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**Recommendations from the South West Clinical Senate Council on the impact of geography on the delivery of the Three Shifts, with a specific focus on coastal communities.**

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## Background

The delivery of the Three Shifts [[1]](#footnote-1), Hospital to Community, Treatment to Prevention and Analogue to Digital, represents a transformative agenda for health and care systems across England. However, its successful implementation of these shifts is significantly influenced by geography, particularly in coastal communities where structural, demographic, and environmental factors create unique challenges and opportunities.

Coastal areas in the South West of England, such as Cornwall, North Devon, and Torbay, exemplify the geographic complexities that shape health outcomes and service delivery. These regions are often characterised by dispersed populations, limited transport infrastructure, and they have a higher proportion of older residents [[2]](#footnote-2). Such factors hinder access to centralised healthcare services and increase reliance on localised, community-based care. For example, long travel distances to hospitals and sparse public transport networks make the shift from hospital to community care both essential yet logistically demanding [[3]](#footnote-3). In these settings, mobile health units, community paramedicine, and telehealth services become critical enablers of equitable care delivery.

The shift from treatment to prevention is similarly shaped by place. Coastal communities often experience higher levels of deprivation, seasonal employment, and housing-related health risks such as damp and poor insulation[[4]](#footnote-4). These conditions contribute to elevated rates of chronic illness, including cardiovascular disease, respiratory conditions, and mental health disorders. Preventative strategies in these areas must therefore be tailored to local realities, by addressing not only clinical risk factors but also the social determinants of health. Community navigators, social prescribing, and place-based public health interventions have shown particular promise in these contexts.

The third shift (from analogue to digital) presents both a challenge and an opportunity. Many coastal communities suffer from digital exclusion due to poor broadband infrastructure, low digital literacy, and limited access to devices. This digital divide disproportionately affects older adults and those in deprived areas, limiting the uptake of remote consultations, health apps, including the NHS App, and accessing online health information. Bridging this gap requires investment not only in infrastructure but also in digital inclusion initiatives, for example, training, community access points, and hybrid service models that blend digital and face-to-face care [[5]](#footnote-5).

Research from the University of Exeter and Cornwall Council Public Health has further highlighted how these geographic factors intersect with occupational and cultural dimensions, particularly in fishing communities. Workers face high levels of occupational risk, irregular working patterns, and cultural norms that discourage “seeking help.” These factors complicate access to healthcare and reduce engagement with preventative services. The introduction of mandatory medical certification has added a new layer of complexity, with some avoiding healthcare altogether for fear of jeopardising their livelihoods.

Despite these challenges, coastal communities are also fertile ground for innovation. Their strong social networks, local knowledge, and history of resilience make them ideal testbeds for integrated, community-led models of care. Initiatives such as the Coastal Navigators Network [[6]](#footnote-6) and the Peninsula Research and Innovation Partnership [[7]](#footnote-7) are already demonstrating how place-based approaches can drive meaningful change.

## Chief Medical Officer’s Annual Report 2021: Health in Coastal Communities

Research comparing coastal and non-coastal areas that contributed to the Chief Medical Officer’s (CMOs) Annual Report in 2021 highlighted several significant health and socioeconomic disparities affecting coastal communities.

1. Coastal areas have a higher burden of diabetes, heart disease, cancer, mental health issues and chronic obstructive pulmonary disease (COPD). The primary contributors of this are age and deprivation, however the variations in health service standards, indicators and emergency admission are also thought to play a key role in this disparity.

Life expectancy: Difference between average MSOA-level SMRs in coastal and
non-coastal areas as a percentage of average SMR for non-coastal MSOAs  
Figure 1. Coastal SMRs relative to non-coastal - University of Plymouth©

The report also highlighted that life expectancy is significantly lower in coastal areas compared to non-coastal areas. Mortality rates when analysed by Middle Layer Super Output Area (MSOA) indicate that the average number of deaths from all causes is 8.8% higher in coastal regions [[8]](#footnote-8). Furthermore, standardised mortality rates (SMRs) are higher in coastal areas for cancer, stroke, respiratory disease, circulatory disease, and preventable diseases - a category that the University of Plymouth defined as “*causes where all or most deaths could potentially be prevented by public health interventions in the broadest sense*” [[9]](#footnote-9).

1. The report also indicated that coastal communities have a lower uptake of higher education, as well as higher rates of hospital admission for young people due to “health-risking” behaviours. It is suggested that limited employment opportunities further exacerbate the development of children and young people, which has led to significant disparities in hospital admissions for both self-harm among 10 to 24-year-olds and drug and alcohol misuse in under 18s.
2. Researchers at the University of Plymouth who contributed to the CMO’s 2021 report identified that digital inequity is a vital component of these disparities and categorised the digit equity into three areas:

* *Digital Connection:* Access to the same digital facilities and services as the general population,
* *Digital Employability:* Equal opportunities for jobs in the digital economy,
* *Digitally enabled participation*: The ability to use digital tools to participate equally in societal activities.

The findings from this report underscore the urgent need for targeted intervention to address the unique health and socioeconomic challenges faced by coastal communities.

## Understanding Coastal Communities in the South West

The CMOs Annual Report in 2023 *Health in an Ageing Society [[10]](#footnote-10)* highlighted that rural and coastal areas are ageing at a faster rate than in urban areas. This is partially due to internal migration, i.e. people retiring to coastal and rural areas.

The population in coastal areas is ageing rapidly. According to the Office for National Statistics (ONS), the population of individuals aged 75 and over in the South West of England is projected to increase by approximately 57% between 2022 and 2043, rising from 652,994 to 1,026,317[[11]](#footnote-11). By 2043, this age group is expected to make up 16.1% of the region’s population, with some local authorities, such as Dorset, projected to have over 22% (1 in 5) of their population aged 75 and over.

As mentioned earlier, disability prevalence is higher in coastal areas. The 2021 Census reported that Torbay (23.8%), Plymouth (21.7%), and Cornwall (21.1%) had some of the highest proportions of disabled residents in the South West, compared to the England average of 17.3%[[12]](#footnote-12). Similarly, frailty amongst adults aged 50 and over is concentrated in coastal districts, with Torbay showing the highest prevalence at 15.3% [[13]](#footnote-13).

Substance misuse is another issue faced by coastal communities, who exhibit high levels of drug and alcohol dependency, alongside unmet treatment needs and elevated rates of drug-related deaths and hospital admissions [[14]](#footnote-14). These issues are closely linked to socioeconomic deprivation, poor mental health, and limited access to services. In addition, young people and vulnerable groups are particularly affected, including through exploitation in county lines operations [[15]](#footnote-15).

These findings highlight the need for geographically tailored public health strategies that address the unique demographic, economic and health service challenges faced by coastal communities.

## Reflections on the Work of Health Innovation South West: Closing the Health Innovation Gap – A Rural and Coastal Challenge. [[16]](#footnote-16)

With 2.3 million people dispersed across the region, the South West has one of the lowest population densities in England. Having over 600 miles of coastline results in challenges for accessing care, with travel time to a Type 1 ED [[17]](#footnote-17) being twice the national average. Organisations such as Health Innovation South West play a key role in identifying, testing, and preparing solutions that are tailored to the unique needs of these communities. The organisation supports system-level innovation aligned with national and local priorities, while adapting approaches to the specific demographic and geographic context of the South West.

Some key initiatives highlighted in their report include:

* Point-of-care testing to reduce travel and hospital visits,
* AI-enabled remote monitoring for heart failure patients, improving medication management and reducing admissions,
* Neonatal Oral Antibiotics at Home (NOAH), allowing earlier discharge of eligible infants.

These initiatives emphasise the importance of a system-wide approach to innovation, by involving collaboration across Integrated Care Boards (ICBs), Education, and National Health Innovation Networks. This place-based ecosystem is designed to translate innovation into real-world impact and inform national policy through insights gained from the South West’s rural and coastal context.

The South West’s experience offers valuable lessons for other regions, particularly in addressing the health needs of ageing populations and geographically isolated communities. By prioritising innovation in these areas, there is potential to drive broader health and economic benefits across the country.

## Reflections on The Three Shifts: A Community Perspective from Torbay

Healthwatch Devon, Plymouth and Torbay (DPT) are an organisation that listens to the experiences of local people using health and social care services. It works to ensure that community voices influence how services are planned and delivered, helping to improve care across the region [[18]](#footnote-18).

They shared a community-focused perspective on the health and social care challenges facing Torbay, a coastal area marked by significant socioeconomic disadvantage and demographic pressures.

Key challenges identified were:

* Economic Disadvantage – Torbay’s economy is heavily reliant on tourism. This results in low-paid, insecure, and seasonal employment. The Torbay area has one of the lowest median wages in the United Kingdom alongside a high demand for social housing [[19]](#footnote-19).
* Ageing Population – The average age in Torbay is 49, so compared to the UK average of 40, Torbay is experiencing rapid demographic ageing. It is projected that by 2045, nearly half the working age population will be over 65 [[20]](#footnote-20).
* Housing and Crime – Poor quality housing and rising crime rates, particularly in town centres are further exacerbating health and wellbeing issues.
* Health Inequalities – There is a life expectancy gap of over eight years within the region, which is further compounded by high levels of loneliness, anxiety, and early entry into care homes [[21]](#footnote-21).

Addressing these complex and interrelated challenges requires a strategic and community-centred approach. Healthwatch DPT described ways to use the Three Shifts Framework to transform health and care delivery in coastal areas like Torbay:

1. Shift 1: From Hospital to Community  
   This shift places strong emphasis on delivering care within communities, through initiatives such as social prescribing, befriending schemes, and volunteering opportunities. Healthwatch DPT suggested strengthening support for carers and expanding the role of Patient Participation Groups (PPGs) to drive local health action. Practical examples of this approach include the delivery of COVID-19 vaccinations in community settings and the provision of small grants to empower grassroots health initiatives.
2. Shift 2: From Analogue to Digital  
   This shift highlights the underutilisation of existing technologies and the need to raise public awareness of available digital tools. Healthwatch DPT advocates for the use of personalised digital solutions to support self-care and enable remote health monitoring. A practical example of this in Torbay is the implementation of blood pressure testing in public libraries, where monitors can be borrowed by residents, improving access to preventative care.
3. Shift 3: From Hospital to Community  
   When referring to this final shift, Healthwatch DPT called for a holistic, community-led approach to health, addressing social determinants such as poverty and housing. They encouraged co-design and co-delivery of services, and the empowerment of communities to take ownership of local health initiatives.

The advocation for a revitalised town centre through the development of high-density, eco-friendly housing and supported living spaces was evident, as well as the importance of using coastal communities like Torbay as a testing ground for national policy, given their advanced demographic and economic challenges.

## 2.0 The Questions

The following questions were presented to the South West Clinical Senate for deliberation during the meeting:

How does geography impact on the 3 Shifts; with a specific focus on coastal communities:

* Why does innovation in rural and coastal places need to be prioritised, understood and supported in national policy and local strategies?
* How can we create the right conditions that drive the adoption of innovation in coastal communities?
* What could be the mitigations and solutions to the geographical issues facing coastal communities?
* How can we engage with newly retired people moving to coastal communities to support their health and wellbeing in the future?

## 3.0 Recommendations

The South West Clinical Senate makes the following recommendations:

## 3.1 Innovative and Community-Based Care

Innovation should encompass both new ideas and the adaptation and mobilisation of effective past solutions. The council recommends strongly advocating for community-based care over reliance on acute hospitals in future health and social care planning, as this can enhance accessibility and provide better personalised care.

It is worth noting the importance of early health screening on improving health outcomes for both younger and older people. Therefore, lowering the age threshold for routine screening and health checks could have long-term benefits for coastal communities. Using the ‘Nurses on Tour’ health assessment model delivered by nursing students could be beneficial to delivery of these initiatives.

Furthermore, promoting the use of digital tools for self-health assessments to identify early warning signs and encourage proactive health management could also improve population health and well-being.

There is a need for proactive engagement with younger populations as health issues are emerging earlier. Therefore, targeted health education and preventative measures would be useful to explore for the younger age groups including school children.

## 3.2 Digital Literacy and Technology Integration

Intergenerational digital literacy programmes should be considered, where students teach older adults to use technology, this can foster and not only improve digital literacy but also strengthen community bonds.

Ensuring ongoing digital literacy support and tailoring the NHS App to local populations for targeted health messaging will help all community members benefit from digital health tools.

Additionally, utilising anonymised health data, such as Dorset's DiiS System, can empower communities to understand their health needs and act on local health trends. This would also benefit local health and care professionals so they can better tailor the services to these needs.

## 3.3 Utilisation of Community Assets and Resources

Better use of underutilised community assets, such as buildings and spaces, can support health and social care initiatives. Repurposing schools when not in use during weekends and holidays and other empty commercial buildings for delivering local health and care interventions maximises resource utilisation.

Creating volunteering opportunities for newly retired individuals, especially those new to the area. This would include community engagement information provided during Primary Care ‘new patient’ appointments and ‘health checks’ to encourage active participation in local health initiatives and volunteering.

## 3.4 Collaboration and Integration

Cross-sector collaboration between health, social care, and community services is essential for creating a more integrated and effective support system. Breaking down silos and fostering a cohesive support system orientated around the specific needs of the different coastal communities is essential.

This could be driven by parish councils and local networks and will enhance community-led initiatives. It is recommended that the planning of health and care service delivery should involve these local organisations and Primary Care PPGs.

Revisiting successful COVID-era innovations, such as patient-initiated follow-ups (PIFU), can further improve patient autonomy and care efficiency.

## 3.5 Addressing Regional and Local Needs

Addressing regional disparities, particularly in the often-overlooked South West region, is crucial. Planning and innovative solutions must consider local contexts and specific community characteristics and health and care needs. For example, improving transport infrastructure for coastal communities, balancing the economic prioritisation of tourism alongside resident needs, and engaging second homeowners in community activities are key steps.

Additionally, addressing transport and digital barriers, especially in off-season periods, will improve connectivity and access to services.

## 3.6 Building Trust and Engagement

Building trust with tight-knit communities through consistent and transparent engagement of all age groups is vital.

Furthermore, ensuring protected time and capacity for health and care staff to engage in innovative practices and mobilise new initiatives will foster continuous improvement. A good example of this is establishing local ‘group consultations’ for specific health conditions, which could be led by clinicians working in primary or acute care. A further example is the use of social prescribing and creative health activities which are evidence-based, that can improve an individual’s well-being.

Engaging retired clinicians in community health initiatives could assist in maintaining local services especially during times of increased demand, such as holiday season and vaccination programmes. Retired clinicians could also be used to engage with local communities encouraging people to participate in health-related activities such as screening and vaccinations.

The delivery of reliable and consistent health and social care services are essential for building trust and ensuring continuity of care.

## 3.7 Strategic Guidance and International Comparisons

Using NICE guidance to shape local strategies for supporting carers and the delivery of out of hospital services should be at the core of all strategic planning. Particular initiatives focused on the needs of local communities such as frailty, substance misuse, and long-term conditions ensures the delivery of evidence-based care.

We recommend proposing the South West as a “testbed” for innovative health solutions and leveraging its unique demographic challenges, could help to drive progress. Comparing coastal health strategies with countries like Spain and Italy can help identify best practices and improve local approaches.

## 4.0 Conclusion

The South West Clinical Senate Council’s examination of the ‘Three Shifts’ within coastal communities highlights the profound impact of geography on healthcare delivery. Coastal areas, with their unique structural, demographic, and environmental challenges require tailored approaches for successful implementation of the ‘Three Shifts.’

The recommendations in this report emphasise the necessity of innovative, community-based care models that leverage local assets and resources. Improving digital literacy and technology integration is crucial to bridging the digital divide and ensuring that our populations have equitable access to healthcare services. Furthermore, fostering collaboration across sectors and engaging communities in the co-design and delivery of health initiatives are pivotal for sustainable health improvements in the South West.

Addressing the specific needs of coastal communities is essential for reducing health disparities. The experiences that the South West offers, has valuable insights for other regions facing similar challenges and it demonstrates the potential for place-based strategies to drive meaningful change. The South West and especially our coastal communities, would be a good place to design and test the implantation of the governments proposed ‘neighbourhood health’ in rural settings.

Ultimately, the successful implementation of the ‘Three Shifts’ in coastal communities will depend on continued innovation, community engagement, and a commitment to addressing the unique geographic and socioeconomic factors that shape health outcomes. By prioritising these elements, we have the opportunity to create a more resilient and equitable healthcare system for all our coastal citizens.

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## Appendix 1: Links to Speaker Presentations

Speaker presentations are available to download on the South West Clinical Senate website. Please follow the link to the website: [Home - South West Senate (swsenate.nhs.uk)](https://www.swsenate.nhs.uk/)

|  |  |
| --- | --- |
| **Presentation Title** | **Speaker** |
| Understanding Coastal Communities | **Professor Maggie Rae,** Deputy Regional Director of Public Health Programmes, NHSE SW  **Doug Haines,** Programme manager, SW Regional Public Health Team, OHID |
| Closing the Health Innovation Gap: A Rural and Coastal Challenge | **Pip Peakman,** Executive Director of Innovation, Health Innovation South West |
| The Three Shifts: A Community Perspective | **Kevin Dixon,** Chair of Healthwatch Devon, Plymouth, Torbay |

## Appendix 2: Senate Council Membership

The table below shows the Senate Council membership (at the time of writing this report) with those who attended the meeting highlighted in blue.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Membership Type** | **Name** | **Job Title** | **Organisation** | **Attendance at Meeting** |
| **Standing Members** | | | | |
| Standing Member | Dr Marion Andrews-Evans BEM | Chair of the South West Clinical Senate Council | NHS England | Yes |
| Standing Member | Fiona Baldwin | Assistant Director Clinical Programmes / Networks and SW Clinical Senate | NHS England | Yes |
| Standing Member | Mark Juniper | Regional Director | West of England Health Innovation Network |  |
| Standing Member | Prof. Maggie Rae | President of the RSM Epidemiology and Public Health Section, Deputy Director – Regional Public Health Programmes | NHS England | Yes |
| Standing Member | Debi Reilly | Regional Director | NHS England |  |
| Standing Member | Debbie Rigby | Chair of the Citizens’ Assembly | Citizens’ Assembly | Yes |
| Standing Member | Rebecca Whitting | Ínterim Portfolio Director – Implementation, SW HIN | South West Health Innovation Network |  |
| **Core Members** | | | | |
| Core Member | Dr Mary Backhouse | GP | North Somerset CCG |  |
| Core Member | Dr Clare Barlow | Consultant Medical Oncologist | Somerset Foundation Trust | Yes |
| Core Member | Marie Crofts | Chief Nursing Officer | NHS Gloucestershire ICB |  |
| Core Member | Bruce Daniel | Head of Pathology | NHS England |  |
| Core Member | Dr Peter Davis | Consultant Paediatric Intensivist | University Hospitals Bristol & Weston NHS Foundation Trust | Yes |
| Core Member | Dr Anne Frampton | Consultant in Paediatric Emergency Medicine | University Hospitals Bristol & Weston NHS Foundation Trust |  |
| Core Member | Dr Giorgio Gentile | Consultant Nephrologist | Royal Cornwall Hospitals NHS Trust |  |
| Core Member | Dr Emma Jones | Consultant Healthcare Scientist in GI Physiology | University Hospital Southampton |  |
| Core Member | Dr Nicolas Kennedy | Consultant Anaesthetist and Intensivist | Somerset NHS Foundation Trust |  |
| Core Member | Prof. Minesh Khashu | Clinical Lead for Poole Hospital | University Hospital Dorset |  |
| Core Member | Hannah Little | Assistant Chief Nursing Officer – cancer services | North Bristol NHS Trust |  |
| Core Member | Dr Ann Lyons | Consultant Colorectal Surgeon | North Bristol NHS Trust |  |
| Core Member | Joanne Meacham | Head of Nursing Adult Community Services |  | Yes |
| Core Member | Will Mongare | Clinical Nursing and Quality Manager / CAMHS Case Manager | NHS England |  |
| Core Member | Dr Anita Pearson | Specialist in Gender Health Care | Devon Partnership Trust | Yes |
| Core Member | Miss Anne Pullyblank | Consultant Colorectal Surgeon | North Bristol NHS Trust |  |
| Core Member | Dr Amelia Randle | Clinical Lead SWAG Cancer Alliance and GP | Somerset CCG | Yes |
| Core Member | Rebecca Reynolds | Director of Public Health | BATHNES Council |  |
| Core Member | Lynn Sawyer | Deputy Chief AHP | North Bristol NHS Trust | Yes |
| Core Member | Alex Sharp | Head of Clinical Development | SWASFT | Yes |
| Core Member | Prof Parag Singhal | Consultant General Medicine, Diabetes and Endocrinology | University Hospitals Bristol and Weston NHS Foundation Trust |  |
| Core Member | Dr Christine Spray | Consultant in Paediatric Gastroenterology, Hepatology and Nutrition | United Hospitals Bristol Healthcare Trust |  |
| Core Member | Mrs Harley Stephens | Consultant Therapeutic Radiographer | University Hospitals Bristol and Weston NHS Foundation Trust | Yes |
| Core Member | Mark Stone | Pharmacist Consultant/Devon LPC Project Lead, Vice Chair of the East Cornwall Primary Care Network | Devon Local Pharmaceutical Committee and Tamar Valley Health Practices |  |
| Core Member | Carol Stonham MBE | Respiratory Nurse Specialist, Primary Care | NHS Gloucestershire ICB |  |
| Core Member | Dr Miles Wagstaff | Consultant Paediatrician and Neonatologist | Gloucestershire Hospitals NHS Foundation Trust |  |
| Core Member | Richard Walters | Physiotherapist | University Hospitals Plymouth NHS Trust | Yes |
| Core Member | Dr Paul Winterbottom | Consultant Psychiatrist | Gloucestershire Health and Care NHS Foundation Trust | Yes |
| Core Member | Dr Peter Wright | Director of Healthcare Science and Technology | University Hospitals Plymouth NHS Trust |  |
| Core Member | Dr Katie Yeadon | Consultant General Surgeon | North Devon Healthcare Trust |  |
| Core Member | Julie Zatman-Symonds | Deputy Chief Nurse | NHS Gloucestershire ICB | Yes |
| **Co-Opted Member** | | | | |
| Co-Opted Member | Dr Geeta Iyer | Chief Medical Officer | NHS Bristol, North Somerset, and South Gloucestershire ICB |  |
| Co-Opted Member | Dr Paul Johnson | Chief Medical Officer | NHS Dorset ICB |  |
| Co-Opted Member | Dr Bernie Marden | Chief Medical Officer | NHS Somerset ICB |  |
| Co-Opted Member | Dr Anathakrishnan Raghuram | Chief Medical Officer | NHS Gloucestershire ICB |  |
| Co-Opted Member | Christopher Reid | Chief Medical Officer | NHS Cornwall and Isles of Scilly ICB |  |
| Co-Opted Member | Amanda Webb | Chief Medical Officer | NHS Bath and North East Somerset, Swindon, and Wiltshire ICB |  |
| **Non-Voting Members** | | | | |
| Non-voting Member (professional in training) | Dr Matthew Boissaud-Cooke | Neurosurgery Specialist Registrar | University Hospitals Plymouth NHS Trust |  |
| Non-voting Member | Jane Jacobi | Implementation Consultant | National Institute for Heath and Care Excellence | Yes |

## Appendix 3: Other attendees at the meeting

|  |  |  |  |
| --- | --- | --- | --- |
| **Membership Type** | **Name** | **Job Title** | **Organisation** |
| Guest Speaker / Citizens’ Assembly Representative | Kevin Dixon | Chair of Healthwatch Devon, Plymouth, Torbay | Healthwatch Devon, Plymouth, Torbay & Citizens’ Assembly |
| Guest Speaker | Doug Haines | Programme manager, SW Regional Public Health Team, Office for Health Improvement and Disparities, DHSC | NHS England |
| Guest Speaker | Pip Peakman | Executive Director of Innovation | Health Innovation South West |
| Citizens’ Assembly Representative | Paul Trainer | Citizens’ Assembly Representative | Healthwatch Devon, Plymouth, Torbay & Citizens’ Assembly |

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