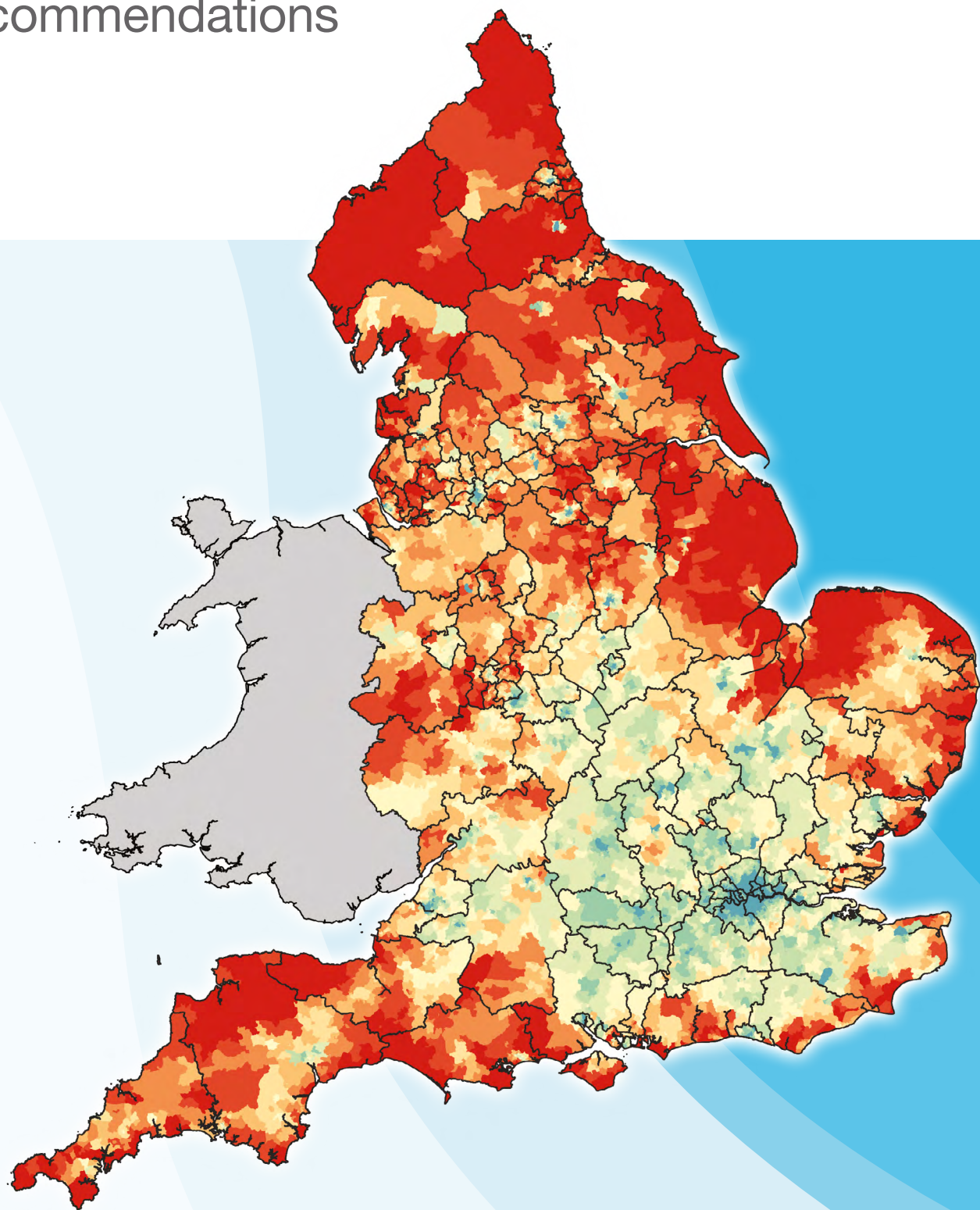# Chief Medical Officer's Annual Report 2021
Health in Coastal Communities – Summary and recommendations

Map showing prevalence of coronary heart disease in England.

Introduction

The last year has seen the public health focus dominated by combatting COVID-19. With other health colleagues, I intend to write a report on technical lessons learned from COVID-19, but the pandemic in the UK is still evolving rapidly. COVID-19, which has had its greatest effects on those with chronic health conditions, has however reinforced the importance of local variations in health, and the concentration of pre-existing health conditions and chronic disease in certain geographies. It is important we do not lose sight of these enduring health challenges as we face the largest pandemic for a generation. The Chief Medical Officer's Annual Report 2021 concentrates on one of the most important of these challenges: health in coastal communities.

Coastal communities, the villages, towns and cities of England's coast, include many of the most beautiful, vibrant and historically important places in the country. They also have some of the worst health outcomes in England, with low life expectancy and high rates of many major diseases. For example, Blackpool, one of the country's favourite holiday destinations, has the worst life expectancy in the UK despite remarkable efforts by local health and civic leaders.

The central argument of the report is that the health challenges of coastal towns, cities and other communities are serious, and their drivers are more similar than their nearest inland neighbour. This means a national strategy to address the repeated problems of health in coastal communities is needed in addition to local action. If we do not tackle the health problems of coastal communities vigorously and systematically there will be a long tail of preventable ill health which will get worse as current populations age.

There are many reasons for poor health outcomes in coastal communities. The pleasant environment attracts older, retired citizens to settle, who inevitably have more and increasing health problems. An oversupply of guest housing has led to Houses of Multiple Occupation which lead to concentrations of deprivation and ill health. The sea is a benefit but also a barrier: attracting NHS and social care staff to peripheral areas is harder, catchment areas for health services are artificially foreshortened and transport is often limited, in turn limiting job opportunities. Many coastal communities were created around a single industry such as previous versions of tourism, or fishing, or port work that have since moved on, meaning work can often be scarce or seasonal.

Given the known high rates of preventable illness in these areas, the lack of available data on the health of coastal communities has been striking whilst researching the report. Coastal communities have been long overlooked with limited research on their health and wellbeing. The focus has tended towards inner city or rural areas with too little attention given to the nation's periphery. Data is rarely published at a geographical level granular enough to capture coastal outcomes, with most data only available at local authority or Clinical Commissioning Group (CCG) level. As a result, deprivation and ill health at the coast is hidden by relative affluence just inland which is lumped together. The report aims to explore the experiences of local leaders, along with analysis of what data exist, to help us understand the health and wellbeing of coastal communities.

Coastal communities are not homogenous, and each is shaped by its own unique history and culture. They do, however, share many similar characteristics, which should help some common policy responses. A resort town like Blackpool, for example, has more in common with Hastings, Skegness or Torbay than with Preston, just 18 miles inland. Fishing or port communities have particular, shared, challenges. A national strategy informed by these common groups, and underpinned by local actions aligned with a sustained evidence-informed strategy, will help reduce health inequalities in these areas.

The report will highlight the significant strengths in coastal communities along with many exemplary and impressive examples of local work taking place to support the health of local citizens. They should not however, in my view, face the considerable health challenges alone. The vulnerability of these communities is not a new revelation, and the economic problems they face have been highlighted in several recent reports including in relation to the impact of COVID-19 [1,2,3].

Whilst the focus nationally over the summer may be directed towards visitors, with many opting to stay in one of the UK's many beautiful coastal towns, it is important to remember that the coast is also home to millions of people and that the health and wellbeing of these populations has been long neglected and overlooked.

Report structure

The full report can be accessed via the [Chief Medical Officer Annual Reports](#) page on GOV.UK. The chapters included in the full report are outlined below. This document includes the summary of key themes identified and my recommendations.

Chapter 1 includes 10 case studies written by Directors of Public Health and others who work with and in coastal communities. These case studies range from large port cities, to local authorities covering smaller seaside towns. The case studies provide an overview of the demographic structure of the population and their health and wellbeing outcomes, along with both the strengths and challenges facing their communities. These case studies highlight what local level, place-based working can achieve.

Chapter 2 consists of analysis by the Office for National Statistics (ONS) using their own granular coastal definition to explore the wider determinants of health including demographic and migration patterns, deprivation, employment, education and housing. Given the limited relevant data available on housing, especially the private rental sector, section 2.8 further explores housing via a case study from Blackpool Council.

Chapter 3 is an analysis by colleagues from Plymouth University exploring the burden of disease and health service data at a granular level using their own definition of a coastal community.

Chapter 4 includes analysis by Health Education England (HEE) on the medical workforce in coastal communities and their ambitious programme of reform to overcome some of these challenges.

Chapter 5 is a summary of flooding and coastal communities written by the Public Health England (PHE) Extreme Events Team. This was raised as a concern by local leaders working in coastal communities.

Chapter 6, written by colleagues from Exeter University, explores the benefits of coastal living. The coast has much to offer with research suggesting that there is a protective effect to health and wellbeing from living on the coast.

Running through the report is the fact that coastal communities have multiple, overlapping but addressable health problems. If we are serious about improving the health of the nation, coastal communities are a good place to start.

Professor Christopher Whitty – Chief Medical Officer for England.

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3   *The effect of the Covid-19 pandemic on our towns and cities.* Centre for Towns. https://www.centrefortowns.org/reports/covid-19-and-our-towns

Summary of key themes

The following are key themes arising from the report.

1.   Health and wellbeing in coastal communities.

2.   Deprivation and health.

3.   Mental health.

4.   Migration and demography.

5.   Health services and medical workforce.

6.   Economy and employment.

7.   Education.

8.   Housing.

9.   Benefits of coastal living for health.

10.   Coast-specific issues.

11.   Limitations of data and definitions.

12.   A strong case for national action.

Health and wellbeing in coastal communities

Many coastal communities are remarkable and beautiful places but have some of the worst health and wellbeing outcomes in England. Capturing these outcomes accurately has historically been challenging as data are often not available at a granular level and are averaged out with nearby healthier inland towns.

The report demonstrates that coastal communities have a higher burden of disease across a range of physical and mental health conditions (for example Coronary Heart Disease in Figure 1). This is partly driven by age structure and partly by concentration of deprivation, however, even after accounting for these and other factors, there remains a 'coastal excess' of disease. This is true across many conditions and risk factors. Figure 2 plots these 'coastal effects', demonstrating the extent to which, having accounted for all other factors, populations in coastal areas experience higher or lower disease prevalence rates.

Life expectancy (LE), healthy life expectancy (HLE) and disability free life expectancy (DFLE) are all lower in coastal areas and the Standardised Mortality Ratios (SMRs) for a range of conditions, including preventable mortality, are significantly higher in coastal areas compared with non-coastal. The case studies in the report describe a high proportion of people with long term conditions, with one in four people in Morecambe having a limiting, long-term illness or disability (25.0%), significantly more than the national average.

The Director of Public Health (DPH) in Hull, for example, highlights how poor health occurs prematurely and is largely the result of preventable diseases affecting LE and HLE/DFLE – "far shorter lives are spent in far poorer health." This is echoed by the Director of Public Health of North East Lincolnshire who describes people in their most deprived communities "old before their time".

This concentration of poor health and wellbeing in coastal communities also provides a clear and geographically defined target for national action. If we could improve the health of coastal communities, the median health for the entire country would be lifted. Improving health here would mean a significant part of the long tail of lower life expectancy in England would be reduced.

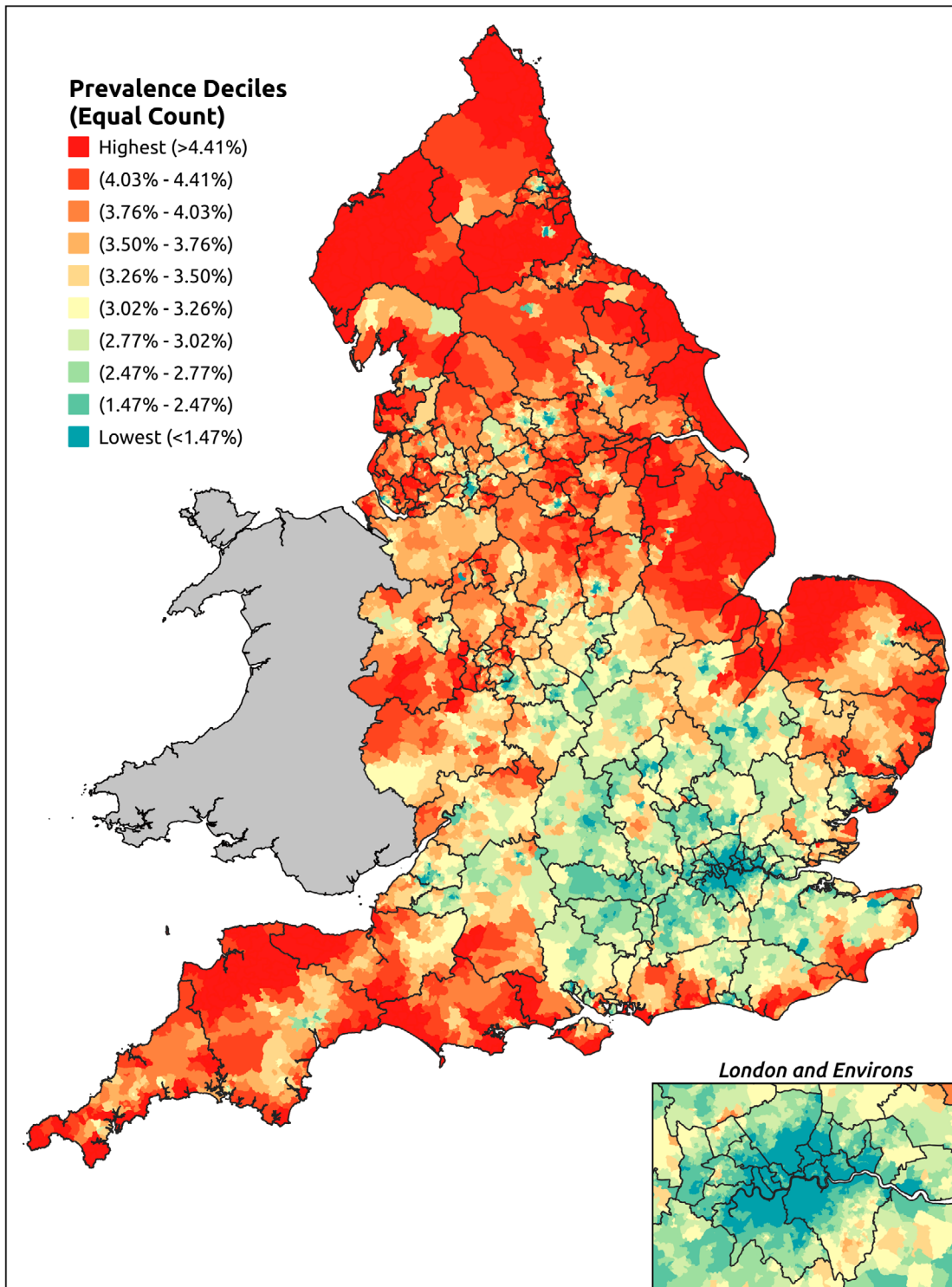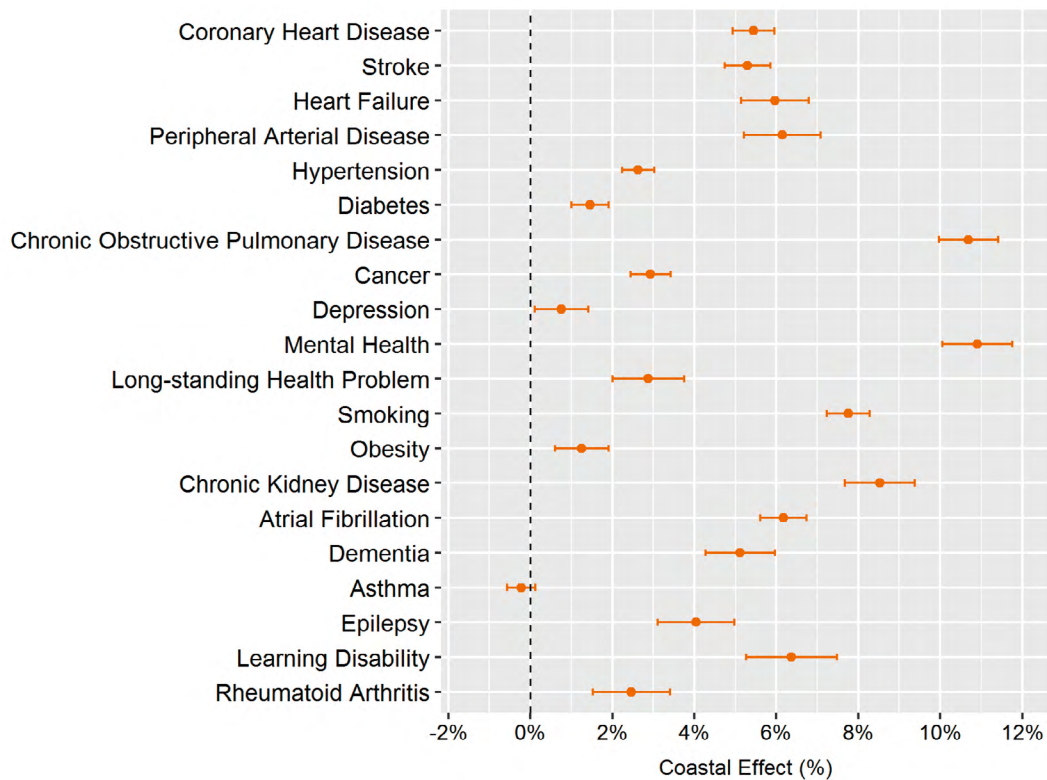**Figure 1:** Crude GP QOF Prevalence of Coronary Heart Disease attributed to LSOAs: 2014/15 – 2018/19

Prevalence Deciles (Equal Count)

- Highest (>4.41%)
- (4.03% - 4.41%)
- (3.76% - 4.03%)
- (3.50% - 3.76%)
- (3.26% - 3.50%)
- (3.02% - 3.26%)
- (2.77% - 3.02%)
- (2.47% - 2.77%)
- (1.47% - 2.47%)
- Lowest (<1.47%)

London and Environs

Figure 2: Estimates of the 'coastal effect' on the number of patients on selected GP disease registers: 2014/15 – 2018/19
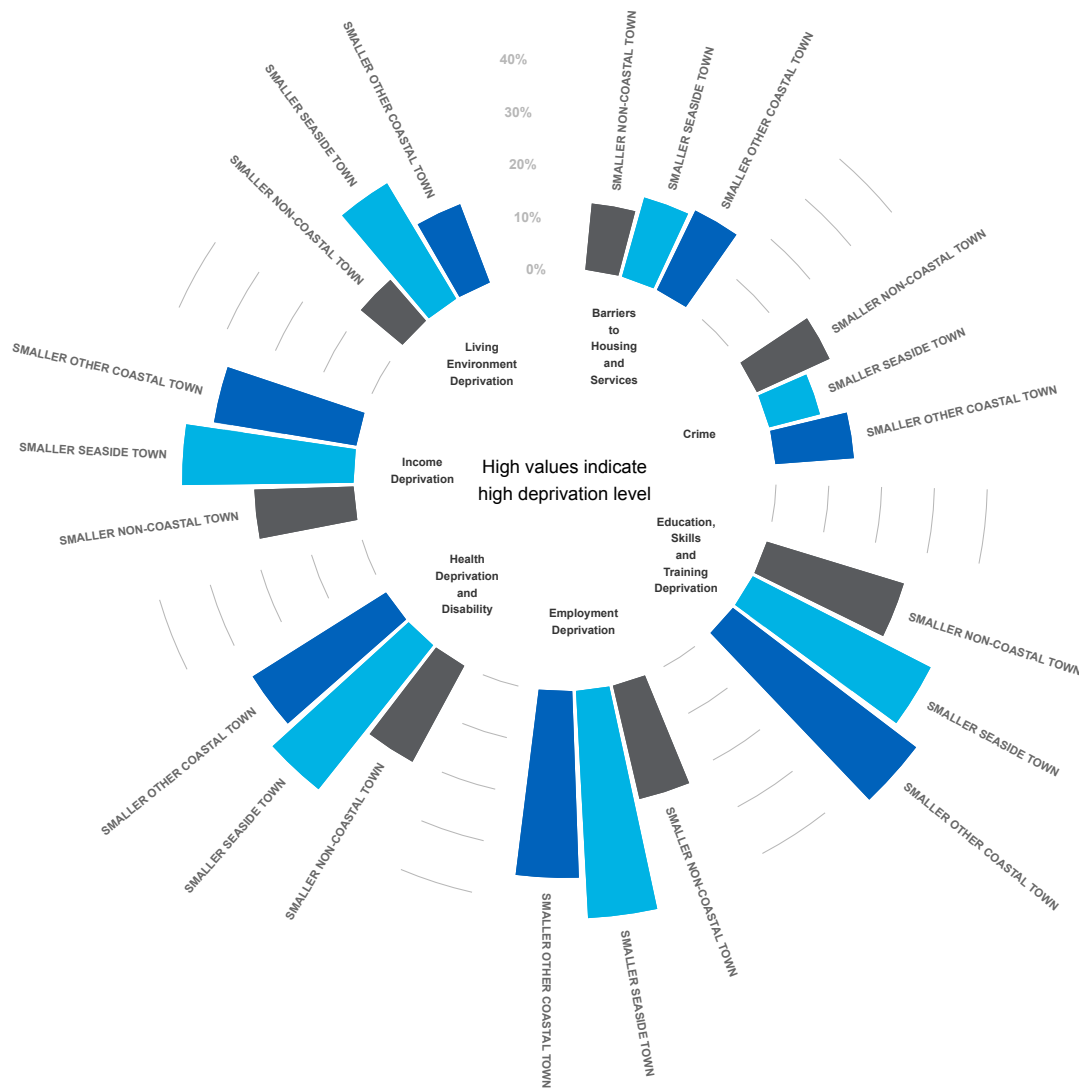

Deprivation and health

High levels of deprivation, driven in part by major and longstanding challenges with local economies and employment, are important reasons for the poor health outcomes in coastal communities. ONS, in their analysis for the report, found that deprivation was higher in coastal communities compared to non-coastal, with smaller seaside towns and large coastal (non-seaside) towns being especially deprived. Figure 3, for example, shows that smaller coastal towns had a higher share of population living in the most deprived areas of England across almost all domains of deprivation. This is echoed by all case studies in the report, including Blackpool, the most deprived local authority in England and Hastings, the most deprived in the South East.

Figure 3: Percentage of small towns' resident population living in the 30% most deprived neighbourhoods in England, 2019

Source: Ministry of Housing, Communities and Local Government – English Indices of Multiple Deprivation, 2019, compiled for towns and cities by the Office for National Statistics

Several risk factors which are important drivers of health outcomes have a strong correlation with deprivation. Obesity for example, is higher in those who live in more deprived areas which are often obesogenic environments compared to less deprived neighbourhoods. Peoples' circumstances and environments can make it difficult for them to change unhealthy behaviours[1]. Whether we can be active or eat healthily is impacted by a number of socio-economic factors, such as income, housing, education, access to space and sale of unhealthy foods.

Risk factors, including smoking, are higher in coastal communities, with analysis suggesting an excess coastal prevalence rate of 6.71%. Many coastal Directors of Public Health highlight smoking as a key concern in their case studies. Hartlepool and Blackpool for example, describe that almost one in four women smoke during pregnancy, and in Hull, despite the proportion of women smoking in pregnancy falling, it is still twice that of England (20.6% compared with 10.4%). Despite a downward trend in smoking rates nationally, it is clear geographical inequalities remain, and that targeted intervention to high risk groups and geographies is required.

Excess alcohol use is also commonly raised as an issue by coastal Directors of Public Health. Along with other coastal communities, Morecambe and Hastings have high rates of hospital admission for alcohol-related harm. The Torbay case study highlights worse admissions for alcohol-related conditions compared to the English average and Blackpool has the highest rate of hospital admissions for alcohol-related harm in the country. The report also found that alcohol-attributed admissions in 0-17-year olds were higher in coastal communities.

ONS analysis of alcohol-specific mortality rates found a mixed picture. Large urban areas appeared to have a higher alcohol-specific mortality rate. There was a statistically significant higher alcohol-specific mortality rate in males in large towns (both coastal and non-coastal) compared to smaller non-coastal towns. Mortality figures, however, are unlikely to represent the overall burden of the challenges associated with alcohol and further analysis of alcohol related indicators at a granular level in relation to coastal communities would be beneficial. Improving the ability of Directors of Public Health to input into licensing applications in their local areas is likely to have a significant impact on health outcomes, especially in coastal communities.

Coastal Directors of Public Health outlined substance misuse as a concern. In Hull for example, the estimated prevalence of opiate and/or crack cocaine use is more than twice that of England (18.1 versus 8.9 per 100,000 population aged 15-64 years). These local data are supported by the national ONS analysis which found that the mortality rate due to drug poisoning was higher in coastal towns compared to non-coastal.

Mental health

Mental health problems demonstrate social gradients in the same way as physical health problems[2].

There is a high burden of mental ill-health illustrated by QOF data in coastal communities. The rates of self-harm among 10-24-year olds were also found to be higher in coastal compared with non-coastal communities.

These findings are mirrored by the case studies, with Clacton, reporting the second highest mental health need in the country. According to the case study, patients in Morecambe Bay Primary Care Network are 20% more likely to have depression than the national average, and in Somerset, hospital admissions for self-harm are significantly raised compared to the rest of England and appear to be increasing with time. Hartlepool has a higher prevalence of mental health disorders than the England average for both the 16 years + population and the 65 years + population.
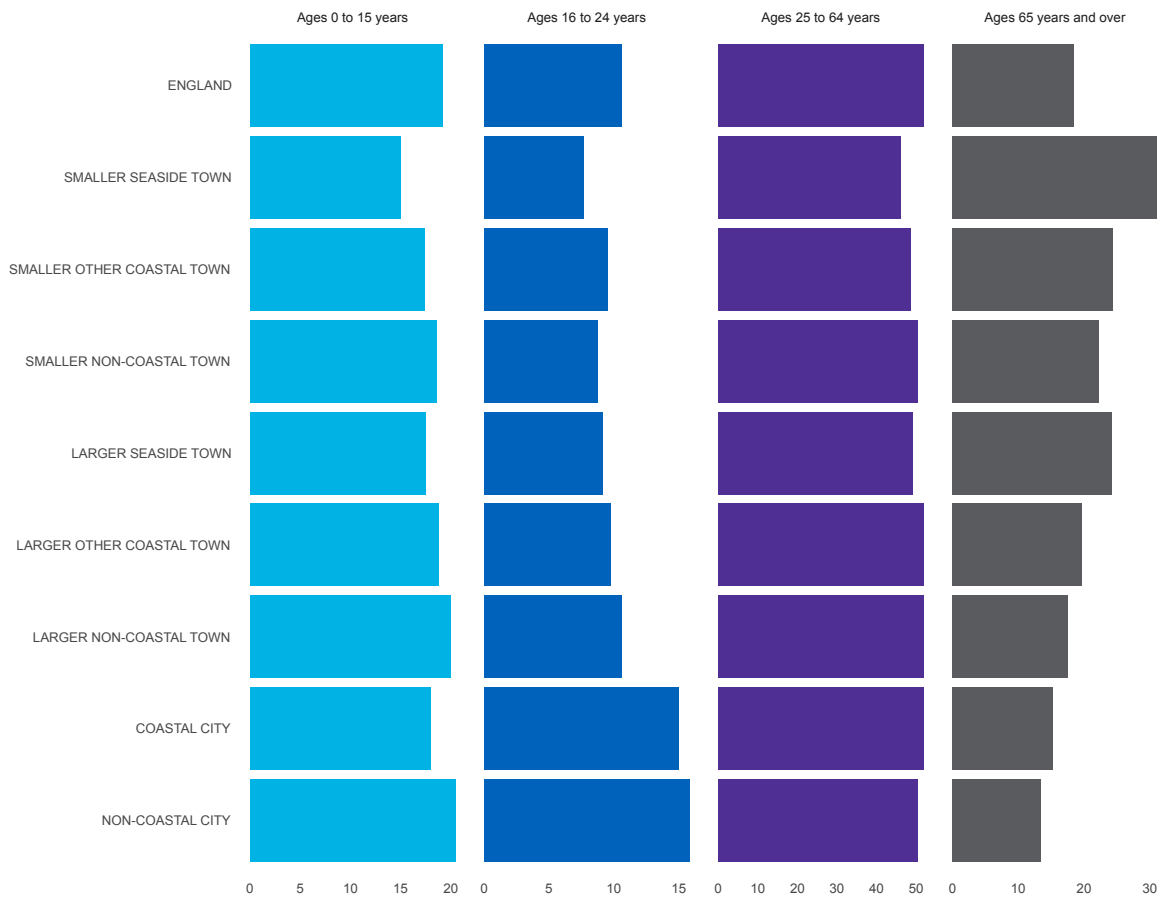
Researchers at Liverpool University have created the Small Area Mental Health Index (SAMHI), which is a composite measure on mental health from multiple sources at lower geographical level (lower super output areas)[3]. This index also shows a coastal pattern of disease which is largely explained by deprivation, migration and age profile of coastal populations.

Demographics and migration patterns

Coastal communities more often have a higher proportion of elderly residents than the general population, and this is set to increase over the following decades. The ONS analysis found that coastal towns and cities have higher shares of residents in the 65 years or over age group and lower shares in the 0 to 15 years age group (Figure 4). This finding is mirrored in the population pyramids of each case study. This age difference is likely driven by migration out of large cities as people grow older and may also be similarly seen in rural areas.

Figure 4: Population by age groups, England 2019

	Ages 0 to 15 years	Ages 16 to 24 years	Ages 25 to 64 years	Ages 65 years and over
ENGLAND				
SMALLER SEASIDE TOWN				
SMALLER OTHER COASTAL TOWN				
SMALLER NON-COASTAL TOWN				
LARGER SEASIDE TOWN				
LARGER OTHER COASTAL TOWN				
LARGER NON-COASTAL TOWN				
COASTAL CITY				
NON-COASTAL CITY				

Source: Office for National Statistics – Population estimates
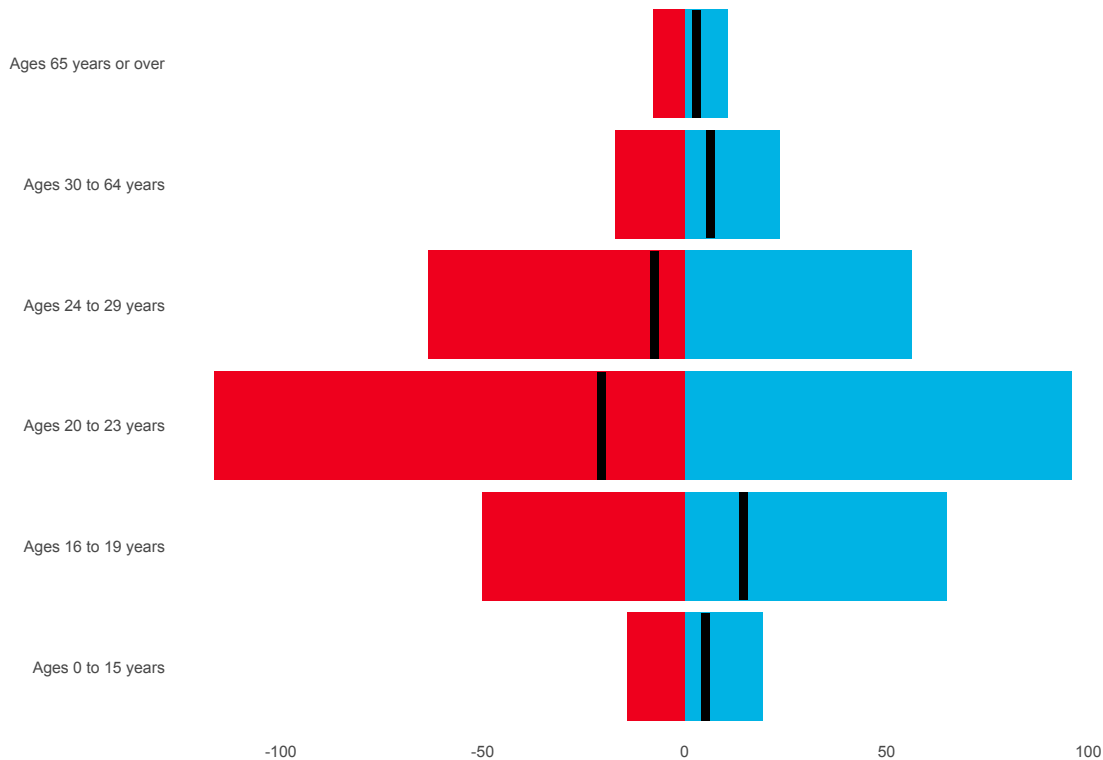
Migration

The case studies and wider literature describe three key populations who migrate to and from the coast. There is an in-migration of the elderly population, retiring to the coast (as they do to other semirural areas). Secondly, some coastal areas including Blackpool, Morecambe and Hastings experience in-migration of a transient, vulnerable younger population driven by the availability of cheap housing. There is also an out-migration of young people in search of employment opportunities not available locally.

Granular migration data below local authority level was not available nationally for ONS analysis. Despite this, analysis at local authority level provides an indication of movement to coastline local authorities (although this may not equate directly to coastal areas, especially in large local authorities with small coastlines). The analysis suggested that coastline local authorities saw a net outflow of two age groups: the 20 to 23 years age group and the 24 to 29 years age group. All other age groups had a net inflow, including the 16 to 19 years age group which is likely due in large part to migration into coastline local authorities with universities or other higher and further education.

Figure 5: Net moves from coastline local authorities to inland, by age group (per 1,000 population), England, 2019

Source: Office for National Statistics – Population Estimates

Both current and future demographic and migration patterns have public health implications for the burden of disease and service provision in coastal areas. Given the elderly population, considering the needs of older people is essential. PHE highlighted this in their commissioned evidence review of health inequalities in older populations in coastal and rural areas[4]. The review found a paucity of literature in coastal communities. As a result, they are due to publish a further report, in partnership with Age UK, to assist those working in coastal communities to understand the issues affecting older people in previously under-recognised groups, including older men, older people from ethnic minority and LGBTQ communities.

Migration patterns are also relevant to population health and wellbeing. Evidence suggests that triggers for moving in the elderly can include a change in partnership, such as widowhood or a change in health and economic status during the last 12 months[5]. Understanding the *reasons* for migration are likely to be important especially for ensuring appropriate support and services.

Health services and medical workforce

There is evidence of a significant health service deficit in terms of recorded service standards, cancer indicators and emergency admissions in coastal communities. The reasons for this are unclear, however possible explanations include challenges with the retention of medical workforce and access to services.
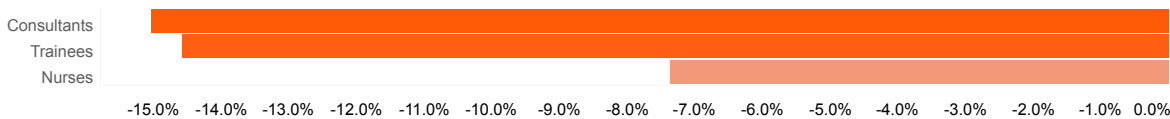
The case studies emphasise that coastal communities, especially those in coastal areas that are also sparse, such as West Somerset and Lincolnshire, face challenges with access to services, but also challenges with service delivery where they struggle to reach the critical mass needed to sustain specific services.

Medical workforce

Challenges to the recruitment and retention of health and social care staff is a common concern expressed by coastal Directors of Public Health and NHS leaders. Morecambe, for example, describes the challenges of recruiting and retaining General Practitioners and experienced practice nurses, and how these inequalities in primary care provision further compound the health issues within the community.

HEE's analysis for the report found that despite coastal communities having an older and more deprived population, they have 14.6% fewer postgraduate medical trainees, 15% fewer consultants and 7.4% fewer nurses per patient. This is shown in Figure 6.

Figure 6: Deficit in consultants, trainees and nurses in coastal communities

HEE is planning an ambitious set of reforms to address these concerns. Their approach to undergraduate reform, along with the review of the distribution of post-graduate medical trainees in coastal areas, will be a step towards reducing the disparities in coastal communities. HEE's approach to generalism is especially welcomed, given the aging population in coastal communities, who are likely to have a greater number of long-term conditions.

Economy and employment

Employment is a key challenge in coastal communities and impacts health in multiple ways. ONS analysis for the report shows that the unemployment and part-time employment rate is higher in coastal towns. There is also a greater dependency on the public sector for employment in coastal communities.

The drivers of employment patterns in coastal communities are varied. The case studies illustrate that higher levels of unemployment, part time and seasonal work may be due to a decline in traditional industries which were central to the original reasons these communities thrived and grew, such as previous versions of tourism, fishing, engineering and manufacturing. These industries have changed over recent decades and the historical 'purpose of place' has changed. Poor transport connections, peripheral location and long distances to local employers are also a challenge, along with limited awareness of opportunities outside the local area. A person in a coastal community looking to work outside their area has literally half the geographical options of inland towns (the other half is the sea). Lack of diversification in the local economy is problematic; however, some areas have been able to adapt, whilst others, for various reasons, have found this more challenging. These findings are also highlighted by the House of Lords Select Committee on Seaside Towns and the Coastal Communities Alliance[6,7]. North East Lincolnshire's Director of Public Health describes how a third of economic inactivity is due to long-term sickness and is linked to high rates of chronic disease in some of their neighbourhoods.

COVID-19 has had a significant impact on unemployment rates in coastal communities. The case studies suggest that this is due in large part to their reliance on tourism and hospitality, but also the already low levels of employment and opportunities. Increases in unemployment-related benefit claims during COVID-19 were not equal across the country. Areas that started out with higher claimant rates and those with a higher reliance on tourism were hit especially hard[8]. Coastal areas like Blackpool, Devon and Cornwall have been particularly affected. This is supported by other reports, including by the Institute of Fiscal Studies, which found that many coastal areas are notably vulnerable along both health and employment dimensions[9,10]. Whilst the effects of the initial COVID-19 waves will fade, these communities are more vulnerable to economic shocks of many kinds.

Poor employment prospects underpin many drivers of poor health outcomes, and good quality, stable jobs are important in ensuring positive health outcomes. Local areas, however, have embraced various innovative strategies to improve employment prospects, including working with local anchor institutions. The NHS's work on anchor institutions is an example of how the health sector can support this given the NHS and social care are major employers in many coastal communities.

Education

Poor educational attainment is linked to worse health outcomes over a lifetime[11]. Analyses from the report suggest that children in coastal communities have worse education attainment compared to those in non-coastal areas. This is especially true for progression to higher education. There is, however, disparity between different types of coastal communities as outlined by ONS.

The case studies mirror these findings. In Clacton, for example, the proportion of children achieving a good level of development is statistically significantly worse than wider Tendring, Essex and national comparators, with only 53% achieving a good level of development at age 5 compared with 58% in Tendring and 62% in Essex. Morecambe and Torbay report high numbers of children receiving Special Educational Need (SEN) support, with Torbay emphasising that poor outcomes are often masked by the high performance of pupils in the grammar school system.

The Director of Public Health in Lincolnshire describes how poor educational attainment includes low aspirations that may be tempered by home and community expectations. Access to local higher education opportunities is also harder than for most inland communities. Travel times from coastal Skegness or Mablethorpe to Lincoln are over two hours when using public transport, making on-campus learning unviable for those who need to live at home. Young people often leave coastal areas to pursue higher education given the lack of local opportunities, and the Morecambe public health team describe how these young people rarely return, making recruitment into local businesses and the development of the local economy more difficult.

The Coastal Communities Alliance summarise several reasons for the patterns of comparatively low education attainment in coastal areas which include: a transient workforce with a high percent turnover of pupils; lack of access to further education; lack of employment opportunities and investment in skills development and lack of adaptation to peak and low season patterns of employment[6]. With support from the Coastal Communities Fund, Lincolnshire is piloting courses that are adaptable to the seasonal nature of coastal communities, with the aim of encouraging young people to continue in education that is flexible to their needs.
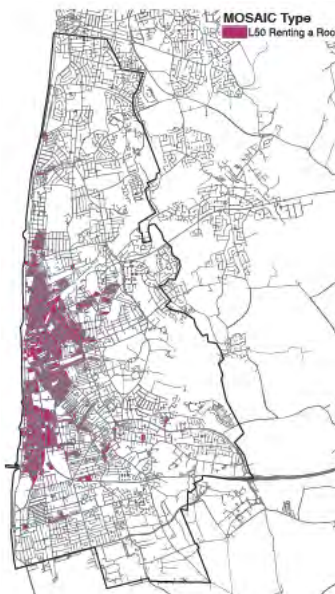
Housing

Housing, especially the private rented sector and other accommodation including Houses of Multiple Occupation (HMOs) and static caravan parks, is a key issue for coastal communities. HMOs in seaside towns have often been converted from now comparatively cheap former guesthouses, designed for a previous form of seaside tourism. Directors of Public Health and local government leaders raise concerns about the challenges of poor quality, but cheap HMOs, encouraging the migration of vulnerable people from elsewhere in the UK, often with multiple and complex health needs, into coastal towns. This has implications for both service provision and support. Blackpool's Director of Public Health describes the tight relationship between poor quality private rented housing and low life expectancy, with those living in the failing private rented housing of inner Blackpool dying prematurely (Figure 7).

Static caravan parks present a different set of challenges, often being the home for part of the year for older citizens with multiple health needs or migrant workers, but without the service provision designed in to support them.
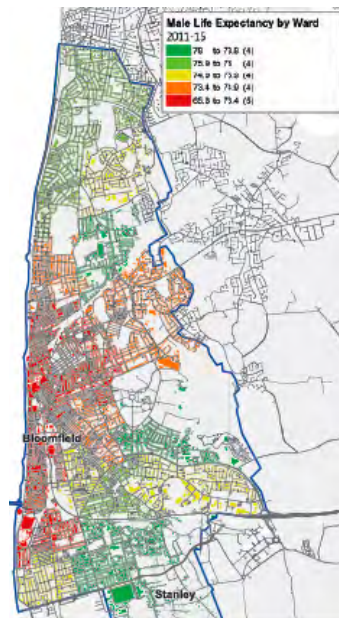
Figure 7: Approximate location of HMOs and Male Life Expectancy

Approximate location of HMOs   **Male Life Expectancy**

Source: Blackpool Public Health Annual Report 2017

Source: Public Health England Local Health

Benefits of coastal living

Although the report demonstrates the many health challenges of coastal communities, paradoxically coastal areas are generally intrinsically healthier. Once socio-economic and demographic characteristics are accounted for, those living closer to the coast report better health on average than their inland counterparts. The report highlights that there are health benefits (both physical and mental) to living near the coast which are not merely the result of selective migration. These may include better access to outdoor spaces for exercise, social contact and lower air pollution. There are also opportunities from new initiatives such as the English Coast Path. These geographical advantages provide a good starting point for many of the changes that need to occur.

Problems caused by the physical geography of the coast

Flooding is more common in many coastal areas, through combinations of storm surges from the sea, and fluvial (river) flooding as many are built on river outlets of flood plains. Flooding can have a significant health impact both in the short term and long term. Drowning, physical injuries and water contamination may impact in the immediate aftermath, whereas mental health problems, access to health care and loss of employment can have severe long-term consequences. Modelling of future flood risk indicates significant increases in future coastal flood risks with coastal local authorities including Hull, the City of Portsmouth, and Sedgemoor District Council at particular risk. Climate change will exacerbate this risk.

Having half of the surrounding area as sea makes transport, digital connection and wider connectivity more difficult. The time taken to get from coastal communities to major conurbations for work, specialist healthcare, retail and leisure is often considerable, providing a physical reason for some coastal community challenges.

Limitations of data and definitions

A key challenge for the report has been the minimal research and limited data available at small area geographies. Several key public health indicators were not available or accessible for analysis at lower level geographies. The Directors of Public Health and chapter authors clearly highlight that the granularity of analysis makes a major difference, and that health outcomes in coastal communities can be significantly masked when analysis is at a wider geographical footprint such as local authority or CCGs.

Data from Clacton highlight that a key issue in recognising and understanding the severity and rate of the decline in the area, is that data are usually presented on a wider Tendring footprint, which includes some areas that are relatively affluent. If just the wards identified as Clacton are considered, the level of deprivation around the education and childhood deprivation domains exceed almost all comparators.

A further limitation is that there is no nationally agreed definition or consensus on what constitutes a 'coastal community'. Academics, institutions, and policy makers have adopted a variety of definitions. These range from the narrower specification of seaside resorts, to broader classifications which include every local authority with a coastline or estuary. Each definition has its limitations and there is commonly an element of subjectivity in the categorisation. Certain 'sub-categories', for example, port-towns or seaside towns may sometimes be an appropriate narrower definition depending on the purpose for categorisation.

A strong case for national action

The UK, and England specifically, is a coastal nation. A high proportion of the worst health and wellbeing outcomes in England are concentrated in coastal communities. The specific health challenges of coastal communities often have much more in common with one another than their nearest inland neighbours, making a national strategy to complement local and regional initiatives a sensible approach. If we could reduce the health disparities in coastal communities, the impact locally would be very positive. Given the scale, improving health in coastal communities means the median health and wellbeing of the whole country would also be lifted, and the long tail of poor health outcomes in the nation would be reduced appreciably. Many of these challenges are amenable to strong, targeted, long-term action. The report highlights many problems, but they are problems to which in many cases there are solutions. We have suggested some specific recommendations for action, but these should be viewed as a starting place. Coastal communities have major public health challenges, and we have a responsibility to meet them.

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Recommendations

The report has three key recommendations, and several more specific recommendations.

Lead government departments and organisations are listed where appropriate, but this is not exhaustive, and this work needs a whole of government response.

Key recommendations:

1. Given the health and wellbeing challenges of coastal communities have more in common with one another than inland neighbours, there should be a **national strategy to improve the health and wellbeing of coastal communities**. This must be cross-government as many of the key drivers and levers such as housing, environment, education, employment, economic drivers and transport are wider than health.

2. The current **mismatch between health and social care worker deployment and disease prevalence in coastal areas** needs to be addressed. This requires action by HEE and NHSE/I.

3. The paucity of **granular data and actionable research into the health needs of coastal communities** is striking. Improving this will assist the formulation of policies to improve the health of coastal communities. Local authorities, ONS and NHSE/I need to make access to more granular data available. Research funders, including NIHR and UKRI, need to provide incentives for research aimed specifically at improving coastal community health.

Detailed recommendations:

1. **Develop a national cross-government strategy on health and wellbeing of coastal communities**

    The strategy should consider cross-government action on the following:

1.1	Planning for the ageing population in coastal and other peripheral areas, with consideration to migratory patterns, and the potential for a deficit of social care and healthcare workers relative to older populations	Cross-government

1.2	Opportunities for joint working from early years through to further education to improve both health and educational outcomes for children and young people in coastal communities	DfE, MHCLG
1.3	Opportunities for joint working to maximize economic opportunities for coastal communities including maintaining the current focus on the role of the NHS as an anchor institution	NHSE/I, DWP, DHSC, MHCLG
1.4	Review of incentives in the private rental sector in coastal communities, specifically HMOs which draw a transient vulnerable population to coastal communities	MHCLG, HMT
1.5	How to mitigate the transport links which make coastal communities more peripheral	DfT
1.6	Specific plans for major risk factors concentrated in coastal communities – especially high rates of smoking in pregnancy, alcohol and substance misuse	DHSC, NHSE/I
1.7	Looking at funding formulas which disadvantage coastal communities	MHCLG, DHSC, HMT
1.8	Making more of the potential health and wellbeing benefits of living in coastal communities	DEFRA, MHCLG

2. Maintain focus on the current and proposed future medical education reforms which includes the geographical redistribution programme

Additional work is required to;

2.1	Take account of the coastal deficit in the location of new medical schools, and actively recruit in coastal communities to existing medical schools	HEE, DHSC
2.2	Increase GP and specialty training placements (including public health) in coastal areas	HEE, NHSE/I
2.3	Increase access of coastal communities to specialist healthcare, including via digital methods	HEE, NHSE/I
2.4	Build upon learning from the COVID-19 pandemic and HEE's Future Doctor report to strengthen the focus on maintaining generalist skills, which are doubly useful in populations with multimorbidity in peripheral areas further from specialist care	HEE

2.5	Review whether current funding arrangements are a disincentive to GP, nursing and other NHS and social care workers moving to coastal areas	HEE, DHSC
2.6	Consider the wider workforce including social care and other NHS workforce in addition to the medical and nursing workforce	NHSE/I, DHSC

3. Improve data and research into coastal communities

This work should include the following actions:

3.1	Review the availability, access and applicability of data on health and wellbeing outcomes and their determinants at lower geographical levels. This includes the analytical capacity across the system to collate, analyse, interpret and disseminate the existing data. This needs consideration of data sharing arrangements	OHP, ONS
3.2	Further multi-disciplinary research is required to understand the multiple drivers of poor health outcomes in coastal communities and test effective interventions and solutions. This requires specific incentives to leading health academic groups by research funders	NIHR, MRC, ESRC
3.3	Analysis suggests that there may be service level challenges in coastal communities. Further research is required to assess this including reviewing the actual, versus expected disease prevalence and service provision in coastal and non-coastal communities	Health inequalities team in NHSE and DHSC
3.4	Research on the health and wellbeing of coastal communities should be encouraged in coastal universities where appropriate, for example through civic agreements between universities and local authorities	NIHR, MRC
3.5	Review migration patterns at lower level geographies to improve understanding of their impact on local communities	ONS
3.6	Improve joint working between local authorities and academic institutions data sharing arrangements	Research funders, especially NIHR, MRC, ESRC

3.7	Given the commonality of interest between coastal areas, learning networks of those leading population health in these areas should be encouraged, linked to academic institutions with an interest in building the knowledge base on health improvements	ADPH

Further recommendations

4.1	Continue work to ensure Directors of Public Health in every Integrated Care System (ICS) are an integral part of the ICS Executive leadership team/ board	DHSC
4.2	The high rates of excess alcohol use in coastal communities, and specifically issues in resort towns, further strengthens the case that public health should be added as a licensing objective in the Licensing Act 2003	HO, DHSC