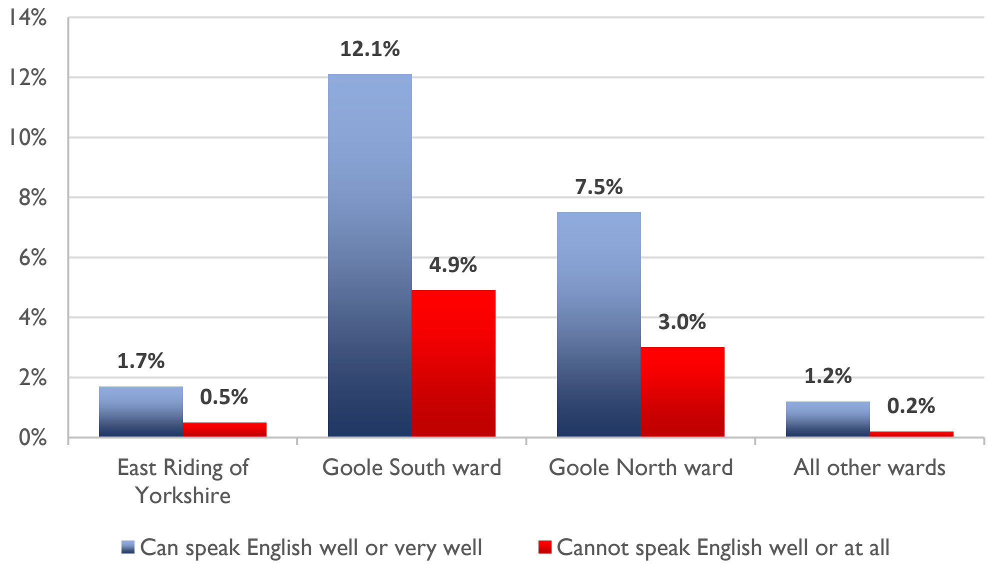
Table 2.1 - Top 10 main languages spoken in the East Riding, residents aged 3 years and over, 2021.

Main language	**Count**	**% of population (aged over 3 years)**
English	326,484	97.81%
Polish	1,672	0.50%
Latvian	626	0.19%
Russian	575	0.17%
Romanian	529	0.16%
Portuguese	355	0.11%
Lithuanian	344	0.10%
Bulgarian	276	0.08%
Arabic	240	0.07%
Spanish	207	0.06%
All others	2,501	0.75%

Source: Census 2021, indicator TS024 - Main language (detailed)

Of the 2.2% percent of the East Riding population whose main language was not English, 0.5% of the East Riding population could not speak English or could not speak English well. Goole had the highest number of residents with a non-English main language, accounting for 39% of all residents whose main language was not English.

Figure 2.15 Percentage of East Riding population whose main language is not English, by proficiency in English



Source: TS029 Proficiency in English, Census 2021.

2.4 Inclusion Health Service

The East Riding Inclusion Health service has been designed utilising proactive outreach and engagement strategies to reach underserved populations, recognizing that barriers to healthcare often extend beyond traditional service models. It uses a dedicated mobile vehicle to deliver accessible outreach and inreach healthcare to individuals with complex inclusion health needs. It operates following the guidance of the NHS Inclusion Health Framework, facilitating referrals and promoting collaboration across wider service areas such as housing with local organisations.

2.4.1 Key services

The East Riding Inclusion Health Service provides the following services on the vehicle and within the community:

- Primary and community health access
    - Opportunities for these groups to access healthcare, including GP and dental registrations, alongside advice on preventive health, health promotion, and lifestyle choices.
- Support for wider determinants of health
    - Guidance on housing, employment, benefits, debt management, and domestic abuse services to address health's social determinants and mitigate early harm.
- Targeted health interventions
    - Immediate access to harm reduction services like needle exchange, wound care, screenings, NHS health checks, and mental health support. It also offers practical support through resources such as hygiene supplies, emergency weather gear, and food.
- Specialised and person-centred support
    - Substance use support, overdose prevention, BBV testing (e.g., Hepatitis B and C, HIV), and education on safer substance use, contraception, and bloodborne infections. The team provides advocacy and even accompanies individuals to appointments to ensure continuity of care.
- Rapid-response

  - Identification of immediate safeguarding needs for at-risk individuals, such as survivors of domestic abuse or modern slavery, and referral to appropriate services.

The Inclusion Health Service partners with numerous of system partners across the public, voluntary, and community sectors to enhance the support available to its service users. Notable collaborations include The East Riding Homeless Hub in Bridlington, The Shores in Withernsea, The Hinge in Bridlington, Cherry Tree Centre in Beverley, and the People's Pantry in Market Weighton and Pocklington. The network also includes Migrant Health, Thwaite Hall, various hostels, Montague House, Haven, YPSMS/IPED, Bishop Burton College, East Riding College (Beverley and Bridlington sites), Driffield College, and numerous local services and organizations such as the Active Communities Team, Healthy Lifestyles Team, Active Withernsea, Housing, and Oral Health. Community groups like Mind, Humber Bridge Well-being Hub, Zion Church (Cottingham), Reform Church (Cottingham), Methodist Church (Hedon), and the Primary Care Network (PCN) are also engaged.

The Inclusion Health Service has actively participated in Pride and LGBT+ events, IPED initiatives, and has previously offered support to various migrant resettlement programmes. By incorporating feedback from service users and community stakeholders, the program continuously adapts to meet evolving needs.

2.4.2 Key activities

The Inclusion Health Service has had a high level of community interaction and support provided across the East Riding. A summary of key activities during the period of January 2024 to September 2024 includes:

- A total of 1,982 engagements on the Inclusion health vehicle alone
- Advice on substance use has been offered through 366 activities year-to-date
- Support for emotional wellbeing has been provided 28 times
- Blood pressure checks are regularly conducted, with follow-ups and referrals to GPs when necessary, and general advice and support have been provided 97 times so far
- 107 hygiene kits distributed
- Signposting and referrals include consistent connections to drug and alcohol services (East Riding Partnership), mental health services, and other community health resources, such as Community Links and Health Trainers. Specific inquiries, including those related to menopause, cholesterol, BBV testing, dental health, and COVID, are addressed as needed, alongside regular assistance with housing and homelessness.

2.4.3 Feedback from professionals and people engaged with the service

The East Riding Partnership (ERP) and the Alcohol and Drugs Service (ADS), operating under the Humber Teaching NHS Foundation Trust, are commissioned by East Riding of Yorkshire Council's Public Health to deliver the Inclusion Health Service as part of an integrated addictions and inclusion health service. We have consulted with ERP and ADS to gather insights to inform the inclusion health needs assessment. By collecting their feedback, we aim to identify areas for improvement and enhance the overall effectiveness of the inclusion health service. The findings are as follows:

Engagement with inclusion health groups:

- People who are rough sleeping or homeless: The service attends the Homeless Hub in Bridlington to actively engage with homeless individuals, providing essential support with access to health care such as GP registrations, signposting to other services, and providing substance use, mental health, and other health advice

- People with substance dependence: signposting and referral to treatment services, harm reduction advice and interventions including naloxone and needle exchange
- People involved in the criminal justice system: Efforts are made to support individuals who have been involved with the justice system, including those recently released from prison, to aid their reintegration into society.
- Vulnerable migrants and refugees: Services are tailored to meet the unique needs of migrants and refugees, offering support, information, or advice with, housing, language barriers, and integration into the community.
- Victims of modern slavery: Specialised support can be provided to victims of modern slavery, however, a more targeted approach is required
- LGBTQIA+ individuals: There is some engagement with LGBTQIA+ individuals, focusing on providing inclusive and supportive services that address their specific needs and challenges.
- Sex workers: Engagement with sex workers is limited, indicating a need for more targeted outreach and support services to address their unique circumstances and vulnerabilities.
- Others identified based on emerging needs: The service provision is adaptable, identifying and responding to emerging needs within the community to ensure comprehensive support.

What is working well: The level of engagement varies significantly across different groups. There is a strong focus on:

- **Homeless populations:** Intensive efforts are made to provide immediate and long-term support, including shelter, healthcare, and pathways to permanent housing.
- **Individuals with mental health needs:** Services are designed to address the mental health challenges faced by individuals, offering counselling, therapy, and support groups.
- **Substance use:** Programs are in place to support people who use substances, focusing on rehabilitation and harm reduction.

Existing relationships are well-established with:

- **Prison leavers:** There are ongoing efforts to support individuals transitioning from prison back into the community, providing resources and guidance to reduce recidivism.

Areas to strengthen: There is a recognized need for more targeted approaches to better engage with:

- **Sex workers:** Developing more focused outreach and support services to address the health, safety, and social needs of sex workers.
- **Care leavers:** Implementing programs to support young people leaving the care system, helping them transition to independent living.
- **Victims of modern slavery:** Enhancing support services to provide comprehensive care and assistance to victims, ensuring their safety and well-being.
- **Gypsy, Roma, and Traveller communities:** Engagement with these communities focusing on providing culturally sensitive support, ensuring access to healthcare, education, and social services.

Data Collection and Analysis

- Use of System One for data capture, which records demographics, venue-specific interventions, and complexity factors, including mental and physical health and substance use.
- Data supports inclusion health and rough sleeper initiatives, aligning with the NHS inclusion health framework.

Health Needs and Service Gaps:

- Roma, Gypsy, and Traveller communities show low engagement with mainstream services.
- Challenges engaging with sex workers due to the nature of their work and service geography.
- Trust and stigma barriers across multiple groups, complicating outreach and service uptake.

- Barriers: Geographical dispersion, trust issues, and the need for culturally tailored approaches are prominent. This includes addressing fear of services, diverse communication needs, and enhancing collaboration with partners who hold pre-existing trust.

Existing Strengths and Best Practices

- **Inclusion Health and Addiction Service Model:** The service's holistic approach, addressing multiple complexities, supports empowerment, self-esteem, and increased health prioritisation among service users.
- **Community Engagement:** Established pathways and relationships with East Riding service users and stakeholders, emphasising adaptability and innovation to meet evolving needs.
- **Interventions offered**: Signposting, referrals, education and brief interventions, harm minimisation & safety, screening and assessment and NHS health checks. Dental health, sexual health & other physical health needs, needle exchange. Early intervention and prevention work.

Challenges

- **Engagement and Trust Issues**: Engaging with sex workers is challenging due to the nature of their work, often conducted at home, and the geographic spread of the East Riding. Additionally, there is a reluctance among some individuals to acknowledge issues and work with mainstream services. Certain groups prefer to remain hidden or are coerced into staying hidden, making engagement and trust-building difficult.
- **Diversity and Organisational Fear**: Diversity within these groups can lead to fear of organisational involvement and suspicion towards the service's agenda. Trust-building is a significant challenge, especially with groups that are wary of external intervention. However, involvement can be easier when colleagues from other organisations have already established trusting therapeutic relationships.

2.5 Identified inclusion health groups

The purpose of this section is to identify health inequalities that may be present amongst inclusion health groups local to the East Riding, and where there are opportunities for change in response to unmet need. This collation of available data has also been used to highlight where there are clear gaps in knowledge and information, where more work needs to be focused. Literature from research and national-level studies has been used to provide narrative on some of the known trends or experiences for these populations across the country, which has helped to highlight where and/or why there could be unmet need locally. Insights from interviews with professionals who have expertise with each group has also been added to this narrative to highlight particular barriers, gaps, and challenges in the work happening across the East Riding with inclusion health groups. A full summary of this consultation is contained within section.

2.5.1 Vulnerable migrants

Vulnerable migrants are defined by the UK Government's Migrant Health Guidance (2017) as being those who may 'be vulnerable to potential health needs because of their experiences either before, during or after migration'. These health needs may arise particularly in those who are:

- Asylum seekers and refugees
- Unaccompanied children
- Those who have been trafficked
- Undocumented migrants
- Low paid migrant workers

Migrants may be exposed to many factors that influence their health needs and Figure 2.16. identifies a number of these factors at 3 different stages of the migration process.

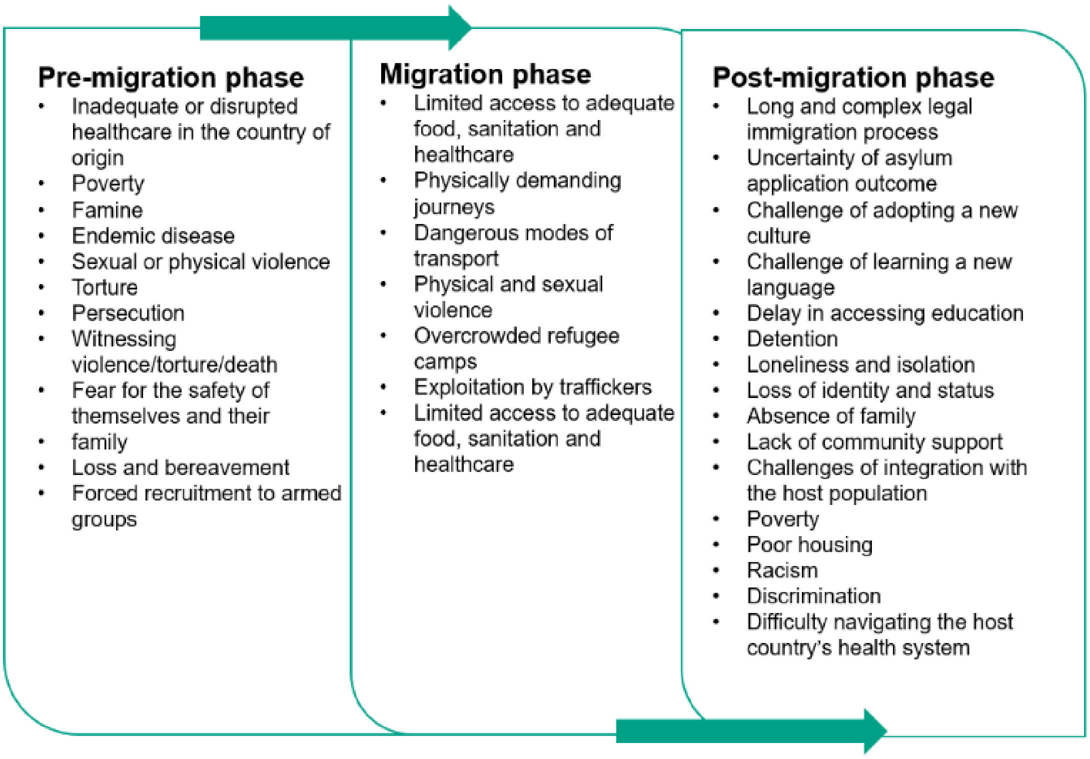
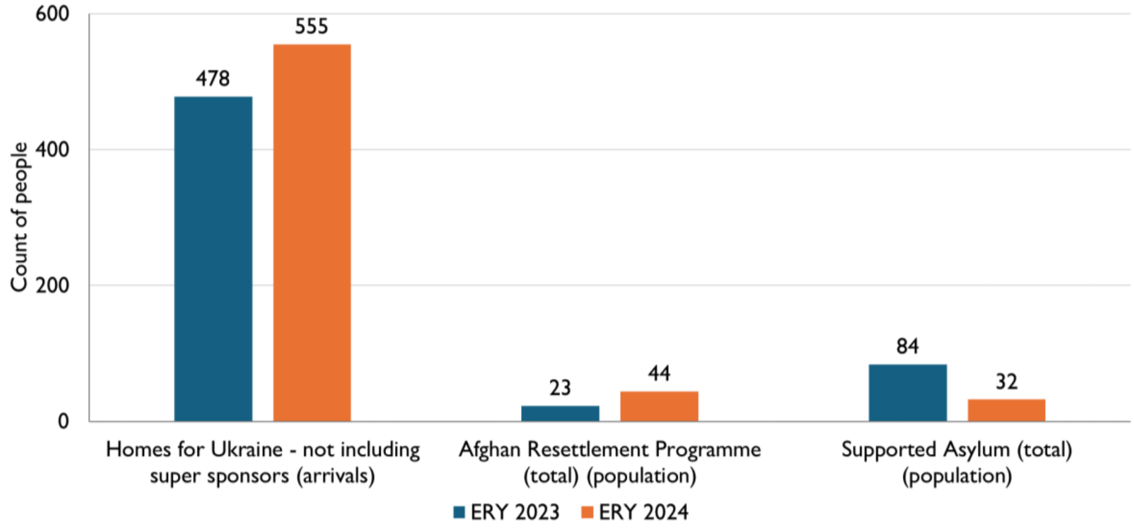


Figure 2.17. Factors that influence the health of migrants. *Source:* UK Government Migrant Health Guidance (2017)

There are 3 migrant related groups for which data is routinely collected at local authority level. These include individuals on the Homes for Ukraine scheme, those under the Afghan resettlement Programme, and asylum seekers receiving support. Figure 2.18 displays counts for each of these groups in the East Riding for June 2023 and June 2024 (GOV.UK., 2023). Homes for Ukraine had the highest count in the county as at June 2024 with 555 individuals (a 16% increase over the previous years figure). The Afghan resettlement Programme and asylum seekers receiving support recorded lower numbers with the former increasing 91% between 2023 and 2024 and the latter decreasing by 74%.

As a percent of the total local authority population, these 3 groups combined equated to 0.18% in the East Riding, the lowest proportion of all local authorities within the region. In contrast Hull, the local authority with the highest proportion, recorded 0.49%, whilst the regional and UK averages were 0.34% and 0.41% respectively.

Figure 2.18 – Immigration group counts for East Riding of Yorkshire, 2024.



Consultation with the charity organisation Welcome House, who operate across Hull and the East Riding to support migrants, refugees, and asylum seekers, revealed that loneliness was a key problem faced by many migrant groups. The charity has identified common themes of loneliness and isolation amongst this community, and has worked with them to build connections and relationships in our local area, hosting events, English classes, creating WhatsApp groups, and leading family days out. They have also highlighted that isolation and language issues are often acting as barriers to access to health care, with many migrants not being aware of the services and support available or how to access it. Welcome House's work in helping to signpost and empower migrants to access health care demonstrates the value of the VCSE network in engaging and building relationships with inclusion health groups, and how important it is that commissioned services, particularly the Inclusion Health Service, care closely connected with the VCSE.

Local case study: experiences of migrants in Goole

The SMILE Foundation, along with partner organisations, conducted a series of discussions with local migrant populations in Goole, during 2024. The aim of the discussions was to understand if these residents would understand where they would go if they needed help, how their experience of support and services could be improved, to try and support their health and wellbeing, skills and employability and to understand their health needs including access to child vaccinations.

A report was produced to summarise the findings and is available from the East Riding JSNA website (https://eastridingjsna.com/migrant-population-in-goole/). The report highlighted a number of key issues:

- Challenges with GP services: Participants reported difficulties in contacting their GPs and concerns about the quality of care received, with comments about busy phone lines and inadequate medical assessments.
- Language barriers: Language barriers were a significant issue for residents where English was not their first language. It impacted their ability to understand and use healthcare services effectively, highlighting a need for better communication and support.
- Registration issues and discrimination: Some participants faced challenges registering with local healthcare providers and experienced discriminatory practices based on accents, which affected their ability to secure appointments. Some residents had to travel to Hull to see a dentist.

- Mixed vaccination experiences: There was a mixed experiences with vaccinations. Some residents were confused and frustrated about vaccinations offered in England that had already been provided in their country of origin. There were no major issues reported for unvaccinated children accessing initial vaccinations.

The sessions identified opportunities for partnership working to improve healthcare access by providing multilingual support, clearer explanations of healthcare systems, and collaborations with community organisations. There were recommendations of tailoring educational programs for residents whose first language is not English and to make efforts to address discrimination in healthcare provision to ensure fair and equitable access for all residents.

2.5.2 People who are sleeping rough and / or experiencing homelessness

For this needs assessment, the definition used for rough sleepers and persons experiencing homelessness is the one used within the OHID (2022) document 'Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG)'. This distinguishes between two cohorts:

- *Cohort 1: Individuals at risk of rough sleeping, because they are:*

- *in unstable or unsafe accommodation*
- *sofa surfing*
- *in short term or emergency accommodation, such as hostels, shelters and bed and breakfast or other forms of emergency accommodation set up in response to events such as the COVID-19 pandemic*
- *presenting to the local housing authority as being homeless or at risk of homelessness*

- *Cohort 2: Individuals who are rough sleeping*
  - *"The DLUHC definition of rough sleeping is: people sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or "bashes" which are makeshift shelters, often comprised of cardboard boxes)."*

Demographics

Interviews with local professionals described the cohort of rough sleepers in the East Riding as being typically older people with complex needs who have been through multiple accommodation settings that have failed to result in street homelessness.

Using the above definitions, data from East Riding of Yorkshire Annual Autumn Survey*[2]has revealed that between 2010 and 2023 there were on average 11 rough sleepers counted per year within the East Riding (Figure 2.19). Numbers have varied from 7 in one year (2021) to 19 (2019). Between 2017 and 2022, rough sleepers in the East Riding were predominantly male, aged over 26 years and

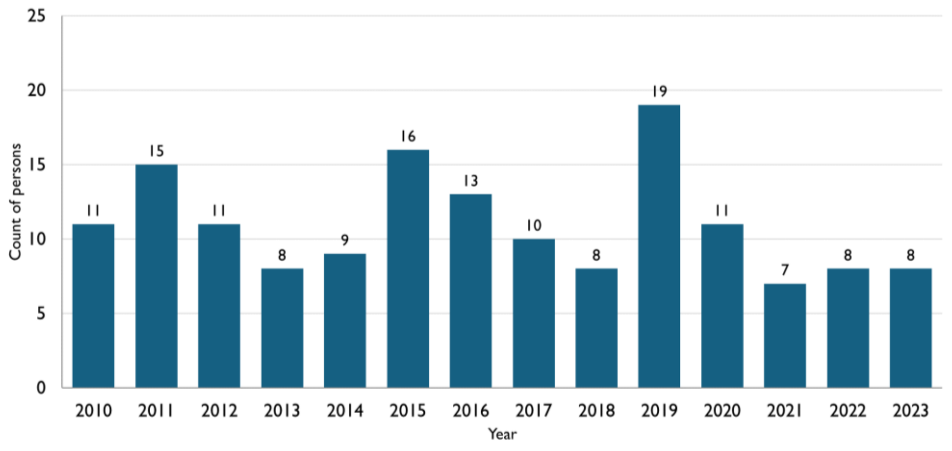
*The annual autumn survey of rough sleepers is conducted by local authorities, who are required to submit their data to the Ministry of Housing, Communities and Local Government (MHCLG) by the end of January each year. The survey covers the period from 1 October to 30 November, and local authorities can choose any night within this period to conduct their count. Counts can be either be an actual count of rough sleepers or an intelligence based estimate.

of a UK nationality. In 2023 rough sleepers in the Yorkshire and Humber region comprised 7% of England's total rough sleeping population (it was 6% per year on average between 2010 and 2023).

However, quarterly monitoring figures reveal that the actual number of people sleeping rough in the East Riding is significantly higher, with an estimated 38 individuals in Q1 of 2024. During this period, 423 people were at risk of sleeping rough. In Q2, the number at risk dropped to 279, while the actual number of rough sleepers increased to 49. Additionally, the number of rough sleepers engaged in structured treatment fell from 23 in Q1 to 7 in Q2. Further investigation is needed to understand this significant drop.

There is some discrepancy between the reported statistics and anecdotal evidence of the number of rough sleepers across the East Riding; housing officers have said the current number for summer 2024 is around 15, with almost daily changes particularly in the summer period due to the highly transient population seen at coastal settings such as Bridlington. Contrary to the trend seen in official figures (Figure 2.19 – Count of people in the East Riding local housing teams and Rough Sleepers Navigators who work directly with this population have commented on there being a general increase in rough sleeping and homelessness across the East Riding over the recent years. This has been linked to the increasing cost of living and ageing population in the east riding creating a 'perfect storm' of competing pressures.

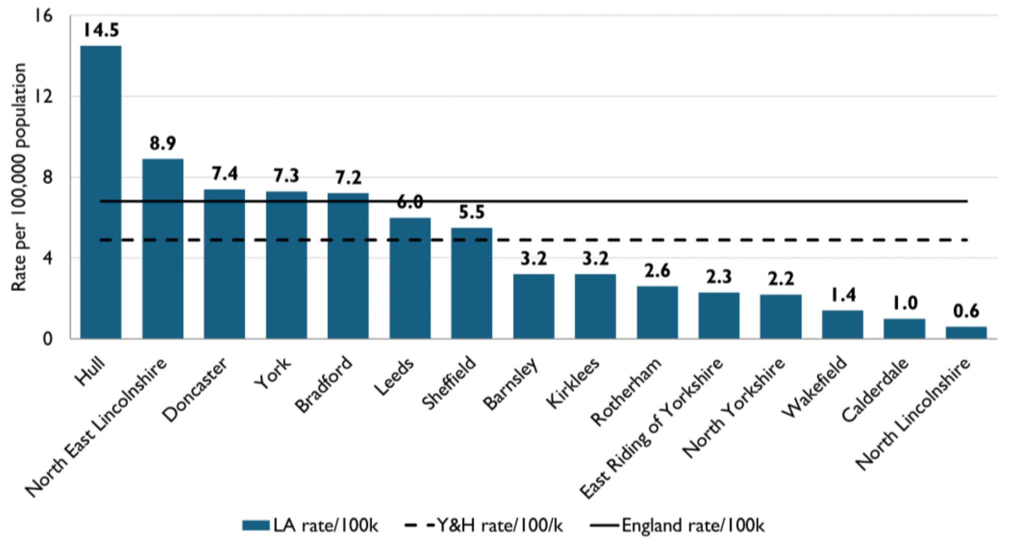
Figure 2.19 – Count of people in the East Riding who are rough sleeping



Source: DLUHC Annual Autumn Survey 2023, Gov.UK 2023.

Figure 2.20 compares the rate of people sleeping rough per 100,000 population for local authorities in the Yorkshire and Humber region during 2023, with the East Riding recording the 5th lowest rate (2.3 per 100,000), lower than both region and national averages (4.9 per 100,000 and 6.8 per 100,000 respectively).

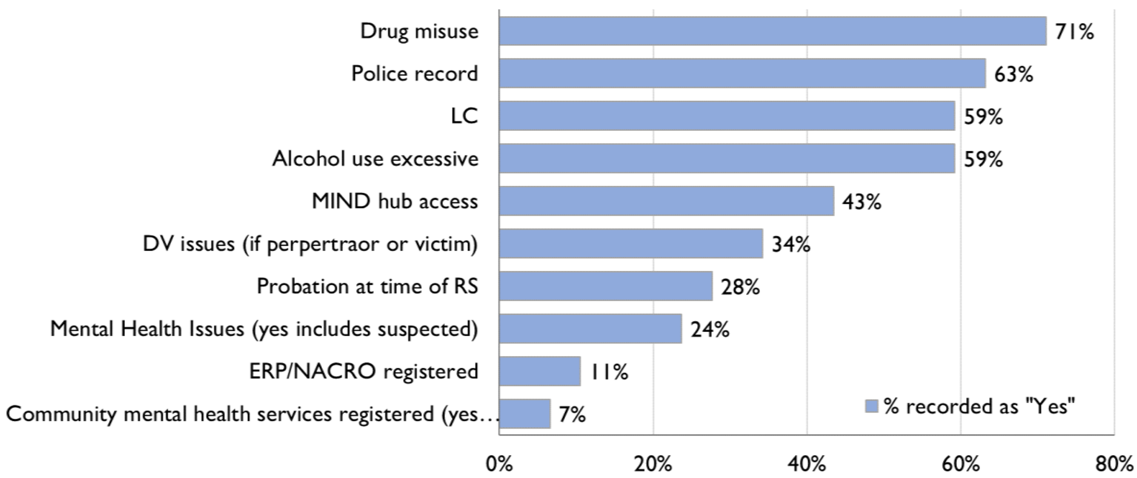
Figure 2.20 – Rate of rough sleeping for local authorities within the Yorkshire and Humber region per 100,000 population



Source: DLUHC Annual Autumn Survey 2023, Gov.UK 2023.

The Outreach Service, commissioned by the Council's Housing Team conduct a survey twice a week (both at midnight and 5 a.m.) to ensure accurate reporting of who is on the streets and sleeping out. Even if the individual does not wish to engage with the service a welfare check is undertaken to ensure the team knows who the individuals are and where they are located and also to enable risk mitigation planning to be put in place. Between April and September 2024, there were 76 new rough sleepers identified in this 6 month period, approximately 13 per month. The age of several individuals were unknown but most were aged between 25 and 59 years (57 in number, 75% of the total), with 10 (13%) aged under the age of 25 and a small number aged over 60. Figure 2.21 displays some additional known characteristics about this cohort of 75 rough sleepers, with over 70% recorded as having drug use treatment needs and almost 60% excessively using alcohol.

Figure 2.21 – Known data around people who are sleeping rough in the East Riding (April- September 2024)



N.b. A description of other parts featured in the chart can be viewed below:

- ERP/NACRO: relates to support from East Riding Partnership or NACRO in terms of drugs and alcohol use. This is considered a strong indicator of substance abuse.
- CMHT: refers to Community Mental Health Team support, a significant indicator of vulnerability.
- MIND Hub: this is in relation to attendance by individuals of the Homeless Hub in Bridlington which supports those Homeless or at risk of Homeless in Bridlington which necessarily includes those rough sleeping and used by the majority (but not all) of those rough sleeping in Bridlington (our dominant location for East riding Rough sleepers). This is part funded by East Riding of Yorkshire Public Health.

- Probation whilst RS: indicates whether an individual is required to work with Probation as an ex-offender when street homeless.
- LC: LC (Local Connection) relates to Housing Duties which fall upon the East Riding (or not) when a rough sleeper presents to the council as homeless. This impacts on the housing offer or advice the council can give each specific individual.

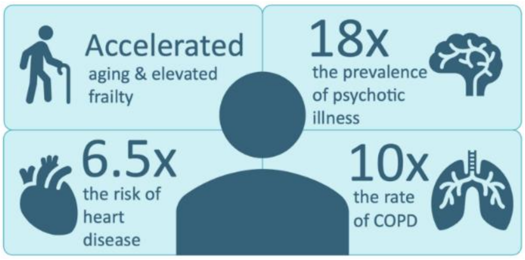
The Housing Team are also working closely with the CCTV team in Bridlington on a pilot project to identify vulnerable adults and this work enables the team to observe those who are homeless. This is particularly relevant to Bridlington as the team estimate that 80-90% of those people who are street homeless in the East Riding are street homeless in Bridlington, which has been the case historically. Numbers usually peak in the summer months when the weather is warmer and individuals are attracted to coastal areas for a variety of reasons.

There are infrequent reports of rough sleepers in the Goole area, but the team believe that is less common in the town owing to the availability of cheaper housing, houses of multiple occupancy and hostels such as YMCA. There are rough sleepers recorded within rural areas of the East Riding, but these numbers are few in number, as individuals generally gravitate towards where amenities, services and opportunities exist. The other area which sees sporadic reports of rough sleepers in Beverley. As a market town, in close proximity to the City of Hull the team frequently visit the area to offer support to anyone identified as street homeless. The team work closely with both statutory and non-statutory partners in a trauma informed way to ensure the support that individuals want, and need is provided to them. A network of support from members of the voluntary sector compliment the work undertaken by the team and provide an essential link to individuals who are unwilling to engage with statutory agencies.

Health outcomes

Research has evidenced how homelessness is a serious risk factor for poorer physical and mental health outcomes and is associated with increased risk of mortality (Thomas., 2011). Life expectancy is lower than the general population, with people who are sleeping rough or homeless dying on average 30 years earlier. Causes of death are more likely to occur from external factors such as drugs, alcohol, suicide (9 times more likely than the general population), infections (2 times more likely), and accidents (both falls and road accidents are 3 times more likely), as opposed to a long-term condition. Many homeless people suffer from mental health problems and substance misuse which are often linked and can be both a reason and a result of homelessness. The use of drugs and alcohol are frequently used as a coping mechanism but cause a third of all homeless deaths.

Figure 2.22 - Common conditions and homelessness.



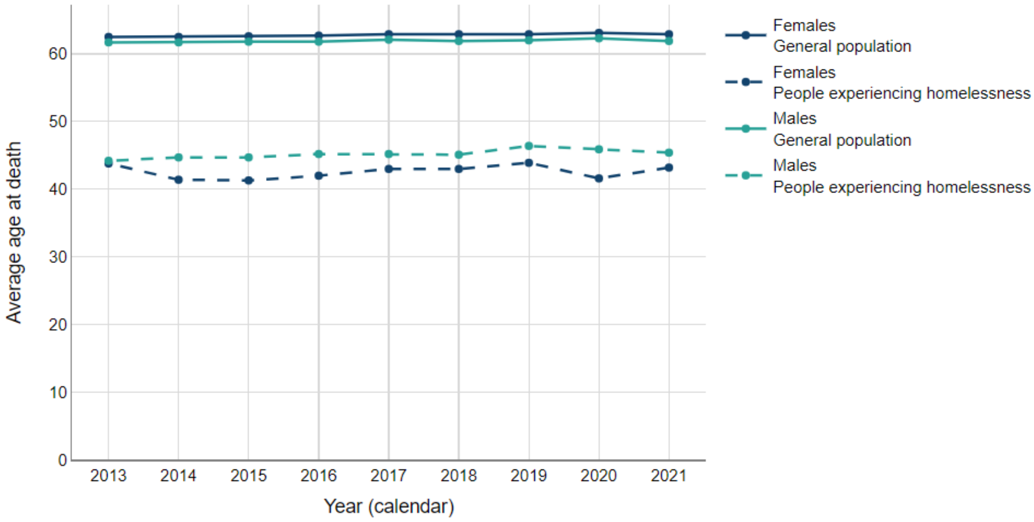
Source: Fryer et al., (2024).

Physical health

People who are sleeping rough or homeless are at an increased risk of having poorer health outcomes, with around 63% reporting a long term illness, disability, or infirmity (Homeless Link., 2022). A 2020 survey conducted by the Ministry of Housing, Communities, and Local Government (MHC&LG) had found this number to be even higher, with 83% reporting at least one physical health issue. These most commonly included joint aches, dental issues, and chest pain/breathing problems.

Physical health issues are prevalent to the extent that they are known to exacerbate the effect of ageing, with early onset frailty being common (Hertzberg & Boobis., 2022). They are also a recognised determinant of the far earlier average age of death (Figure 2.26) amongst the rough sleeping and homeless population, which OHID's Spotlight tool reported in 2021 as being 45.4 years for males and 45.2 years for females. In contrast, for the general population it was 61.9 and 62.9 years respectively.

Figure 2.23 - Comparison of the average age of death between people experiencing homelessness and the general population for England, split by sex, 2013 - 2021.



Source - OHID Spotlight, 2024

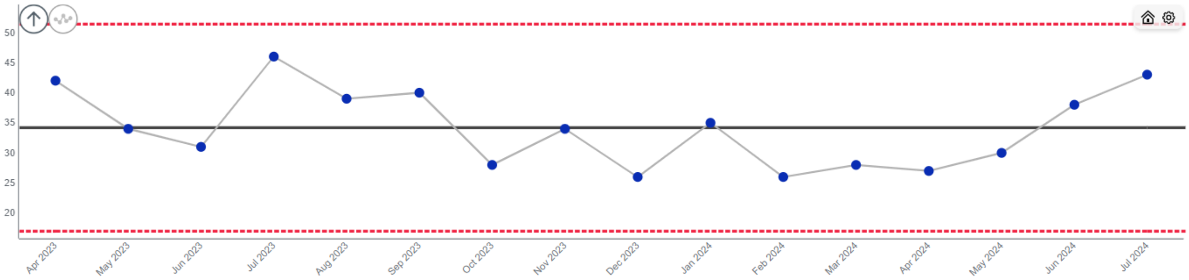
Mental health

Mental health issues have also been reported as highly common amongst this population, with an 86% prevalence found in the MHC&LG survey sample (2020). These were most frequently listed as depression and/or anxiety, with the majority of this group also reporting having more than one mental health issue. Amongst people who are homeless or sleeping rough, mental health issues are typically highly comorbid with poorer physical health outcomes, and can be both a key cause and product of homelessness (Thomas., 2011).

The East Riding's Rough Sleepers Mental Health and Wellbeing Service (RSMHWS) is situated at the HEY Mind-run specialist rough sleepers 'Community Hub' site at Wellington Road in Bridlington, and provides vital support to people registered with ERYC who are sleeping rough or at risk of homelessness. This service is run by HEY Mind and collaborates with local housing teams and organisations who may already be engaged with the person (such as Emmaus, Probation, Community Mental Health Teams etc.). The service helps to stabilise crisis situations and eliminate barriers to essential support services, including mental health and specifically trauma-informed talking therapies, safeguarding, addiction, welfare, training, and employment, whilst ensuring access to physical health clinics.

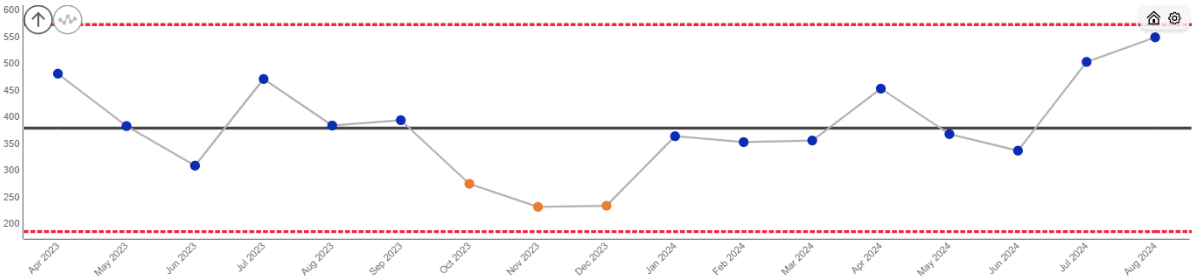
Over the 2023-2024 12-month period a total of 128 individuals were supported by RSMHWS and each was registered with a GP (Figure 2.24 - Number of clients engaged with RSMHWS by month, 2023-2024. . Including outreach this totalled 4,066 attendances, equivalent to 535 one-to-one support sessions, 693 group session attendances, 2,295 drop-in attendances, and 543 outreach sessions delivered.

Figure 2.24 - Number of clients engaged with RSMHWS by month, 2023-2024.



Some seasonal variation in attendance rates was seen, with numbers dropping notably over the winter months. In response to this the service has been proactive in providing increased outreach and support beyond the Wellington Road site.

Figure 2.25 - Total number of RSMHWS sessions attended by month, 2023-2024.



Health behaviours

Substance use

The Department for Levelling Up, Housing and Communities (DLUHC) each year reports the percentage of homeless households with a recorded support need related to drug or alcohol dependency. Table 2.2 displays the results found for 2022/2023, where 4.7% of households had an alcohol dependency and 6.1% had a drug dependency. Where households did not have children the prevalence rose to 6.9% and 9% respectively. A lower proportion of households reported both alcohol and drug dependency (1.8% of all households, rising to 2.7% for those without children).

Table 2 – Homeless households with identified support need pertaining to drug or alcohol dependency

	All households	Households with children	Households without children
Alcohol dependency	4.7%	0.5%	6.9%
Drug dependency	6.1%	0.7%	9.0%
Both alcohol & drug dependency	1.8%	0.1%	2.7%

Source: OHID Spotlight

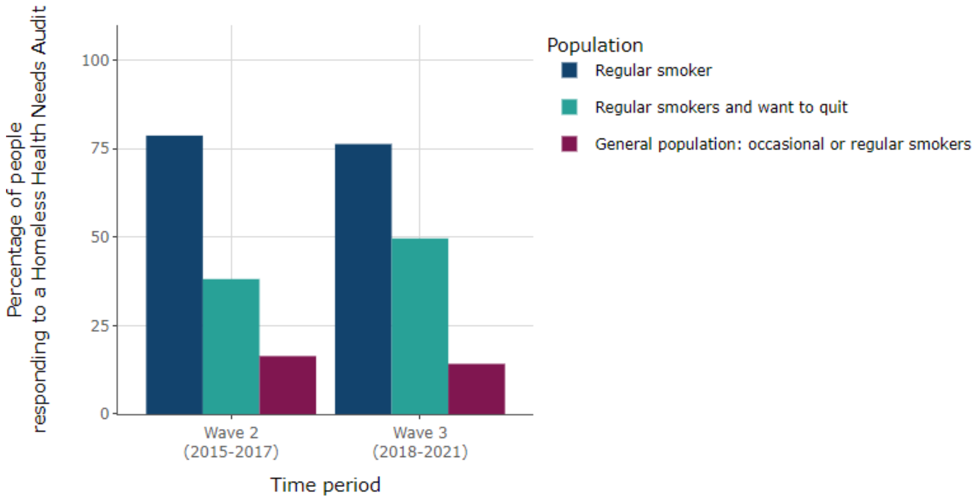
In the national MHC&LG survey (2020), 60% of participants reported needing support for drug or alcohol abuse, with 49% needing support for drug abuse and 23% for alcohol abuse (MHC&LG., 2020).

Smoking

Results of questions asking about smoking behaviours from a national survey examining the physical and mental health needs of people who are homeless can be viewed in Figure 2.26 -. This reported a very high prevalence of regular smokers in the homeless population in both the 2015-2017 period

(78.8%) and 2018-2021 period (76.4%) compared to the general population (16.4% and 14.2% respectively).*[3]

Figure 2.26 - Percentage of respondents to Homeless Health Needs Audit who report regular smoking compared to the general population, England, 2015-17 / 2018-21 comparison



Source: OHID Spotlight., 2024

Wider determinants

Aldridge (2020) revealed that homeless individuals face a higher risk of illness and death, with nearly one-third of deaths among this group nationally being preventable. This rate is higher compared to housed individuals in deprived areas due to delayed and inappropriate healthcare interventions. The study underscores the importance of healthcare providers being sensitive to the stigma experienced by homeless patients, evidencing the essentiality of early intervention and harm reduction work. Furthermore, the Homeless Reduction Act 2017 requires hospitals to refer homeless patients to local housing authorities, but it does not specify a timeline. The lack of clear definitions for inadequate housing and homelessness impedes a comprehensive understanding of the health impacts of living without a stable home.

Access to services

Bridlington has the greatest number of people rough sleeping or at risk of rough sleeping. To improve the support available in Bridlington and improve access to services the Rough Sleeper Mental Health and Wellbeing Service (RSMHWS, referred to colloquially as 'the Homeless Hub') on Wellington Road has been established as a collaboration between HEY Mind, HNY ICB, and East Riding of Yorkshire Council Public Health. This is a community service providing a safe and welcoming environment where people can access essential services, engage in social activities, and receive comprehensive support from various agencies. The primary aim of the RSMHWS is to stabilise crisis situations and eliminate barriers to essential support services. This includes mental health support, safeguarding, addiction services, welfare assistance, training, and employment opportunities, as well as access to physical health clinics. The service is committed to ensuring healthcare equity and access, promoting health education, conducting screenings, addressing broader health determinants, protecting vulnerable populations, and fostering healthier communities. Positive feedback from engagement events with ERVAS and HEY Mind highlighted the RSMHWS' significance in providing support and a safe space, and additional feedback from various agencies and service users in June and July underscored the Hub's role in promoting social networks and engagement

*This comparison was made using figures for the general population drawn from data the GP Patient Survey, which records patients as 'occasional' or 'regular' smokers.

activities. providing comprehensive support that includes mental health, addiction, welfare, and physical health services.

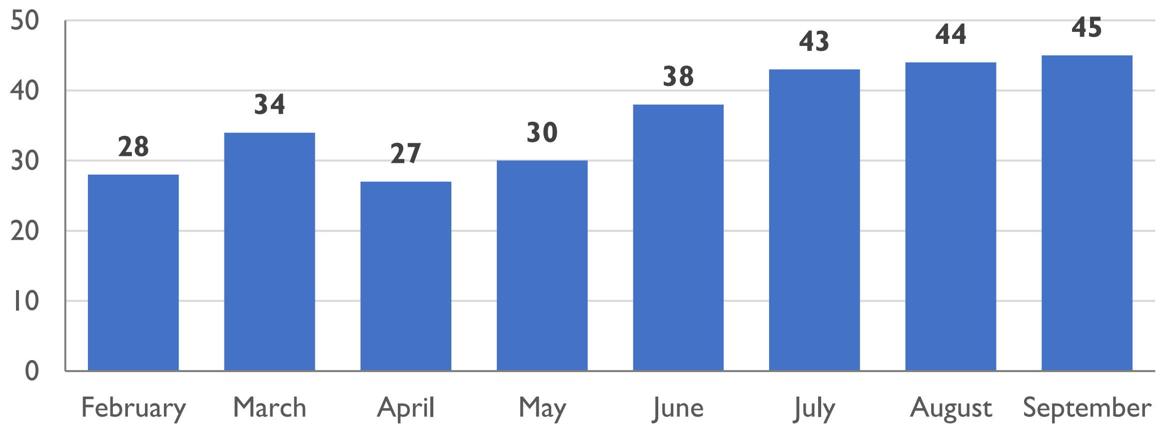
The RSMHWS offers regular drop-in sessions where individuals can receive support, engage in group activities, and access essential services, including health clinics. These provide regular check-ups and address various health issues, including mental health, physical health, and substance use. The service also provides facilities for heating food, washing and drying clothes, showers, and dental hygiene.

The following organisations are partnered with RSMHWS to ensure there is a comprehensive offer of wraparound support:

- Department of Work and Pensions (DWP) - benefits advice and support, which including health-related benefits.
- Blue Door - support for individuals experiencing sexual assault, including health and psychological support.
- Your Health - fortnightly drop-ins providing health advice and support, including managing chronic conditions and preventive care.
- Humber Teaching Foundation Trust East Riding Partnership - Joint working with alcohol and drug services to address substance abuse issues, SMART Recovery sessions, and attendance from the Inclusion Health Vehicle to aid with signposting to wider health services
- HEY Mind – mental health support, running the Rough Sleepers Mental Health & Wellbeing Service (RSMHWS) from the Hub
- Bridlington PCN – supports all attendees to be either registered or in the process of registering with a GP, and holds monthly drop-ins
- ERYC Housing team
- ERYC Adult Social Care team
- Humber Teaching Foundation Trust Community Mental Health Service
- Humber Teaching Foundation Trust YourHealth
- City Health Care Partnership – wound care, oral health, sexual health
- VCSE, including: The Hinge, Emmaus, SASH, Matthews Hub
- Bridlington Antisocial Behaviour Team
- Castle Hill Hospital Department of Infection
- Humberside Police
- Probation

Figure 2.27 shows the increasing number of attendees to the hub in 2024 so far.

Figure 2.27- Number of RSMHWS attendees, 2024.



Since its launch in April 2023, the RSMHWS has supported 146 unique individuals by August 2024, highlighting a significant need that was initially underestimated. The number of rough sleepers increased from 12 in July 2022 to 22 in July 2024, in line with national trends of increasing homelessness.

The RSMHWS plans to expand its support to Blenheim Road, offering medium-term housing with a recovery and rehabilitation model. This facility will allow for the colocation of services to enhance impact. Hull and East Yorkshire Mind will extend its Mental Health and Wellbeing Support to Blenheim Road, providing holistic support to improve outcomes. The service will continue to provide workforce colocation, therapy sessions, and physical health services at Blenheim Road, ensuring a seamless transition and comprehensive support for service users.

2.5.3 Gypsy, Roma, and Traveller communities

Gypsies, Roma and Travellers (GRT) are umbrella terms that refer to different groups of people who share a nomadic or semi-nomadic lifestyle and culture (GOV.UK., 2022) This group includes:

- Gypsies, including Romany people, English Gypsies, Scottish Gypsies, and Welsh Gypsies
- Roma, who are a distinct group of people and mainly concentrated in Eastern and Central Europe.
- Travellers, who are a diverse group of people who have a long history of travelling within the UK and Ireland. They include Irish Travellers, Scottish Travellers, Welsh Travellers, New Travellers and Showmen.

Under the Equality Act 2010, Romany Gypsies, Irish Travellers and Roma People are recognised in law as being an ethnic group protected against discrimination. However, this group has a long history of social discrimination and inequality, leading to GRT communities having now been recognised by the UK Government to be ‘among the most disadvantaged people in the country and have poor outcomes in key areas such as health and education’ (Written submission from HM Government (GRT0059), February 2017). Their addition to the Department of Health’s national Inclusion Health Programme formally recognised how systemic, social disadvantages such as ‘high levels of illiteracy, lack of good quality health supporting accommodation, lack of knowledge of mainstream services, mistrust of authority’, and registering and accessing primary care have acted as barriers contributing to poorer health outcomes amongst this community (DHSC., 2013).

Locally, anecdotal evidence from professionals working with the GRT community (2024) have said they have experienced difficulties capturing health-related data due to a prevalence of stigma surrounding health within this community. This is particularly the case for mental health and sexual health issues, which has led to a lack of conversation, awareness, and understanding around the topics. Sex education remains a taboo subject and many parents choose to remove their children from school classes on the topic. These are ingrained attitudes and have made it difficult to engage with communities until individuals reach crisis point, meaning there has been little opportunity for preventative work. A deep mistrust for authorities has also proved a barrier for professionals, however on-site workers have built strong, trusting relationships with communities, providing a crucial point of access with individuals who have lived experience. Ingrained societal preconceptions about the GRT have reinforced their social isolation, which is apparent in the health system both from their reluctance and difficulty to access services and also staff treatment and understanding of their community whilst engaged with services.

Demographics

The 2021 Census reported that within England and Wales (E&W) almost 68,000 people identified their ethnicity as Gypsy or Irish Traveller, and approximately 101,000 as Roma, equating to 0.1% and 0.2% of the total E&W population respectively. However, it is believed that these figures are a significant undercount of the true population total (estimated to be over 300,000 for the 2 ethnic groups combined), owing to a distrust with public services in general and therefore a lack of engagement with the Census (The Traveller Movement., 2022).

In the East Riding, persons recording their ethnicity as Gypsy or Irish Traveller numbered 324, whilst the total Roma population was 118, representing a respective 0.1% and 0.03% of the total East Riding population. Table 2.3 displays counts (and proportions) by age group of these ethnic groups.

Error! Reference source not found. in Appendix B provides a summary count by East Riding ward, of Gypsy or Irish Traveller and Roma populations. Howdenshire recorded the highest count of Gypsy or Irish Travellers (n=50, which represented 0.3% of the total ward population) and Goole South recorded the highest count of Roma population (n=54, 0.5% of the total ward population).

Table 2.3 - Age group as a percentage of total population for White: Gypsy or Irish Traveller and White: Roma population.

Age Group	White: Gypsy or Irish Traveller		White: Roma		ERY total population
	Count	% of total	Count	% of total	% of total
Aged 15 years and under	76	23.5%	23	19.5%	15.8%
Aged 16 to 24 years	27	8.3%	13	11.0%	8.1%
Aged 25 to 34 years	74	22.8%	25	21.2%	10.2%
Aged 35 to 49 years	57	17.6%	38	32.2%	16.8%
Aged 50 to 64 years	54	16.7%	16	13.6%	22.7%
Aged 65 years and over	36	11.1%	3	2.5%	26.4%
Grand Total	324	100%	118	100%	100%

Source: Census 2021.

Health outcomes

Physical health

In the East Riding, 10.2% of people identifying as Gypsies or Irish Travellers reported their health to be 'bad' or 'very bad health', almost twice the proportion reported by the overall East Riding population (5.4%). See Table 2.4. This was also the case in England and Wales overall where the respective figures were 12.5% and 5.2%.

The age demographic of this population is much younger than the overall East Riding population (as shown in Table 2.3) and so this higher level of morbidity cannot be explained by having an ageing population. The Roma population in contrast reported a lower than East Riding prevalence, at 4.2%.

Table 2.4 – Self-reported general health classification for the Gypsy or Traveller population compared to the Roma population and East Riding of Yorkshire (ERY) total.

General Health	White: Gypsy or Irish Traveller		White: Roma		ERY overall
	Count	% of population	Count	% of population	% of population
Bad or very bad health	33	10.2%	5	4.2%	5.4%
Fair health	48	14.8%	9	7.6%	14.4%
Very good or good health	243	75.0%	104	88.1%	80.3%
Total	324		118		

Self-reported disability in the Gypsy or Irish Travellers population (26.9%) was higher than the East Riding overall (18.6%), however the Roma population recorded a lower than local authority average at 7.6%.

Table 2.5 – Self-reported disability classification for the Gypsy or Traveller population compared to the Roma population and East Riding of Yorkshire (ERY) total

Disabled under the Equality Act	**White: Gypsy or Irish Traveller**		**White: Roma**		**ERY overall**
	Count	**% of population**	**Count**	**% of population**	**% of population**
Disabled	87	26.9%	9	7.6%	18.6%
Not disabled	237	73.1%	109	92.4%	81.4%
Total	324		118		

National work has revealed that cancer is particularly stigmatised across the GRT population, with an overriding fear of cancer itself and healthcare overall leading to views that it is bad luck and/or shameful to talk about it (Families, Friends and Travellers., 2024). This attitude is likely one explanation for a pattern of people from GRT communities preferring to hide health conditions and consequently typically not presenting to health services until crisis point. Although there are no exact figures for the East Riding, this pattern of avoiding General Practices has been recognised nationally to have contributed to an inefficacy of screening initiatives and an onset of premature frailty amongst this population (see *Access to services*).

Mental health

A webinar held by Friends, Families and Traveller (Michelle Gavin., 2024) highlighted how Gypsy and Traveller communities are more vulnerable to poorer mental health outcomes, being 3x more likely to experience anxiety, 2x more likely to experience depression, and ultimately 6x more likely to die by suicide than the general population. Like many other socially disadvantaged groups, overlapping identities such as also being carers, prison leavers, LGBTQIA+ etc. can have a compounding effect and further widen these inequalities.

Wider determinants

Gypsies and Travellers largely endure worse outcomes regarding health inequalities when compared to the Roma population, as well as the UK population overall (House of Commons., 2019). Friends, Families and Travellers (2024) identified a number of significant barriers faced by GRT communities across the UK, including:

1. A general exclusion across most elements of the conditions of living
2. Lack of visibility in mainstream datasets
3. Distrust in services for fear of discrimination
4. Wrongful registration refusal in primary care
5. A lack of available information and digital exclusion, plus low literacy levels and educational attainment presenting challenges for effective communication
6. Inequalities and difficulties in access to healthcare waiting lists for nomadic populations
7. Inequalities in mental health care
8. The premature onset of long term condition.

Figure 2.28 - Inequalities in the wider determinants of health amongst the Gypsy and Traveller population.

WORK ENVIRONMENT	EDUCATION	POVERTY	ACCOMODATION	SOCIAL INCLUSION	WATER AND SANITATION
22% of those in employment from a Gypsy or Traveller background work in elementary occupations	**60%** of Gypsies and Travellers have no formal qualifications	**3x** children from Irish Traveller families are over 3 times as likely to be eligible for free school meals than white British children	**10,000** Gypsy or Travellers have no place to stop as a result of a chronic national shortage of sites	**44%** of the British public report having a negative opinion about Gypsies Roma and Travellers	**3,000** families living roadside have limited or no access to basic water and sanitation

Source: Friends, Families and Travellers (2022)

These barriers highlight impact that wider determinants of health (see Figure 2.12) such as stable and good quality housing, education, and social inclusion are having on this community, which has notably poorer health outcomes compared to the general population.

Access to services

Anecdotal evidence is consistent in explaining fear of health services and stigma surrounding health conditions act as some of the greatest barriers to GRT communities accessing services.

In Primary Care settings the Care Quality Commission (CQC, 2016) reported that Gypsies and Travellers often face difficulties in registering with GPs, which leads to poor access to services such as health screening and secondary care. According to the CQC, this lack of access impacts their end-of-life care, as they tend to present late for medical attention. An example of this can be seen in a Family, Friends and Travellers (2024) investigation into cancer screening, which revealed GRT communities were not engaging due to:

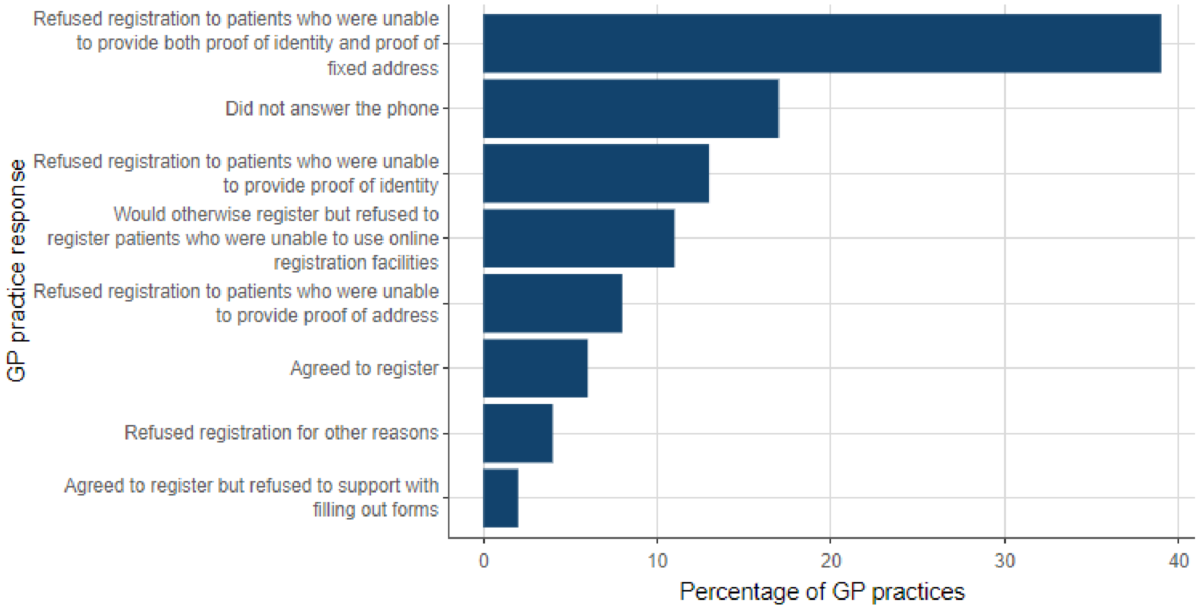
- The fear of screening being painful and being ashamed to go (believing the tests might imply to others that the person is indulging sexual behaviour).
- Fear of the results
- Prioritising children's health over their own and so missing screening appointments
- Not being registered with a GP due to being a transient population and therefore not being able to receive letters
- For those who are registered with a GP, there are not always literacy/digital considerations for those who might struggle
- Fear that someone of the opposite gender would be performing the screening

However, this work was also positive in finding that small changes to communication, information, and education can also improve understanding and willingness to engage, such as:

- Ways to communicate:
    - People didn't like video information communication about services within medical settings as it felt like they were talking down to them. They preferred something within their own environments. Showing videos of the screening facilities helped to reduce the fear around it.
    - Roma people refer to cancer as "Kuvva"; using familiar terminology helped
    - Men weren't comfortable talking to GPs about their conditions, so leaflets where men could circle on the illustrations what was wrong helped this.
    - Co-production helped
    - They wanted straightforward information (where to get it done, what to look out for, why would this leaflet talk to them)

OHID (2024) reported the results of a mystery shopper exercise conducted by Friends, Families and Travellers between March 2020 and April 2021. In the exercise the mystery shopper stated that they were Romany and had no proof of identity nor did they have a fixed address as they were travelling. The exercise looked to record the response that was given and is reported below in Figure 2.29, highlighting a mainly negative experience with only 6% of practices agreeing to register the mystery shopper. This is despite that anyone in the UK is entitled to register and consult with a GP for free.

Figure 2.29 - Percentage of attempted GP registrations for Romany people with no fixed address by response, March-April 2021.



Source: OHID Spotlight Tool analytics.phe.gov. uk/apps/spotlight/

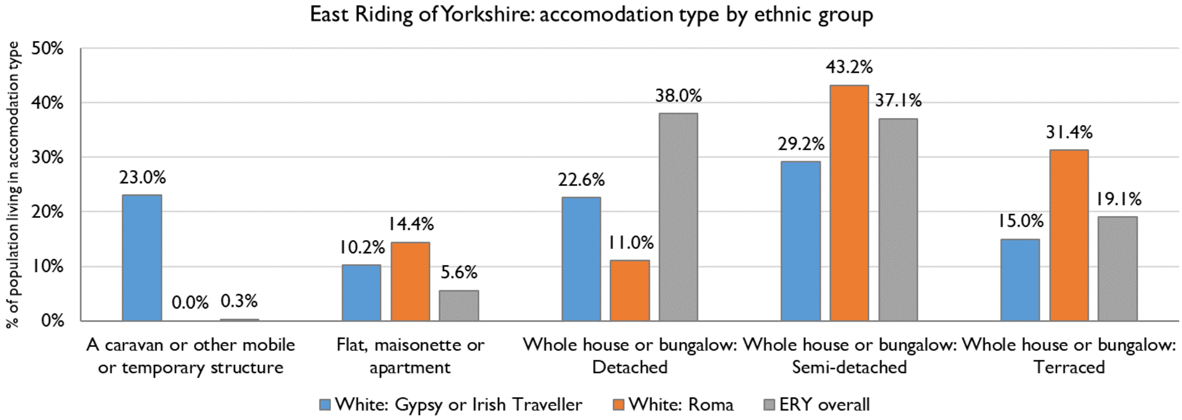
Across secondary care settings, a lack of cultural understanding of Gypsies and Travellers was reported by the CQC (2016) in hospitals, with hospital staff not having sufficient understanding of their cultural practices, such as the need for extended family to visit the dying person, leading to conflicts and feelings of discrimination. Negative interactions with hospital staff included rudeness, threats to call the police, and restrictions on parking caravans.

Accommodation and place of residence

Census data shows that across the East Riding, the majority of the Gypsy or Irish Traveller and Roma populations live in houses, with 23% of White Gypsy or Irish Travellers living in a caravan or other mobile or temporary structures (Figure 2.30). This is likely to be situated within one of the three authorised Gypsy and Traveller sites in the East Riding, at Cottingham, Bridlington, or Eppleworth. The official combined total population for these three sites was 152 as of 9th September 2024, however this is expected to not be completely accurate due to some ambiguity surrounding the number of people staying on a pitch with the licence holder.

On a similar theme, it has been noted that across the East Riding there is a general absence of data pertaining to the GRT community's accommodation, with many in this population being transient across areas of Yorkshire and an unknown number accessing social housing or traveller sites. Accommodation type and resultant living conditions are therefore key to understanding more about the unmet needs for the East Riding GRT community and how these may be driving some of the health inequalities we see.

Figure 2.31 - Note this does not include people living in communal establishments, such as university halls of residence or care homes, Census 2021.



Education

Friends, Families & Travellers (2023) stated that GRT communities in the UK have the lowest educational attainment at all key stages up to and including KS4, compared to other ethnic groups in the UK. This has resulted in 60% of the GRT population having no formal qualifications (Friends, Families & Travellers, 2024 webinar).

Children from GRT communities (Friends, Families & Travellers 2023) were found to have some of the highest rates of school exclusions in the UK. In the 2021/22 school year, Gypsy/Roma pupils had a suspension rate of 25.6%, and Irish Travellers were at 19.3%, compared to the national average of 6.9%. Gypsy/Roma pupils also had the highest permanent exclusion rates (0.3%, compared to the national average of 0.1%).

Contributing factors to these low educational attainments and high exclusion rates included bullying and racism (Friends, Families & Travellers 2023), with GRT experiencing racist bullying and prejudicial treatment in schools. A 2019 Friends, Families & Travellers survey found that 86% of pupils reported bullying as the biggest challenge at school, followed by racism (73%). Another factor was 'Digital Exclusion', which posed significant barriers to learning for GRT children, especially during the COVID-19 pandemic. Limited access to devices and parents having insufficient digital skills only further widened the attainment gap.

Nationally, special educational needs (SEN) in mainstream schools is most prevalent with GRT groups. The 'White - Traveller of Irish heritage' group recorded the highest prevalence of both SEN Support and EHC plans (25.9% and 7.3% respectively) of all ethnic groups, whilst 'White – Gypsy/Roma' groups had the 2nd highest prevalence of SEN Support (22.4%) and 4th highest of EHCPs. This is in contrast to, for example, 'White British' pupils who reported 15.1% having SEN Support and 5.1% with an EHCP. Higher levels of SEN were also recorded in both these ethnic groups within East Riding schools, but caution should be taken when interpreting these local proportions due to the very small numbers involved.

Gypsy and traveller children have a higher proportion of SEN than the national average, due to a complex interplay of factors that affect their development, learning, and well-being. As well as the aforementioned lack of cultural recognition in schools and parental involvement in education, other factors include:

- *Issues relating to early identification and intervention:* Gypsy and Traveller children may not have access to regular health checks, developmental screenings, or early years education, which can help identify and address any developmental delays or difficulties. They may also face challenges in accessing specialist services, such as speech and language therapy, occupational therapy, or educational psychology, due to long waiting lists, referral processes, or geographical distance.

- *Lack of continuity and consistency in education:* Gypsy and Traveller children may experience frequent changes of schools, interruptions in their learning, or gaps in their education, due to their mobility, exclusion, or non-attendance. This can affect their academic progress, social and emotional development, and self-esteem. It can also make it harder for teachers to assess their needs, provide appropriate support, or monitor their outcomes.

These barriers highlight impact that wider determinants of health (see Figure 2.12) such as stable and good quality housing, education, and social inclusion are having on this community, which has notably poorer health outcomes compared to the general population. In particular, Friends, Families and Travellers (2024 webinar) highlighted how Gypsy and Traveller communities are more vulnerable to poorer mental health outcomes, being 3x more likely to experience anxiety, 2x more likely to experience depression, and ultimately 6x more likely to die by suicide than the general population. Like many other socially disadvantaged groups, overlapping identities such as also being carers, prison leavers, LGBTQIA+ etc. can have a compounding effect and further widen these inequalities.

2.5.4 Veterans

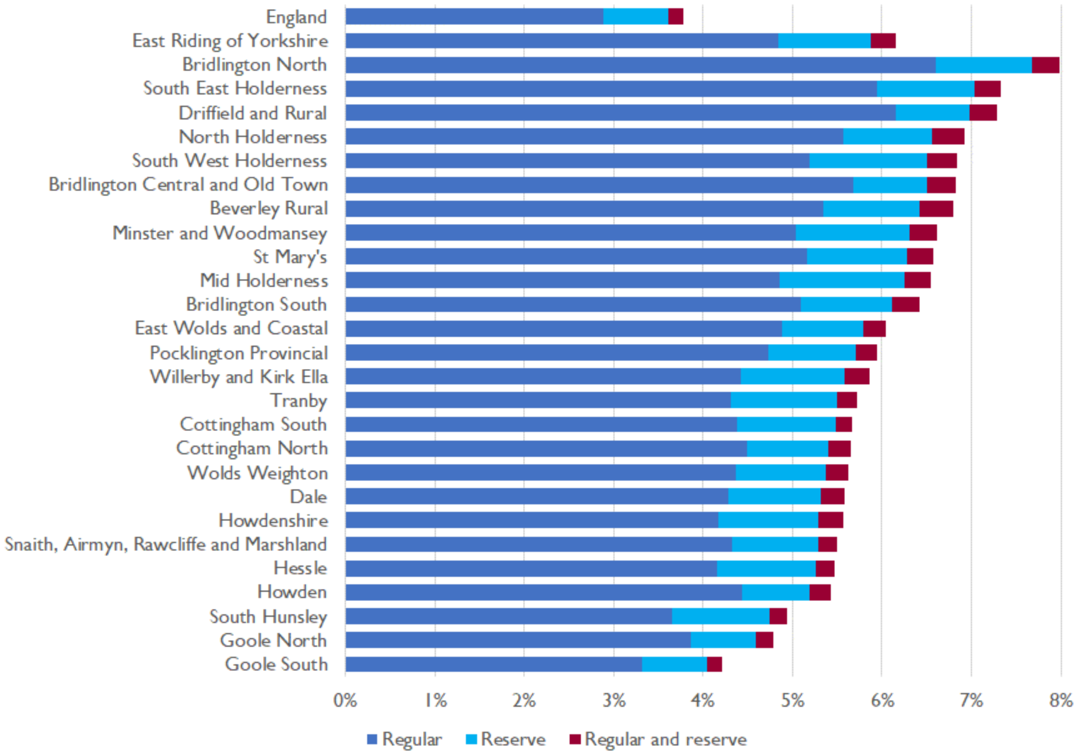
The Office for National Statistics (ONS) defines a veteran as someone who has served in the UK Armed Forces for at least one day and is no longer serving. This includes those who served in the regular or reserve forces, or merchant mariners who served on legally defined military operations. However, consultation with local professionals explained that the veteran identity is much more nuanced, and different groups have emerged within this cohort who have very different needs and support requirements. A generational divide is typically seen, with a cohort of older veterans now aged 65+, younger veterans more recently discharged, and veterans' families. Consideration must be given to the distinct cultures and identities within these groups, and the resultant differences in attitudes, perspectives, and needs amongst them.

East Riding Council is committed to upholding the Armed Forces Covenant and supporting the Armed Forces Community, recognising the contribution of veterans along with serving personnel. Currently across the East Riding work is being undertaken in partnership with veterans, local authority staff, and VCSE, as East Riding Community Covenant Delivery Group Organisations. Further details about the Armed Forces Covenant can be found on the East Riding website: https://www.eastriding.gov.uk/council/working-with-our-partners/armed-forces-community/armed-forces-covenant/.

Demographics

The 2021 Census reported that there were 17,732 veterans in the East Riding at that time, which equated to 6.2% of the total population. This is a higher proportion than the England average of 3.8%.

Figure 2.32 Percentage of the population aged 16 years and over who had previously served in the UK armed forces, 2021, local authorities in England and Wales.



N.b. Circled section denotes East Riding of Yorkshire. *Source:* ONS https://www.ons.gov.uk/peoplepopulationandcommunity/armedforcescommunity/bulletins/ukarmedforcesveteransenglandandwales/census2021

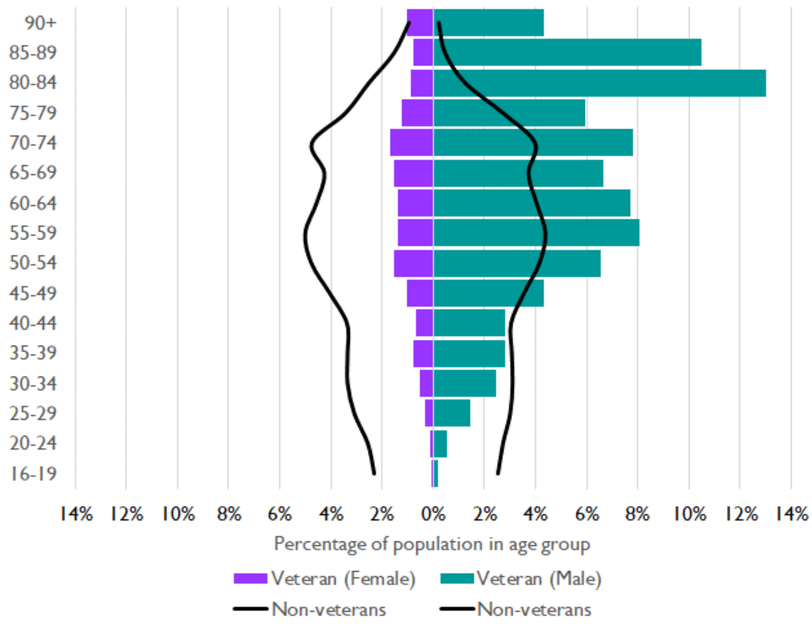
Whilst all wards in East Riding of Yorkshire have a higher proportion of veterans than is seen across the whole of England, seven wards (Bridlington North, South East Holderness, Driffield and Rural, North Holderness, South West Holderness, Bridlington Central and Old Town, and Beverley Rural) all have a significantly higher proportions of veterans than the overall average seen across East Riding of Yorkshire (Figure 2.34)

The structure of the veteran population differs substantially to the non-veteran population in relation to age and sex, with the veteran population being much older and mainly male. Of the total UK armed forces veteran population in East Riding of Yorkshire, 14.9% (2,644) were female (compared with 53.9% of the non-veteran population) and 85.1% were men (15,090). These populations refer to residents aged 16 and older.

Almost one-third (30.5% or 5,404) of veterans were aged 80 years and over, reflecting National Service and War Service from 1939 to 1960. This compares with 6.9% or 18,715 people who were aged 80 years and over in the non-veteran population.

Over half of veterans (55.4%, or 9,825) were aged 65 years and over. This compares with 29.8% or 80,670 people who were aged 65 years and over in the non-veteran population.

Figure 2.33 - Percentage of the usual resident population aged 16 years and over by previous service in the UK armed forces for the East Riding of Yorkshire split by age group and sex, 2021



Source: *Census 2021*

Health outcomes

> *"The key differences between the working age ex-Service community and the general population are that they are more likely to be out of work, to have unpaid caring responsibilities, to report health conditions that limit their daily activity – particularly difficulty hearing and musculoskeletal problems – and they are more likely to report being depressed."* The Royal British Legion (2014)

There are known poorer health outcomes amongst the veteran population compared to the general population, with many of them having been discharged from the armed forces on medical grounds. These are commonly mental and behavioural disorders and musculoskeletal disorders and injuries (Ministry of Defence, 2024). Those who have been deployed in combat roles are at a higher risk of common mental disorders (CMDs), alcohol misuse and probable PTSD compared to non-deployed personnel and also the general population (Sharp et al., 2023). Factors that were found to contribute to this higher risk included, childhood vulnerabilities, combat experiences, a culture of alcohol use and difficulties transitioning to civilian life.

When asked in an ERYC survey which area they felt would be the most useful to focus support and services, the most common answer (69.9%) was 'general health and wellbeing', closely followed by 'mental health' (66.2%) and 'physical health' (63%). This shows that consistently more than two thirds of the East Riding's veteran population sample felt that there remained gaps and unmet needs in health and wellbeing that the East Riding could do more to support.

Physical health

There is a disproportionate prevalence of disability within the veteran population compared to the non-veteran population in the East Riding. 30.6% of veterans are classed as disabled under the Equality Act, with 13.6% of these individuals having their day-to-day activities limited a lot. This is highly similar to the England statistics (32% and 15.3% respectively) and likely is reflective of the older age profile of the veteran population compared to the non-veteran population (ONS Census., 2021).

East Riding of Yorkshire Council's Armed Forces Needs Assessment (AFNA) consultation survey (N=382) revealed that almost half (49%) of the veterans who responded experienced sensory disorders such as disruptions to their hearing and/or sight, and 49% also stated struggling from musculoskeletal disorders. 40% of veterans felt that physical health advice and support would be helpful to them. Table 1B (Appendix B) contains a summary of their expanded answers, which particularly included comments detailing that access to low cost or free services would be useful, and help with maintaining a healthy weight.

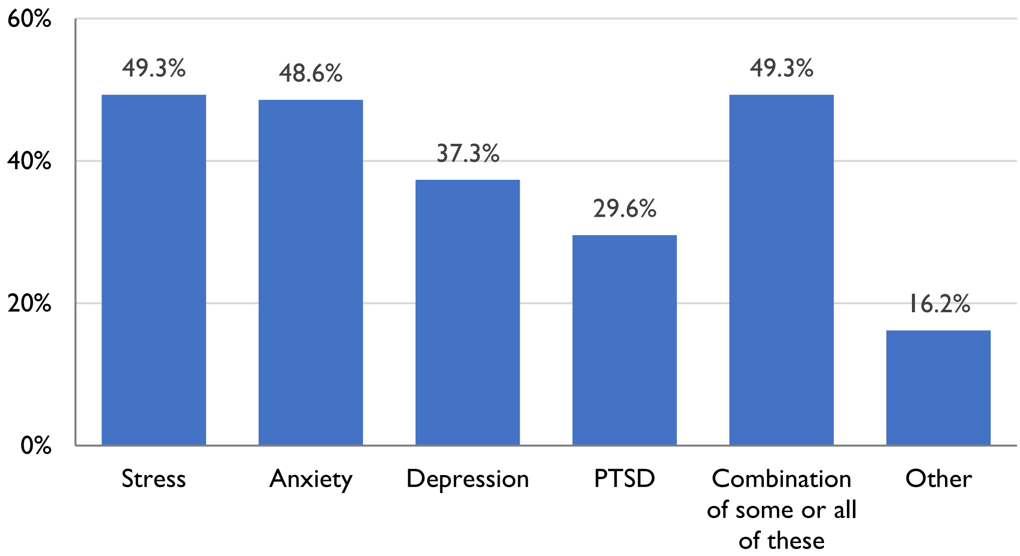
Over half (53%) of veterans responded that physical health support could be improved across the East Riding. When asked to detail expand on how this could be done, common answers included access to free facilities and gyms as particular areas. A summary of these answers is included in Appendix B.

Mental health

Mental health is one of the most prominent health and wellbeing challenges faced by veterans. Research has found that veterans are at far greater risk of experiencing common mental health disorders such as anxiety and depression compared to the general population, and have a significantly higher prevalence of post-traumatic stress disorder. This has ramifications for physical health and health behaviours, with a particularly high comorbidity with substance use especially alcohol amongst the veteran population compared to non-veterans (Rhead et al., 2020). Notably, this research has also suggested this comorbidity is restricted to male veterans, which may suggest that gender-specific pathways could be valuable on a local level to help reduce the distinct disadvantage faced by certain groups of the veteran population compared to the general public.

The Government Veterans Strategy Action Plan (2022) recognises the need for national investment into veterans' mental health services, launching Op COURAGE across the NHS as a nation-wide mental health support service as well as the Veterans Trauma Network. In the East Riding's local survey 80% of veteran respondents were aware of this service, but it had only been accessed by 19%.

Figure 2.34 - Percentage of participants who indicated they struggle with the following as a result of serving in the Armed Forces



Veterans' responses to the question of 'are you aware and have you accessed any local mental health services' showed that an average of 83.7% of people had heard of each of the 15 services listed, yet only 10.8% accessed the services on average. This shows that even when awareness of services is good, and almost half of respondents had a combination of some or all common mental health issues, there may still be an unwillingness to engage.

> *'As a veteran it was hard for me to admit I had a problem becoming a member of the British Legion really helped and allowed me to realise that help is there but I felt safe with my military brothers talking about the issues this led to them helping me get some support' – survey respondent*

Over half (56%) of respondents felt that mental health support could still be improved, particularly with regards to accessing services and staff understanding of specific needs, such as by embedding peer support and those with lived experience within mental health services (see Appendix)

> *'[In the] East Riding more Veterans should be involved in helping Veterans . Veterans cannot and should not be treated as Civilians even though they technically are because once a Members of HMF Always a Member. I have been a civvie over 30 years but definitely do not think or act like one & frankly until that is addressed it will be like a huge void between those offering giving and those receiving them.' – survey respondent*

Health behaviours

Substance use

Interviews with local professionals working with veterans explained how substance use behaviours differ amongst different groups and generations of veterans. They commented that a culture of excessive alcohol consumption was characteristic amongst older veterans, which had been traditionally seen as a 'rite of passage' and a way to bond with peers. In contrast, they felt that younger veterans from more recent conflicts showed less of a drinking culture but are increasingly utilising both recreational and prescribed drugs. Both have become more accessible in recent decades and may be perceived as a quicker or more effective means of managing pain and mental health. This aligns with national research demonstrating that Armed Forces populations have a historical culture of alcohol use, with a greater prevalence of alcohol related harm and dependence compared to the general population in the UK (Fear et al., 2007). This culture extends to the veteran population, particularly amongst those of an older generation (ibid). Research has found that amongst UK veterans, substance use behaviours including drinking alcohol may often be a form of 'self-coping' and are highly comorbid with mental health needs. Evidence shows that the veteran population is at an increased risk compared to the general population of comorbid mental health disorders and alcohol use disorders (AUDs) (Barrington et al., 2023).

In the East Riding, for the 2023-24 period 1.6% of clients (N=82) engaged with East Riding Partnership*[4]were veterans. The anecdotal evidence from those working close to the community that there is a high prevalence of alcohol use suggests that alcohol and substance use treatment and support may be an unmet need amongst this population.

Wider determinants

Comments from professionals working with local veterans in the East Riding have highlighted how the ageing of this cohort has often led to complex health and social care needs, with the older generation of veterans now aged 80+ having a legacy of very little health care and welfare support when they were serving. A culture of mistrust and stigma around medical services them has contributed to health and wellbeing deterioration that may have been preventable if support was received earlier and willingness to engage was greater.

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*Data includes engagement figures for Community Drug and Alcohol Team (CDAT), Open Access, Aftercare, and Primary Care services.

Access to services

The East Riding professionals interviewed explained that the veteran identity itself was acting as a key barrier to engagement with local services; in many cases veterans were not aware there were services to support their needs due to not identifying as a 'veteran'. Unmet needs amongst the community have therefore often arisen due to missed opportunities to access support they are entitled to. This demonstrates the need for stakeholders across the East Riding to ensure access to available services is maximised by working with the veteran community to challenge stereotypes, inform and educate, and build relationships. This is a pattern nationally, with just over half (52%) of veterans considering themselves a veteran (Burdett et al., 2013). This is particularly characteristic of younger veterans who may not see themselves as having served long enough to be entitled to veteran's services and/or do not associate with the typical stereotype of an older veteran. This has been widely recognised as a challenge for health services to engage with veterans, whose access generally requires them to explicitly identify as a veteran. This is a barrier for veterans who do not self-identify, leading them to potentially miss support across all conditions of living including mental health services, financial assistance, and employment support.

> *"As a proud veteran I struggled asking for help. I suffered from PTSD and extreme depression. I did not know where to find help. It took me 12 months to get an appointment to see a mental health professional just to be told I needed help and then had to wait 24 months before I was given 6 hour long sessions to help diagnose the issues I had." (ONS Veteran's Survey., 2022)*

It has become apparent from consultation with local veterans is that there is insufficient signposting to armed forces-specific services. 80%*[5] of veterans consulted said they had not been told about any support or services that are only for members of the Armed Forces community. This may be linked to the fact they are failing to be identified as veterans when engaged with health care services, as 71% also said they had not been asked by their GP surgery if they were a member of the Armed Forces community and did not think that they were aware. Along with a need to enhance awareness of the support available generally, this points to a gap with the GP surgeries.

Those who are accessing services are often presenting with complex and comorbid physical and mental health issues, posing an additional challenge for services provided to cope with potentially complex and comorbid needs. This is being seen on an national scale, manifesting particularly through increased waiting lists, which have themselves become a barrier to accessing co-occurring treatment.

A survey by the UK Government survey in 2022 revealed that there were a number of health-related challenges faced by veterans, which emphasised the need for better access to medical services and improved coordination of veteran services (ONS, 2022). In transitioning to civilian life, veterans reported a lack of adequate health services, with 41.6% highlighting this in mental health services, 34.5% mentioning issues with the NHS, and 16.7% pointing out deficiencies in dental services. There were difficulties in registering with NHS dentists or doctors and a lack of understanding of military experiences and the Armed Forces Covenant by NHS professionals. This was made harder by the issues experienced of transferring medical records.

The lack of support for specific conditions was highlighted, including conditions such as noise induced hearing loss and musculoskeletal issues, with veterans often having to fund their own hearing aids and waiting long periods for physiotherapy. Mental health support within the NHS was also deemed inadequate, particularly for conditions like Complex PTSD, due to long waiting times. There was a strong sentiment that veterans should receive prioritised medical services or specific veteran medical services due to the service-related nature of their health issues. There was confusion about available

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*Unpublished[5]data from East Riding of Yorkshire Council Armed Forces Needs Assessment Survey. For full list of results please contact kerry.hooley@eastriding.gov.uk.

services and a need for better coordination and communication among service providers. Suggestions included a 'one-stop-shop' for veteran services, a centralised database for veteran support and a quarterly newsletter to keep veterans informed about available services and updates, to reduce confusion and fragmentation.

Impact on families

Professionals working with veterans who were interviewed for this needs assessment said they felt that support for veterans' families and children/young people (CYP) was an unmet need in the East Riding. This is due to there being a wealth of support and wrap-around services available for families of serving personnel which was lessened upon the transition to being a veteran, yet similar challenges around relocations and finding suitable housing and schools whilst adjusting to a new community. This can be especially impactful for children, who may have additional education needs due to these disruptions; yet unlike the children of active military service personnel, children of veterans are not recorded within schools where they might be identified and be provided with extra support and so their needs can get missed Instability can be particularly disruptive for children with SEN, who often require a consistent and stable educational environment. Each move necessitates a transition to a new school, where the child must adapt to different teaching styles, new classmates, and varying levels of support for their specific needs. These children may have difficulty forming new friendships and trusting new educators, leading to increased anxiety and behavioural issues. The lack of a stable social network can further isolate them, compounding the difficulties they face in new environments.

Similar challenges persists for access to and continuity of health care, with veterans' families relocating between local authorities or NHS places often being constantly placed at the bottom of waiting lists or struggling to register for already-full health services such as dentists.

2.5.5 Care leavers

The East Riding of Yorkshire's Corporate Parenting Strategy 2024-2027 (page 8) defines care leavers as:

> *"A care leaver is broadly defined as a person aged between 16 and 25, who has been looked after by a local authority for at least 13 weeks since the age of 14, is either currently in care or has left care and has been looked after for a period of time after their 16th birthday."*

In the UK, there are about 80,000 children in care at any one time, and about 10,000 young people leave care each year. Care leavers are a diverse group of individuals, with different backgrounds, experiences, and needs. They may have entered care for various reasons, such as abuse, neglect, family breakdown, or disability. They may also have different legal statuses, depending on whether they are still in care, have left care, or have been adopted. Care leavers are frequently moved around, expected to be semi-independent at a young age, and left alone after 18. The service tries to prepare them for the transition, but faces challenges such as shortage of foster carers, lack of suitable accommodation, and resistance from young people. The service also tries to continue supporting care leavers until they are 25, but faces difficulties such as maintaining contact, engaging with partners, and meeting diverse needs.

Care leavers face a range of challenges that affect their health and wellbeing, such as poorer physical and mental health, lower life satisfaction, reduced life expectancy, a lack of support networks, low self-esteem, isolation, difficulty in accessing services, managing tenancies and transitioning to adulthood. These challenges are often related to their pre-care and in-care experiences, such as abuse, neglect, disruption, and instability. Care leavers are also more likely to struggle with financial difficulties, educational attainment, employment opportunities homelessness, and the threat of prison than their peers who have not been in care. Identification of care leavers by services and within existing datasets is poor.

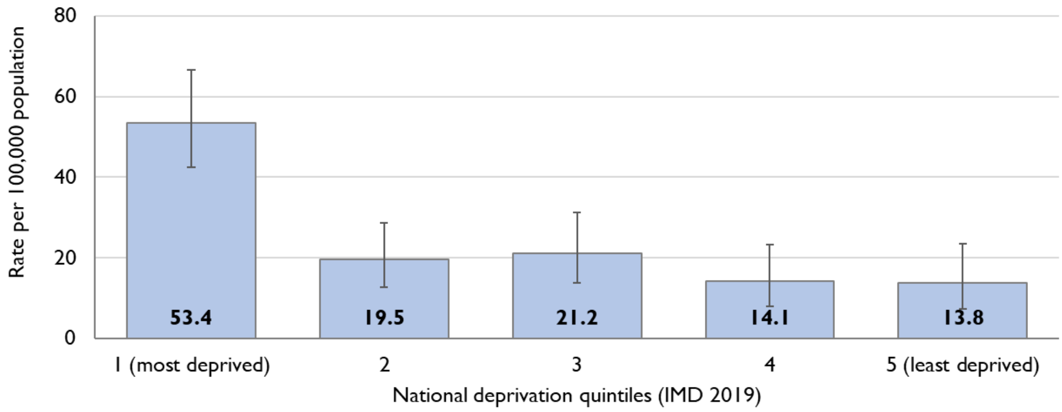
The Pathway Team is East Riding of Yorkshire Council's leaving care service and supports all young people who are looked after from the age of 16 onwards. They provide with help and support as individuals leave care, and up to the age of 25 if needed. Throughout the following sections, comments on challenges faced in the East Riding have come from insights shared by the Pathway Team, who were interviewed and asked to comment on key issues that they had observed from their experience within the East Riding.

Demographics

As of March 2024 there were 162 care leavers known to the East Riding of Yorkshire local authority, 56% were male and 44% female. Just less than half (46%, n=76) resided within the East Riding, 36% lived in Hull and 17% elsewhere.

Using the national deprivation quintiles framework, Figure 2.37 shows the distribution of care leavers across the deprivation quintiles. A higher rate were found to be living within quintile 1, the 20% most deprived areas of England, compared to any other quintile. With a rate of 54.4 per 100,000 population, quintile 1 was over 3 times higher than the rates of the least deprived quintiles of 4 and 5 (rates of 14.1 and 13.8 respectively).

Figure 2.35 – Distribution of care leavers across deprivation quintiles of the East Riding, crude rate per 100,000 population (March 2024).



Source: The Pathway Team, East Riding of Yorkshire Council, 2023.

The age of the care leavers within the March 2024 cohort are shown in Figure 2.36, with the numbers subsequently decreasing by each year of age. The highest proportion of care leavers in the East Riding are aged 18-20 years.

Figure 2.36 - Care leavers in the East Riding, count by age (March 2024 cohort). Source: The Pathway Team, East Riding of Yorkshire Council, 2023.

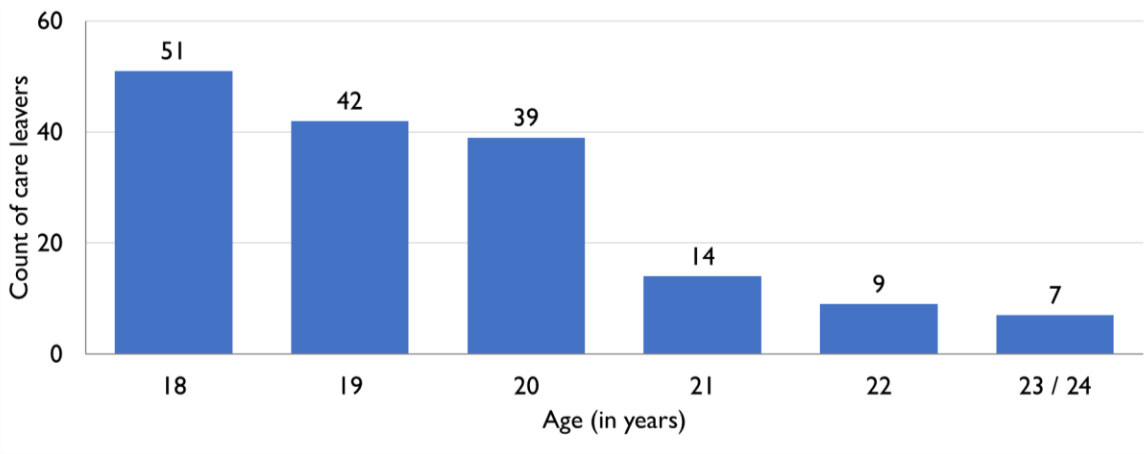


Table 7 reports that there was a fairly equal divide in the 3 types of activities that the March 2024 cohort of care leavers were pursing.

Table 6 - Care leavers activity since leaving care, March 2024 cohort. Source: The Pathway Team, East Riding of Yorkshire Council, 2023.

Leaving Care Activity	**Person Count**	**Activity as % of total**
In education (full or part time)	55	34%
Not in education, employment, or training (NEET)	53	33%
Engaged in an apprenticeship (full or part time)	54	33%
Total	162	100%

Health outcomes

The East Riding Pathways Teams gave a presentation on the health inequalities faced by Care leavers, citing:

- Care leavers are between 4 and 5 times more likely to attempt suicide compared to other young people.
- Young women who are looked after are 3 times more likely to be a parent by the age of 18 compared to the general population.
- 24% of care leavers report having a disability or long term health problem compared to 14% in the general population.
- Care experienced young people are more than 5 times more likely to die early compared to those with no experience of care.

Consultation with local professionals who work with Care Leavers across the health care system has clearly conveyed that Care Leavers are marginalised group who face health inequalities, often facing multiple points of deprivation and marginalisation due to experiencing traumas and adversity. One challenge is that particularly in clinical settings such as PCNs and A&E, Care Leavers are not recorded in data sets meaning there are current gaps in intelligence around their unmet needs.

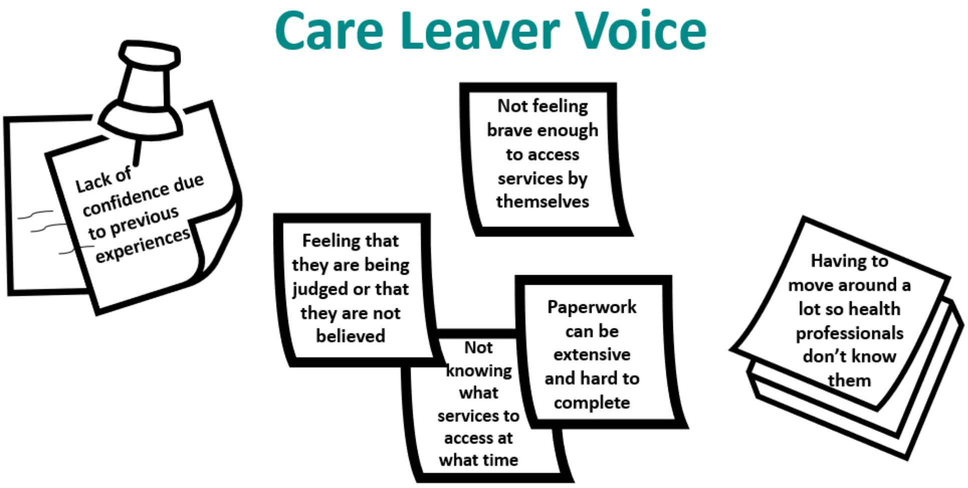
Another gap is that Care Leavers' health needs may not be identified until crisis point, due to there being no specific Care Leavers' service and services which do work with them until they reach 18 being focused around meeting immediate social care needs.

Mental health is a notable area of inequality, with Care Leavers at risk of poorer mental health outcomes often linked to having adverse experience and traumas, experience of stigma and discrimination, a negative self-image, and low sense of self-worth. Individuals may also have difficulties coping with stress, adversity, or change, and may lack the skills or resources to overcome the challenges they encounter. They may also experience feelings of loneliness, isolation, or abandonment, and may have trouble forming trusting or lasting relationships. This can contribute toward the development of mental health support needs. Care leavers are more likely to suffer from mental health problems, such as depression, anxiety, or post-traumatic stress disorder, than their peers who have not been in care.

Nationally, these factors have been linked to increased levels of substance use amongst Care Leavers, and a higher risk of becoming involved in crime, either as victims or perpetrators, due to factors such as poverty, homelessness, or peer pressure.

Wider determinants

Figure 2.37 Care Leaver Voice (The Pathway Team, East Riding of Yorkshire Council, 2023)



Access to services

The Health Foundation (McKeown et al., 2023) noted that youth panel members identified several factors that specifically influenced their health outcomes as care leavers. These included a lack of health literacy, which meant that they did not know how or when to access different health services. Experiences of healthcare were often negative and involved mistrust, disbelief, judgement, or mistreatment from health professionals. Finance was highlighted as a barrier to accessing healthcare services, as they had to consider the costs of transport, prescriptions, dental care, or taking time off work. They also expressed frustration with the bureaucracy within the healthcare system, such as losing medical notes, having to repeat processes, or filling out complex forms. The youth panel members suggested some possible solutions for reducing health inequalities for care leavers, based on their own views and experiences. These included providing free prescriptions for care leavers, making care leavers aware of the support that is available to them, flagging care leavers in healthcare or GP systems to alert health professionals to their needs, improving training and education for healthcare professionals on care leavers' experiences and challenges, and improving the mental health offer to care leavers by providing more sessions, shorter waiting lists, and tailored support.

In the East Riding, professionals commented that care leavers face numerous obstacles in accessing services, including financial issues such as anything from affording a bus pass to rigid service policies that penalise missed appointments by pushing them to the back of the queue. These challenges are compounded by the varying social, emotional, and behavioural experiences of the individual. It was felt that often individuals had a negative experience whilst using the services which was impacting their long-term trust of the authority/NHS and willingness to engage with such services. This is exacerbated by negative language and assessments related to their parents' capacity and parenting skills. An example of where this may be happening was with maternity services, with pregnancy and maternity care cited as a complex issue for Care Leavers due to facing stigma around young parenthood.

Professionals commented particularly on how the cost of living crisis has impacted Care Leavers' access to health services, with choices often having to be made between attending an appointment and paying for transport or the weekly budget for food for example, and difficulty in accessing appointment times due to being in full time job(s) or education.

Homelessness, poverty, or social exclusion

The risk of experiencing homelessness, either temporarily or permanently, is greater in care leavers than their peers who have not been in care. This may be due to the lack of suitable or affordable accommodation, or the lack of support or preparation for independent living. Care leavers may also face poverty, due to the low income, unemployment, or debt. Additionally, issues of social exclusion, due to the discrimination, marginalisation, or stigma might be encountered from society.

In the East Riding, almost a third of the care leavers from the March 2024 data cohort were residing in 'Semi-independent, transitional accommodation and self-contained accommodation', almost twice as much as the next accommodation category (Table 7).

Table 7 – Care leavers accommodation type. East Riding March 2024 cohort.

Leaving care accommodation type	Count	% of total
D: Semi-independent, transitional accommodation and self-contained accommodation	51	31.5%
B: Parents/relatives	26	16.0%
U: Independent living	26	16.0%
E: Supported lodgings	23	14.2%
Z: With former foster carers	21	13.0%
K: Ordinary lodgings, without formal support / or C: Community home / residential care	8	4.9%
Y: Other accommodation	7	4.3%
Grand Total	162	100.0%

Source: The Pathway Team, East Riding of Yorkshire Council, 2023.

Other challenges: insights from the Pathways Team

The Pathway Team is East Riding of Yorkshire Council's leaving care service and supports all young people who are looked after from the age of 16 onwards. They provide with help and support as individuals leave care, and up to the age of 25 if needed. The team commented on key issues that they had observed from their experience within the East Riding:

Lack of support from family, friends, or professionals – there is often a sudden loss of support and guidance when individuals leave care, and they may struggle to cope with the practical and emotional aspects of living independently. They may also have difficulty maintaining or establishing positive relationships with their birth families, foster carers, social workers, or other professionals who have been involved in their lives.

Gaps in health and education: There are significant gaps in health literacy and education for care leavers, who are often overrepresented in figures of not in education, training, and employment. Addressing these gaps is crucial for improving their overall well-being.

Lack of Leaving Care Health Nurse: there is no Care Leaver's service in the East Riding; elsewhere there are nurses attached to this service who support care leavers in accessing and navigating health services and understanding their health needs as they transition to adulthood.

Older children being referred: in line with national trends, there are increasing referrals for young people aged 16-17 who have not previously been involved with social services. A number of those young people have not engaged in any employment or education or training for a period of time and often there has been a breakdown in the family which requires the local authority to step in as a duty of care under the Children's Act.

2.5.6 Sex workers and people experiencing sexual exploitation

The Home Office recognises sex work to constitute 'the provision of sexual or erotic acts or sexual intimacy in exchange for payment or other benefit/need' (Hester et al., 2019). This often falls into three broad categories: those who operate in massage parlours, those who work on the streets, and those who advertise online.

Some sex work is non-consensual or heavily coerced, and is instead recognised as sexual exploitation, often as a form of modern slavery or trafficking. Individuals who are being sexually exploited are likely to have differing and increased health effects and are highly vulnerable.

This section contains the available qualitative and quantitative intelligence around people who sex work, and those who are being sexually exploited and may be victims of modern slavery. These are very different cohorts of people and may have very different needs. More work is needed to understand more about both populations, particularly regarding people who engage in consensual sex work. This remains a stigmatised occupation and identity and therefore is a relatively 'hidden' population to local authority services.

Demographics

In 2015, Brooks-Gordon et al. (2015) estimated that there were over 78,000 sex workers in the UK, with close to 5,000 within the Yorkshire and Humber region.

At the time of being interviewed (October 2024), Humberside Police had identified 69 profiles listed on Adult websites for females who were sex working with an East Riding address. These have been identified with regards to modern slavery investigations, as it was deemed possible that some of these could be linked to sexual exploitation or modern slavery. Conversations with representatives of Humberside Police's Modern Slavery task explained that cases of sexual exploitation linked to modern slavery or trafficking across the Humber region were predominantly linked to foreign nationals, with many being Romanian, Thai, Chinese, or Brazilian.

Health outcomes

Street sex workers (SSWs) are often highly stigmatised and marginalised who confront many obstacles. They are more susceptible to negative consequences for their physical and mental health since they are more likely to be the targets of abuse, exploitation, discrimination, and criminalisation.

OHID (2022) highlighted a number of key health and wellbeing issues relating to sex workers:

- *Mental Health:* Sex workers face considerable mental health challenges, including anxiety, depression, and trauma. These issues are more pronounced among on-street sex workers due to the higher levels of violence and exploitation they experience.

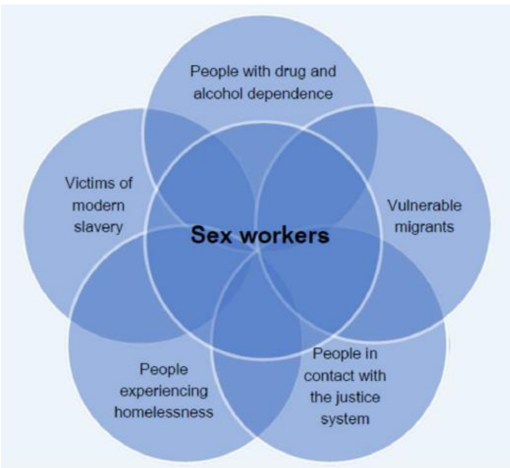
- *Addiction*: Substance abuse and addiction are prevalent among sex workers, especially those working on the streets. As addiction often coexists with mental health issues, it creates a complex web of health challenges.
- *Sexually Transmitted Infections (STIs):* Sex workers are at a higher risk of contracting STIs.
- *Access to Healthcare*: There are significant barriers to accessing mainstream healthcare services for sex workers. These barriers have been exacerbated by the COVID-19 pandemic, which has further marginalised this group and limited their access to essential health services.
- *Physical Health*: Physical health issues, including injuries and chronic conditions, are common.

In the East Riding, the physical and mental health needs of sex workers are relatively unknown due to there being very little opportunity to specifically identify people who are sex working. Sexual health services give some insight, with 519 individual sex workers attended sexual clinics that were residents of the Yorkshire and Humber region in 2019, and 238 in 2020. 92% of those attending in 2020 were female, mostly born in the UK and predominantly aged 25-34. Fewer than 10 sexual health clinic attendees in 2019 were East Riding residents, and in 2020 this was fewer than 5*.[6]This data is reliant on individuals attending sexual health services self-reporting they are a 'sex worker'**,[7]and therefore will likely not be a completely accurate picture of the proportion of people engaged with sexual health services who sex work or the scale of sexual health needs amongst those who do sex work across the East Riding. This is a potential gap in monitoring and surveillance and there could be unmet sexual health needs for people who sex work. Further investigation could be undertaken as an element of sexual health needs assessment and co-production with sexual health services as well as those with lived experience.

Wider determinants

Sex working is recognised as being highly intersectional with other inclusion health groups, as displayed in Figure 2.38. Although there is limited local data specifically about sex workers, their broader health needs might be captured within the framework of existing services (e.g. drug and alcohol treatment).

Figure 2.39 - Intersectionality of sex working with other inclusion health groups



Source: *OHID 2024 "A public Health approach to sex work, Yorkshire & Humber"*

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*This data is suppressed due to small numbers being potentially identifiable.
**Data is collected from the Genitourinary Medicine Clinic Activity Dataset (GUMCAD), a sexually transmitted infection (STI) Surveillance System, which collects information from all commissioned sexual health services in England. This dataset has a specific field for 'sex worker' which allows for some monitoring of attendance at sexual health clinics, but only if the patient discloses they are a sex worker.

Access to Health care

People who sex work are at increased risk of complex needs, and so health care services should ideally be flexible, trauma-informed, and well-resourced. Instead, national-level research has shown that access to primary care and mental health services for street sex workers is inadequate (Potter et al., 2022). This identified several conditions which may constitute barriers to health care access across the country:

- Inflexible, regimented services
- Lack of trauma-informed care:
- Under-resources services, which don't have capacity to manage complex and/or comorbid care needs
- Lack of trust and inconsistent relationships with healthcare providers
- Lack of knowledge/training from professionals which could inadvertently be propagating stigma and/or missing complex needs

There is currently no East Riding-specific information around access to services for people who sex work, but findings from Yorkshire & Humber level scoping exercises displayed in Figure 2.40 revealed the following:

Figure 2.41 - A public Health approach to sex work: Key findings from a regional scoping exercise, Yorkshire & Humber

Source: OHID., 2024

2.5.7 Prison leavers

The transition from prison to community life presents a myriad of challenges for prison leavers, particularly in terms of health. In the UK, prison leavers often face complex health needs that require comprehensive and coordinated care to ensure their successful reintegration into society.

Substance use is one area where this transition is managed well, alongside supporting other wider determinants such as housing needs and employment. Continuity of care is described as the ongoing and coordinated delivery of healthcare and supportive services to individuals transitioning from prison to community settings, ensuring that their physical, mental, and social health needs are met consistently throughout this process, NICE guidelines emphasise coordinated discharge planning, including continuity of medication and referrals to community healthcare providers, to reduce gaps that may lead to poor health outcomes. This includes mental health services, substance use treatment, and general health support to help manage chronic conditions, reduce reoffending risks, and support overall reintegration.

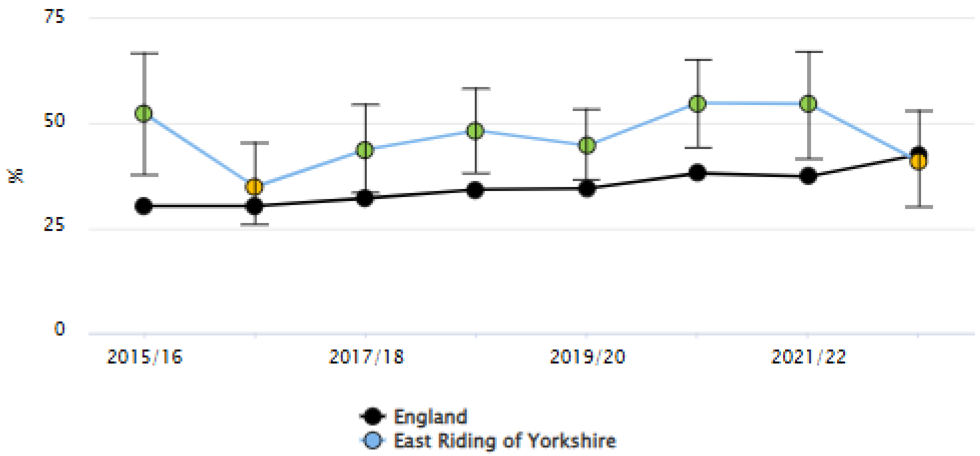
Table 8 – Adults released from prison, transferred to a community treatment provider for structured treatment and successfully engaged for East Riding of Yorkshire and England, 2021-22.

Drug group	East Riding transfers	East Riding engaged	Proportion engaged	England transfers	England engaged	Proportion engaged
Alcohol and non-opiates	7	<5	*	1,518	203	13%
Non-opiate only	7	<5	*	1,296	236	18%
Opiates	35	24	69%	12,843	5,720	45%
Total	**53**	**29**	**55%**	**16,986**	**6,345**	**37%**

**Denotes a percentage derived from a count lower than 5. Source: OHID Adult Drug Commissioning Support Pack: 2023-24. This indicator is the same as PHOF C20.*

Figure 2.424 demonstrates that over most periods between 2015/16 and 2022/23, East Riding ex-prisoners successfully engaging with treatment has been higher than the national average, although there was a reduction in the East Riding in 2022/23, it wasn't a statistically significant one. Nationally, the proportion successfully engaging has been slowly increasing over time.

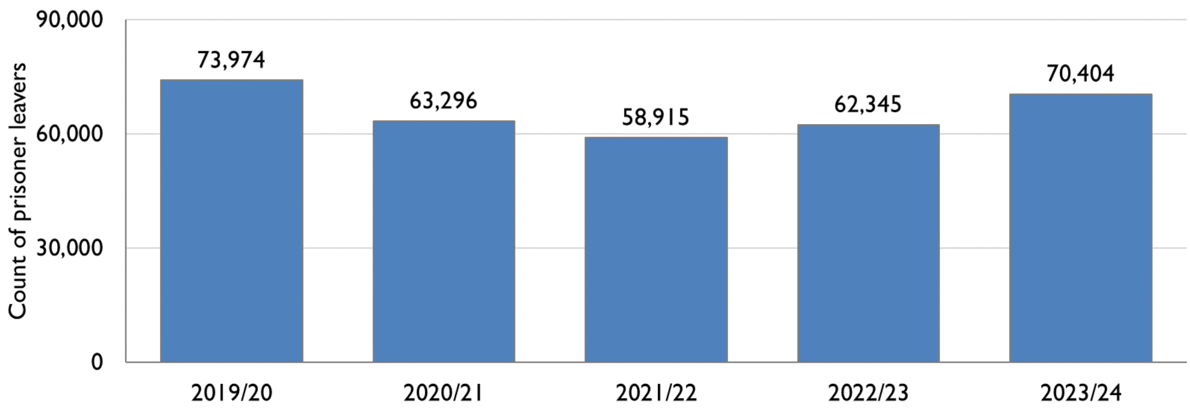
Figure 2.42 - Adults with substance misuse treatment need who successfully engage in community based structured treatment following release from prison. East Riding compared to England.



Source: OHID Fingertips

There were 70,040 prisoners released in England and Wales, during 2023/24, an increase of 12% on the previous year (Ministry of Justice., 2023; NACRO., 2024). Of those released, 13.1% (9,210 individuals) were released homeless, which equated to approximately 770 per month; this was an increase over the 11.3% (7,055) released homeless the year before. Between the two years, there was a 45% rise in the number of people rough sleeping three months after being released from prison (rising from 2330 to 3375), whilst women released from prison who are rough sleeping increased by 48% (445 to 660).

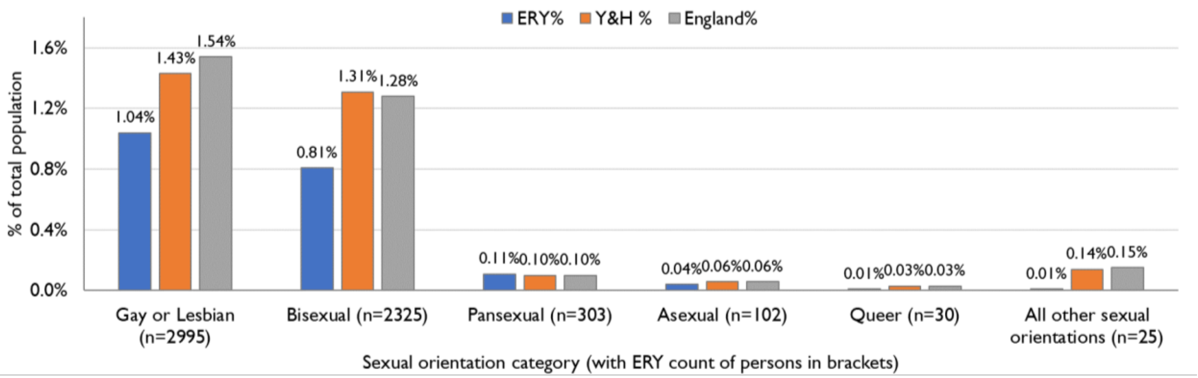
Figure 2.43 – Prison leavers in England and Wales by financial year



2.5.8 LGBTQIA+ groups

The 2021 Census, in England and Wales, recorded 89.4% of the population aged over 16 years identifying as straight or heterosexual, while 1.5 million (3.2%) identified with an LGB+ orientation, including gay or lesbian, bisexual, or other sexual orientations. In the East Riding, 91.2% identified as straight or heterosexual and just over 2% (almost 5,800 individuals) stated they were LGB+ orientation. There were approximately 7% of the East Riding population who did not answer the question. Figure 2.44 displays the sexual orientation categories (excluding straight/heterosexual or not answered) in the East Riding at a more granular level.

Figure 2.44 – Sexual orientation for East Riding, Yorkshire and Humber, and England populations, Census 2021.



It is established throughout research across the world that LGBTQIA+ groups have an increased risk of poorer health outcomes compared to heterosexual populations. The LGBT Foundation's *Hidden Figures* report (2023) highlights health inequalities experienced by LGBTQIA+ populations in the UK, which are particularly apparent for mental health. LGBTQIA+ individuals are at a higher risk of experiencing depression, anxiety, and suicidal ideation, with their increased risk being often linked to societal stigma, discrimination, and the stress associated with concealing one's identity. Studies have shown that LGBTQIA+ youth are particularly vulnerable, with higher rates of self-harm and suicidal behaviour compared to their heterosexual and cisgender peers. Across the UK the average wellbeing scores were lower for LGBTQIA+ groups, particularly amongst women, and the prevalence of mental, behavioural or neurodevelopmental disorders being higher (NHS Digital., 2021). Bisexual women are four times more likely to have long term mental health problems than heterosexual women (Women and Equalities Committee report., 2019). 3% of gay and bisexual men attempted to take their life in 2013, compared to just 0.4% of men in general, and the prevalence of self-harm amongst trans young people is much higher than young people in general (Women and Equalities Committee report., 2019).

Physical health inequalities have been seen for LGBTQIA+ populations, such as a greater prevalence of cardiovascular disease, cancers, and respiratory illness (Women and Equalities Committee Report., 2019). These have also been linked to higher rates of smoking and alcohol consumption in LGBTQIA+ communities. Across 2023 a total of 161 individuals (1.8%) engaged with East Riding substance use treatment services who identified as LGBTQIA+.

Sexual health is another area where they may potentially be unmet need and vulnerabilities; men who have sex with men (MSM) have been identified as a group disproportionately burdened with HIV infection in England (NICE, 2014) and so are a key risk group. It was estimated in 2016 that 13% of men who have sex with men, were also infected with HIV, and were also unaware of their infection. Connecting in with local sexual health services may give a better insight into the needs for the East Riding.

It is difficult to ascertain what health inequalities are present amongst LGBTQIA+ populations in the East Riding specifically as we do not consistently collect data on sexual orientation and gender identity across all health services, nor have a consistent form of engagement with LGBTQIA+ communities who may not be accessing health services at all. Where individuals are presenting to services or organisations, data may still not be accurate due to reporting sex at birth as opposed to present. More work is needed to be done to support the analysis of available data such as that from the Census, Health & Wellbeing Survey, and Pride events, as well as connecting in to LGBTQIA+ - specific spaces led by the VCSE to understand more of people's experiences.

Consultation with members of the East Riding's adult transgender community*[8]revealed that access to healthcare was a key barrier for many, arising from feelings of mistrust and hostility from staff. Though in some cases this had manifested from transphobic attitudes, most commonly this atmosphere was suggested as being the product of staff being 'uncomfortable' using correct terminology and/or being fearful of doing so. Ultimately this arises from training provision and education towards staff and healthcare professionals. This has been experienced across the country, with healthcare staff being unsure of which terminology to use, when to use it, or simply lacking knowledge or understanding (McNeill, McAteer, & Jepson., 2023). On a similar theme, a lack of engagement with GPs in the East Riding by trans people was suggested by some to be a consequent result of their lack of training and experience with transition, fostering feelings of mistrust and antipathy. Only 11% of practitioners surveyed in the East Riding have had any level of training on terminology, and 1 in 5 reported they were 'not so' or 'not at all confident' in providing appropriate support and care to trans and non-binary people.

Data demonstrates that Covid-19 has heightened health inequalities experienced by the LGBT+ community (Phillips et al., 2021). This is associated with increased feelings of loneliness and isolation amongst this group; in addition to leading to an even greater prevalence of mental health issues within the pandemic, isolation from individuals' support systems and friends/family networks has been linked to higher risk of physical conditions including heart disease, dementia, stroke, hypertension, and increased mortality (ibid).

*East Riding Transgender Needs Assessment, 2023[8]

2.5.9 People who are using drugs and alcohol in a harmful way

NHS England recognises that people who are dependent on drugs and/or alcohol are an inclusion health group, due to having an increased risk of poor health outcomes and facing stigma and potentially discrimination across society. It is possible that these individuals may lead difficult lives, with complex daily routines that mean they can face additional barriers to accessing services, such as unsuitable appointment times or opening hours, lack of awareness of services and support available, comorbid treatment needs such as mental health, and failure for physical health needs to be recognised or treated unless substance use abates.

As demonstrated in each section of this needs assessment, people who use substances or are in recovery are likely to be a part of other inclusion health groups and may have intersecting risk factors for poorer health outcomes. For a comprehensive insight into people who use substances or have lived experience of substance use, the East Riding Drugs Partnership (ERDP) has published a needs assessment (2024) with the data available across parts of the system relating to drug use, treatment, support, and recovery needs. The ERDP Strategy (2024) has also identified inclusion health as a key focus area, including to

- Reduce risk of drug use amongst high-risk populations including young people and inclusion health groups

- Reduce drug related harm amongst inclusion groups by supporting the recommendations of the present needs assessment and increasing engagement with inclusion groups

- Increase engagement in treatment by ensuring accessible and equitable substance use treatment and recovery services for members of inclusion health groups

The ERDP needs assessment (2024) can be found on the Council's JSNA webpage here: https://eastridingjsna.com/east-riding-drugs-partnership/

3 Inclusive Health Systems

3.1 Qualitative insights: consultation with Bridlington VCSE

A consultation event by ERYC Public Health and Hey Smile Foundation was held with voluntary and community groups in Bridlington. Community representatives were invited to discuss the meaning of inclusion health and what they feel the needs are locally. Three focal areas for the session were identified as being barriers, engagement, and connections.

3.1.1 Barriers

We asked VCSE representatives what barriers they felt were present in working with services, with the public, and with each other in terms of inhibiting signposting and referral opportunities. Discussion centred on what individuals felt was restricting access to health services and community groups, what challenges had been experienced in working with the public and particularly with hard-to-reach groups, and whether there were issues noted with signposting and referring between health services. From these conversations, it emerged that the barriers experienced align with the following five themes:

1. *Communication and coordination*: issues came up frequently with regards to feeling there is a lack of communication between health services. This is particularly challenging given the constantly changing nature of the VCSE sector, meaning it is difficult to stay informed of which options and support are available and led by whom. This also can make data sharing difficult, which then itself acts as a further barrier reinforcing a lack of awareness of needs. Local meetings such as the Goole Local Links group are potential ways to overcome these barriers and provide a space to discuss local needs and ensure awareness of available services and organisations.

2. *Access and engagement*: were cited as barriers inhibiting the community's engagement with VCSE. This was particularly in regard to challenges in marketing and promoting services to the public as it was felt that awareness of the services and VCSE offers within the community was in some cases lacking. In some cases this has been exacerbated by digital requirements causing exclusions such as online-only marketing. Language similarly has posed a barrier affecting communication with certain groups in the community such as vulnerable migrants, as well as professional jargon acting as a barrier for VCSE groups connecting in with commissioned services. Physical difficulties to access such as transport requirements and mobility issues can also pose a barrier to engagement.

3. *Service provision and adaptation*: were highlighted particularly in relation to funding, with a lack of flexibility such as short-term funding as well as inadequate grants limiting the scope of work to short-term projects that are insufficient to meet community needs. Including more local input in funding bids would help to ensure grants fit the needs and that the optimal work can be taken within the scope of the grant requirements. Another aspect of this inflexibility is in the service provision itself, with many VCSE organisations recognising that lack of out-of-hours availability for services is a barrier to community engagement. The ability of VCSE organisations to mitigate for this either by aiding access to services or through their own offer is limited by challenges to volunteer recruitment and their subsequent operation at restricted capacity. Organisational changes both within the VCSE network and commissioned services can impact service provision and cause confusion regarding what the current offer is and who it is appropriate for.

4. *Community engagement and support*: identified as a key enabler to connecting with inclusion health groups and hinderances to this are thus a major barrier for the VCSE. Particular

challenges lie in the public perception and stigma surrounding certain populations such as the Traveller community, and feelings of mistrust from within some of these communities preventing access and engagement with these groups. Overcoming this requires a trusting rapport to be sustained between VCSE groups, commissioned services, and inclusion health groups as well as a positive perception from the wider community towards the work of VCSE groups, services, and inclusion health groups. This highlights the importance of holding compassionate conversations and ensuring public awareness of their local offer; clear signposting of services and specific marketing and outreach with inclusion health groups is conducive to this.

5. *Technological challenges*: can pose a barrier to data sharing and spreading information, particularly given disparities across the VCSE in their own knowledge and capacity to use technology and operate within GDPR constraints. Technology and internet access within the community can pose an additional barrier to community awareness of local services and VCSE organisations, which can impact upon their engagement as well as the coordination efforts of these organisations.

3.1.2 Engagement

The VCSE representatives were asked to discuss which groups of the community they engaged with and to describe the contact they had with inclusion health groups. Conversation turned to VCSE groups discussing what they felt were the key enablers of their engagement with each other, ability to engage with inclusion health groups, and for the community to come forward to engage with them. Five themes consistently came up as 'enablers' for this engagement:

1. Tailored services and community solutions
    - Using evidence based approaches to develop effective and tailored services to find local solutions designed to address specific community needs.
    - Building trust between inclusion groups and with services and VCSE
2. Inclusive access and engagement
    - Overcoming identified barriers to access such as considering inclusivity factors and ensuring access is not exclusive of certain members of the community due to timings, location etc.
    - Developing engagement strategies for how we can reach diverse populations
3. Structured support and social prescribing
    - Using existing structures such as social prescribing to connect individuals with appropriate services and support, aiding VCSE signposting and increasing awareness and understanding across communities
4. Community collaboration and networking
    - Key to this is an understanding and awareness of the different VCSE groups and their roles within the community. Larger, established and trusted organisations can help to facilitate smaller organisations' engagement with the community, but this is dependent on collaboration and shared initiatives across the VCSE network.
    - This is a potential opportunity to implement successful models from other communities, such as Home-start's befriending service in Goole. Communicating shared learning and best practice across VCSE networks across the East Riding is conducive to this.
5. Addressing stigma and perception
    - Physical changes should be made where possible to address elements that are known to add to stigma, such as that associated with community buildings like the Crown community building perception as a 'job centre' or uniform and presentation of drug treatment services.

3.1.3 Connections

We asked VCSE representatives what they feel is working well across the VCSE sector, who they are strongly connected in with and how this connection has arisen, and where they feel they would benefit from having stronger connections. This conversation centred on the importance of having strong local networks, emphasising how collaboration, accessibility, and emotional support are conducive to maintaining connections within communities.

Regarding where the VCSE would benefit from having stronger connections, six themes arose:

1. Local connections and networking
   - There needs to be clear links between the VCSE, private sector, council and other organisations sending referrals, commissioners with an on-the-ground understanding of services, and communities.
2. Collaboration and referrals
   - Services need to be designed to support collaboration; joined-up commissioning and more engagement from service users about their experiences can support this
   - There needs to be stronger links with GPs, employment agencies, social prescribers, and groups dealing with wider determinants beyond just health services
3. Support services and resources
   - Stronger connections between services would help to overcome some of the known gaps: lack of face-to-face offers, short and insufficient appointment duration, lack of appointments, long waiting lists, short-term funding and unsustainable capacity/staffing levels etc. would be eased if there were clearly defined pathways between services and knowledge of what support other services could offer.
4. Social and emotional connections
   - Connections into the community are based on trust and emotional connection; services and VCSE need to be capable of understanding and working compassionately with individuals who have lived experiences, including trauma-informed care, understanding isolation, building trust, and recognising domestic abuse.
5. Information sharing and advocacy
   - Connections will be strengthened between services if we raise awareness of the local offer and share data and learning.

3.2 Inclusion Health Survey findings

3.2.1 Key findings from the VCSE

The aim of the VCSE Inclusion Health Survey was to evaluate the current capabilities, challenges, and gaps within the Voluntary and Community Sector (VCSE) in supporting inclusion health groups. The findings are based on a survey conducted across 16 VCSE organizations in the region, focusing on groups such as those experiencing homelessness, poor mental health, LGBTQIA+ individuals, and vulnerable migrants.

Unmet needs and recommendations identified by the VCSE

This section outlines the key unmet needs for VCSE organisations working with inclusion health groups, identified as current gaps from their survey responses.

1. Increased funding and revised funding models for commissioning into the VCSE, overcoming current limitations which restrict their ability to expand inclusion health projects or make long-term plans
   - *"We don't have the funding to implement projects focused on marginalised groups*".

2. Improved collaborative working between the VCSE, the local authority, and local health and care providers, including representation on a strategic level as experts working with the group.
    - *"We need to collaborate with the local council and other groups to share resources and enhance service delivery".*
3. Further training across the VCSE on inclusion health and how to support inclusion health groups
    - *"We're unsure about the specific inclusion health needs of the communities we serve".*
4. Capacity building across VCSE organisations, including CPD for smaller organisations on how to be ready for commissioning and professionally-run. This would support the scaling of services to have impact in communities and serve local inclusion health groups, maximising the efficiency with which funding can be used.
    - *"Our small size limits the number of beneficiaries we can support weekly".*
5. Training around data collection and reporting by the VCSE, encouraging organisations to implement data collection methods to track the demographics, health outcomes, and service engagement of marginalised groups.
    - 71.43% of VCSE respondents currently do not collect specific data on inclusion health groups.

3.2.2 Key findings from professionals

The Professionals Inclusion Health Survey aimed to gather insights from professionals working with vulnerable populations to assess current engagement levels, service gaps, and challenges in addressing the needs of inclusion health groups. Respondents from various organizations, including NHS trusts, local councils, and service providers, participated in this survey to provide a comprehensive overview of service delivery to marginalized groups.

A total of 20 professionals responded, representing the organisations: Humber NHS Trust, East Riding Partnership, Probation Service, Citizens Advice Hull, and more. These respondents reported engaging with various inclusion health groups:

- People with drug and alcohol dependence: 95%
- Homeless individuals: 85%
- People in contact with the justice system: 85%
- Gypsy Roma and Traveller communities: 75%
- Vulnerable migrants and refugees: 75%
- Sex workers: 75%

60% of these organisations capture data related to inclusion health groups, primarily through medical records and system reporting tools like SystemOne. This data was predominantly focused on health needs, demographics, and service interactions for targeted interventions, particularly for vulnerable mothers, LGBTQIA+ clients, and individuals with mental health challenges.

Professionals also identified current strengths and best practices in their work with inclusion health groups, particularly in the following areas:

- Multi-agency collaboration: Integration with local councils, social services, mental health teams, and addiction services to provide holistic support.
- Outreach initiatives: Using health vans and community outreach to engage hard-to-reach populations.
- Specialist support: Dedicated health visitors for vulnerable populations, such as Gypsy Roma communities and pregnant women.
- Training and workforce development: Organizations have prioritized workforce training on LGBTQIA+ issues, health inequalities, and trauma-informed care.

Unmet needs and recommendations identified by professionals

This section outlines the key unmet needs for professionals working with inclusion health groups, identified as current gaps from professionals' survey responses.

1. Increased funding to expand capacity and specialist roles tailored to inclusion health groups, supporting pathways, outreach, and complex needs.
    - *"Time and funding—we would love to have more specialist roles to develop areas such as mental health pathways and support but currently do not have the funding or capacity."*
2. Improved access to mental health services and capacity to cope with complex needs of inclusion health groups
    - *"Mental health services are severely lacking and taking a long time to access."*
    - *"Transition from children's services to adult services for children with neurodiversity and/or complex health needs is a huge issue. We have no transition service and therefore we have people who slip through the net."*
3. Improved housing and homelessness support, with a person-centred approach taken across the system
    - *"Lack of housing across the region and poor support. Individuals' circumstances not being taken into account when completing homelessness assessments nor vulnerability or risk."*
4. Tailored assertive engagement strategies working with those who have trusted relationships already with communities, building trust and understanding of local authorities and health professionals
    - *"We really do need to concentrate more on engaging groups who are suspicious of health professional engagement. i.e., Gypsy/Roma travelling groups."*
5. Flexible service delivery models which accommodate the lifestyles of inclusion health groups, including being responsive to individual circumstances and having simple, straightforward referral processes
    - *"Being responsive and flexible—appointment times can be rigid and waiting lists too long. Issues around prescribing. Lack of resources."*
    - *"Being [no fixed address], having no phone, no travel, or ability to get to GP... living chaotic lifestyle may not always comply with first appointments."*

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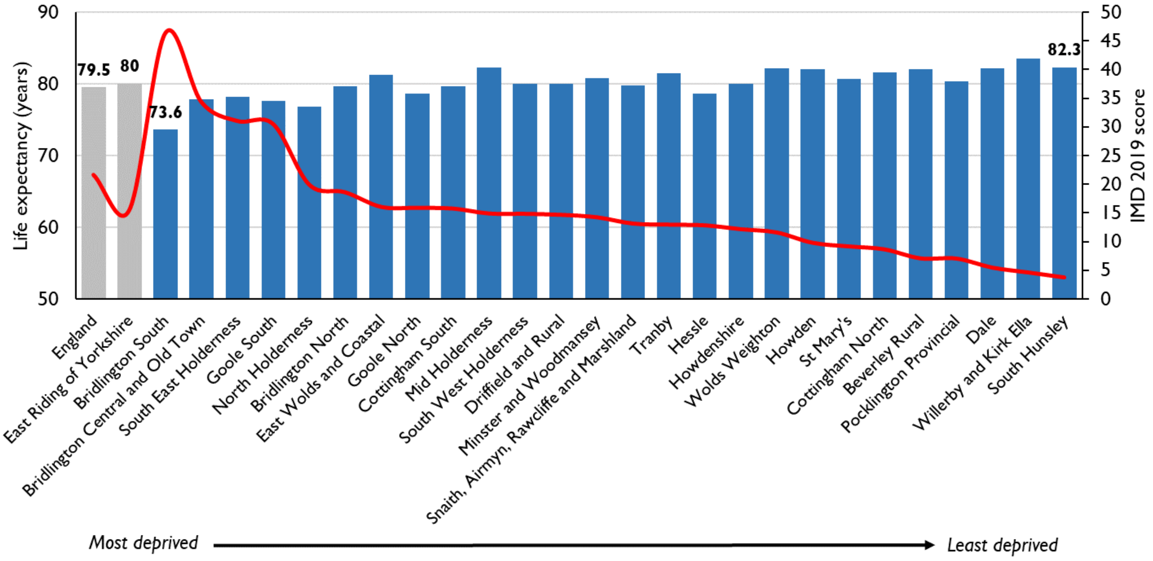
5 Appendices

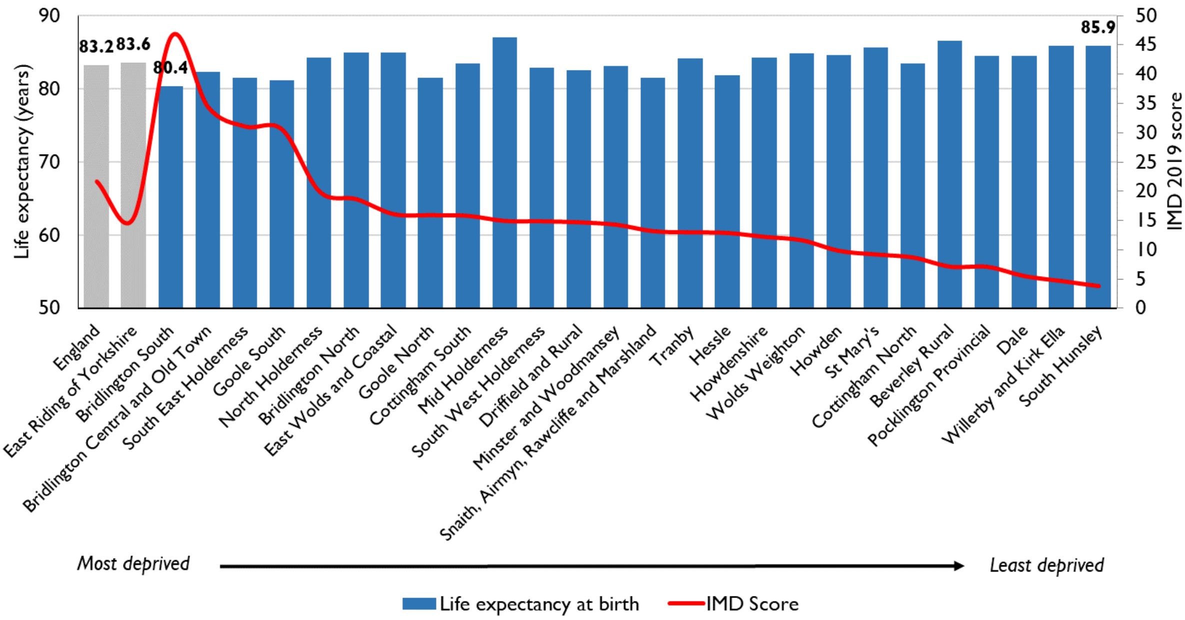
Appendix A – Health inequalities associated with deprivation: Live Expectancy

Figure 5.1 Male life expectancy at birth across all East Riding wards, ranked (left to right) from most deprived to least deprived (2016-2020)



N.b. Y axis does not start at zero. Source: Public Health England Fingertips, 2024. LE at birth wards, 2019-21.

Figure 5.2 Female life expectancy at birth across all East Riding wards, ranked (left to right) from most deprived to least deprived (2016-2020).



N.b. Y axis does not start at zero. Source: Public Health England Fingertips, 202. LE at birth wards, 2019-21.

Appendix B – Further data on inclusion health groups

Gypsy, Irish Traveller or Roma

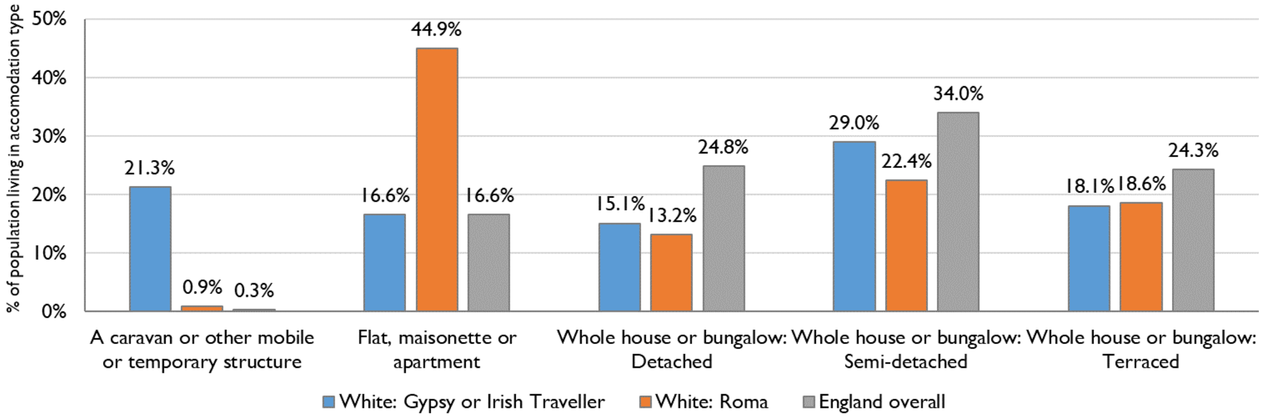
Demographics

Table 9B- Gypsy, Irish traveller or Roma population counts by ward area. Please note, population totals may differ in this table compared to other tables, due to issues of rounding.

Ward Name	Total: All usual residents	White: Gypsy or Irish Traveller	White: Roma	White: Gypsy, Irish Traveller, or Roma	% White: Gypsy or Irish Traveller	% White: Roma	% Gypsy, Irish Traveller, or Roma
Goole South	10,732	25	54	79	0.2%	0.5%	0.7%
Howdenshire	15,841	50	9	59	0.3%	0.1%	0.4%
Cottingham North	7,906	26	1	27	0.3%	0.0%	0.3%
Bridlington South	14,285	40	0	40	0.3%	0.0%	0.3%
Wolds Weighton	17,196	32	6	38	0.2%	0.0%	0.2%
East Wolds & Coastal	14,559	17	5	22	0.1%	0.0%	0.2%
Bridlington Central & Old Town	10,847	16	0	16	0.1%	0.0%	0.1%
Dale	17,285	24	0	24	0.1%	0.0%	0.1%
Howden	5,372	6	1	7	0.1%	0.0%	0.1%
Snaith, Airmyn, Rawcliffe & Marshland	10,012	10	3	13	0.1%	0.0%	0.1%
Pocklington Provincial	18,623	16	8	24	0.1%	0.0%	0.1%
Willerby & Kirk Ella	13,407	3	8	11	0.0%	0.1%	0.1%
North Holderness	10,438	8	0	8	0.1%	0.0%	0.1%
St Mary's	15,958	8	4	12	0.1%	0.0%	0.1%
Goole North	11,223	5	3	8	0.0%	0.0%	0.1%
Beverley Rural	14,439	3	6	9	0.0%	0.0%	0.1%
Minster & Woodmansey	16,358	5	5	10	0.0%	0.0%	0.1%
Hessle	15,487	7	1	8	0.0%	0.0%	0.1%
Bridlington North	13,269	6	0	6	0.0%	0.0%	0.0%
South East Holderness	14,750	4	2	6	0.0%	0.0%	0.0%
Tranby	10,306	4	0	4	0.0%	0.0%	0.0%
Mid Holderness	13,769	3	2	5	0.0%	0.0%	0.0%
Driffield & Rural	15,584	5	0	5	0.0%	0.0%	0.0%
South West Holderness	14,237	3	0	3	0.0%	0.0%	0.0%
South Hunsley	10,746	0	1	1	0.0%	0.0%	0.0%
Cottingham South	9,614	0	0	0	0.0%	0.0%	0.0%

Accommodation

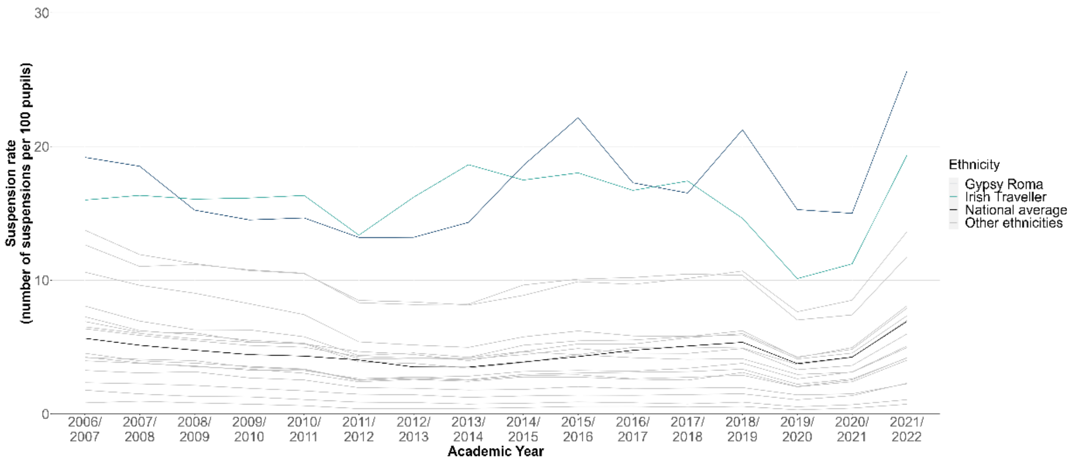
Figure 5.3 Accommodation type by ethnic group, GRT population, England and Wales, 2021



Source: Census 2021

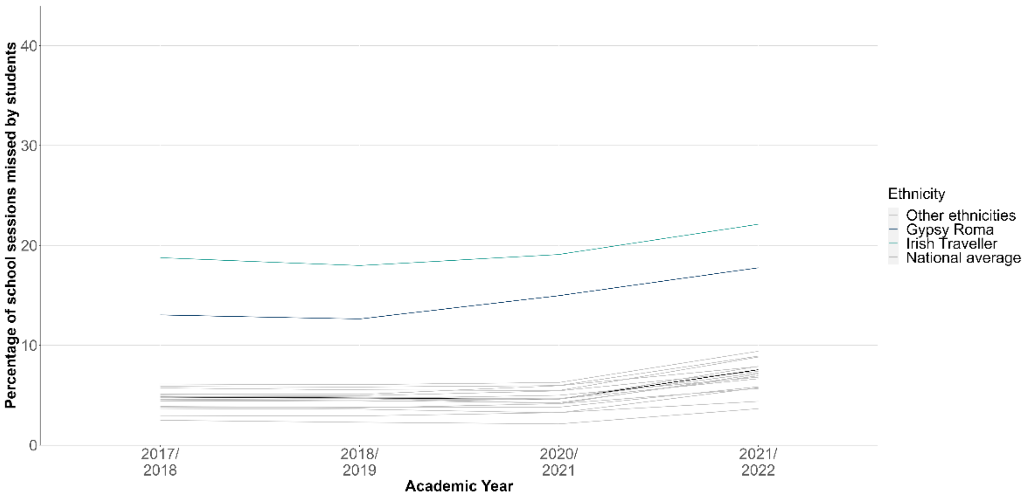
Education

Figure 5.4 - Suspension rate of Gypsy Roma and Traveller pupils, 2006/07 - 2021/22



Source: Department for Education

Figure 5.5 Overall absence rate of Gypsy, Roma and Traveller pupils, 2017/2018-2021/22



Source: Department for Education

<u>**Veterans**</u>

Table 10 - Summary of answers to the question 'please provide details of the support needed' with regards to physical health advice and support that would be helpful to veterans

Source: Unpublished data from East Riding of Yorkshire Council Armed Forces Needs Assessment, 2024. Contact kerry.hooley@eastriding.gov.uk for more information and data.

Key theme	**Summary of comments**
Healthcare access	Difficulty seeing a doctor and reliance on nursing staff
	Long wait times for medical results and treatments
	Need for full medical reviews
	Access to scans for injuries
	Pain management and therapy
	Access to NHS dental practice
	Hearing issues, hearing tests and improved hearing equipment
	Mental health support, including PTSD, depression, anxiety, and stress
	Cancer support
	Cardiomyopathy and related health and wellbeing assistance
Mobility and physical health	Support with walking and standing for long periods
	Mobility scooter
	Blue badge application difficulties
	Struggles with carrying shopping and dislocating shoulders
	Physical injuries (e.g., lateral tear of the hip, bilateral knee injury, lower back injury, brittle bones, MSK issues)
	Obesity support
	General health and fitness
	Personalized health plans for remaining active
Fitness and exercise	Access to affordable or free gyms and personal advisors
	Gym accessibility and military discounts for short-term memberships
	Access to leisure fitness and coaching centres for swimming and other wellbeing activities
	Free access to council-operated swimming pools and gymnasiums
	Closer leisure facilities
	Keeping fit and mentally alert
Veteran-Specific Concerns	Feeling overlooked as a veteran
	Lack of resources tailored to military needs
	Difficulty accessing services locally, sometimes needing to go to Wales
	Signposting for claims against the MOD for injury and loss of hearing
	Mental health adaptation in employment
General Wellbeing	Access to wellness clinics
	Free activities
	Stress-related problems
	Mental health support
	Understanding PTSD and making others aware of the signs
	Help with mental illness
Administrative and Logistical Issues	Difficulty with blue badge applications and travel requirements
	Discrimination concerns regarding local council services
Dental Care	Getting sufficient access to a dentist
	Dental and hearing issues
Weight and Fitness Post-Service	Gained weight and health issues since leaving service
	Struggling with fitness and losing weight due to past accidents
Employment and Mental Health	Mental health adaptation in employment
	Stress-related problems

Appendix C – Consultation with professionals on inclusion health groups

In addition to the survey a range of targeted semi-structured interview sessions with key stakeholders were held to enhance the understanding, assess current engagement levels, service gaps, and challenges in addressing the needs of inclusion health groups. This appendix contains a summary of the notes made throughout this consultation, which have been used to inform the narrative and recommendations in section 2.5 of the Needs Assessment.

People who are rough sleeping, at risk of rough sleeping, and people experiencing homelessness
Key findings from meeting with ERYC Housing department who support individuals involved in addressing homelessness, particularly rough sleeping. Key points include:

1. **Rough Sleeping in East Riding (ER)**: There's a high number of rough sleepers (15) - 02/07/2024, mostly in Bridlington. The population is transient, especially in summer, and services like Emmaus (providing outreach with lived-experience workers) help build trust and reduce stigma.
2. **Challenges and Resources**: The homelessness response includes crash pads, outreach workers, and in-reach support. Tailored services for complex cases are costly but effective. Rising homelessness is linked to the cost of living and landlords struggling with mortgages. Limited housing stock (around 11,500 units) contributes to the pressure.
3. **Data Collection**: Data collection is done through partnerships (e.g., Emmaus and Mind Hub). Information sharing is critical for early intervention. There's a need for better integration between systems like Emmaus and the Locator system used by the local authority.
4. **Funding**: The Rough Sleeping Initiative (RSI) funds outreach workers and navigators, but resource scarcity remains a significant issue. Last year's funding was fully spent, and this year's budget is already stretched.
5. **Good Practices**: Multi-agency approaches, especially for individuals with trauma, and cross-border information sharing are highlighted as effective practices. However, geographical differences within the region necessitate tailored responses for different areas.
6. **Healthcare Barriers**: Access to GP and mental health services is challenging for rough sleepers, often requiring outreach efforts like bringing healthcare to the streets.

This emphasised the need for additional funding, better resource allocation, and tailored responses to meet the specific needs of individuals across the East Riding of Yorkshire. The consultation and the Homelessness Strategy highlighted the following recommendations

Resource Limitations: **Funding and resource constraints** are impeding progress. While the strategy lays out ambitious goals to reduce homelessness, the operational side reflects the struggles with limited budgets and staff.

Data and Information Sharing: **Data collection and collaboration** between agencies like Emmaus are critical. The strategy aims to formalise data-sharing protocols, while the notes highlight the practical need for better integration between systems like Locator and Emmaus.

Tailored, Trauma-Informed Services: The importance of trauma-informed care. The strategy discusses the importance of personal housing plans, whilst the consultation detailed the hands-on work of the navigators who support rough sleepers by meeting them where they are, ensuring they receive the care and appointments they need.

Gypsy, Roma, and Traveller Communities
The Gypsy/Traveller Support Service at ERYC and a traveller site visit conducted by HEY Smile Foundation provided an overview of the conditions and services accessed by residents at three traveller sites: Eppleworth, Woodhill, and Woldgate.
Health and Welfare:

- Residents generally access GP, hospital, and dental services, with outreach programs for dentistry and health visitors.
- Mental health and sexual health issues are rarely addressed due to stigma in the traveller community.
- Physical health problems are common, ranging from mild to severe.
- Vaccination rates are reasonable, but continuity with booster shots is uncertain.

- Foodbank usage varies due to cultural pride.

Education and Digital Literacy:
- Good school attendance until middle years (5-8), after which attendance drops.
- Low literacy rates are prevalent, but most residents are digitally literate, relying on mobile data.

Community Engagement:
- Travellers are hesitant to access services, especially mental and sexual health, until issues become severe.
- Trust is key to engaging with the community; known staff are more successful than outsiders in building relationships.
- Site-based staff are essential in bridging gaps, helping residents access services, and giving them a voice.

Key challenges and barriers faced that were raised:
Stigma and Service Access:
- Stigma is a major issue, with healthcare providers, schools, and other service workers often reluctant to engage with travellers.
- Using "traveller site" as an address complicates access to services like healthcare and education.
- There's also a stigma within the traveller community regarding mental health, leading to isolation of those with needs.

Service Provision Gaps:
- Some traveller populations, especially those living in housing outside official sites, are poorly understood and lack adequate services.
- Areas like Goole have a high traveller population, but little is known about their specific needs.

Recommendation
- Implement more community-based activities, such as outdoor cooking and family history sessions, to build trust and engagement.

- Provide practical support like borrowable play equipment and emotional literacy programs for children.

- Address the lack of services in transient populations, especially regarding mental health, sexual health, and housing conditions.

Overall, while some progress has been made in accessing healthcare and building trust, significant barriers remain due to stigma, poor living conditions, and reluctance to seek help until crisis points are reached. Better outreach and continued focus on trust-building with familiar staff are crucial to overcoming these challenges.

Criminal Justice

As part of the consultation, we spoke to NACRO, who works with people involved in the criminal justice system (CJS), particularly those whose substance misuse contributes to their offending. NACRO provides support to individuals referred from police, courts, probation, prisons, and self-referrals. They work with clients for 3-6 months and offer through-care for individuals coming out of prison, often on license conditions. The service focuses on addressing the reasons for substance use, motivation for change, and the impact on the individual's life and family. Here is a summary of our findings.

Target Population
- The service is aimed at adults (both male and female) with substance misuse issues, including those using alcohol or recreational drugs.
- A notable increase in drug-related deaths (DRDs) has been observed, and the service prioritises managing health outcomes, including mental and physical health.

Current challenges
- Increased complexity of cases, particularly around mental health, domestic violence, and safeguarding.
- The impact of COVID-19 has led to more high-risk individuals with complex mental health needs.
- Difficulties in accessing mental health services, particularly for prison leavers, and delays in referrals for ADHD assessments.

Best Practices

- NACRO highlights the importance of partnership working and joint visits with probation services.
- They have a dedicated team passionate about engaging clients at different stages of involvement in the CJS.
- They aim to improve the use of lived experience mentors and volunteers in their programs.

Service Gaps and Recommendations

- Gaps include a lack of housing support, mental health services, and continuity of care for prison leavers.
- The need for more staff and early engagement (pre-release) for those in prison to address issues before release.
- Concerns about increasing caseloads due to early release and changes in court orders, which may necessitate group sessions instead of individual support.

Overall, the complexity of the challenges NACRO faces, the need for more comprehensive support for prison leavers, and the importance of early engagement and partnership working in managing complex cases.

Modern Day Slavery

We consulted with a range of partner who are member of the modern-day slavery partnership, yo evaluate the state of modern slavery in East Riding, assess current services and resources, highlight service gaps, and recommend actions to enhance the identification, prevention, and support for victims of modern slavery. This includes a focus on vulnerable inclusion health groups who face systemic barriers.
Modern slavery is defined as exploitation for personal or commercial gain through various forms, including:

- Human trafficking
- Forced labour
- Debt bondage
- Sexual exploitation
- Domestic servitude

The findings from the consultation addresses the broader socio-environmental factors that make certain inclusion health groups, such as migrant women, vulnerable to exploitation.

National and Local Context

Globally, nearly 50 million people are trapped in modern slavery. In East Riding, the issue is often hidden, leading to low public awareness and underreporting. The Humber Modern Slavery Partnership, led by Andrew Smith, has been working since 2016 to coordinate local anti-slavery efforts and ensure a strategic approach that takes into account social and health-related vulnerabilities.
The following strategic priorities have been identified through the work of the East Riding Local Modern Slavery Forum and the Humber Modern Slavery Partnership:

- **Community Awareness and Engagement**: Raise public knowledge about modern slavery and build trust within vulnerable communities.
- **Workforce Training and Development**: Equip professionals with the skills to identify and support victims, especially those from inclusion health groups.
- **Victim Safeguarding and Support**: Improve victim support services, focusing on health and safe housing for those at risk.
- **Intelligence Gathering and Enforcement**: Strengthen intelligence sharing and enforcement to disrupt criminal networks.

Partnerships

- **East Riding Modern Slavery Forum**: This multi-agency group includes the police, NHS, and local authorities, focusing on raising awareness, training, and improving intelligence gathering. The Modern Slavery Forum focuses on specific themes like sexual exploitation and labour exploitation, using targeted enforcement activities.
- **Humber Modern Slavery Partnership (HMSP)**: Led by Andrew Smith, the partnership integrates local and national policy, legislation, access to services, and commissioning of anti-slavery

responses. It emphasizes building relationships with community groups, such as the Hull Afro-Caribbean Society, to break down barriers and establish trust.

- **Policing Operations**: Operations such as *Operation Lewis* (sexual exploitation) and *Operation Mirage* (nail salon exploitation) have targeted high-risk sectors. Safe housing protocols have been developed between local authorities for those awaiting National Referral Mechanism (NRM) decisions.

Data collection and reporting

- **National Referral Mechanism (NRM)**: Collects data on victims by nationality, age, and exploitation type, though there are gaps in data on inclusion health groups. More information is needed to understand how effectively victims are supported post-referral.

Victim support services

- The Salvation Army and partner agencies provide support for victims through safe housing, counselling, healthcare, and employment assistance. However, there is limited access to dedicated safehouse accommodation in Humberside, which highlights a service gap.

Key challenges identified

- **Low Public Awareness**: Public knowledge of modern slavery is limited, and there is significant denial of its presence in local communities.
- **Victim Engagement**: Many victims, especially those from marginalised communities, fear authorities and are controlled by traffickers, making it difficult to engage them.
- **Data Gaps on Inclusion Health Groups**: There is insufficient data on how vulnerable groups (e.g., migrant women, homeless individuals) are affected by modern slavery. Inclusion health strategies could help identify and address the needs of these populations.
- **Cultural Competency and Trust**: Building trust between authorities and vulnerable communities is challenging. Lack of cultural awareness and understanding further hinders engagement and reporting.
- **Limited Resources**: Most modern slavery work is an addition to professionals day jobs, creating barriers to integrating anti-slavery responses into their everyday roles.
- **Barriers for Young Victims**: Young victims, particularly indigenous British children, often do not recognise their exploitation, and support systems do not adequately address their needs.

Service Gaps

- **Inclusion Health Focus**: There is a lack of focused efforts to address systemic health barriers (e.g., poorer baseline health of migrant women) that make individuals vulnerable to exploitation.

- **Coordinated Service Delivery**: A dedicated modern slavery team would enhance coordination and service delivery, ensuring victims receive timely support.

- **Safe Housing Availability**: While local authorities have developed temporary housing protocols, there is no dedicated safehouse accommodation in Humberside, increasing the risk for victims.

- **Trust Building with Communities**: More work is needed to build trust with vulnerable communities, particularly through partnerships with voluntary and community sector organisations (VCSEs).

- **Data and Intelligence Gaps**: More data is required on inclusion health groups and how modern slavery affects them. Existing data does not sufficiently cover key vulnerable populations.

Recommendations:

Expand Public Awareness Campaigns

- Develop targeted campaigns that reach marginalised communities, focusing on health, exploitation drivers, and barriers.
- Utilise community leaders and trusted figures to improve cultural competency and build trust with vulnerable populations.

Establish a Dedicated Modern Slavery Taskforce

- Create a dedicated multi-agency taskforce responsible for the implementation of anti-slavery initiatives, ensuring better coordination of services and follow-up on cases.

Improve Data Collection and Monitoring

- Enhance data collection on inclusion health groups and improve tracking of outcomes for victims post-NRM referrals. Use this data to drive targeted enforcement and prevention strategies.

Strengthen Victim-Centered Support Services

- Expand access to safehouse accommodation and other localised support services, ensuring victims are not placed in high-risk environments such as hostels or hotels.

- Collaborate with local service providers and VCSEs to offer more accessible, culturally competent services.

Increase Workforce Training on Modern Slavery and Inclusion Health

- Implement comprehensive training programs that include an inclusion health framework, equipping professionals to address the specific needs of marginalised groups vulnerable to exploitation.

Develop Trust with Vulnerable Communities

- Work with community groups and VCSEs to establish long-term trust and engagement. Offer shared resources (e.g., meeting spaces, funding) to strengthen community voices.

While significant progress has been made in addressing modern slavery through partnerships, forums, and enforcement operations, key gaps remain, particularly around public awareness, victim engagement, and services for inclusion health groups. Implementing these recommendations will improve coordination, prevention, and support services, ensuring a more effective response to modern slavery in East Riding.

People being sexually exploited and victims of modern slavery

We consulted with Humberside Police who provided a summary of the challenges faced by Humberside Police in addressing modern-day slavery (MS) and human trafficking, focusing on sex work, pop-up brothels, and proactive operations such as "Operation Lewis." The team works in collaboration with local authorities and other services but faces limitations due to a lack of engagement from victims and resource constraints in outreach and safeguarding.

The Humberside Police team has small unit that focuses on combatting MS, human trafficking, and exploitation. The team conducts proactive work, particularly targeting pop-up brothels identified through online adverts and risk factors (e.g., images or phrases indicative of exploitation). Humberside Police service commitments are as follows:

- **Proactive Visits**: Safeguarding and signposting to relevant services during visits to brothels and other suspected exploitation sites
- **Operation Lewis**: A force-wide initiative targeting MS-related crimes, particularly in Hull and Scunthorpe where cheap accommodation and higher populations make the areas hubs for exploitation.
- **Partnerships**: Collaboration with other agencies, including efforts to include health workers in proactive brothel visits, though resource limitations prevent this from being a standard practice.

Service Gaps

- **Engagement Barriers**: A lack of cooperation from victims due to fear of traffickers and legal consequences, as well as cultural and immigration-related concerns.
- **Data Gaps**: Challenges in accurately capturing data related to MS, as cases may be recorded under drug-related crimes or other categories due to misidentification or incomplete recognition of MS indicators.
- **Current Data Collection**: The focus on sex workers has led to monthly MS investigations and the use of National Referral Mechanisms (NRMs). Intelligence submissions are increasingly linked to MS. There is a growing emphasis on data related to organized immigration crime, including small boats.

However, there is a recognised need for more precise data and better definitions to avoid misclassification

- **Data Limitation:** Data is sometimes captured under other crime types (e.g., drug-related crimes), leading to underreporting or misclassification of MS cases.

Current Services:
Humberside Police has a dedicated team for MS, which is not a standard practice in all forces across the UK. The team's proactive efforts, such as visits to industries like car washes and investigations of MS risks, are considered strength. Partnerships with external agencies, such as discussions with the Red Cross to create reception centres for victims, highlight the proactive nature of the force's work.

Gaps in Service:

- Lack of dedicated facilities (e.g., reception centres) to engage with victims outside of the police station environment.
- Limited capacity to include health workers in proactive visits to pop-up brothels, despite it being identified as a best practice.
- Police experience basic lack of engagement from victims due to fear of retaliation or deportation. There is also a need to raise awareness and improve recognition of MS, both within law enforcement and among victims.
- Local Authorities/Red Cross: Working with local authorities and the Red Cross to create safe spaces for victims is seen as a necessary step forward, but more resources and coordination are needed.

Best Practice

- **Operation Lewis**: This force-wide operation looks for risk factors in online ads and conducts proactive visits to suspected brothels. It also involves safeguarding measures and signposting for victims.
- **Collaboration with Health Services**: Efforts to have health workers accompany police during proactive brothel visits are considered a best practice but are limited by capacity.

Recommendations

Short-term:

- Increase data accuracy by improving the classification and recognition of MS in crime reports.
- Work toward establishing reception centres in collaboration with the Red Cross to provide victims with a safer environment for engagement.

Long-term:

- Build capacity within health services and police teams to ensure proactive visits are accompanied by health professionals to better address the complex needs of victims.
- Continue to raise awareness of MS, especially in less visible sectors such as domestic servitude, and strengthen collaboration across agencies to share intelligence and best practices.

Vulnerable migrants

Introduction
This section assesses the needs of migrants and refugees in the East Riding area, focusing on isolation, integration, and access to essential services. Initiatives led by Welcome House, which began in February with food packages during Ramadan, have since expanded to broader social support, including regular drop-in sessions and family gatherings. The target population includes refugees and asylum seekers across East Riding, many of whom live in isolated pockets with limited social networks. While basic demographic data is collected, more detailed insights could further inform service targeting.

Current Service

- **Community Engagement Activities**: Social gatherings such as drop-ins at Armstrong Centre, social events, and park visits aimed at reducing isolation.
- **Communication and Outreach**: Use of WhatsApp groups for localised engagement (e.g., Beverley group).
- **Mental Health and Wellbeing Support**: Welcome House addresses mental health needs by fostering community bonds and minimising isolation.

- **Empowerment and Education**: Information and guidance on health services, social support, and integration to help clients become self-sufficient.

Identified Needs and Gaps

- **Isolation and Loneliness**: High levels of isolation, often exacerbated by language barriers and lack of community connection.
- **Access to Information**: Limited awareness about available services, which affects health, education, and community integration.
- **Language and Cultural Barriers**: Language proficiency limits engagement and integration efforts, especially in forming connections with those of similar cultural backgrounds.
- **Mental Health Support**: Mental health is a significant concern, with many asylum seekers experiencing feelings of isolation and needing support.
- **Sustainability of Services**: Current funding limitations challenge the sustainability of existing services; current funding is set to end in February 2025, and no ongoing funding has been secured relating to Welcome House

Recommendations

- **Strengthen Partnerships**: Enhance collaborations with VCSE networks, local authority staff, health services, and educational institutions to improve support.
- **Increase Funding and Resource Allocation**: Secure long-term funding to ensure service continuity and explore diversified funding sources.
- **Expand Language and Cultural Support**: Implement more tailored language and cultural orientation programs to aid integration.
- **Data Collection and Analysis**: Develop more comprehensive data collection and analysis frameworks to better track demographics, service utilisation, and outcomes for inclusion health groups.
- **Community Outreach and Awareness**: Increase awareness of services, especially for newcomers, by expanding promotion of drop-in sessions and other initiatives.