Ebb and flow: living a life with illness in a remote seaside town.

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Dedication

To Pete. You are greatly missed. Thanks for all those road trips and encouragement in life. You will be relieved to learn that I finally finished it.

Acknowledgements

This thesis could not have been completed without the kind support of many people who have helped sustain my progress over the last five years. Firstly, I would like to thank my two academic supervisors, Professor Liz Walker and Dr Moira Graham, who believed in me, guided me, and retrieved me from wayward tangents and deep rabbit holes. I also thank Dr Liz Price for first encouraging me to undertake a PhD, without which I may never have embarked on this journey.

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Contents

Abstract

This study is an ethnography of a small, remote northern seaside town and its working-age residents with multiple health conditions. The site of the ethnography is Skelsend, a once-popular destination for holidaymakers across the region and beyond. However, the town has experienced decades of economic decline, losing much of its tourist industry, infrastructure, and railway. Most residents live in neighbourhoods statistically measured as significantly socially disadvantaged.

The thesis aspires to elucidate how a specific location's local social, cultural, and economic context might influence the experience of living with illness. Moreover, the intersection of exogenous social structures with local structures might impact the lives and agency of working-age residents with long-term health conditions as they strive to maintain their well-being in the context of illness.

Fieldwork was enabled by volunteering at two local charities in the town and engaging in several community events, before conducting semi-structured interviews with residents and relevant health and community workers. The study uses a critical realist methodology to assist in revealing contingent structural relationships that influence the lives of working-age residents living with multiple illnesses. A critical realist reinterpretation of Bourdieu's (1990) habitus, capital and field based on habitus as a reflexive disposition is also incorporated within the study to gain further insight.

The study highlights the different needs of residents, which depend on how they use the physical space of Skelsend to optimise capacity for well-being, which is dependent upon field positions within the town. I conclude that access to the natural environments around Skelsend and its largely peaceful, friendly atmosphere benefits residents. However, security of access to capital, both social and economic, within the social space of Skelsend and spatial immobility are highly significant determinants of whether residents can realise projects of well-being in the context of living with multiple illnesses.

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Abbreviations

AIC: Auto-Immune Condition

COPD: Chronic Obstructive Pulmonary Disease

DSA: Disability Support Allowance

DWP: Department of Work and Pensions

EA: Economically Active

EI: Economically Inactive

ESA: Employment Support Allowance

HMO: Houses of Multiple Occupancy

IAPTS: Improving Access to Psychological Therapies

IMD: Indices of Multiple Deprivation

LSOA: Lower Super Output Area

MHC: Mental Health Condition

NWBHM: New Wave British Heavy Metal

ONS: Office for National Statistics

PIP: Personal Independence Payments

SSM: Social Super Market

TMSA: Transformational Model of Social Activity

UC: Universal Credit

WCA: Work Capability Assessment

Preface: A note about this study

This ethnographic study concerns the working-age population of a town I have named Skelsend in the fictitious County of Woldenshire, who live with multiple health conditions. Skelsend is a small rural seaside town in the north of England with approximately 6,000 residents. Due to the town's small size, considerable extra measures have been required to protect residents' identities. Therefore, throughout this ethnography, I have developed pseudonyms for all the people I have encountered and all the organisations mentioned in Skelsend. I have also created pseudonyms for place names around the region of Skelsend, including the nearest city, which I refer to as Haxton.

Rather than refer to specific job titles, I refer to the sector or use a vague descriptor. When referring to an individual's health condition, I have used descriptors that do not directly refer to the health condition to protect identities further unless, as in the case of diabetes, the illness is highly prevalent in the town. Consistent with local discourse, I refer to people who have moved into the town as incomers and those lifelong residents as locals. It is possible to have lived in Skelsend for twenty years and still be considered an incomer by locals. Consequently, I also reference long-term residents, who may have lived in the town for twenty years or more but are still not considered local. Although I acknowledge that many people continue to work into their eighth decade, for this PhD study, I needed to determine an upper and lower age limit. To avoid excluding the recently retired and their valuable insights into working life with health conditions, I stretched the working age upper limit to 67 years. The lower limit is set at 18 years of age.

In much of the literature, living with multiple health conditions is medically referred to as multimorbidity. The Academy of Science (2018) defines multimorbidity as two or more co-existing long-term health conditions within one body and can include mental and physical health combinations. However, debate exists about the continued usage of this term. The NIHR (2020) recommends referring to multiple long-term health conditions instead of multimorbidity. For this thesis, I use the term multiple health conditions, referring to the long-term co-existing health conditions experienced by residents.

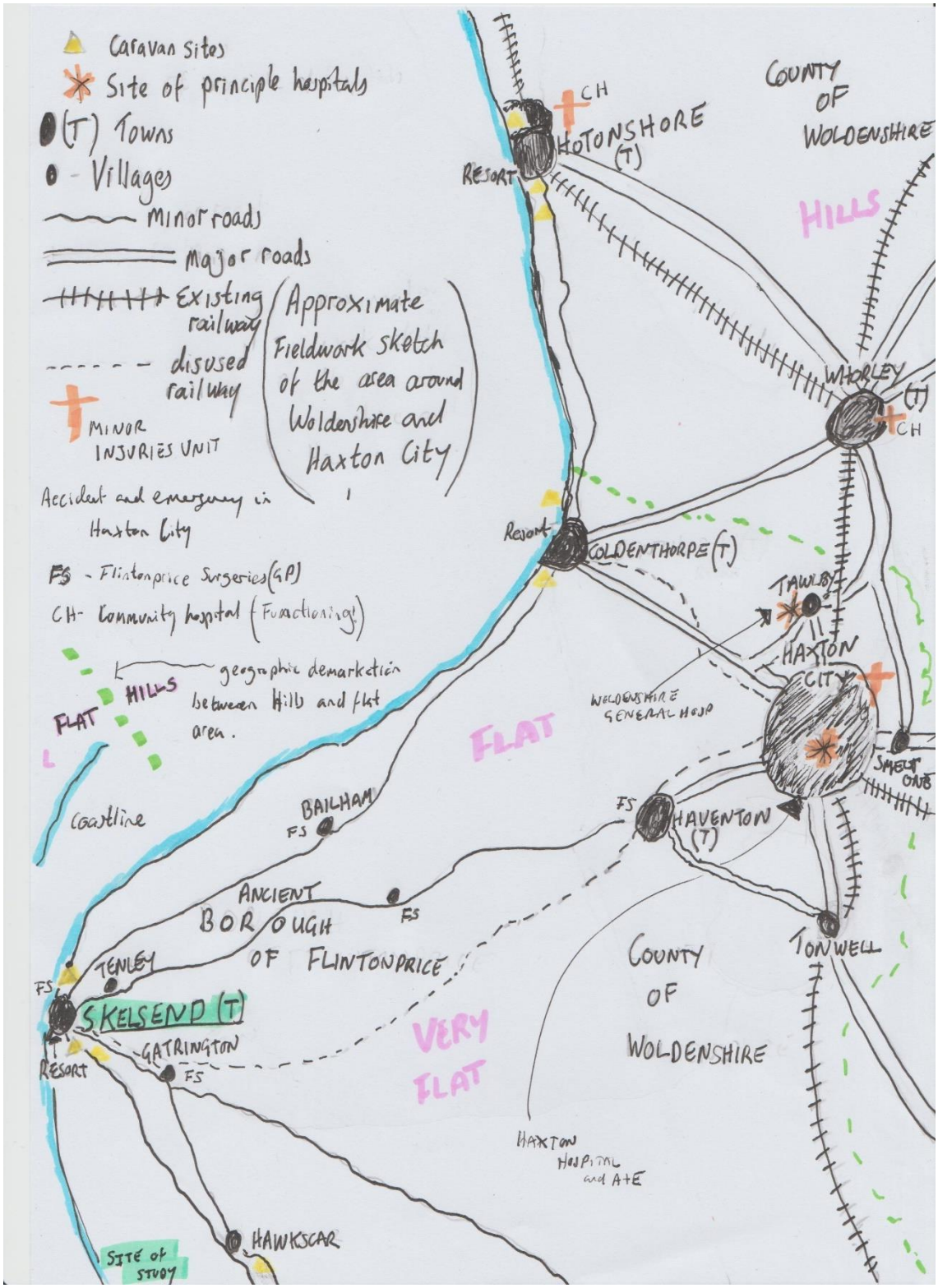

Figure 1: Fieldwork map of area

Chapter 1 Introduction

This qualitative study aims to contribute to understanding how social structures operating within a specific location, namely Skelsend, a small, remote, and rural seaside town in northern England, may influence the lives and experiences of working-age adults living with multiple health conditions. The study aims to identify prominent social structures operating in the town that influence residents' capacity to optimise well-being and shape the lived experience of life with multiple health conditions in a remote coastal location.

The study asks the following research questions: (1) Are there characteristics of this small seaside resort that help residents optimise their ability to maintain well-being while living with multiple health conditions; (2) Are there any features of the town's decline as a resort, seasonality, and spatial disconnection which may negate those beneficial characteristics; (3) What are the residents' experiences in attaining material security through access to economic capital, whether from employment within the town, through commuting, or through accessing social security financial support, and the extent to which this influences their well-being; (4) How do residents access health services from this remote location, considering who might be disadvantaged and why. These questions were answered using a critical ethnographic approach that considered structural causation to observed experiences and how residents interacted with them.

Volunteering with two local independent charities immersed me in the local issues people experienced and frequently discussed. Following initial ethnographic fieldwork, I conducted semi-structured interviews with working-age residents with multiple health conditions at various locations in the town. Several residents accepted the opportunity to undertake a subsequent walking interview, also called 'go-along' interviews (Carpiano, 2009), although other residents opted to participate in photo-elicitation interviews. Semi-structured interviews were also undertaken with pertinent community workers and health professionals working in Skelsend. I collected data about Skelsend from online public sources, including news, social media outlets, and statistics from official central and local government sources.

Although ethnographic fieldwork formally commenced in November 2021, I commenced some initial voluntary work following the lifting of lockdown in June

2021. I used this period of accessing the field to develop connections with people and organisations in Skelsend, helping to prepare the ground for subsequent in-depth fieldwork and subsequent recruitment of interview participants. Ethnographic fieldwork carried on alongside interviews, and as I became better known, I was invited to several activities in the town, which helped broaden recruitment. I adopted an ethnographic approach to compile relevant contextual data about Skelsend and to nurture relationships with people who might otherwise feel reticent about sharing their experiences with a researcher. This approach also helped collect the views of people willing to speak with me during incidental or arranged meetings, but who preferred not to be interviewed.

I adopted a laminated critical realist methodology and thematic analysis to elucidate the intersecting social structures. This provided a framework to examine the stratified levels of social reality that interact with residents' social and health-related circumstances to influence the lived experience of illness. To complement a critical realist methodology, I have judiciously employed Bourdieusian concepts framed in a manner compatible with critical realism (Akram, 2023; Decoteau, 2016; Elder-Vass, 2007). This methodological approach assisted in developing conceptual themes and identifying influential social causations that exist below the surface of social reality.

Why working-age and multiple health conditions?

The increasing incidence of multiple health conditions is observed across high income countries (Kingston et al., 2018; Pearson-Stuttard et al., 2019). People living with multiple health conditions tend to have a lower life expectancy, often have reduced functionality, and experience reduced quality of life (Navickas et al., 2016). It is a growing phenomenon that increasingly challenges public health systems across Europe and elsewhere (Abebe et al., 2020; Navickas et al., 2016). A micro-simulation study by Head et al. (2024) estimated the trajectory of multiple health conditions within England's population, projecting an 84% increase between 2019 and 2049, accelerating from 19.2 million to 35.3 million people. Pearson-Stuttard et al. (2019) estimated that, by 2035, the number of people living with four or more conditions would increase from just under 10% to 17% across the UK population.

Stafford et al. (2018) estimated that 30% of people living with four or more long-term conditions in the UK are under sixty-five. The projected increase in people living with

multiple health conditions is significantly more marked in the most deprived quintile of the working-age population (Head et al., 2024). Therefore, a study that considers the structural impacts on the working-age population to predispose them to accumulating more health conditions is both socially beneficial and expedient in the context of policy development. Further, a study of multiple health conditions of working-age people also helps to highlight a location's economy by examining the capacity of a town's economic and social structures to accommodate the employment of people living with health conditions.

Why Skelsend and small seaside towns?

It is necessary to situate health and how people are embedded within a particular geographical context and consider how the broader determinants of health and well-being are influenced by local social and economic factors (Bambra, 2016; Bambra at al., 2019; Macintyre and Ellaway, 2003). As Macintyre and Ellaway (2003:26) state, "People create places, and places create people." Research strongly suggests that coastal communities, including seaside towns, have specific challenges arising from their geography and local economy (Agarwal et al., 2018; Beatty et al., 2008, 2014; Corfe, 2017; House of Lords, 2019) and, in recent years, more research has focused on the health of coastal communities and the well-being of residents (Asthana and Gibson, 2022; White et al., 2020; Whitty, 2021). Many seaside towns have been challenged by several decades of resort shrinkage and consequent economic decline, impacting the lives of residents (Corfe, 2017; House of Lords, 2019; Whitty, 2021).

Smaller seaside towns, for example, tend to be more remote and rural, are poorly serviced by public transport, and depend on tourism. They are also more exposed to seasonality and declines in the tourist industry (Beatty et al., 2010; House of Lords, 2019). Moreover, because they are severed from geographically broader labour markets and have poor transportation links, employment opportunities are, for many people, greatly restricted (Lloyd and Blakemore, 2021). Consequently, people are more likely to depend on the opportunities in those towns. Meanwhile, consolidating services and amenities to larger urban areas has moved health services from rural locations like Skelsend to larger urban areas, rendering them less accessible (Shucksmith et al., 2023).

It is important to note that there is a tendency within the literature, especially quantitative studies, for seaside towns to be conflated with coastal settlements more broadly, including large cities and towns with better transport connections with other urban areas. This study is important because it is situated in a small seaside town that cannot rely on an alternative industry to tourism and is poorly connected to other towns in the area.

The difficulties faced by many small seaside towns described in the literature can be found in Skelsend. Most of Skelsend's residents reside in neighbourhoods within the most deprived decile on the Indices of Multiple Deprivation (IMD), whilst the town's rural green hinterland is relatively affluent (Gov.UK, 2019). The local labour market hosts a proliferation of low-paid work, whilst most of Skelsend's residents live in neighbourhoods within the most disadvantaged decile for health and income deprivation (Gov.UK, 2019). Working-age economic inactivity within the town due to poor health and disability is amost double the national average (Woldenshire County Council, 2022). Health service provision has, over recent years, been rationalised with services removed from the town and consolidated in larger conurbations. The town's connectivity by public transport is poor; for example, to reach Haxton by bus, the only means of public transport, takes approximately seventy-five minutes. During fieldwork, if one were to commute to Haxton from Skelsend for full-time work five days a week, it would cost £260 every four weeks.

Therefore, Skelsend is a quintessential small seaside town that enables a study of the intersections between people, multiple health conditions, and typical small seaside town characteristics, such as spatial disconnectivity, health inequality, social and economic deprivation, and poor service access. It is a town nested within a relatively affluent rural county, with much better health outcomes (Gov.UK, 2019), thereby exemplifying health inequality within a localised area. Consequently, Skelsend is an ideal location to consider the myriad structural impacts faced by residents living in seaside towns with multiple health conditions.

A biographical note

During fieldwork, I became immersed in the town and could observe, first hand, the structural impacts on the lives of residents and how the residents responded to them. My involvement within the town and the interpretation of events and experiences therein necessitated personal interpretation and reflection.

I came to this PhD research project as a middle-aged man with a long career in adult social care, fulfilling various roles spanning more than three decades, including, more latterly, working as a social worker with adults who live with physical and cognitive impairments. I have long held an interest in how political economy influences social life and the health and well-being of communities, and this research provided a very personal, and often moving, opportunity to consider these issues. I also have an historical interest in the site of this study, having ancestry in this area, and other ancestry from what would have been a remote, isolated coastal village a few miles south of Skelsend.

The thesis

Fundamentally, within this thesis, I argue that, whilst the environment of a small seaside town like Skelsend can prove restorative should one relocate there during working life, and with multiple health conditions, the likelihood of overcoming the barriers of living in a remote town with few economic opportunities can be undermined by insecure access to economic capital. It is fair to say many incomers enjoy a considerably better quality of life when moving to a town like Skelsend. Indeed, for many, Skelsend represents a sanctuary that facilitates a distancing from difficult past experiences. However, there is a tendency amongst lifelong residents, especially younger adults with multiple health problems and those requiring work opportunities and having poor access to capital, to struggle to overcome the difficulties of the location and lack of opportunity to benefit from the positive environmental characteristics of the town. Although access to economic or social capital may help mitigate barriers to accessing services, the tendency towards concentrating health facilities on fewer sites away from rural locations like Skelsend (Shucksmith, 2023) results in detrimental health outcomes for many residents. Meanwhile, for many residents, the process of accessing much-needed financial support from the Department of Social Security (DWP) is a negative mediating factor

within their experience of living in Skelsend, magnifying disadvantage and often mental and economic distress.

Thesis outline

Following this introduction, Chapter 2 provides an overview of the literature and pertinent themes relating to multimorbidity, health inequalities, relevant issues concerning health, seaside towns, and work and accessing social security. Chapter 3 outlines the methodological framework informing the thesis. I employ a critical realist-informed methodology, consistent with a critical ethnography, complemented by Bourdieusian concepts. I discuss how more recent critical realist theorists have revised elements of Bourdieu's (1990) theory of habitus in connection with capital and field to accommodate and potentially improve critical realist understandings of the causation of social phenomenon, referred to by Elder-Vass (2010) as emergence. Chapter 4 provides an overview of methods used to collect qualitative data, including the ethnographic strategy and the semi-structured interviews undertaken with participants. This chapter also provides a brief overview of the residents of Skelsend who participated in the interviews. Chapter 5 describes Skelsend, assisting the reader with a contextual understanding of the town's trajectory and enabling readers to locate themselves within Skelsend before approaching the main findings chapters.

Chapter 6, the first findings chapter, strikes an optimistic tone and narrates the motivations for residents relocating to Skelsend. The chapter describes how the town's affordability facilitates access to a broader range of people, including those from areas of intense urbanisation and, in some cases, social deprivation. For many of these residents, the slow pace of life in the town, the supportive communities that they contribute to, the seascape, and the green rural hinterland provide a conducive environment for restitution. In contrast, Chapter 7 shifts toward melancholy, describing the multiple impacts on many residents from the diminution of resort life and the town's consequent incremental dissolution of purpose. The town's spatial redundancy and disconnection have significant implications for those people who are less mobile, have poor access to capital, and require working opportunities conducive to illness to sustain well-being. The potential tension of needs between

those seeking restitution from spatial calm and those requiring improved infrastructure and economic opportunities becomes increasingly apparent.

Chapter 8 focuses on those residents unable to work and describes how accessing necessary financial support from the DWP impacts the residents' well-being and their ability to maintain well-being. Emerging from this chapter are narratives of residents who routinely experienced stigma and state discipline for their apparent lack of utility toward the valorisation of capital through illness. Paradoxically, residents also report how their attempts at improving physical activity threatened the very income they relied on, thereby enslaving them to passivity. Chapter 9 describes the difficulties in accessing services critical to health in Skelsend, the paucity of local provision that struggles to meet demand and the difficulty of reaching hospitals and other health facilities from a distance. The consolidation of services away from peripheral areas like Skelsend has a disproportionate impact on residents with mental health conditions and insecure access to economic and social capital. The chapter also discusses food landscapes, attitudes and lifestyles concerning health and well-being, providing a further contextual layering of social structure and human agency.

The thesis concludes with a combined discussion and conclusion chapter that interpolates theory and research literature and further analyses research findings. Adopting a critical realist analytical position alongside Bourdieusian concepts, I identify social structures and mechanisms within these structures to explain some of the prominent causes of the social phenomena presented in this thesis that constrain and enable well-being. I attempt to understand social causation as tendencies through a prism of lamination, acknowledging a stratified ontological social world. This open social world hosts interactivity between human agency and different levels of social structure, which, in the context of this study, influence the human experience of working-age life with multiple health conditions in a rural seaside location.

Chapter 2 Literature Review.

Introduction

While reviewing the literature pertinent to this study, I considered how the layering of social structure may influence the experiences of working-age people living with multiple health conditions who are residents of the smaller, more rural seaside resort towns situated throughout much of the UK. The objective of the literature review was to develop an appreciation of prominent socioeconomic formations that might shape localised community structures, which can potentially influence the experience of multiple health conditions. Neighbourhood community structures relate to individuals' health and macro structures, such as government bureaucracy and public policy.

The social and economic context defined by structural and political factors affecting a location is an essential determinant of health. For instance, a policy environment that supports labour market flexibility and public austerity may encourage the promulgation of further commodification of labour, thereby institutionalising material insecurity (Harvey, 2005; Standing, 2011); this will include people living with multiple health conditions (Harwood, 2015). Labour market flexibility may combine with the increased prevalence of seasonal labour in traditional UK coastal resorts (Corfe, 2017), thereby affecting the working conditions of people living and working with multiple health conditions with weak leverage within the local labour markets. Bambra et al. (2019) refer to this as a vertical structure of influence, but this aspect of social structure can also be referred to as the upstream determinants of health (Naik et al., 2019).

Meanwhile, the degree of social connectivity at a local level and how embedded individuals are within a community have important implications for health (Berkman and Glass, 2000). Relationships between people within a neighbourhood, family or workplace can be called horizontal structures of influence (Bambra et al., 2019). Horizontal structures and relationships between people are influenced by public policy and economic formation intersections, which impact people in pursuit of objectives relating to well-being in the context of illness. The intersections between these social structures shape the lived experience of people living with multiple health conditions and the relationship between their illness and work.

This literature review first discusses multiple health conditions, their prevalence, and their relevance to public policy, before considering them in the broader context of health inequality and upstream determinants that reproduce inequalities. The literature review then moves on to the relationships between people and place and how this intersection may result in people being exposed to harmful forms of social stress, increasing their predisposition towards accumulating health conditions and negating strategies to achieve well-being, despite illness. Continuing the theme of place, I then introduce seaside resorts, discussing the well-established decline in the fortunes of those places, which still hold considerable nostalgia for many and are regarded as restorative by many people, despite the apparent neglect of public spaces within these towns and lack of opportunity structure for younger residents.

Given the location of this study, being a rural, comparatively remote seaside town, I discuss the lack of connectivity and relative isolation impacting these communities and briefly speculate, through the presenting literature, the impact on health caused by the lack of connectivity to other larger urbanised conurbations. I then discuss the benefits of proximity to the coast, and contrast optimism with the challenges and tendency towards increased exposure to the determinants of health. I conclude the literature review by considering the nature of work in seaside towns and how the structure of local labour markets may mitigate against residents' well-being, before considering the significant challenges of overcoming the difficulties in accessing financial support through the Department of Works and Pensions (DWP). The latter is a form of work, and I refer to it as the work of non-work.

The contested term of multimorbidity

Over several years, a significant body of research literature has accumulated referencing multimorbidity and the challenges this poses to healthcare systems (Navickas et al., 2016; Stafford et al., 2018). However, the use of the term is contested by many health practitioners, researchers, and patients (Chew-Graham et al., 2019; Kingston et al., 2018; NIHR, 2020; Taskforce on Multiple Conditions, 2019). Ethnographic research undertaken with people living with multiple health conditions conducted by the Taskforce on Multiple Conditions (2019) found that the term multimorbidity encouraged a reductionist approach to treatment, reducing the complexity of multiple conditions to a single disease entity. Participants disagreed

and felt multimorbidity was a negative label, which they found distasteful and associated with death (Taskforce on Multiple Conditions, 2019). Porter et al.'s (2020) qualitative research with older patients reported that people felt the term failed to reflect their lived reality, concluding that multimorbidity is a biomedical construct obfuscating an authentic appreciation of the body. In response to this criticism of multimorbidity, many professionals argue that the term should be replaced with something people find relatable (Chew-Graham et al., 2019; Khunti et al., 2023). The Taskforce on Multiple Conditions (2023) suggests one should refer to 'multiple health conditions' or 'living with a number of conditions', whilst the NIHR's (2020) preference is 'multiple long-term health conditions'.

Moreover, health organisations advocating reforms to improve healthcare for people with multiple health conditions have stressed that moving away from the single disease model towards a more holistic appreciation of their patients is necessary (Academy of Science, 2018; World Health Organization, 2016). This sentiment is reflected in Naylor et al.'s (2012) report regarding the combination of mental health and long-term physical health conditions, which concluded that although people often experience poorer quality of life and health outcomes, any detriment to their well-being could be ameliorated through closer integration between primary care and mental health services (Naylor et al., 2012).

Multiple health conditions in the UK

An increasing incidence of multiple health conditions is observed across high income countries and has been described as potentially challenging to the very sustainability of health systems in the UK and elsewhere (Navickas et al., 2016). Moreover, people with more than one long-term condition experience an inferior quality of life compared with those living with a single disease, while the quality of life is measured to deteriorate cumulatively with each condition (Li et al., 2016). Head et al. (2024) projected that the increase in the incidence of multiple health conditions would be prominent within the most deprived quintile of the IMD (Gov.UK, 2019), with the main driver of the increase being the working-age population.

With the projected increase in the prevalence of multiple health conditions, the demands on the healthcare system increase exponentially. Cassell et al. (2018) estimate that approximately a quarter of the UK population living with multiple health

conditions use over 50% of the overall health resources, and 79% of prescriptions are for people living with multiple health conditions. Pressures from escalating multiple health conditions in hospitals are most evident. For instance, unplanned hospital admissions of people with four or more health conditions rose from one in ten in 2006/2007 to one-third of all admissions in 2015/2016 (Stafford et al., 2018). McParland et al.'s (2022) research on admission to Emergency Departments over twelve months in Greater Glasgow and Clyde found that one in five patients were being admitted with multiple health conditions. Multiple health conditions significantly increased the likelihood of readmission within thirty and ninety days and the likelihood of inpatient mortality (McParland et al., 2022).

Many people living with long-term illnesses are required to manage unpredictable disease patterns, with many conditions exhibiting fluctuating symptoms and severity. Conditions that might present as fluctuating include autoimmune conditions, including lupus (Walker and Price, 2015), multiple sclerosis, inflammatory bowel disease and rheumatological disorders (Steadman et al., 2015). Fluctuating mental health conditions include bipolar disorder, depression, and schizophrenia (Steadman et al., 2015). The unpredictable nature of these conditions has implications for working life and access to benefits (Vickers, 2001; Price et al., 2019). As Coyle and Atkinson (2018) attest, experiences of multiple health conditions do not necessarily conform to any categories or predictable linear trajectories. Instead, people are subjected to extensive differentiation of symptoms and functional impairments, rendering it hard for them to maintain a sense of control (Coyle and Atkinson, 2018).

Health inequality and multiple health conditions in the UK

Health inequality permeates the UK, inflicting an excessive cost to the nation's health, particularly to people residing in more deprived areas (Bambra, 2016; Mercer et al., 2018; Marmot, 2015; O'Brien et al., 2011). Marmot (2004, 2015) and Marmot et al. (2010, 2020a, 2020b) write extensively about the social gradient of health resulting from the conditions in which people live and work. These social conditions, significantly indicative of elevated propensity towards morbidity and life expectancy, are also referred to as the social determinants of health. As Marmot et al.'s (1991) Whitehall studies exemplify, one's life chances concerning health are greatly affected by the social and occupational gradient of health (Marmot et al., 1991). More recent

work by Marmot et al. (2010, 2020) demonstrates how the social gradient of health was exacerbated between 2010 and 2020 with life expectancy stalling, and, for women in the poorest area decile, life expectancy went backwards.

Several authors have concluded that competition in social status within unequal countries predisposes people to chronic illness accumulation (Kawachi and Kennedy, 2006; Marmot, 2004; Wilkinson and Pickett, 2018). The more unequal the society, the greater the tendency towards conspicuous consumption and status competition (Wilkinson and Pickett, 2018). Wilkinson and Pickett (2018) and Kawachi and Kennedy (2006) argue that the higher the inequality of income between people, the greater the level of competition, which in turn provokes anxiety and stress affecting the body (Kawachi and Kennedy, 2006). Khanolkar et al.'s (2021) longitudinal study followed the health trajectory of people born in 1946 from the age of thirty-six to sixty-nine, and found that people born into socioeconomic disadvantage develop multiple health conditions earlier in life and are more likely to accumulate conditions rapidly.

Meanwhile, perhaps reflecting the increased social stress of urbanicity (Finnemann et al., 2024), Knies and Kumari (2022) identified that rates of multiple health conditions were higher in urban centres within the most deprived deciles of the IMD. Stagg et al.'s (2023) analysis of health survey data from southeast London, focusing on associations between multiple health conditions and urban working-age adults, revealed that the development of the first health condition was primarily associated with elevated levels of stress from life events, smoking, being overweight and having a poor social network. However, a subsequent accumulation of health conditions was associated with living in a low-income household and early exit from employment, with depression being the most prevalent condition among unemployed people (Stagg et al., 2023). In contrast, the risk of morbidity was reduced for those holding a more favourable social and economic status (Stagg et al., 2023). The health detriment of urban living in this study contrasts with the perceived benefits of living by the sea, which are later discussed in this chapter and beyond. Lawson et al. (2013) conducted a Scottish health survey study based on patients living with multiple health conditions and their self-reported health. They found that the quality of life score in the highest quintile for deprivation was a third less than in more

affluent areas. Notably, the reported quality of life differences were the most marked amongst the cohort aged between twenty and forty (Lawson et al., 2013).

Health inequality, place, and multiple health conditions

The landmark government-commissioned Marmot study, *Fair Society Healthy Lives* (Marmot et al., 2010), and its tenth-anniversary review report commissioned by the Health Foundation (Marmot et al., 2020) provide comprehensive statistical evidence detailing the extent to which there are associations between where one lives and health outcomes. The adverse social determinants of health are concentrated in neighbourhoods experiencing socioeconomic disadvantage. The latter anniversary report detailed how, on average, life expectancy has stalled, and that, for women, it declined in areas like Skelsend, which is measured as being within the most deprived decile in England (Marmot et al., 2020). The review corroborates and consolidates evidence of the social gradients of health, which demonstrate that people living in poorer parts of the country are more likely to accumulate avoidable non-communicable health conditions and live a more significant proportion of their lives in poor health (Marmot et al., 2020).

Stafford et al. (2018) found that 28% of people living in the most socially deprived quintile live with multiple health conditions compared to 16% in the least deprived areas (Stafford et al., 2018). As several studies exemplify, the uneven spread of people with multiple health conditions reflects wider health inequalities within the UK. For example, residents of economically disadvantaged communities are more likely to develop multiple health conditions (Kings Fund, 2020; Stafford et al., 2018) and develop health conditions significantly earlier (Barnet et al., 2012; Calderon-Larranga, 2019). Indeed, Mercer et al. (2012) conclude that in the most deprived areas, compared to the least, the onset of multiple health conditions is likely to occur ten to fifteen years earlier.

Socially deprived areas of the UK, where people live with an increased likelihood of developing multiple health conditions, strongly tend to produce poor outcomes relating to the social determinants of health (Bambra, 2016; Dorling, 2013, 2015; Marmot, 2015). Despite this, during the austerity period between 2009 and 2018, local authority spending reductions were significantly deeper amongst those councils providing services to the poorer parts of England (Marmot et al., 2020). Indeed,

Marmot et al.'s (2020) report identified a local authority spending gradient akin to an "inverse care law" (Tudor-Hart, 1974). The least deprived areas experienced the lowest reductions in spending, whereas the more deprived an area, the more significant the reduction in spending on services (Marmot et al., 2020). This is also reflected in primary care, where consultation times with General Practitioners and patients living with multiple health conditions are shorter in areas measured as deprived than in less deprived areas (Gopfert et al., 2021; Mercer et al., 2018), whilst GPs are more likely to experience a greater intensity of stress in deprived locations (Mercer et al., 2012).

Moreover, reflecting the complexities of multiple health conditions, mental illness features more prominently as a contributor to multiple health conditions in areas of deprivation (Barnet et al., 2012; Moffat and Mercer, 2015). Fone and Dunstan's (2006) study regarding local authority ward deprivation in Wales demonstrated that economic inactivity is correlated with poor mental health. They further discovered that mental distress is comparatively higher across all employment categories in deprived wards (Fone and Dunstan, 2006). There is sufficient evidence to conclude that socially deprived neighbourhoods are predisposed to present with a higher incidence of multiple health conditions. This susceptibility towards the increased likelihood of morbidity demonstrates that neighbourhood circumstance plays an instrumental role in shaping the experience of multiple health conditions.

However, it is argued that localised contributors to health inequality are not sufficiently reflected in national public health policy (Kriznik et al., 2018; Singer et al., 2019). Although successive administrations acknowledge social deprivation as fundamental to health inequality, strategies to reduce health inequalities have primarily emphasised individual responsibility (Kriznik et al., 2018). The emphasis on individual behaviours risks overlooking an area's local social and economic characteristics and their effects on health and illness (Bambra, 2016; Marmot, 2015; Wilkinson and Pickett, 2009). More specifically, the lack of policy attention to environmental factors results in stark health inequalities that have implications for the prevalence and experience of multiple health conditions.

Local infrastructure, such as the labour market, education, health, and welfare services, are influenced by broader macroeconomic influences and public policy

(Bambra, 2016; Bambra et al., 2019; Lynch, 2020). These influences are transmitted to residents of the local community. Local characteristics can shape the relationships between health, people, and places (Cockerham, 2013). These environmental factors might be experienced differently by people with multiple working-age health conditions. For instance, strong neighbourhood bonds might provide health benefits to residents (Berkman and Glass, 2000). On the other hand, a weak local economy, poor work opportunities, and a comparatively high reliance on social security may place residents at a health disadvantage (Bambra, 2011; Crisp, 2009).

Upstream macro determinants of health inequalities

Bambra (2016) argues that politics is a crucial determinant of health inequality due to its role in constructing broad socioeconomic environments. Dorling (2015:327) may have referred to income inequality as the "mother of underlying causes"; however, as Rustin (2018) argues, an examination of causes must identify the root cause of the reproduction of the cause of inequality residing within the structures of the social and economic system. This requires an understanding of the political economy of health, the "scaling-up" explanation for health inequality (Bambra, 2016; Bambra et al., 2019), being a fundamental "cause of causes" of the social determinants of health (Marmot, 2015:52).

National governments and their political choices largely shape upstream determinants of health, which may later affect downstream, more localised determinants (Bambra, 2016). However, as Lynch argues, governments are constrained by the prevailing paradigm of political economy, which, since the 1980s, has been neoliberalism (Lynch, 2020). The neoliberal paradigm within which governments operate mandates that policy must be consistent with international competitiveness and market credibility (Lynch, 2020). This dominant paradigm of economic management instils an imperative upon states to liberalise social relations to optimise their utility to the market (Harvey, 2005). This marketisation of the economy since the 1980s has resulted in significant structural changes within society and in how inequality was considered in relation to public policy (Bambra, 2016; Lynch, 2020).

Whereas excessive inequality during Keynesian social democracy was deemed socially and economically detrimental to the nation's polity, neoliberalism,

increasingly gaining traction from the late 1970s, reframed inequality as a public good (Lynch, 2020). These political changes are reflected in the social structure and have assisted in recasting the labour market and, over a protracted period, the welfare state (Lynch, 2020). The subsequent defenestration of trade unions and the imposition of flexible labour markets have contrived to increase human commodification and exposure to market discipline and the conditions promoting the flexible accumulation of capital (Gamble, 1988; Glyn, 2006; Harvey, 1989, 2005). Meanwhile, the protective structures of the post-war welfare state have incrementally been stripped away (Beresford, 2016; Gamble, 1988, 2016; Harvey, 2005). Therefore, the neoliberalism of the past four decades has primarily defined upstream determinants or the vertical structures of influence (Bambra, 2016).

In the UK and across Europe, the social democratic parties, in the face of neo-liberal political hegemony, tend to abandon explicit calls for wealth redistribution as a means of ameliorating the social determinants of health; instead, when securing power, they adopt a more technocratic approach aimed at addressing lifestyles and behaviours harmful to health (Lynch, 2020). This lifestyle drift approach to health policy overlooks ill health's social and economic context to focus on behavioural determinants (Bambra, 2016). Moreover, the previous Labour government period in the UK increased NHS expenditure, especially in socially disadvantaged areas (Bambra, 2016). However, as Bambra (2016) argues, the improvement in health outcomes amongst the poorest in society was only modest. Indeed, it was the middle classes whose health benefited from increased health expenditure (House of Commons, 2009). Instead, people living on low incomes remained considerably more susceptible to developing long-term conditions, as evidenced by the first Marmot Review reporting at the end of that Labour administration (Marmot et al., 2010).

The higher concentration of multiple health conditions within areas of social disadvantage is at the heart of what Dixon and Mendenhall (2023) conceptually refer to as a syndemic, a term coined by Singer (2000). The confluence of upstream social determinants of health, for instance poor housing, education, income, and access to transport, interacts with the biological relations of illness, resulting in an elevated risk of people within a given area who might be subject to such social determinants of

health. As Dixon and Mendenhall (2023:1) argue, the syndemic model is exemplified by “the harmful social conditions and injurious social connections” that might abound and predispose people, over time, to the accumulation of health conditions. However, there is a tendency across health research to pay insufficient attention to how macro-political structures influence the localised contextual determinants of health, including the impacts of labour markets and broader welfare support systems (Bambra, 2016; Lynch, 2020; Pickett and Dorling, 2010; Rustin, 2018). Several research contributors have argued that to reduce the incidence of multiple health conditions, public policies must address broader issues of social justice, connectivity and empowerment (Marmot, 2015; Singer et al., 2019; Wilkinson and Pickett, 2009). Indeed, as Smith and Weinstock (2019) maintain, efforts at improving health inequalities without addressing broader social justice issues are likely to fail or be seriously undermined.

This need is reflected by Coventry et al.’s (2014) qualitative research with patients experiencing multiple health conditions and living in areas that were variously measured as most deprived and least deprived on the IMD. Coventry et al. (2014) found that poor access to economic and social resources was a significant barrier to self-management of conditions. Poor access to capital undermined patients’ capacity and motivation to adopt a lifestyle conducive towards long-term well-being. Indeed, among the least well-resourced patients living in deprived areas, there existed a resigned belief that living with health conditions was expected, and this curtailed motivation to maintain lifestyles more conducive to health (Coventry et al., 2014).

Place, social stress and predisposition towards illness

Seaside towns, like other depressed areas of the UK, can attract unwanted and undeserved labels. Journalistic portrayals of economically disadvantaged neighbourhoods with residents struggling with various forms of social deprivation often accentuate negative aspects of a given place (Halliday et al., 2020; Walton, 2000). Residents in declining seaside towns are also affected by the negative stereotyping of where they live, attacking their sense of identity and connectedness to the locale they might be rooted within (Wenham, 2020). Stigma arising from negative social judgements can become individually internalised, shaping the perception of a person’s world and influencing behaviour (Halliday et al., 2020, 2021;

Wilkinson and Pickett, 2018). Furthermore, the stigma attached to a locality can erode the community bonds essential to emotional well-being (Wacquant, 2007).

Such places affected by these dynamics are symbolically devalued and subject to what Wacquant (2007) termed as a "territorial stigma", which contributes towards the disintegration of community relations, the erosion of trust and social connectivity between people, reinforcing the felt social stress within neighbourhoods. Many seaside towns and other bounded spatially maligned neighbourhoods are subject to demeaning public media discourses that construct their identity (Kearns et al., 2013), with pejorative newspaper headlines denigrating inhabitants of struggling towns being all too frequent (Walton, 2000). Within many towns, there exists a self-reinforcing declinist narrative that solidifies a maligned image of redundancy and decay, which, in turn, impacts the capacity of the town to attract the necessary capital needed for regeneration required to provide the opportunities for residents to flourish and self-actualise (Farr, 2017; Gale, 2005; Telford, 2022). However, this negativity is further perpetuated within public discourse, in newspaper reports and grey literature documenting the plight of seaside towns using prejudicial rhetorical language to describe dynamics affecting these towns (Kearns et al., 2013; Whitley and Prince, 2005). This tendency is exemplified by Burgart et al.'s (2013:7) think tank report, which describes the tendency of people with vulnerabilities, such as addictions and mental health difficulties, to be moved by authorities to seaside towns and, thereby, turning those areas into "veritable dumping grounds". Indeed, a House of Lords report (2019:6) describes seaside towns as a "national embarrassment", amongst many other sources of negative framings.

An autobiographical reflection of neighbourhood poverty is provided by McGarvey's (2017) *Poverty Safari,* which describes his experience of living in a Scottish community scarred by extreme deprivation and poverty. McGarvey (2017:194) illustrates how stress caused by the neighbourhood environment is an integral feature of poverty, describing it as "the connective tissue" between localised disorder, including violence and long-term health conditions (McGarvey, 2017:194). The author describes how the threat of violence fosters a pervasive sense of hypervigilance, which, if felt daily, leaves people living with perpetual feelings of stress and anxiety (McGarvey, 2017). Exposure to common daily threats, such as

those described by McGarvey (2017), has been observed to stimulate a biochemical response that, after prolonged exposure, reduces the body's capacity to resist infection and potential illness (Ross and Mirowsky, 2001). Neighbourhoods blighted by general disorder, such as antisocial behaviour, neglect, vandalism, and street drinking, contribute towards the development of morbidity by provoking stress in the residents that live amongst these conditions (Ross and Mirowsky, 2001). Meanwhile, Stansfield and Bell (2019) describe how low social status fosters social anxiety through comparison with others, evidencing an association between higher levels of the stress hormone cortisol and lower socioeconomic status. People living in spaces widely disparaged for deprivation and othered are, arguably, more likely to be exposed to these physiological conditions, which have real effects on the body that might elevate risks of accumulating long-term health conditions.

Seaside towns and the narrative of decline and redundancy

It is important to distinguish between seaside towns and coastal towns. Seaside towns have specific infrastructure resulting from their tourism history (Leonard, 2016; Ward, 2015), whereas many coastal towns have combinations of post-industrial and touristic features or some purely post-industrial characteristics. The literature often references coastal towns, conflating towns developed through tourism and settlements developed through non-touristic industries. While some larger towns and cities combine industry and tourism, smaller seaside towns depend on tourism and a comparative absence of other industries. The seasonality of resort life, its touristic legacy and its decline are prominent features in those communities (Agarwal et al., 2018).

The decline of the seaside holiday resort is documented as starting in the 1960s through a combination of factors relating to the increased accessibility of foreign holidays, increased domestic choices of leisure activities, railway closures and cultural changes (Farr, 2017; Gale, 2005; Houghton, 2023; Kennell, 2011). Significantly, many seaside towns struggled to compete with the increased accessibility of foreign holidays, and many once bustling popular resort towns caused these towns an existential threat (Rickey and Houghton, 2009). Diminishing tourism over several decades and the absence of replacement industries have impacted many residents' well-being. The decline of tourism has resulted in some

seaside towns becoming bereft of purpose, leaving residents struggling to find new opportunities and identities (Reid and Westergaard, 2015).

Walton (2000) argues that seaside towns should be considered similar to industrial towns; their industry, however, rather than producing a physical product, is satisfying the needs of holidaymakers and visitors. Therefore, the built environment of many seaside towns, especially mono-sectoral towns that, like Skelsend and many small seaside towns, have developed through tourism (Beatty et al., 2011), have been left to wither, with spaces and people becoming increasingly redundant (Kennell, 2011; Ward, 2015). This decline is a similar experience shared with other towns dominated by traditional industries, such as coal and steel production (Telford, 2022; Walton, 2000). The process of de-industrialisation, arguably, runs parallel to the cultural and economic transitions fundamentally challenging the existential foundations of many seaside towns, and significantly smaller towns more dependent upon the proceeds from tourism (Lloyd and Blakemore, 2021; Telford, 2022; Walkerdine and Jimenez, 2012).

Consequently, because of an over-reliance on a fading industry, small seaside towns, in comparison with other small towns, both inland and coastal, have proportionately more of their residents living in areas measured as being deprived by the IMD in the domains of employment, income and health (Whitty, 2021). A report undertaken by the Social Market Foundation highlighted that seaside towns harbour pockets of growing deep social deprivation (Corfe, 2017). Moreover, smaller seaside towns tend to be more remote and inadequately connected to more significant economic hubs (Corfe, 2017; House of Lords, 2019) and, crucially, disconnected from a continuous labour market because of their geographical isolation (Lloyd and Blakemore, 2021). A reliance upon depleted seaside tourism, low levels of business investment and poor connectivity can restrict opportunities for many residents, especially younger adults (McDowell et al., 2020; Ward, 2015).

The social and economic foundation of the physical space of many seaside towns has progressively faded through the era of post-modernity and flexible accumulation (Agarwal, 2005; Gale, 2005), which has wrought significant changes in cultural attitudes concerning the consumption of leisure activities (Agarwal, 2005; Gale, 2005). Harvey (1989), in his book, *The Condition of Post Modernity*, discusses how,

in the then unfolding era of flexible accumulation, often referred to as post-Fordism, time and space become more intensively compressed, influencing cultural dispositions, and disrupting consumption patterns. The resulting dispositional change of attitudes towards leisure consumption was not favourable to traditional seaside destinations and the organisation of resort life (Agarwal, 2005; Farr, 2017; Gale, 2005). Agarwal (2002) advises that the decline of seaside towns started earlier than this cultural shift brought on by post-modernity, which, although a contributory factor, should not be used exclusively to explain the decline of many of England's seaside towns, the causes being a complex web of economic and social phenomena.

Many seaside town spaces accommodating resort infrastructure and activity have been replaced by infrastructure designed to meet the needs of the retired, changing the 'ecology' of the town (Leonard, 2016; Walton and Browne, 2010). Over time, other seaside infrastructure, such as hotels and bed and breakfast accommodation, has progressively converted into care homes, residential flats, and houses of multiple occupancy (HMOs) (Agarwal, 2002; Smith, 2012; Ward, 2015), reflecting this transition in the use of social space. Small seaside towns, like Skelsend, are especially noted for having low levels of social housing but high levels of private rental accommodation (Beatty et al., 2011). Instead of hosting holidaymakers, they are more likely to host people with vulnerabilities attracted to seaside towns by the affordable rents offered in the repurposed accommodation (Beatty and Fothergill, 2004; Smith, 2012; Ward, 2015). Smith (2012) concurs, describing how inexpensive, poor-quality housing, particularly HMOs and flats, funnel people living with vulnerabilities into seaside towns, intensifying disadvantage within a specific location.

The poor maintenance of housing stock, repurposed and appropriated by landlords, who are often absent, coheres together, resulting in visual signs of neglect and decline (Burgart et al., 2013; House of Lords, 2019; Smith, 2012; Ward, 2015). These residents' needs, especially those of the vulnerable residents who move into the town, are often unmet. Indeed, they also become further disconnected from services and potential employment and training opportunities due to the disconnection from more significant urbanised economic hubs with a greater capacity to generate opportunities (Houghton, 2023; Ward, 2015). Moreover,

sedentary residents worry about the increased demand for services. Houghton (2023), for example, remarks on how tensions develop between so-called locals and, often, quite vulnerable incomers caused by increased demand for stretched public services. Beatty et al. (2008) reported that many people moving into seaside towns had low incomes, and their lack of spending power further contributed to localised economic malaise. This tendency has become a long-standing trend. Subsequently, a House of Lords report (2019) highlighted that the prevalence of HMOs creates transience in seaside residential areas, bringing little economic benefit but intensifying demand for local public resources.

Spatial amputation: the loss of collective modes of transport

Many small seaside towns lost their rail link in the 1960s following the Beeching Report in 1963, which accelerated the scale of contraction of Britain's rail network, predominantly impacting small rural towns and villages, including peripheral seaside towns like Skelsend (Loft, 2013). Subsequently, many seaside towns, including Skelsend, witnessed a fall in visitor numbers, and the decision to prioritise road infrastructure above rail left places like Skelsend disconnected from their hinterland (House of Lords, 2019; Loft, 2013). Between 1950 and 1980, 42% of lines were closed along with 60% of stations across Britain (Gibbons, 2018), with one-third of the population of the UK losing its rail service (Barrett, 2022). Preference for the convenience of the car above the train was indicative of a trend towards encouraging individual mobility instead of collectively shared means of transport (Crisp, 2023). Gibbons et al. (2018) argue that these rail closures changed the spatial structure of these towns and, in doing so, restricted opportunities. Following the removal of the lines, there was a drain of skilled workers and younger adults from affected areas (Gibbons et al., 2018).

Reflecting a long-established trend away from public communal transport in favour of individualism and extended choice provided by the car, bus services were subject to deregulation in 1986. Over time, according to Allen (2020), small rural towns became increasingly isolated and disadvantaged by deregulation, with fewer services made available. Bus services to the peripheries of England have faced increased pressure during the era of public austerity, with local authorities reducing services by 43% between 2009 and 2019 (Allen, 2020). According to Houghton (2023), bus services

poorly connect smaller seaside towns with other towns and cities, increasing economic disadvantage and leaving residents isolated. Between 2016 and 2020, rural areas in England and Wales lost 480 bus services (May et al., 2020a).

Meanwhile, bus fares rose dramatically by 62% between 2012 and 2022 (Barrett, 2022), reducing accessibility for people struggling with low incomes. The increased transport costs have been accompanied by a growing trend for public amenities, for instance banking, GP surgeries, post offices, and job centres, to become centralised within more prominent urban locations, reducing access in rural locations (Shucksmith, 2023). Furthermore, steep local authority spending cuts during the austerity period have caused a further reduction in services that can be locally provided, thereby obliging residents of rural towns and villages, including Skelsend, to travel further afield to access services and amenities. According to May et al. (2020a), transportation accessibility and affordability exemplify how residents of rural areas are subject to paying a “rural premium” to access necessities for well-being.

However, seaside towns, like Skelsend, are measured as significantly deprived and are least able to overcome the barriers of poor transport accessibility and connectivity. According to Frost (2024), residents in poorer areas and on low incomes are likely to be poorly serviced. Poor areas with higher concentrations of economically inactive residents have higher ratios of non-car users, a characteristic of left-behind places (Barrett, 2022). The combination of expensive fares, fewer bus services, and amenities consolidated away from rural areas and peripheral small seaside towns has real negative consequences for residents’ well-being should they lack reliable access to a car. For example, demonstrating the possible impact on health, getting to a GP appointment from a small rural town was calculated by Allen (2020), on average, to take 54% longer than in larger towns.

Coastal and rural seaside health

Like Skelsend, smaller seaside towns are often considered rural locations, especially those surrounded by an expansively green hinterland. Rural locations provide clean air, which, Milojevic et al. (2017) contend, can assuage some of the socioeconomic disadvantages experienced by residents. However, although natural blue and green spaces surround them, small seaside towns poorly connected to larger economies and conurbations face multiple disadvantages (Beatty et al., 2011; Whitty, 2021).

The environment, which, on the one hand, is a source of pleasure, can also place residents at a disadvantage.

Reflecting on the relationship between the local economy and local health (Marmot et al., 2020; Whitty, 2021), it is perhaps no coincidence that ten of the worst twenty communities for public health in England and Wales are coastal communities (Corfe, 2019). People living in poorer coastal communities spend more time living with health conditions and have shorter life expectancy due to preventative morbidity (Whitty, 2021). Meeting the health needs of residents in these communities by the coast is further impacted by the reported difficulty in recruiting and retaining GPs and other staff to peripheral locations on the coast (House of Lords, 2019; Whitty, 2021). Evidence suggests that coastal areas are badly affected by alcohol and substance misuse. Blackpool endures the highest mortality rate in the UK from alcohol-related deaths, and Scarborough has a mortality rate from drug misuse, which is 2.5 times the national average (House of Lords, 2019). Meanwhile, doctors are prescribing antidepressants in coastal areas in the north and east of England at twice the rate as the rest of the country (House of Lords, 2019). Many rural areas are classified as food deserts, defined by their shortage of affordable healthy food products (May et al., 2020a). Food deserts are often located in areas of social deprivation and frequently host obesogenic environments, awash with the availability of nutritionally poor calorie-dense food (Dimbleby, 2023).

The health disadvantage of people living in seaside towns is occluded by their wealthier hinterland (Haynes and Gale, 2000; Whitty, 2021). Burke and Jones (2019) contend that the socioeconomic disadvantages many people face in rural areas are overlooked by the influential IMD, which fail to recognise impediments to well-being caused by location. Most of the data about community health is based on statistics gathered at the local authority level or areas covered by the now-defunct Clinical Commissioning Groups (Whitty, 2021). This lack of granularity can result in resource allocation decisions failing to regard localised neighbourhood needs. The House of Lords (2019) report on seaside towns concluded that the Carr-Hill funding formula failed to reflect the complexities caused by the predisposition towards the earlier onset of multiple health conditions that prevail in coastal communities.

Seaside restitution and blue space

Despite the evident disadvantages of living by the coast, which can adversely influence health and well-being, the coast has long been regarded as providing an environment where people can find restitution (Hassan, 2003). Originally the preserve of the middle classes, seaside towns became a temporary haven for the working classes during the later Victorian and modernist eras, a location to escape the polluted and noisy environments of industrial workplaces and cities (Hassan, 2003). From the 1960s, holidays in seaside towns to escape the oppressive urbanicity increasingly gave way to retirees relocating to resort towns permanently to live in the fresh air, rather than spend retirement in the congested and polluted city (Walton, 2000). The collective sense of sentimental nostalgia concerning the seaside and the desire to connect with an ostensibly less complicated past permeates the public imagination (Jarret and Gammon, 2016; Peirson, 2023).

Spending time in natural environments, pleasant green spaces, water courses or the coast is beneficial for one's well-being and reduces feelings of stress and anxiety (Pool et al., 2023; White et al., 2013a). Research literature highlights the health benefits of having access to blue spaces, such as the sea; in particular, spending time in blue spaces has been found to have a positive impact on mental well-being (McCartan et al., 2023; Vert et al., 2020) and encourages increased levels of physical activity (Pasanen et al., 2019; Thompson and Wilkie, 2021; White et al., 2016, 2017). Bell et al.'s (2015) research through 'go-along interviews' by the coast found participants describing their time as therapeutic, a sensory and immersive experience, providing space and opportunity to develop connections with others sharing and mutually appreciating the blue space. Garret et al. (2019), in their research on English urban coastal areas, concluded that living on the coast is better for one's mental health and could reduce mental health inequality. Similarly, Wheeler et al. (2012) provide evidence demonstrating that the health benefits of coastal proximity are more pronounced in areas of deprivation. As with Milojevic et al.'s (2017) findings on fresh air in rural locations, Wheeler et al. (2012) demonstrate how natural environments can offset the disadvantage caused by being comparatively remote.

Work, chronic illness and the occupational gradient of health

One's relationship with work and how we obtain the economic capital necessary to reproduce sustenance and maintain well-being is an intrinsic feature of the contextual jigsaw within biographical narratives. As Marmot (2004:127) reminds us, "work casts a long shadow" over our lives and is particularly influential with regards to personal health and well-being. Work and how residents secure their means of maintenance in the context of their health and place of residence is most pertinent to this study, given its working-age focus.

Siegrist and Marmot (2004) found an occupational gradient for all-cause mortality: that lack of autonomy and control is a mediating factor (Theorell et al., 2015). The further down the occupational status hierarchy, the greater the risk of morbidity and premature mortality (Marmot, 2004). Theorell et al. (2016) and Bambra (2016) conclude that people from poorer backgrounds are more likely to work in conditions considered more physically and psychologically detrimental to health than their wealthier contemporaries. Marmot (2015) contends that scarce personal resources to exercise control and influence over one's life is a consequence of how one's subjective environment can determine health and well-being. This lack of control is related to a social gradient, whereby the lower down one is in the social hierarchy, the less control one can exercise over maintaining one's health; this is also reflected in the workplace (Marmot, 2004, 2015). A meta-analysis study of workplace environments in Western nations found that the combination of low decision latitude and high-intensity working conditions increased the risk of developing depression (Theorell et al., 2015). Workers further down the occupational gradient are more likely to be exposed to this scenario (Marmot et al., 2006). In contrast, whilst executives and senior managers are required to cope with intensive work, they are afforded some protection by having greater autonomy over their working practices (Marmot, 2004).

Workers living with health conditions face barriers to career advancement that might provide more autonomy and control due to the health-related impediments they need to overcome. Research from the Work Foundation found that disabled workers are less likely to hold managerial positions, but more likely to work shifts and undertake routine manual work (Steadman et al., 2016). Accordingly, this predisposes workers

with health conditions to have less power in the workplace and limited autonomy and control over their work. According to Vickers (2001), the paucity of workplace adjustments to accommodate people living with health conditions arises from a failure to recognise that illness is an inescapable reality of life and will often affect employees with sometimes unpredictable fluctuating presentations. Instead, illness is regarded more generally as an abnormality, and organisations must protect themselves rather than accommodate illness at work, reflecting the everyday reality of life (Vickers, 2001). As Coyle and Atkinson (2008) maintain, the workplace assumes a standardised expectation of quality and productivity regardless of a worker's varied capacity to meet those standards consistently. Consequently, workers living with multiple health conditions experience reoccurring anxiety about their ability to meet expectations and be able to contribute to and fit into their team (Coyle and Atkinson, 2018).

The Joseph Rowntree Foundation has concluded that disabled workers, including those with multiple health conditions, are disproportionately affected by low pay and underemployment (Joseph Rowntree Foundation, 2020). More generally, disabled workers are paid inferior rates of pay in comparison to their non-disabled colleagues holding the equivalent qualifications (Joseph Rowntree Foundation, 2020). Evidence also exists that employers can be reluctant to employ people with restricted functionality caused by health conditions or long-term disability (Harwood, 2015; Remnant, 2018). Procedures and policies seem to focus more on short-term acute illness, based on the presumption that people returning to work can perform as well as before (Remnant, 2018). Research has demonstrated that despite organisations claiming to uphold both the requirements of The Equality Act (2010), employers often hold negative views about employees who have disabilities (Remnant, 2018). The workplace does not always provide a conducive or supportive environment for people with multiple illnesses (Vickers, 2001).

Coyle and Atkinson (2018) argue that many employers remain disinclined to undertake reasonable adjustments to accommodate people with multiple health conditions. Harwood (2015) found that austerity during the coalition's office period had resulted in less accommodation for workers with disabilities and fewer development opportunities. Evidence provided by Harwood (2015) suggests that

increasing numbers of workers with disabilities found that their labour became more intensive during the early part of the decade. Further, disciplinary procedures have become more austere and less understanding of mitigating circumstances emanating from disability or illness (Harwood, 2015).

Indeed, people living with what Coyle and Atkinson (2018:56) call “body variability” have challenges about how they survive within a working environment. According to Coyle and Atkinson (2018), the need to sustain financial self-sufficiency in the face of such challenges can provoke a sense of hopelessness (Coyle and Atkinson, 2018). The workplace and the benefits system seem to lack the flexibility to accommodate people exhibiting such nonlinear disease trajectories. Compounding this difficulty further are the unseen chronic illnesses that people live with, while colleagues and managers fail to appreciate how the difficulties that fluctuating illnesses impact functionality (Vickers, 2001).

Qualitative research by Harwood (2015) on the impact of the coalition government’s austerity measures upon disabled workers found that disabled workers were required to take up a form of self-employment due to low benefit levels and the threat of sanctioning from the DWP (Harwood, 2015). Perhaps self-employment allows people with conditions that might restrict working life, physically or mentally, to afford greater flexibility to sustain their working activity. Notably, men working with disabilities are more likely to be self-employed, with 20.6% working on this basis compared to 17.6% of non-disabled men (ONS, 2020). However, there is no discernible difference among women regarding any disparity towards the likelihood of self-employment (ONS, 2020). Participants in Harwood’s (2015) study lamented that they had to engage in poorly protected casual labour rather than being self-employed. The precarious conditions of self-employment often resulted in worsening health.

Work by the sea

Evidence suggests that many of the UK’s coastal communities have experienced a significant economic decline that has influenced the type and quality of work available (Corfe, 2019). For instance, a community that has lost its traditional industries and is poorly connected will likely host a labour market that provides poorly paid and insecure work opportunities for its residents (Crisp et al., 2009).

Poorly paid work is not uncommon in coastal communities; half of the tenth lowest-paid localities in England are on the coast (Corfe, 2019). Rural areas also tend to host a profusion of low-paid work (Vera-Toscano, 2020). Insecure transient work, connected to tourism, is a prominent characteristic of many resort seaside towns, especially those mono-sectoral towns more reliant on the seasonality of tourism (Estate Gazette, 2020; Houghton, 2023; House of Lords, 2019; Simpson et al., 2021; Ward, 2015). This development is mainly due to the legacy of the touristic development of the local economy; the integral insecurity contributes massively to localised poverty and deprivation (Agarwal et al., 2018).

The constant ebb and flow of economic life based upon the seasonal tourist trade has meant that insecurity has always been a factor of life for many people living in seaside towns (Walton, 2000). Resort towns dependent on tourism tend to abound with small independent businesses who trade long, intensive hours over summer when the sun shines to make sufficient money to carry them through the following winter (Walton, 2000). Two major factors driving the spatial redundancy affecting seaside towns is the long-term decline of the resort, typical of many small mono-sectoral seaside towns dependent upon tourism, and its dysconnectivity from its hinterland, disconnecting the town from the extended labour market beyond the bounds of the town itself (Beatty et al., 2011; Corfe, 2019; Lloyd and Blakemore, 2021). For people working whilst living with multiple illnesses or looking for work, their employment opportunities are shaped by these economic, spatial, and social characteristics.

People gaining qualifications in disconnected seaside towns are more likely to move away from the area (House of Lords, 2019), resulting locally in what Green (2016:149) describes as a “low skills equilibrium” typical of poorly connected rural locations. The paucity of career opportunities in many seaside towns results in the flight of younger adults, exacerbating already existing demographic concerns (Rhodes, 2019). There have been several qualitative studies that detail the experience of male manual workers and underemployed young adults in seaside towns that describe the foreclosed futures, thwarted ambitions, employment insecurity, feelings of being trapped and lack of opportunity structures typical of resort towns (McDowell et al., 2020; Reid and Westergaard, 2017; Simpson et al.,

2021, 2022). The adverse psychological effects on workers subjected to labour market conditions, described by Simpson et al. (2021) as “place precarity”, tend to result in a pessimistic outlook and feelings of resignation. Adults with multiple health conditions must seek work to secure the sufficient economic capital necessary to maintain well-being within these seaside labour markets.

The work of non-work

Throughout the research literature regarding the DWP operations and how this institution’s policies and procedures impact people, a particular language is assumed, which I have endeavoured, where possible, to avoid. For instance, references to claimants and benefits have become oppressively value-loaded and connected with rhetorical devices that predominate throughout public discourse that denigrate people seeking help from a system which, in most cases, they have contributed towards before illness, which has necessitated the need for financial assistance (Thiel, 2022). Therefore, during this study, I used the more neutral phrase service user, which is more commonly used in adult social care services, rather than benefit claimant or recipient.

Research literature comprehensively details how securing financial support from the DWP has progressively become trickier following decades of welfare reforms aimed at reducing levels of dependency and encouraging social inclusion through work (Gamble, 2016; Garthwaite, 2016; Ryan, 2019; Saffer et al., 2018). Indeed, Patrick (2017) contends that overcoming the obstacles that require negotiating to access and maintain necessary support becomes a form of work. I refer to this as the work of non-work, the work required to secure access to the necessary funds to maintain oneself. Access difficulties, delays in processing, forms that are long and confusing, perpetual assessments, and regimes of conditionality all feature as being detrimental to well-being within the literature, but not particularly successful in achieving a moral imperative of successive governments in integrating people living with long-term health conditions into the labour market (Garthwaite, 2014a; Geiger, 2018a; Patrick, 2017; Wright et al., 2020). Indeed, Dwyer et al.’s (2023) appraisal of research over the last decades concludes that the imposition of an austere welfare regime, far from supporting people, can cause extreme hardship, further disengagement from work and exacerbating symptoms. Patrick (2017) argues that the labour involved in

securing the support required to maintain a semblance of material well-being can be a stressful job. In more extreme cases, DWP work placement schemes for those deemed fit to work have mandated unpaid physical labour under the threat of sanction, causing an exacerbation of health conditions (Burnett and Whyte, 2017).

Social security and perpetual assessment

In essence, reforms during the Conservative-Liberal Democrat coalition government (2010-2015) meant that people with chronic debilitating and possibly degenerative conditions must undergo a continuous assessment to receive state support (Price et al., 2019). For instance, the Work Capability Assessment (WCA) criteria have undergone several changes contributing towards the inappropriate and inaccurate assessment of claimants, resulting in prolonged appeals that have caused considerable stress amongst claimants, increasing their vulnerability (Garthwaite et al., 2014; Geiger, 2018b; Hansford et al., 2019). Garthwaite et al. (2014) describe how the assessment criteria have become stricter, detailing how service users are assessed as fit to work at subsequent assessments despite no possible improvements in their health status.

Considerable anxiety detrimental to health is caused by inconsistent and unreliable assessment, the demands of conditionality and surveillance. Taken together, these conditions of ostensible support create a hostile environment in which service users, out of necessity, people living with illness, are required to engage (Fletcher and Wright, 2018; Pring, 2017; Ryan, 2019). This inconsistent application of administering assessments is demonstrative of how people with illnesses are moved arbitrarily from being considered as deserving to non-deserving claimants (Price et al., 2019), and how little control people have over a process critical to their well-being (Saffer et al., 2018). The inconsistencies and failures of administering WCAs to rationalise and police disability benefits have resulted in cases of desperation and even suicide (Geiger, 2018a).

The benefits system fails to appreciate people’s needs arising from multiple and fluctuating health conditions (Coyle and Atkinson, 2018; Price et al., 2019). It fails to consider the effects of interacting with multiple illnesses and bases assessments upon the singular most severe illness (Grieger, 2018). The unpredictable symptoms caused by an interaction of health conditions become overlooked because of a

single focus on one illness. This failure to consider conditions holistically may make people with multiple health conditions particularly vulnerable. Those who may exhibit fluctuations in functionality or unseen conditions like mental health are at a greater risk of being wrongly assessed, and how their condition may affect service users is frequently misunderstood (Grieger, 2018a; Wright et al., 2022).

Conditionality

Demonstrating personal responsibility necessitated by a policy of increased conditionality in return for financial support was a fundamental principle of the New Labour government's welfare reform agenda (Barker and Lamble, 2009; Driver, 2013; Macleavy, 2011). However, the subsequent coalition government reforms of 2010-2015 were emboldened by the financial crash of 2008, which Gamble (2016) argues created the political space to invoke the moral economy of the New Right, a discourse which lent ideological support for an intensification of welfare reform and, more specifically, conditionality (O'Hara, 2020; Wright et al., 2020).

The sanctioning regime has created a culture of fear for many people with long-term health conditions, resulting in worsening mental health of many people living with long-term conditions (Wright and Patrick, 2019). Sanctioning disproportionately falls on people with disabilities and long-term health conditions (Geiger, 2018a) and is often especially harsh on people with mental health conditions who are disproportionately impacted (Garthwaite, 2016). Should a service user be assigned to a work-related activity group during the WCA, they must undertake evidence that they are looking for work at least 35 hours a week and have applied for several jobs. Failure to meet this requirement results in a financial penalty at the discretion of their advisor (Garthwaite, 2016). The enforcement of the penalty is based on the work coach's interpretation and can be arbitrary (Dwyer et al., 2020).

May et al.'s (2020a) research on food banking and the impact of austerity in rural England found that sanctioning was disproportionately more evident in rural areas. However, this should not be surprising; many job centres closed in rural areas and small towns during the harsh period of public austerity, and their functions were absorbed into the larger job centres in more urbanised locations (May et al., 2020). For many service users, including people with illnesses living in small seaside towns,

inadequate public transport could threaten their ability to get to job centres for appointments and, therefore, be more vulnerable to the sanctioning regime.

Meanwhile, service users are under surveillance and must demonstrate that they are seeking work by being active online and logging on to the system (Wright et al., 2020). The threat of sanctioning compels service users to apply for jobs they are unsuitable to undertake, and, for many, it is a mandatory, futile, and demoralising process, impacting well-being adversely (Garthwaite, 2016; Wright and Patrick, 2019). Dwyer et al. (2023) contend that the evidence demonstrating that sanctioning encourages people to look for work is weak. Indeed, rather than the policy having a firm evidence base, benefit sanctioning seems to be propelled by short-term political expediency and ideological preference (Dwyer et al., 2023). Wright and Patrick's (2019) longitudinal study concluded that conditionality and sanctions resulted in financial distress and made entry into paid work even less likely.

Stigma and blame

Representations of people with long-term conditions and disabilities have become subject to a binary construction which polarises service users between deserving and non-deserving (Garthwaite et al., 2011; Larsen et al., 2013; Price et al., 2019). Media discourse commonly employs phrases such as workshy or scrounger to demean service users and make them feel like cheats (Garthwaite et al., 2011; Price et al., 2019). This pejorative language has contributed towards developing a narrative, which Briant et al. (2013) contend, drawing on Cohen's (2002) work on "moral panic", has socially constructed service users as "folk devils". This environment has intensified the stigma felt by people unable to sustain employment consistently (Newton et al., 2013; Saffer et al., 2018). Thiel's (2022) qualitative study interviewing people who receive state support, to explore their moral economy, found resentment from participants about how they had been negatively framed and stigmatised by public discourse. Instead of being acknowledged for their prior contributions to the system through previous paid work or informal caring roles, they felt their citizenship and their rights had been traduced, and they were unfairly regarded as cheats, no matter what their illness or disability (Thiel, 2022).

The moralising tendency within public debate has been accompanied by the government's approach to work and welfare, which asserts that illness should not

prevent people from working (Ryan, 2019). Moreover, people living with invisible conditions are significantly affected by this climate because they are more susceptible to negative judgement and scepticism about their conditions (Saffer et al., 2018). This felt stigma has resulted in people becoming isolated as they avoid neighbours and friends, fearing negative judgements (Newton et al., 2013). This prejudicial stigma is often felt more keenly by people who have unseen conditions and often become subject to public disapproval based on a lack of understanding regarding the fluctuating nature of health conditions such as those which impact mental health (Saffer et al., 2018). Shucksmith (2023) and May et al. (2020) contend that this is especially apparent in rural areas, where anonymity is impossible in a small location where everyone knows everyone else.

Summary

By its very nature, the literature review of social structures impacting the lives of working-age residents of small rural seaside towns needs to have selected boundaries given the myriad of intersecting relevant structures. Therefore, I commenced this review to survey some of the most prominent areas that might prove critical to fieldwork. The social structures of seaside towns across micro, meso, and macro domains of reality can enhance health and present detrimental barriers, preventing people from optimising their capacity for well-being in the context of living with multiple illnesses. Meanwhile, external structural factors operating through institutions like the DWP further challenge people with multiple health conditions. The punitive premises based on ideological assumptions inform a regime of conditionality and perpetual assessment that manifests as a barrier towards optimising well-being in the context of living with multiple illnesses.

Chapter 3 Methodology Chapter and Analytical Framework

The primary research question of this ethnography is to elicit the prominent social structures that operate within Skelsend to shape the lived experience of working-age residents with multimorbidity and how those structures may influence the experience of illness. Therefore, it would be advantageous to ontologically define what social structure means in the context of this ethnography. In doing so, I shall elaborate upon key features of critical realist methodology and ontological definition of social structure and causative mechanisms that work through social structures to manifest as emergence (Elder-Vass, 2010). Emergence in this ethnography is the social phenomena experienced by residents of Skelsend living with multimorbidity and the manifest social events that impact their lives.

Although, the methodology I have used has been primarily guided by critical realism. I have afforded space, where appropriate, to complement the critical realist-led evaluation of fieldwork data with an adaptive, reflexively stratified version of Bourdieu's habitus (Elder-Vass, 2010; Decoteau, 2016; Öğütle, 2013). The purpose of this amalgamation, as will be explained, is to provide a framework of analysis that acts, as Bhaskar (1989:24) writes, as an “underlabourer” to construct plausible, albeit fallible, explanatory power regarding the social phenomena observed and depicted in this ethnographic account.

Critical realism and natural necessity

Critical realism is founded upon the ontological presuppositions of natural necessity (Bhaskar, 1989, 1993). The principal progenitor of critical realism initially referred to as transcendental realism, Roy Bhaskar (1975), bases natural necessity within critical realism on what he described as the holy trinity of critical realism: ontological realism, epistemological relativism, and judgemental rationalism (Bhaskar, 2016). Firstly, ontological realism assumes that a reality exists independent of human experience. Secondly, epistemological relativism considers knowledge as socially produced, fallible and subject to change. Thirdly, judgemental rationalism, also known as retroduction, posits that although knowledge is fallible, it is possible to generate a set of explanations about the world that is more plausible than others (Bhaskar, 2016). A further essential principle central to critical realism’s philosophical foundations is avoiding the epistemic fallacy, reducing reality, being, to our

knowledge of reality or being (Bhaskar, 1975, 1986). The epistemic fallacy is avoided by the theoretical application of depth ontology that perceives reality as stratified, with a deep layer containing unseen mechanisms that cause events and influence human experience. Within critical realism's depth ontology as applied to social life, it perceives three fundamental domains of reality: the empirical, the actual and the real (Bhaskar, 1975; Collier, 1994). The depth ontology of natural necessity provides the basis of a meta-theory, which overcomes the paradigmatic binaries of positivism and constructionism whilst avoiding the *epistemic fallacy*, reducing being to our knowledge of knowledge of being (Alderson, 2021; Bhaskar, 1989; Price and Martin, 2018).

Fletcher's (2017) use of the iceberg metaphor provides an accessible, helpful depiction of the three domains of reality fundamental to critical realist depth ontology, delineating the domains of the empirical, actual and the real. The visible tip of the iceberg is the domain of the empirical. Applied to the findings, this domain hosts, for example, the spoken narratives of residents, social media data, survey data and the observations recorded in field notes. Just below the water's surface is the domain of the actual, hosting the events that may or may not be observed. Although many of these events may not be witnessed and are sometimes transcendental, they are manifestations of contingent casual social structures. Finally, deep below the water's surface is the domain of the real. In this domain, the underlying mechanisms, contingent upon the relationships within social relations and between social relations, have causative powers that, when realised, manifest as social phenomena in the domains of the empirical and actual (Fletcher, 2017).

The applicability of this model to social research is explained by Alderson (2021:50-51) by offering the example of qualitative research into type 2 diabetes. The condition, diabetes, and its effects on human bodies and psychological well-being, are observed empirically through patient interviews. This is the domain of the empirical. The prevalence of diabetes, interpreted as a series of events, is evidenced by reports quantifying how many people live with the condition. This is the domain of the actual, in which occurring events may or may not be observed (Alderson, 2021). However, critical realism is interested in identifying the causes of the phenomena in the empirical and actual domains. Therefore, the deep domain of the real is of

fundamental interest because it is where unseen causal mechanisms are situated that produce the effects, observed or not, in higher domains of the empirical and real. Causative mechanisms are known by their manifest effects. In Alderson's example, she offers gender, income, class, and ethnicity as potential causative mechanisms (Alderson, 2021).

Therefore, critical realism provides a methodology explaining how structural disadvantages predispose people to illness. As Karadzhov (2019) elucidates when referring to mental health recovery, critical realism can explain how the social context, including structural inequalities, resonates in people's lives and can impede their attempts to restore and maintain well-being. As mentioned in the literature review, Marmot (2015:52) refers to the need to locate the "causes of causes"; critical realist methodology can help to fulfil this need. For instance, people who are identified as having chronic obstructive pulmonary disease (COPD) may smoke. Smoking is known as a cause of COPD. Critical realist methodology can be used to unearth the causes of smoking by looking at deep structural causes and causative mechanisms that may not be apparent on the surface of reality. In doing so, one asks what mechanisms produced by social relations cause the social determinants that predispose one to smoke.

In critical realist methodology, these underlying causes must be found in the domain of the real (Bhaskar, 1986, 1989, 1993; Collier, 1994), and this is achieved through the process called judgemental rationality, or retroduction (Bhaskar, 2016; Danermark et al., 2019). Alderson (2021) describes judgement rationalism as a process micro-regress, whereby the researcher inquires as to what state of affairs must exist for the social phenomena observed to manifest and identify the most plausible explanation with everything justification explain how the manifest social phenomena emerge into reality in the domains of the actual or empirical (Alderson, 2021; Bhaskar, 2016; Danermark et al., 2019).

Structures and mechanisms

Before describing the analytical framework, I have applied to the study of Skelsend and the lives of working-age adults living with multiple health conditions, it is necessary to define, from a critical realist perspective, structures, parts, or entities, tendential causative mechanisms, and emergence. Firstly, it is necessary to

establish that causative mechanisms, also referred to as generative mechanisms, are the relationships between parts of a structure that produce causal power that causes social phenomena (Danermark et al., 2019; Elder-Vass, 2010). They are non-deterministic tendencies, contextually dependent on relationships between structures and other mechanisms (Bhaskar, 1989, 1993). Henceforth, I describe them as tendential causative mechanisms. Emergence refers to realising tendential mechanisms that may, or may not be, observed. In this study, they are tendential mechanisms that emerge as effects on residents in Skelsend, or the events that involve and influence well-being in the context of both place and multimorbidity.

Structures are social relations, ontologically distinct from events, actions, and human agency (Archer, 1995; Banfield, 2004). A structure is, as Danermark et al. (2019: 42) describe, a "…set of internally related objects*".* Social structures are social relations, the relationships between structures, individually existing as "internally related objects*".* Structures make it possible for causal mechanisms to be exercised. They do so through what Danermark et al. (2019:47) describe as an "efficient cause". In other words, causative mechanisms operate when initiated by and through social structures. Structures are composed of parts, or, as many critical realist adherents refer to them, entities (Rees and Gatenby, 2014). Structures operate across all three levels of reality: the empirical, the actual and the real (Alderson, 2019), whether they might be governmental institutions, corporations, or even the human body. Institutions as structures are not themselves, according to critical realist ontology, a causative mechanism; instead, tendential causative mechanisms are initiated by and work through the social relations comprising structure within institutions (Öğütle, 2013).

In open systems that comprise the social world, there are no constant conjunctions of events in the positivistic Humean tradition (Bhaskar, 1975; Collier, 1994). That is to say, the realisation of causal mechanisms is not a deterministic universal phenomenon, given society is an open, not closed, system of scientific experimentation (Bhaskar, 1975). Critical realism considers society an open system, which should not be studied like scientific experimentation that artificially produces a closed system*.* Deterministic universal laws of social causation cannot be identified given that, in an open system*,* a myriad of interrelated and evolving social relations

exist, and not all interactional activity can be accounted for (Bhaskar, 1989, 1993). Therefore, causative mechanisms are contingent upon whether social relations are present or absent and the relations between them. Critical realism does not seek the constant conjunctions of positivism; instead, it seeks to identify causal mechanisms that are contingently realised as tendencies (Bhaskar, 1986, 1989, 1993; Collier, 1994). Therefore, they are just that, namely tendencies contingent upon the existence and form of – or, in some cases, absence of – sets of social relations (Bhaskar, 1993; Danermark et al., 2019).

Bhaskar (1993) later revised critical realism, dialectical critical realism, and incorporated the notion of absence; that is, the absence of particular social relations that contribute towards experience and social events. For instance, the absence of secure access to economic capital may result in a detriment to well-being and the capacity of people to manage their health conditions. Dialectical critical realism further identifies two fundamental relationships between structures: social relations within structures and people. These are the repressive power relations constraining attempts to acquire and maintain well-being and the emancipatory relations that enable people to realise the objective of well-being (Bhaskar, 1993; Houston, 2023).

Structure and agency interactions and emergence

Critical realism has a further essential objective to avoid reductionist thinking that may result in either neglecting the contribution of social structure to the causation of social phenomena or what Archer (2007:6) describes as “social hydraulics” – that is, explaining social phenomena purely through a prism of social structure. Reductionist thinking can, however, be avoided by considering the reinforcing effectual relationships between structure and agency and by utilising the concept of laminated social stratification, which considers the intersections between social structures at different levels of social being, from macro, meso and micro levels of society (Layder, 1997). Identifying the relationships between structure and agency not only avoids reductionism through volunteerism or structuralism but is also necessary to avoid the mistake of reification; that is, to imbue causal power directly into structures themselves. It is, therefore, necessary to recognise that causal powers within structures are only realised in connection with human agency (Bhaskar, 1989). Before considering Archer’s (1994) morphogenetic approach to the relationship

between structure and agency, we need to establish realist principles relating to the dualism of structure and agency. Firstly, Bhaskar's (1989) Transformational Model of Social Activity (TMSA) provides fundamental insights. Firstly, one should consider society as an 'ever-present condition and a continually reproduced outcome of agency' (Bhaskar, 1989:92). Secondly, the existence of structure precedes agency. Indeed, although conscious beings have agency, it is a conditioned structured agency, a temporal process stretching over generations (Archer, 1995; Bhaskar, 1989). A further principal component of critical realism is the necessity of maintaining analytical and ontological separation between agency and structure as a precondition to identifying underlying causation in the domain of the real (Archer, 1995). This avoidance of what Archer (1995, 2007) refers to as central conflationism has implications for the complementary use of Bourdieu's concept of habitus within a critical realist analytical framework, an area of contention that will be addressed later in this chapter.

For Archer (1995), interactions and relationships that produce emergence occur between actors, parts of structure and parts of culture. The interaction between agents and society and culture produces "positive and negative feedback*"* through society; the former contributing towards change and the latter reinforcing what already exists (Archer, 1995:11). This is the essence of morphogenetic theory, with morphogenesis referring to how human agency transforms, influences, and elaborates social systems or structures, while morphostasis refers to agency which preserves or reproduces systems and structures (Archer, 1995:166). Crucially, the causative tendencies are realised through the temporal social agency of people, or actions taken over time (Archer,1995). Ontological distinction and temporality are intrinsic features of structure-agency interaction, which Archer (1995) calls *analytical dualism*. Over time, a process of double feedback can occur, with the structured agents transforming and reproducing structures of systems, which, in turn, can later have a transformational effect on the same agents initiating the change in the first instance. Archer (1995:74) refers to this as *double morphogenesis:*

> at the end of a transformational sequence, not only is structure transformed, but so is agency as part and parcel of the same process. As it re-shapes structure, agency is ineluctably shaping itself, in terms of

> organisation, combination and articulation, in terms of its powers and those in relation to other agents. (Archer,1995:74)

To illustrate this, Archer (1995) gives the example of the education system, in which, when in the hands of private ownership, many teachers contributed towards efforts at reform and public control. Once this was established, the resulting morphogene*sis* dramatically changed teachers, their identities, and their roles. Double morphogenesis, such as this, occurs over time, temporality being intrinsic for Archer (1995) in establishing an agent's roles within the duality of praxis of social relationships. Acknowledgement of the centrality of temporality to the analysis of the morphogenetic dynamic, argues Archer, is essential to avoid central conflationism; that is, the conflation of agency and structure, which, many critical realists argue, renders analysis impracticable (Archer,1995).

For example, when applied to Skelsend, incoming residents with multiple health issues are not initially embedded in a social network. The new residents identified this concern and aspired to establish a social network. They then actively sought connections with others and joined community groups. Therefore, they interacted with local structures within the spatial social context. Their participation strengthened the community groups they joined, and, in some cases, they initiated new groups. Their actions helped build the social capital of the town by contributing towards developing a more comprehensive network of social groups. This dynamic Archer (1995) refers to as morphogenesis. Meanwhile, the resulting community bonds provide a greater sense of security and belonging amongst residents, improving their social conditions, and increasing their propensity to experience improved mental well-being. Through temporal and spatial interaction, this positive feedback loop between local structures and agency is an example of double morphogenesis.

Within a realist framework of qualitative analysis, it is also necessary to consider reflexivity as a precursor to agency (Elder-Vass, 2007). Margaret Archer (2007) makes an important contribution with her study on reflexivity and internal conversations. Archer (2007) describes how social agents develop nascent concerns and projects to address concerns about their social environments through inner conversations. Archer (2007) describes four types of reflexivity through inner

conversation. The first is communicative reflexives, which require completion and confirmation by other people. Secondly, autonomous reflexives are self-contained in the conversations that result directly in action. Thirdly, meta reflexives, which critique one's internal monologue. Importantly, however, for this study, the fourth reflexive identified by Archer (2007) is fractured reflexives, an internal conversation of alienation and marginalisation, which intensifies distress and results in adopting a disposition towards a pessimistic resignation.

This pessimistic disposition can also apply to health conditions, thereby impairing the capacity of people to manage health conditions over the longer term. Scambler (2013:321) elaborates on Archer's (2007) fractured reflexives, with a concept of vulnerable fracture reflexive, whereby harmful fatalistic dispositional thinking predisposes one towards behaviours harmful to one's health. Scambler (2013) argues that the vulnerable fracture reflexive is caused by daily intensive stress, social alienation, and an absence of purpose and self-worth. I reflect later within the ethnography regarding working-age residents of Skelsend living with multimorbidity, some of whom conveyed pessimistic dispositional tendencies and, consequently, were more inclined to disengage from supportive services.

Returning to the projects that people develop in connection with these reflexives, Archer (2007) considers how, in pursuing projects about their concerns, such as managing one's health condition in response to medical advice in the context of personal circumstance, agents or people encounter social structures with causal powers that can act as an impingement to their projects or an enabler. In this study, I refer to projects of well-being in the context of multimorbidity and living in a disconnected seaside town that has undergone several decades of economic decline, whilst seeking to identify enabling and constraining factors that undermine well-being.

Social stratification and lamination

Bhaskar's (1986; 1993; 2016) Transformational Model of Social Activity (TMSA) and Archer's morphogenetic approach (1995) conceptions closely correspond, structure pre-exists agency, social structures both constrain and enable human agency, structures are shaped, transformed or reproduced by human agency (Archer, 1995; Bhaskar, 2016). The essential reasoning underpinning TMSA is that people do not

choose social structures; but, through their actions, often routine, often without purposeful deliberation, they transform and reproduce structure (Bhaskar, 1986). Bhaskar's TMSA model, however, develops the notion of ontological social stratification within social relations, which has the potential to be active across the four dimensions referred to as the Four-Planar of Social Being:

a) Plane of material transactions with nature.
b) Plane of intersubjective personal relations.
c) Plane of social relations.
d) Plane of the subjectivity of the agent. (Bhaskar, 1993:160)

The Four-Planar of Social Being provides a basis of stratification known as lamination (Bhaskar, 1993). Overlaying social phenomena with a lamination of social scales of being, such as Bhaskar's (1993) Four-Planar of Social Being, can connect the human body to myriad inflectional points across macro and micro aspects of social reality. Further incorporated within critical realist methodology is the concept of laminated scales of social being, introduced by Bhaskar (1993). Other laminated concepts have since been introduced, which afford further specific levels of stratification, not least Bhaskar's seven-scalar lamination model (Bhaskar, 2016; Haigh et al., 2019). The purpose of lamination is to facilitate the analysis of the "conjunctive multiplicity" of structures, including people themselves as individual agents, and to assist in revealing "patterns of dependency and interaction" (Bhaskar, 2010; 8). Social structures, and their social relations, traverse across a framework of social being with subjective, intersubjective, and objective influences.

Similarly, Layder (1997) offered his work, the Theory of Social Domains, to prevent either voluntaristic or structuralist reductionism and facilitate social analysis through a prism of social stratification. Layder's domains traverse the following scales incorporating micro-subjective and intersubjective aspects of social reality and macro-objective aspects of social reality: the social domains of psychobiography, situated activity, social settings, and contextual resources. Layder (1997) asserts that each domain is interwoven and implicated within each other, with no presumption that any domain should have more prescience or explanatory power than another. Houston (2010) adapts Layder's (1997) model for application within

social work research and separates culture and economy into separate domains, arguing that the two should not be conflated.

As Bhaskar (2016) advises, researchers in their disciplines may develop bespoke laminated models to reflect their study. Accordingly, I have combined my laminated system for Skelsend, elements of Layder's (1997) theory of social domains, Bhaskar's (2016) seven-scalar system of lamination along with Houston's (2010) revisionist version of Layder's model. The laminated framework below elucidates the intersecting nature of social structures that permeate social reality. I have adapted elements of these models of lamination with Skelsend in mind to incorporate the salience of the relationship between resident well-being and the natural environment:

1) **The domain of the person**: The life biography and trajectory, for instance, experience of illness and traumatic events before relocation to Skelsend. This layer of stratification is a micro and **subjective domain** at the individual and biographical level. It may include a health condition trajectory within a life biography (Houston, 2010).
2) **The domain of individual and material circumstances:** This could refer to, for example, financial circumstances, housing, domestic situation, and responsibilities (Bhaskar et al., 2010).
3) **The domain of situated activity:** This consists of frequent and less frequent encounters between two or several people existing as an intersubjective dimension of social reality (Layder, 1997). These could be exchanges on the high street and in the cafes of Skelsend, interactions between work colleagues or people in community groups, or between family members.
4) **The domain of social settings**: The family, the work environment, interface with services, health services, housing, DWP. This level of limitation is a meso level, but also the subjective level of understanding (Layder, 1997).
5) **The domain of place and environment:** Blue spaces, neighbourhood environment, local economy.
6) **The domain of economy and polity:** Government, media, policy formulation, and macroeconomics. This level of lamination is at the macro and contributes to objective conditioning (Layder, 1997**).**

7) **The domain of culture**: This domain can consist of both meso and macro layering of social relativity. This may relate to perceptional dispositions that influence outlook and behaviours and macro cultural influences (Houston, 2010).
8) **The domain of ideologies, transnational and historical trajectory:** Referring to globalisation, neoliberalism, moral conservativism, capitalist development. This is the objective and mega level of social stratification (Bhaskar et al., 2010; Bhaskar, 2016).

There are numerous points of intersection across the laminated scale, entities and structures that accumulate and interact to manifest this outcome, including affordable and easy access to the sea, welcoming social networks, and the individual's life trajectory, including health conditions, experiencing trauma, and previously living within stressful intensive urban environments. There are ethnographic observations, or awareness of events, and reported phenomena of the empirical and actual domain.

Underlying causal mechanisms, which reside in the domain of the real, combine to manifest emergently and are located across a multiplicity of scalar levels across the lamination. These might include the internal dispositions of the person developed through personal experiences, such as stress experienced by urban living, combined with the price mechanism within the housing market, which is mediated by local and broader economic factors determining property valuation. These structural mechanisms are complemented by health benefits derived from human interaction with seaside environmental factors, such as cleaner air and less development. Consequently, experiences of restitution felt by residents who have relocated to Skelsend result from the multiplicity of causative mechanisms that contingently emerge across the laminated scale, from the subjective domains to the macro domains.

The domain of the real: transcending observation towards explanatory power

As the literature review outlines there are several studies demonstrating a social gradient of health (Marmot, 2004, 2015; Marmot et al., 2010, 2020; Schulz et al., 2012; Wilkinson and Pickett, 2009, 2018). There is also sufficient evidence to conclude that areas of higher deprivation are more likely to have a higher

concentration of people living with multimorbidity (Marmot et al., 2020; Mercer et al., 2018). Whilst these studies demonstrate associations between the determinants of health, it can be argued that they fall short of identifying the deep structural causes of these determinants that unequally expose people to poorer health outcomes, including multimorbidity (Rustin, 2018; Scambler, 2015). In the critical realist sense, many epidemiological studies are analytically trapped in the domains of the empirical and actual (Scambler and Scambler, 2015).

Rustin (2018) and Scambler and Scambler (2015) explain that this level of analysis, typical of the laudable attempts to explicate the relationship between social disadvantage and ill health, results in overlooking the actual underlying causation of the reproduction of health inequalities; or, more specifically, when applied to this study, being the emergence of the social phenomena integral to the reproduction of inequality in the capacity to manage one's well-being in the context of multiple illness and geographic location. More succinctly, the material inequality of working-age residents' resources and field positions to fulfil human needs necessary to maintain well-being.

For instance, as discussed, the social gradient of health (Marmot, 2005) is a hypothesis is underpinned by the contention that health inequality is rooted in income inequality (Wilkinson and Pickett, 2010) and other broader social determinants over time (Demakakos et al., 2008). Rustin (2018) argues that the Marmot reports (2010; 2020) quantifiably validate the social gradient of health hypothesis, conflated causation, and association of health inequality. In doing so, argues Scambler and Scambler (2015), their analysis remains at the surface level, the domains of the empirical or actual, thereby abolishing the domain of the real, where deeper structures of social relations responsible for inequality of morbidity and life expectancy mortality can be identified, including political, economic, and cultural social relations (Scambler and Scambler, 2015). Instead of viewing inequalities as both a correlate and a cause of ill health, Rustin (2018) contends that one should consider both ill health and inequality as resulting from the underlying social structure, and how power relations determine the allocation of resources in society.

A reflexive habitus within critical realism

Although the broad application of critical realism shaped my methodological approach to ethnography, I have, where appropriate, utilised Bourdieu's (1984, 1990) habitus, capital, and field to complement the critical realist thematic analysis applied to ethnography. I found this construct pertinent when considering the dietary dispositions of residents within the town's food landscape in Skelsend and attitudes expressed by residents regarding their town and local service rationalisation. My intention during analysis was to use habitus as Mahar et al. (1990:12) describe the concept, as a non-determining 'mediating construct' between residents' positions across the fields of the social space of Skelsend, significantly influenced by their access to capital, economic, social, and cultural factors, and their own dispositional outlook.

To define habitus, Bourdieu (1984:166) explains it as 'necessity internalised' into disposition, and tastes developed generationally through socialisation and significantly influenced by the necessity of labour and its relationships with the means of production (Bourdieu, 1984, 1990). Codd (1990:137) describes this as an "inculcated script" emerging from material conditions and class relations. As Bourdieu (1977:72) describes, it is the "internalisation of externality and the externality of internality" and a set of lasting, durable dispositions. Habitus is pertinent and influential to ways of being.

> …our overall orientation to or way of being in the world; our predisposed ways of thinking, acting and moving in and through the social environment that encompasses posture, demeanour, outlook, expectations and taste. (Bourdieu, 1984:466)

Demonstrating some parallels with Bhaskar's (1993) TMSA and the role of agency, habitus is both a 'structuring structure' in its effects on human beings and a 'structured structure', denoting the temporal effects of structure upon habitus (Bourdieu, 1984). Similarly to critical realism, Bourdieu's (1990) habitus rejects the paradigmatic binary between structure and agency as primary progenitors of social phenomena. As Bourdieu and Wacquant (1992) assert, these apparent opposites reinforce each other. Instead, as social theory, habitus, although having an ontological indeterminant reality (Akram, 2023), purports to operate a reflexive

epistemology incorporating structural and individual cognitive influences (Bourdieu and Wacquant, 1992). Although some critical realist critics firmly opine their opposition to using Bourdieu's theories within critical realism as manifestly described by Archer (1995; 2007), I concur with several realist theorists that Bourdieu's habitus, as a 'structured structure' (Bourdieu, 1977:72), can be incorporated within a critical realist framework of analysis and mutually complementary of each other (Akram, 2023, Decoteau, 2016; Elder-Vass, 2007; Öğütle, 2013). With adaption, through "hybridising reflexivity and habitus*"* (Akram, 2023:49), and ontological revision, habitus can assist in elucidating decision-making in structure and emergence (Elder-Vass, 2007). This adaption involves conceptualising habitus as ontologically stratified, accommodating more significant space for reflexivity, and acting as an intermediary between social institutions and the human body, a structure in its own right.

However, a fundamental tension exists between critical realism and Bourdieu's theory that requires acknowledgement. Like Giddens' (1984) structuration theory, Bourdieu's habitus, has attracted the chagrin of Archer (1995), who contends that habitus, is an example of central conflation, denying the separability between structure and agency that is required to achieve a temporal analysis and is overly deterministic resulting in "hydraulic theorising" that neglects human agency (Archer, 2007:6). However, Bourdieu and Wacquant (1992:133) believe that habitus is misinterpreted by critics as a dynamic that "condemns people to their fate". Instead, Bourdieu wanted to convey an impression of an "open system of dispositions" which are "durable not eternal" affected by the experience, which, in turn, "reinforces or modifies" the habitus, recognising that the "human mind is socially bounded" and "socially structured" (Bourdieu, 1992:126-133).

Critical realist adherents Akram (2023) and Decoteau (2016) acknowledge that reflexivity and change within habitus is recognised within Bourdieu's extensive writing. These occur during moments of social disjuncture caused by significant life events or social change that precipitate a rift between habitus and the field (Akram, 2023; Decoteau, 2016). Since Margaret Archer (1995, 2007) wrote her denunciation of Bourdieu, there has been a methodological rapprochement among many critical realist theorists (Decoteau, 2016; Elder-Vass, 2007, 2010; Öğütle, 2013).

Accordingly, I have sought some accommodation between Bourdieu and critical realism by considering Elder-Vass' (2010, 2007) realist theory of emergence and Öğütle's (2013) and Decoteau's (2016) ontological revision of habitus and standard critical realist stratification that remain faithful to its principal components, outlined earlier, while providing accommodation with an improved methodological synthesis to assist in practical application.

Perhaps Elder-Vass (2007, 2007b, 2008, 2010) contributes to reconciling habitus and critical realism to facilitate practical application. Elder-Vass (2007b) foregrounds mental phenomena as his basis for re-thinking habitus, with neural networks fomenting dispositions, which the social environment has inculcated. This framing remains consistent with Bourdieu's (1993) contention of the temporal internalising of structure to cohere into a habitus. Using this logic, human action results from the interaction of conditioned neural activity shaped by social structure and the social structure itself (Elder-Vass, 2007b). Additionally, according to Elder-Vass (2010), habitus should be adjusted to accommodate space for deliberative reflexivity, while accepting that the capacity for reflexivity will vary by circumstance and social positioning. Habitus becomes as much disposition as it does deterministic.

Meanwhile, Decoteau (2016) reasons that to apply habitus within a critical realist framework of analysis, not only does it need to afford an enhanced space for reflexivity but it also needs to be considered ontologically stratified or layered. Habitus should be considered an embodied disposition with varying degrees of reflexivity dependent upon social positioning across multiple fields (Decoteau, 2016). Disjunctures within fields, or unsettled social relations, arguably more apparent in late modernity (Beck, 1992), may initiate conditions that promulgate increased reflexivity (Decoteau, 2016). However, any resulting structural elaboration through a reflexive habitus depends on collective understandings regarding field disjunctures (Decoteau, 2016).

Further, habitus, an embodied internalised disposition, should be ontologically considered as a social structure evident across the three fundamental domains of being: empirical, actual, and real. Whereas habitus can be observed in the domains of the empirical and actual, the causative mechanism of habitus, along with other mechanisms, exists in the domain of the real (Akram, 2023; Decoteau, 2016). Akram

(2023) has since further elaborated on Decoteau's (2016) proposition, arguing that whilst structures may shape habitus, the causative mechanisms, the fundamental causes of phenomena that operate through structure, operate within an ontologically stratified habitus in the domain of the real. Meanwhile, human reflexivity is contingent on individuals and how they are positioned relative to social structures, and the interactions between structures and people, while manifestations derived from the interactions can be observed in the domain of the empirical and actual (Akram, 2023).

Öğütle (2013) suggests further adaptation and recommends that habitus can be a helpful intermediary concept that connects social institutions with people. Ontologically, however, for Öğütle (2013), this requires the adaptation of the critical realist domain of the actual to accommodate both fields and social institutions. As explained, Öğütle (2013) places institutions ontologically in the domain of the actual, with causative mechanisms operating through them. Institutions are, as Öğütle (2013:493) claims, "the actual executors*"* of causal mechanisms whilst contending that social institutions can be “recognised from the traces on human bodies”. Meanwhile, Öğütle (2013:497) believes social institutions should be considered as fields, quoting Bourdieu and Wacquant (1992:497), who imply the same reasoning:

> …the school system, the state, the church, political parties are not apparatus but fields. (Bourdieu and Wacquant, 1992:497).

Fields of struggle

Acknowledging that one cannot explore habitus without reference to the field is a necessary precondition to understanding. Like habitus, there have been more recent attempts at reconciling critical realism with Bourdieu’s concept of the field to strengthen the potential of their analytical power mutually (Akram, 2023). Akram (2023) and Decoteau (2017) contend that, like habitus, Bourdieu’s conception of relationally embodied structure within field can, if judiciously applied, be used to complement critical realist explanatory power to identify sites of struggle and emergence of social phenomena. I often refer to the characteristics of the spatiality of Skelsend, how it is symbolically and differentially interpreted in the town

dependent upon residents' position in the field and their access to social resources, material, and cultural capital.

For instance, I refer to spatial redundancy, calm, and disturbance. Social space has a multiplicity of fields, each with its logic of practice and containing configurations of objective positions in relation to each other (Bourdieu and Wacquant, 1992). They are fluid sites of struggle, of subjugated and dominating agents of different interests and positions competing for resources and capital (Bourdieu and Wacquant, 1992). The power relations are involved in the social struggle of interests within the social space of a location shape, and produce physical spaces that are appropriated and inhabited by people (Bourdieu, 2018). Important aspects of this study includes the physical spaces that are symbolically devalued and spatially othered with residents by virtue of their residential proximity, feeling socially tainted through their association.

Each positional space coheres to specific properties developed in accordance with its relational ranking within a given field. They are sites of temporal social struggle, intersecting hierarchical relationships of social positions within social space (Bourdieu, 1993; Wacquant, 2018). Like critical realism's insistence upon viewing social structures as open systems and having contingent causative mechanisms, Bourdieu theorised that macro structures, whilst significantly influential to the field, do not result in universal deterministic elaboration of them (Akram, 2023). I have conceptualised fields as being contingently impacted by structure across a laminated spectrum of influential social domains, as described earlier, from subjective domains of the person to objective domains of economy and culture.

There are multiple fields within Skelsend, including, as Öğütle (2013) argues, institutions operating as fields in themselves, such as GP surgeries, health services, and the local labour market. I also reference the field as a delineation of the social space of Skelsend itself, an enveloping field of fields, to help elucidate residents' relative positioning within the town regarding access to the resources and security necessary to maintain well-being. It is a social space within which multiple social structures abound and within which social relations exist. Consequently, residents hold positions in these fields and are positioned in relation not just to institutions and

social settings, but within the overall network of relations of the social space of Skelsend itself, influencing how they use the town as a social and ecological space.

Bourdieu's later works accommodated increased importance concerning the resonance of social space and struggles within social relations in place shape urban landscapes (Hanquinet et al., 2012; Simpson et al., 2022). Social space, contended Bourdieu (2018:107), is defined by its properties, constitutive entities, that is "…as a structure of juxtaposition of social positions", whereby agents and the social resources utilised by them are relationally spatially situated. Although the literature utilising Bourdieu's field concept is situated on urban social spaces, I contend that no reasoned detriment justifies the exclusion of towns with small populations. This analytical undertaking is not dissimilar to Simpson et al.'s (2022) ethnography of a seaside town on the south coast of England, whereby she conceives her place of enquiry as a constituted spatial expression of social relations within which people are rooted. The utility of field, as a conceptual rhetorical device, is caveated with the recognition that its social relations and properties are irreducible to a fixed geographical location (Hanquinet et al., 2012). Fields, therefore, cannot be separated from broader structural influences. For instance, in Skelsend, it is apparent that other structural influences external to the town abound and affect the experiences and lives of residents.

However, I acknowledge Wacquant's (2018) concern that Bourdieu's concept of field is sometimes deployed superficially as a synonym for place in research studies. I have endeavoured to avoid this by conceptualising Skelsend's social space, its field of relations, as a network of social relations within which residents of working-age adults living with multiple health conditions are corporeally embedded. I consider the degree of power a resident may have within these relationships within the field*s* of Skelsend and the overall field of Skelsend and how this may impact well-being in the context of life with health conditions. The causal mechanisms within social structures that produce that power and access to resources and capital, or the absence of power and resources, reside in the domain of the real and require retroductive discernment.

I attempt to undertake this in a way that is consistent with Bourdieu's (2018) contention, that relations with social space and the struggle within the multiplicity of

subfields transmute into actual physical space, as experienced by residents of Skelsend. Residents' access to the differentiated forms and volumes of capital within social space shapes their relationships with physical spaces, where they work, socialise, and the neighbourhoods they live in.

I have been cognisant of Wacquant's (2018) advocacy of typological reasoning when considering Skelsend as a field of networked positions. This considers evaluating the interconnectivity between symbolic, social, and physical spaces. Firstly, the symbolic space of Skelsend relates to how residents perceive and construct a narrative about their neighbourhood and town. The social space of Skelsend relates to how the town's social space is implicated in the distribution of capital and resources, including public and other support services developed from the town's accumulated social capital. The physical space of Skelsend refers to the town's built environment, such as the fading resort infrastructure, the residential housing vernacular, and the buildings that host services for the community.

Additionally, coterminous with the overarching laminated spheres comprising Skelsend's stratified social being, I incorporate the natural environment as a physical space within this typology of space and networked positions. Of prominence is the seascape, which, although it contributes to many residents' narratives of restitution, is often differently and symbolically framed by residents and contingent on their relative position within the social space of Skelsend.

Methodological Framework Summary

Primarily, I adopt a critical realist framework to help elicit and comprehend an understanding of fieldwork data. Critical realism provides a conceptual vehicle to elicit both emergence, the events and social phenomena, as experience by residents and how this shapes their relationship with place and illness. Importantly, in the context of this study, critical realism is useful in considering how social relations within social structures provide a conduit through which tendential causative mechanisms influence the lives of working-age residents with multimorbidity in Skelsend. To avoid a reductionist approach to the analysis of fieldwork data, I have also adopted a laminated schema to assist in comprehending the stratified intersectional influences across social structures and the relationships between

micro, meso and macro social structures and the subjective, intersubjective, and objective domains of reality.

Where applicable, I have attempted to incorporate a habitus, as a set of embodied dispositions, within a critical realist framework in the following ways. Firstly, as Elder-Vass (2010) recommends, adapting habitus to afford more significant space for reflexivity and subsequent deliberative agency contingent upon social circumstance and position. Secondly, as Öğütle (2013) suggests, I shall conceptualise social institutions ontologically as fields and deploy habitus as an intermediary mechanism between fields and bodies. Thirdly, as Decoteau (2016) contends, ontologically reconceptualise habitus as a stratified structure traversing the three domains of social reality: the empirical, actual, and real. The causal mechanisms within habitus, however, are in the domain of the real.

Habitus needs to be considered in connection to capital and the field. I consider field, concerning this study, not just situational but spatial, through the conception of subfields and the multiplicity or relationships between and within these fields within the social space of Skelsend with residents' security of access to different compositions of capital, economic, social, cultural and symbolic (Bourdieu, 1984, 1990). This is seen through their relations within the subfields within space as critical to identifying causation that impacts upon the experience of residents and their lives suffused with the complexities involved in living with multimorbidity in connection to place and life in a typical small seaside town.

The next chapter provides an overview of the methods used in this ethnography, which have been informed by the methodological approach as outlined in this chapter. This chapter will also explain the role of judgement rationalism, a key intrinsic feature of a critical realist-informed study and important in the development of a critical realist thematic analysis. Further, I will discuss how critical realism complements a critical ethnographic method employed for this study.

Chapter 4 The Methods of Data Collection and Analysis

Introduction

I used several qualitative methods to gather data to understand the structural enablements and constraints in working-age residents' ability to achieve well-being despite living with multiple health conditions. Primarily, data was collected through the ethnographic method, including participant observation through volunteering and semi-structured interviews. Interviews were undertaken with working-age residents living with multiple health conditions and pertinent health professionals and community workers based in Skelsend. In addition to the semi-structured interviews, some residents participated in walking or an interview using photographs of Skelsend as a visual prompt to discuss their relationship with the town.

Whilst interviews were partly informed through ethnographic fieldwork data, I also collated online documentary and some social media information about Skelsend. To provide further contextual information to the study, I invited all adult residents to complete an online qualitative survey. I also used extensive fieldwork notes to provide further contextual information. To analyse data, I used a thematic approach informed by other critical realist researchers (Danermark et al., 2019; Fletcher, 2017; Fryer, 2022; Jagosh, 2020) and complemented by reflexive analytical insight provided by Braun and Clarke (2022). This chapter discusses these methods in the context of my study. All organisations I refer to throughout the thesis, including place names and the names of people, have been given pseudonyms. All the methods outlined in this chapter were approved by the University of Hull's Ethical Committee on 9th November 2021.

Why ethnography?

Ethnography is well suited to observing the relationships between people and locations and how social relations within a given place shape people's experience. It allowed me to consider the relations between people, the structures within Skelsend and how they influenced the lives of working-age people with multiple health conditions. I used findings and themes emerging from ethnographic observations in the field to provide a contextual foundation for the semi-structured interviews. I found the ethnographic approach helpful in acquiring comprehensive findings, not just to inform interviews but to address an imbalance of recruitment between incomers and

the locals or lifelong residents. Community workers in Skelsend informed me that the latter was a ‘hard-to-reach’ group. Amongst this group, especially those residing on the large post-war council estate, I discerned a tendency from those residents to be less trusting of what they might perceive as authority figures and services. They were also less inclined to participate in interviews. Furthermore, there were other residents, not just on the estate, who were less inclined to participate for a variety of reasons, often through living a stressful life and/or lack of confidence, and struggles with mental health were also significant impediments to participation in interviews. Therefore, the ethnographic data gathered during voluntary work helped address this imbalance, collecting data relating to the social experience of less confident residents that may have been overlooked or not adequately covered during interviews.

Many proponents argue that ethnography can be an effective medium of qualitative health research seeking to illuminate the lived realities of people and how place intersects with well-being and illness (Pelto, 2013; Rashid et al., 2015; Strudwick, 2021). Ethnography is a research practice that embeds itself into the community of inquiry, whereby the researchers gather data and knowledge by being personally immersed within a group or social activity (Walcott, 2005). Engaging with people and cultural practices over time and participating in various micro-interactions can generate and validate knowledge, whilst revealing the intertwined relationships between people within a particular setting (Culhane, 2017).

Focused and critical ethnography

Most ethnographies nowadays are time-limited and study familiar settings, unlike the classical anthropological studies of the early 20th century. Modern ethnography is often called focused ethnography, in acknowledgement of time constraints and the acceptance of studying known cultures while remaining committed to core ethnographic principles (Knoblauch, 2005). A prior literature review and preliminary research about the study site informed the fieldwork of this research. Willis and Trondman (2000: 5-16) describe this as “theoretically informed ethnography”. Such an approach recognises that communities cannot be understood as devoid of information or prior historical knowledge. Willis and Trondman (2000: 10) advocate that ethnography should record the “lived experience within the social”. In other

words, we should not study a community in isolation from broader social structures and subjective knowledge of these relations.

Culhane (2017) argues that innovative ethnography can potentially expose how power operates at the micro-level and how its effects are realised in people's lives as tangible realities. Similarly, I intended to discover the salient themes relating to stratified social structures and the impact of these on resident well-being and quality of life. My ethnography, therefore, was not just focused but critical, using prior, albeit partial, understanding of the structural disadvantages and environmental advantages towards residents' attempts at optimising well-being in the context of a life with multiple health conditions.

Emerging out of the critical theory of the Frankfurt School, critical ethnography examines the role of social relations, ideology, and political economy within fieldwork, ascertaining what perpetuates inequality and disadvantage within a given research setting (Agar, 1996). This approach assumes that inequality and oppression have a structural form within society and examines the contemporary and historical factors that influence the social power relations that embed structural inequalities (Marshall and Rossman, 2016). Critical ethnography, therefore, explores the broader social context explaining the theory (Van Maanen, 1988).

Critical realism and critical ethnography

Post-modernist approaches challenge the authority of traditional hegemonic knowledge and ethnography (Rees and Gatenby, 2014). It is contended that ethnographic researchers are authors of text from which generalisations cannot be drawn or applied elsewhere (Agrosino, 2007). This challenges applied ethnography, which espouses the idea that research should promote or challenge policy (Agrosino, 2007). The lack of application rendered by post-modernism threatens to blunt ethnography's potency towards advocating for social change. Consequently, the post-modernist approach threatens the ethnographic method, rendering its analysis superfluous as an agent of transformation (Rees and Gatenby, 2014). However, critical realism, with its combination of epistemological relativism, ontological realism, and retroductive approach to analysis, provides a potent framework to assist ethnography in overcoming the post-modernist turn (Barron, 2012; Rees and Gatenby, 2014).

I felt during my time in the field and analysis of data that the critical ethnographic approach and critical realist methodology were complementary and helped develop explanatory power. Rees and Gatenby (2014:2) contend that critical realism connects structure, human perception, and agency. Banfield (2004) argues that critical realist methodology within a critical ethnography can help reveal deep underlying structures that reproduce inequality and disadvantage, for instance how ideology, government and economic structures impact the lives of working-age residents with multiple health conditions in connection with the environment of 'place'. My data collection method sought to generate data regarding the micro level of human interaction and the environment to cast fresh perspectives on health inequalities and power issues.

Applying a critical realist perspective to ethnography assists the researcher in going beyond individuals' subjective view of the world and making theoretical links between subjective understanding and structural precedents that influence them (Rees and Gatenby, 2014). Through its considerations of structural mechanisms, the body being one, as Haigh et al. (2019) reminds us, the analysis goes beyond the reported experience to hypothesise about the effects of social relations tested through human experience (Porter, 1993). Its ontological position recognises the multi-mechanistic layered nature of reality, which transforms human agency and experience and elaborates structures through human activity (Archer, 1995; Price and Martin, 2018). Critical realism, therefore, facilitates a stratified analysis of ethnographic data, assisting in identifying the tendential causative mechanisms emergent from fieldwork data. Accepting an uncertain reality and non-deterministic contingent causation, critical realism within the ethnographic method can defend ethnography against the post-modern challenge of validity (Barron, 2012).

Accessing the field and COVID-19

Coffey (2018) reflects on the importance of careful negotiation, rapport building, and identifying who could be approached to gain access to the field. I needed a few lucky breaks and chance encounters to gain access to sites in Skelsend and conduct the ethnography through volunteering. My fortunate break came at an online regional Knowledge Exchange seminar, where, by chance, a senior figure in Woldenshire Public Health Department was presenting on a project aimed at improving access

and encouraging increased physical activity in Skelsend, at a time when I was considering which seaside town I should study. I was fortunate to arrange a meeting with her and, after discussing my project, she connected me to a project worker running a project called Active Skelsend, aimed at increasing levels of physical activity in the town. She also connected me with a health professional working in the town with a particular interest in the health of neighbourhoods disadvantaged by social deprivation. These initial contacts recommended further contacts and, incrementally, in the New Year of 2021, I built a small informal network of key people working on various sites in Skelsend that provided support for residents, some of whom were this study's target group.

Progress, of course, was impeded by the COVID-19 pandemic, which delayed my plans to volunteer prior to officially commencing fieldwork in November 2021. As the country emerged from lockdowns and restrictions were lifted, reimposed, and then once more lifted, it was initially challenging to acquire volunteering opportunities despite developing valuable contacts. However, a hopeful telephone call to a local charity in Skelsend, the Pear Tree charity in May 2021, proved fruitful. They accepted me as a volunteer and were happy to help facilitate my research. The Pear Tree enabled me to access the field as a preliminary to formal research activity and provided a base to build further contacts.

In October 2021, I also commenced voluntary work at the Social Supermarket in Skelsend, run by a local charity that operated a community centre, a base from which many other outreach services operated. However, gaining access to this organisation was helped by being present in the town and finding out who I should speak with. I also spent time in the town's leisure centre, where a usually quiet cafeteria provided me a base to work and potentially recruit residents and relevant workers for interviews. The managers and coordinators of these organisations kindly hosted my research project, providing me with several bases in the town. I had successfully gained access to the field and started building trust and necessary relationships.

Volunteering and participant observation

Voluntary work provides an opportunity to undertake participant observation by locating the researcher in the arena of study. It requires an immersion that allows the

researcher to see the world as the people living within the community under investigation (Marshall and Rossman, 2016). Personal engagement and participation within the community under study can reward the researcher with a rich seam of information that would not have come to light without that deep level of involvement (Agar, 1996). Hammersley and Atkinson (1998) make a pertinent observation when they argue that participant observation should be a mode of being rather than a research method that facilitates access to situated meanings and nuance that influence human agency. Fetterman (2010) observes that opportunities arise for informal interviews within participant observation, which combines conversation with entrenched implicit questioning. This questioning is expected to help understand the community members' differing opinions and beliefs, which might help explain behaviour (Fetterman, 2010). Moreover, Agar (1996) advises that interview participants can often overlook crucial insights. Participants may also leave out certain information, which could be critical because they regard it as too obvious (Agar,1996). Fetterman (2010) advises that participant observation helps refine our questions in more in-depth interviews.

The Pear Tree, where I volunteered at least once a week, but often more, was a charitable hub providing support for anyone in need in Skelsend, from older people, people with health conditions, disability, or just needing some assistance to help get through a crisis or difficulty. Its mission statement was to "alleviate the consequences of poverty, poor health and loneliness". The latter became more pertinent due to the lockdowns from which people were tentatively emerging. Initially, I helped with the drop-in, but over time as the charity received more white goods and large furniture items, I helped deliver and receive second-hand items. I travelled around the town in an old white battered transit van, visiting households delivering and receiving donations. This activity has helped me get to know the neighbourhoods of Skelsend and, through conversations with residents and fellow workers, I deepened my contextual knowledge of the town.

The social supermarket run by the community centre became my second base. Whilst there, I helped stock shelves, price goods, helped with the lifting and carrying during the delivery, flattened cardboard boxes, took away rubbish and moved stock to the community centre café. Proving my worth as a grafter, thereby contributing to

the community, helped facilitate a willingness to help with recruitment whilst connecting me with other projects, people, and community groups in the town. The community centre also afforded a venue for me to meet interview participants and become acquainted with other outreach services in the town.

After a couple of months of lifting heavy white goods, beds, and furniture in and out of residences across Skelsend and helping to sort out food supplies at the social supermarket, I almost forgot that I was conducting research, so engrossed I became in the work I was undertaking and the support provided to other community workers. However, this experience led to me feeling embedded in the field and provided privileged access to the daily life of these charities that worked with many people living with health conditions in this seaside town. My year volunteering in Skelsend was a most enjoyable experience, something that I felt was a considerable privilege. Without the support generated from the people I got to know while volunteering, I may have struggled to recruit a viable number of participants for the study.

Sometimes, I thought volunteering was very slow, which worried me. However, I found that, just by being present, I connected with people all the time, which proved to be an essential research gateway. It allowed the space for the 'happenstance' described by Van Maanen (1988:2), revealing insightful revelations. As I became more familiar with the town, this prevented me from being seen as a distant and meddling stranger, which would have been a qualitative research killer in the context of this small town. Volunteering was crucial in building my credibility in the town as a researcher and building the necessary rapport to recruit interview participants. Indeed, I could not have recruited or gathered sufficient data without volunteering. Like Bradshaw's (2018) ethnography based in a hospice, whereby he volunteered before undertaking fieldwork on patients' experiences by participating in Tai-Chi, volunteering gave me a sense of credibility in the town. By working in the community, providing complementary assistance to support services, and getting 'stuck in', my identity became more than just a researcher; I had become a hard worker. As my face became more familiar when volunteering, people appeared to speak more freely and personally about their experiences of the town and the benefits and difficulties they experienced that impacted their well-being and others.

During fieldwork, I was struck by how many community groups were operating in the town. I attended many of the groups below, and what was apparent was the amount of local knowledge and informal help that people passed between them. They were not only a means of making connections and friends but also became an informal citizens' advice hub. By the end of fieldwork, I had been in contact with – and, in many cases, participated in – many community organisations. The list below gives a flavour of the groups I had become acquainted with during fieldwork.

Walking Football
Walking Netball
Skelsend Fit Mums Walking Group
Skelsend Thursday Walking Group
Skelsend Community Vegetable Growers
The Pear Tree Care and Drop-In
South Woldenshire Community Centre (operated a social supermarket)
Skelsend Craft Club
Skelsend on Wheels (a weekend event I attended as a marshall)
Skelsend Young Adults Centre
Knitting and Fellowship
A local mental health support group.

Fieldnote diary

Walcott (2005) advised that ethnography requires a commitment from fieldworkers to regularly compile fieldnotes and detailed vignettes of encounters in the field. Coffey (2018:48) impresses on the centrality of fieldnotes as "textual representations of the field" that the ethnographer must develop to capture the scene and dialogue. Agar (1996:31) stresses the importance of capturing what he refers to as "rich points", a deep nuance that bridges gaps in understanding.

My fieldnotes gradually accrued throughout my time in the field. On the completion of fieldwork, I had amassed a diary of 75,000 words, much of which was generated on my reflections and observations during volunteering, but also field walks and visits to public spaces where I noted the atmosphere of the towns and sights and sounds of the environments, the arcades, the cafes and, notably, the seascape. So, not to

detract from participant observation or to avoid potentially inadvertently making other people uncomfortable, I would find discreet corners in the town, often a sparsely patronised café, to write fieldnotes. This was sometimes impossible, as the café opening times are usually quite restrictive. In such circumstances, as Emmerson et al. (1995) and Chang (2008) advise, I would undertake loose jottings, which would be written more extensively later that day, perhaps away from the field.

The original purpose of fieldnotes was to develop a contextual understanding of the town. However, as fieldwork progressed, I found that fieldnotes not only complemented what residents were communicating during the interviews, but provided a more holistic balanced depiction of the town. Fieldnotes acted as a critical counterweight towards interviews that numerically favoured residents who had moved into the town. These residents tended to be better resourced, and more likely to be inclined to participate in interviews than lifelong residents. Therefore, my learning from participant observation in the community through broader ethnographic activity helped ensure less-confident, or more reticent voices were not overlooked.

Some of the fieldnotes were autoethnographic; I wrote short vignettes about my mental engagement with the sea and my impression of the electronic chatter of the arcades. This activity was intrinsic to deepening my connection with the town with which I was becoming more closely acquainted. Chang (2008) comments that detailed autoethnographic writings add life to an ethnography and provide context to cultural interpretation. During early field walks around Skelsend, I would take selective photos, which would be helpful for reflexive personal engagement with the space of Skelsend and subsequent photographic interviews.

Barron (2012) contemplates regret for not including autoethnographic reflexivity within his critical realist ethnographic thesis reasoning decision, which weakened his exploration of complexity and nuance. Personal reflective impressions of the stage of Skelsend assisted in the subsequent analytical process of cohering abductive thematic metaphors, explaining the structural constraints and enablers to achieving restitution and well-being. These constraints and enablers exist as social relations within social structures, intersecting across the scales of laminated social reality, producing emergence, and influencing residents' experiences of this small, secluded seaside town living with multiple health conditions.

A note on pseudonyms

I used a password-protected spreadsheet to record pseudonyms and keep a handle on my fieldwork notes. This was much needed to avoid losing track of who was who. My spreadsheet of people totalled eighty-three residents and workers and a plethora of pseudonymised place names. Everyone that appeared in my fieldnote diary was given a pseudonym.

Online research: developing a body of contextual information

Kozinets (2015), a proponent of netnography, otherwise called online ethnography, claims that online data from various sources, essentially including social media, can provide further insights into a field of study that might otherwise be overlooked. For instance, people may post a grievance or seek advice anonymously (Kozinets, 2015). Before commencing fieldwork at Skelsend, I collected publicly available data about the town from online sources. This included news articles and their comment wrappers, which revealed a tendency for Skelsend to be vilified by residents living in Haxton and other parts of Woldenshire. I recorded job opportunities and housing availability in the town. I also collated data from local Facebook pages, provided pertinent comments about happenings in the town, and expressed thoughts about well-being. Sometimes, people external to Skelsend would ask for information about the town and residents' opinions, which could elicit interesting attitudinal data about their town. I was careful not to include any references to names in the data collected from publicly accessible Facebook sites.

Due to fears that COVID-19 would prevent access to enough people and impede recruitment, I developed an online qualitative survey before fieldwork began. However, despite ongoing COVID-19-related concerns, once I had become embedded within Skelsend, this survey proved unnecessary and was not used in the study in any meaningful way.

Semi-structured interviews

Among the residents of Skelsend, I conducted twenty-eight semi-structured interviews with working-age residents living with multiple health conditions; one of these interviews consisted of a pair of residents interviewed together at their request. Amendments were agreed upon by the University of Hull's ethics committee to accommodate this request before conducting the interview. Eight of those residents I

interviewed a second time, three participated in a walking interview around Skelsend, also known as go-along interviews (Carpiano, 2012), and the other five opted for photographic interviews because of restrictive mobility.

Thirteen interviews were conducted with health professionals and community workers, and five unrecorded interviews were undertaken as part of a broader ethnographic data collection. Interviews with key workers brought further insights from people who gave an overview of the issues impacting residents. They worked in local government, the NHS, social care, and voluntary services. Many of these workers had been identified and agreed to participate during the early months of the fieldwork. Consistent with their wishes, notes were taken for those I undertook unrecorded interviews with rather than an audio recording.

Interviews ranged from twenty-five to ninety minutes, although the majority lasted between forty-five and seventy minutes. They mostly took place at the community centre in Skelsend, but several residents preferred the comfort of their homes or other locations in Skelsend. For instance, one resident preferred the empty back room of his local pub as his preferred venue, with Karaoke reverberating through the walls of the adjacent room and a pleasant, warming open fire as an accompanying backdrop. All interviews were recorded and transcribed, except the five unrecorded interviews with health and community workers. These five interviews were unrecorded at the request of those involved, but I took notes, as agreed with them. Following authorisation from the University's ethics committee, two transcription services transcribed approximately two-thirds of the interviews. All names of residents, workers and places were pseudonymised. Within the ethnography, place names, occupations, and illnesses that risk identifying any participant were replaced by vague descriptors.

About the resident participants

Of the twenty-nine working-age participants with multiple health conditions, I recorded interviews with twenty-one who had moved to Skelsend within the last two decades, of whom sixteen had relocated within the previous ten years. Only seven people could be typically described as born and bred in Skelsend. This certainly reflected the people I met when undertaking the broader ethnographic activity. Of the twenty-two people who had relocated to Skelsend, only two had moved from a rural

area, and one did so out of necessity rather than choice. The broader ethnography revealed a tendency for people to move to Skelsend later in life, predominantly late midlife and beyond. However, amongst the people I recruited for interviews, I noticed that fourteen of the twenty-two people I interviewed who had relocated to Skelsend did so before the age of fifty. Of the twenty-two people who relocated into the town, thirteen were economically inactive during fieldwork, while ten claimed working-age benefits. Eight residents were employed in the town, and two people commuted by car to other locations in Woldenshire.

Interestingly, I found that people who had moved into the town in the last twenty years were more receptive to the study than many of those so-called locals who were “born and bred” in Skelsend. Most participants in the interviews had moved into Skelsend. A few community workers told me that people who always lived in the town tended to be more wary of outsiders and engaging with services. I felt it more likely that people moving into the town would naturally be more predisposed towards seeking new connections and networks than those who already had family nearby. People moving here tend to join social clubs and volunteer to forge those connections and build their social capital. As a result, during my ethnographic activity, it was more likely that it was those people I would encounter and more likely recruit. Perhaps with more time in the field, I may have found ways to correct this imbalance.

Recruitment and sampling

Initially, I adopted an opportunistic sampling strategy consistent with Pelto’s (2013) understanding of this strategy. Although I had a broad understanding of who I needed to interview to gather a holistic representational sample, balancing age, length of residency, balance of illnesses and economic levels of activity, I first took whatever opportunities arose from fieldwork, primarily through the contacts made when volunteering prior to interviews and scoping the field when accessing Skelsend. Active Skelsend, the Pear Tree and the community centre were very helpful in connecting me with interview participants. I designed a flyer, which received prior ethical approval, which these organisations displayed. Two outreach advice services, which operated surgeries from the community centre, also displayed these flyers. The optimum means of recruiting, however, was through volunteering,

being seen around and becoming a familiar face in town. After an initial flurry of interviews from mid-March to mid-April, I moved towards a snowballing sampling approach (Pelto, 2013), with participants supporting recruitment and connecting me with consent to other people.

Hammersley and Atkinson (1995) advise ethnographers to schedule time away from the field to appraise the emerging data and to develop a more selective strategy to acquire the required information. By the end of June, I had undertaken eighteen or so interviews with residents. I started to take stock of what information I was missing, adopting a combined sampling approach that was both theoretical and purposeful in connection with emerging themes.

It was apparent that recruiting lifelong residents or even finding them, was much harder than recruiting people who had relocated into the town over the last ten years and were not at work. Men were also underrepresented initially. The managers of Pear Tree and the community centre helped address this issue to some extent. Tapping into local knowledge was crucial. I was given some further leads to follow up and was able to purposefully sample, selecting people for their knowledge of their experiences instead of my recruitment based upon opportunistic happenstance (Coffey, 2018; Palinkas et al., 2015).

Conducting interviews

All interviews were semi-structured. Residents and workers were given information sheets before the interview and broadly understood the purpose of the interview and the outline of the study. By the time I had commenced interviews in Skelsend, I had already compiled a considerable body of data relating to pertinent aspects of life in the town through ethnographic activities, including volunteering and background research about the town through online sources. This helped provide contextual information, allowing me to appreciate the salient issues impacting the lives of working-age residents living with multiple health conditions. Generally, ethnographers favour interviewing techniques that are not directive, allowing participants considerable latitude (Hammersley and Atkinson, 1995). This hands-off approach reduces the researcher's influence on the participant. However, Hammersley and Atkinson (1995) remind us that the purpose is not to gather uncontaminated pure data. Instead, the researcher should develop an awareness of

their presence's potential effect and develop their interpretation accordingly. However, not interviewing people and failing to answer questions would likely miss valuable insights into the studied communities (Hammersley and Atkinson, 1995).

To strike a balance between the need to ask specific questions and not being directive in a way that might impede expression, I adopted what Marshall and Rossman (2016) refer to as the interview guide, otherwise known as the 'topical approach'. This involved organising the interview with some prepared questions to be covered during the session. The participants are given a high degree of latitude in how they wish to respond and may raise any relevant issues they feel appropriate (Marshall and Rossman, 2016).

These interview guides were refined during the fieldwork to accommodate fresh perspectives that emerged during fieldwork. This was necessary, given I had not anticipated that most people I was going to interview had moved to the town. Participants were invited to discuss their health conditions before considering together how certain aspects of the town might impact their well-being and ability to manage their illness. This could include access to services and amenities, the seasonality of resort life and the town's relative isolation, especially if one relied on public transport.

During our conversational interviews, I encouraged participants to consider life before illness and, if they had moved to the town, whether illness had played a part in their decision to relocate to Skelsend. When we discussed services, it was apparent during fieldwork that getting appointments with the surgery was proving difficult, and travelling to hospitals from Skelsend was stressful for many people with health conditions. During interviews, many people were forthright about the negative impact on their health caused by trying to access social security benefits. Other people discussed work or the lack of quality work opportunities. Additionally, we discussed the environment of Skelsend, access to the sea and countryside and how that might be beneficial to managing health conditions.

Meanwhile, health and community workers were invited to discuss the challenges in supporting residents living with health conditions in the town. I asked if they had observations about the barriers to well-being and positive aspects of Skelsend's

residents' experience. Further, regarding health professionals, we discussed what conditions were more prevalent in the town and potential causes.

Walking and photographic interviews

Towards the end of the interview with participants, I asked residents whether they would like to partake in a subsequent interview involving walking about town, such as a favourite recreational walking route, or around parts of Skelsend that personally resonate with them. These walks assist participants by prompting them to articulate their narrative whilst helping the researcher comprehend the social space from their perspective (Morreti, 2017; Pink, 2013). Sometimes referred to as "go-along interviews", the participant leads walking interviews after the researcher has introduced the theme (Sunderland et al., 2012).

Culhane (2017) argues that standard research methods frequently overlook the importance of the senses in the research process. Sensory ethnography and experience are intuitive and emotional; they elicit possibly unacknowledged emotions. Culhane (2017) describes ethnography as collating 'emplaced' knowledge, a gut feeling aroused by intersubjectivity of engagement between people, places, and concepts. One should acknowledge that it is not always possible to accurately describe emotions through text and words (Pink, 2013). However, though we cannot always accurately convey feelings, attempts to articulate them should not be dismissed. Therefore, walking interviews, as Sunderland et al. (2012) suggest, should aim to include all the senses to consider how the local environment is experienced. For instance, as Moretti (2017) observes, public spaces and landmarks from the past and present are imbued with symbolism and meaning, which can be made apparent to the researcher through walking interviews. Walking interviews prompted discussion about the benefits derived from the blue spaces in the town and the sadness about neglected spaces left to decline.

During the early stages of fieldwork, when undertaking field walks to familiarise myself with the town's geography, I took photographs of various features of the town that stood out, as well as prominent landmarks, historical and contemporary. The primary purpose of this exercise was to compile photographs of the town to use later for the photographic interviews. As Pink (2013) advises, photographs

can enrich the fieldwork experience and subsequent analysis, providing the ethnographer with a different form of contextualisation. Aside from using photographs for four follow-up interviews, taking photographs prompted me to look at the environment of Skelsend differently and helped with subsequent autoethnographic reflection.

Photography has been an important feature of ethnography for many years, although more recent ethnographies often employ collaborative research techniques (Pink, 2013). Photographs of images can remind people of events and provoke emotions that standard research techniques may not (Pink, 2013). As Schwartz (1989) observes, interpreting meanings prompted by photographs depends on the participant's subjectivity shaped through experience. The significance of this may challenge researchers' assumptions by receiving unanticipated responses and bring to the forefront hitherto hidden personal subjective knowledge (Pink, 2013; Schwartz, 1989). Schwartz (1989) advises organising the images taken into themes ahead of interviews to occasion responses from participants. I arranged photos into groups under thematic headers, such as blue spaces, public services, familiar landmarks and street life. Like walking interviews, the photographs focused participants on their relationship with the spaces around Skelsend, provoking memories of when they first arrived in the town or the nostalgia for the lost vibrancy the town once held.

Dramatis personae.

Listed on the next page are the working-age residents of Skelsend living with multimorbidity who participated in semi-structured interviews conducted between 21st March 2022 and 31st October 2022. Interviews were generally concluded by September 2022. However, a couple of interviews needed to be rescheduled to a later date in September and the end of October.

* Denotes the resident participating in a walking interview following the semi-structured interview.

** Denotes the residents participating in a photographic interview following the semi-structured interview.

*** Beth and Amelia were interviewed together at their request.

MHC – Mental health condition

AIC – Auto-immune condition

(EA) – Economically Active (in work, looking for work or preparing for work)

(EI) – Economically Inactive

Table 1: List of Skelsend's residents who participated in recorded interviews

Name	**Condition**	**Age**	**How long**	**Working background**
Claire (EA)	MHC, AIC	40s	Under 5 years	Construction but now social enterprise.
Sean (EA)	Bowel condition MHC	30s	Lifelong	Social enterprise and trades.
Paul* (EI)	AIC, MHC, chronic pain	50s	Under 5 years	Specialist trade, is not working due to illness. Volunteers at the community centre.
Dawn (EA)	Cardiovascular, respiratory, muscle and nerve condition	50s	10–20 years	Local government.
Alice** (EA)	AIC, respiratory	50	Lifelong	Retail part time, previously in the care sector.
Florence*	MHC, chronic pain, cardiovascular	60s	Under 5 years	Retail part time.

(EA)				
Bryan (EI)	Neurological, mental health condition, AIC	50s	Around 25 years	Transport – no longer working due to injury.
Bertha** (EI)	Respiratory illness, MHC, degenerative joint disease	60s	Under 5 years	Not worked recently due to poor health. Volunteers at a local charity.
Mary** (EI)	Diabetes, MHC, AIC, cardiovascular	60s	Under 5 years	Managerial, but has just retired. Helps run a community group.
Helen* (EA)	MHC, neurological condition, diabetes.	40s	Under 5 years	Telecommunications – now part-time social enterprise.
Janey** (EI)	Neurological, AIC, condition, muscular-skeletal condition	60s	5–10 years	Previously independent retail. Now, does not work due to injury and health.
Catherine (EI)	Diabetes, neurological condition, degenerative joint condition, respiratory illness, MHC	40s	10–20 years	Not working due to poor health for several years.

Kim (EI)	MHC, degenerative joint condition	40s	10–20 years	Catering, but has not worked due to poor health for several years.
Gary ** (EI)	Nerve damage following blood infection, degenerative joint disease, MHC	40s	5–10 years	Leisure, independent retail, but can no longer work due to illness.
Cheryl (EA)	MHC, pancreatic condition	40s	5–10 years	Self-employed in tourism, but previously caring.
Mick (EI)	MHC, AIC, chronic pain	50s	Under 5 years	Public services, security, and early retirement due to illness. Runs a community group.
Gemma (EA)	Cardiovascular condition, thyroid-related condition, bowel condition	30s	Lifelong	Care sector.
Dennis (EA)	Cardiovascular condition, MHC	50s	5–10 years	Retail and trades. Works part time in the trades.
Lacey (EI)	MHC, diabetes, gynaecological condition	18 - 30	Moving back and forth between Skelsend/Haxton	Worked previously in the care sector but is currently not working due to health. Volunteers for a charity.

Jimmy (EA)	MHC, Respiratory condition, muscular-skeletal condition	50's	5–10 years	Cleaning services, currently commutes for work.
Jason (EI)	MHC, Skin Condition	40s	Under 5 years	Haulage, though is currently not working due to illness.
Lucy (EI)	MHC, AIU, Respiratory condition	50s	10–20 years	Not currently working, has younger children to support.
Bernie (EI)	Genetic disease, Diabetes	60s	Lifelong	Catering background, though, is no longer working due to illness.
Ben (EA)	MHC, Chronic Pain, Spinal Condition	40s	10–20 years	Independent retail, about to leave work due to illness.
Beth*** (EA)	Neurological condition, MHC	18-30	Lifelong	Looking for training opportunities.
Amelia*** (EA)	Neurological condition, MHC	18-30	Lifelong	Looking for training opportunities.

Nicola (EI)	Respiratory condition, AIC	60s	45 years	No longer working and not required to look for work.
Sam (EI)	MHC, a neurological condition	40s	10–20 years	Did several jobs from office work, no longer working due to illness and inflexible DWP systems. Has younger children to support.
Mark (EI)	MHC, AIC	50s	Under 5 Years	Not working at time of interview, volunteers for a charity shop. Used to work in the creative arts.

Positionality

As an ethnography, this study embraces the position of epistemological relativism and the fallibility of knowledge production. This is an epistemological position that does not struggle to neutralise the personal histories and the cultural paradigm within which we live, which, as Battalgia (1995) argues, shapes our identity and the ways of perceiving the world. Indeed, Rosaldo (1989:175) contends that experience collated through our journey through life can “enable or inhibit particular forms of insight”. In contrast to the realism of early ethnography, Hammersley and Atkinson (1995) urge ethnographers to accept their integral position within the social world they are studying. Chang (2008) advises that one needs to accept that it is impossible to remove oneself from writing ethnography, so she recommends embracing one’s involvement to provide connectivity between data collection and analysis. This is the process of reflexivity, in which positionality is acknowledged and incorporated as adding value to interpretation.

Like all researchers, my positionality is a complex web of intersecting tendencies towards prejudicial predisposition, some of which I may not be cognisant. However, to share my position as a researcher, albeit partially, I am male and commenced fieldwork in Skelsend at the age of forty-seven. By profession, I am a social worker and have worked in various social work positions with adults for over a decade, following several years as a registered manager of a care home operated by the local authority. Before this role, I had worked as a care worker for seventeen years, primarily with older people but also with adults with a learning disability and/or physical disability. While my experience in social work was often useful while volunteering in Skelsend, it was interesting that the grassroots work, shorn of personal computers, and relatability with staff and other volunteers brought me back to my days as a care worker. During the early part of fieldwork, it felt reminiscent of the times I had worked in unfamiliar care homes covering staff absences, being that slightly incompetent stranger.

Aside from my social work and social care career, other formative experiences include the Labour Party and trade union activity. I understood that, despite Skelsend’s working-class base, the area returned Conservative representatives, although this was less apparent at the very lowest tier of government, the small town

council. During the referendum on the UK's membership in the European Union, I joined the campaign for Remain, Skelsend being solid for Leave. I resolved during fieldwork to remain a curious observer of people's views, easing conversation rather than trying to confound or defend a particular position. Taking a step back and endeavouring to understand why people arrive at beliefs and opinions as they do I found surprisingly liberating, and helped me develop a greater sense of regard for alternative viewpoints, even if they might sharply contrast with my own.

I do have ancestry in some of the more remote villages of Flintonprice from when Skelsend was being transformed into a resort town. One small village could have easily become a seaside resort town instead of Skelsend had fate decried differently. My other ancestors from Haxton and Haventon would have taken the train to the coast. They would have been the first generation of day trippers to Skelsend during the seaside Gloriana of the Victorian era. This knowledge acquired over the last decade piqued my curiosity about this rural backwater in a peripheral and forgotten corner of northern England. It was also a location I very occasionally visited for work purposes. It was a place that intrigued me by its remote location, retro feel, and, as I felt then, as with many small resort towns, its fading purpose.

Critical realist thematic analysis

All interviews for this study, including the notes for unrecorded ethnographic interviews, were subject to coding before I developed them into the salient themes discussed in the findings chapters. Insights developed from this process were complemented with the ethnographic fieldwork diary, the analysis of which, although not as strictly applied as with interviews, was iteratively cohered around loose themes. My analytical approach to data rests largely on a critical realist approach to thematic analysis. A critical realist analysis identifies demi-regularities within the data, referring to trends and patterns, although emerging as tendencies rather than the Humean principle of constant conjunctions, the universal general laws of causation (Fletcher, 2017). The other fundamental feature of a critical realist analysis is the identification of causal mechanisms resulting in these demi-regularities (Fletcher, 2017; Rees and Gatenby, 2014). While cohering themes and identifying demi-regularities, I also cross-sectionally referenced data that spoke to the theory of habitus where applicable as a demi-regularity. Influential to my analysis were

Danermark et al. (2019), Fletcher (2017) and Fryer (2022) and complemented this with insights from Braun and Clarke's (2022) development of reflexive thematic analysis.

In reflexive thematic analysis, the researcher's subjectivity is not seen as an impediment towards developing new insights and generating knowledge from data. Overarching themes are built from codes that do not just emerge from data; researchers fashion them through their engagement with data to develop patterns of interpretation and understanding (Braun and Clarke, 2022). A critical realist thematic analysis assumes that the researcher does not have direct access to reality. Instead, the analysis is mediated through the prism of participants' perception of their reality formed by their experience, cultural exposure, and environment (Braun and Clarke, 2022). Correspondingly, the researcher needs to situate data within its broader social context. This undertaking is complemented by the researcher's positionality and subjectivity, which Braun and Clarke (2022) observe needs to be understood and incorporated into the thematic analysis.

The first stage of my analysis involved constructing a coding framework by developing, applying, and reviewing codes. The initial phase of coding was data led and, thereby, inductive. Following Fyer's recommendation (2022), I generated codes from the data inductively, without explicit application to any pre-existing knowledge I had accumulated through familiarisation with pertinent research literature and theory. This allows the researcher, as both Fryer (2022) and Mason (2018) argue, to see "surprises" emerge from data. Where I could, consistent with the analytical stages advocated by Fryer (2022) and Braun and Clarke (2022), I gave these codes descriptors using my interpretation of the data. I then reviewed the codes to see where they could be standardised and consolidated within the emerging coding framework I had accumulated. This was especially necessary given the large number of codes that I had generated.

In contrast to grounded theory, which is data driven and therefore inductive, because critical realism uses more theory within its analysis, there is a much larger role for abduction, with the identification and cohering of demi-regularities being the first stage of abduction and retroduction (Fletcher, 2017). Jagosh (2020) contends that

retroduction, or judgement rationality, is not a distinctive process conducted separately. Instead, retroduction should be undertaken coterminously with inductive and deductive strategies (Jagosh, 2020). In keeping with critical realist analysis, although I initially coded inductively, I found intuitively that, following initial coding, there was a greater movement between inductive, deductive and abductive coding. Abductive coding is the development of abstract themes, a redescription of data through integrating theory with data (Danermark et al., 2019), which I had descriptively coded. Danermark et al. (2019) concur with Pelto (2014) in that whether to code in a manner driven by data or theory should not be a strict binary. There was, therefore, a natural shift on to the second phase of analysis, namely identifying the trends and patterns and abductively cohering themes. The process of constructing overarching themes and demi-regularities alongside developing ideas regarding causative mechanisms causing demi-regularities, trends and patterns in data was, therefore, something I approached iteratively to develop the themes discussed in the findings.

Retroduction

Fryer (2022) postulates that the stages of analysis, familiarising oneself with the data, coding, and themes broadly correspond with the critical realist ontological levels of reality, the domains of empirical, actual, and real. The third stage looks at emergent themes in combination with the literature to ascertain the contingent tendential causative mechanisms that generate experience retroductively. To identify plausible mechanisms within the social relations that operated within the social space of Skelsend, I employed the critical realist analytical theorem of retroduction (Bhaskar, 1989, 2016; Collier, 1994). Potential underlying causative tendencies are explained alongside relevant theory and literature within the later discussion and conclusion chapter. This process, described by Alderson (2021) as a form of ‘macro regress’, can be rudimentarily described as an analytical strategy of thinking backwards (Houston, 2010).

Danermark et al. (2019:117) refer to this process as ‘transcendental augmentation’, by which one seeks to identify the basis of the condition required for an observed or known social phenomenon to exist. Danermark et al. (2019) recommend that researchers seeking to develop an explanatory narrative should analyse abductively,

integrating theory with data and social phenomena, and socially contextualising those observations. This process is fundamental to identifying the specific phenomena requiring explanation. However, robust thematic analysis is required to ensure subsequent abductive and retroductive emerges with validity from the data (Wiltshire and Ronkainen, 2021). The abductive hypothesis building can only occur after demi-regularities have been identified; that is, potential patterns within the data.

Retroduction is often referred to as judgemental rationalism because theories of causal explanation are abandoned on deliberative scrutiny to arrive at a plausible explanatory narrative (Bhaskar, 2016). When undertaking retroductive theorising, one should first consider the causative mechanisms within structures likely responsible for the phenomena and then ask what “properties must exist for X to be what it is” (Danermark et al., 2019:130). To help identify the tendential causation of social phenomena, the retroductive process involves drawing upon theories and literature that offer plausible explanatory power (Wiltshire and Rokainen, 2021).

Meanwhile, critical realism retroduction and Bhaskar’s lamination combine to make sense of data. Rees and Gatenby (2014) argue that the value of the micro-level data collated through ethnographic research requires knowledge of the broader social structures and historical context to identify causal explanations (Rees and Gatenby, 2014). Without reference towards both the historical and social context, the individual narrative is disconnected from structural influences, thereby impeding the development of an understanding of the generative mechanisms of social phenomena. When applied to Skelsend, for example, I have abductively redescribed localised economic decline and the loss of purpose, guided by theory and fallible knowledge of related phenomena such as Spatial Redundancy. Using retroduction, I offer globalisation and neo-liberalism, as macro-casual mechanisms, amongst others, that are significantly responsible for this phenomenon. These are mechanisms within structures that are ontologically located in the domain of the real. The decline of holidays on the coast in favour of foreign holidays and disinvestment of the public realm are events in the domain of the actual. Micro and meso mechanisms also interact with the macro mechanisms identified, such as that mechanism that drives inward migration of people of working age who are permanently economically inactive.

Method summary

A broad range of data collection methods were deployed to gain contextual information, although most data came from interviews and ethnographic fieldnotes. Online methods were helpful in eliciting data about the town and helped deepen my contextual understanding of the town. In this thesis, where possible, I have foregrounded the voices of residents and have tried to authentically embed their voices within the ethnographic data collected on Skelsend. My analysis triangulated the data collected to identify the prominent social structures at the micro, meso and macro levels operating within Skelsend to influence the lived experience of working-age multiple health conditions in a small and remote seaside town.

Chapter 5 Introducing Skelsend

Skelsend is a small pocket of seaside resort urbanisation, surrounded by sea and an undulating green rural landscape. To the north and south of the town, caravan sites stand resolute in futile defiance on disappearing cliff tops, which, slowly but remorselessly, are devoured by the sea. It is not uncommon for people to unofficially live on these sites. The surrounding County of Woldenshire is predominantly rural, but has several larger seaside towns to the north of Skelsend that are better connected to the inland market towns of Woldenshire and the City of Haxton. These resort towns tend to attract more visitors than Skelsend, although this was not always the case.

Skelsend is not just an urban pocket encompassed within blue and green spaces; most of the town's space is a space of disadvantage nested within a wealthy county. Skelsend's nearest city and prominent urban conurbation is the City of Haxton. Although Haxton has its own unitary authority, it is a small city with a population of approximately a quarter of a million. Like Skelsend, Haxton has struggled to find its post-industrial and post-modern purpose. It also has comparatively high levels of deprivation, and, like Skelsend, it has a predominantly low-wage economy (Gov.UK, 2019). For a city, Haxton is poorly connected to other larger cities in northern England. Also, like Skelsend, it is a victim of geography and economic change. Skelsend, then, is a remote town within a poorly connected region.

Nonetheless, Haxton is the city that Skelsend's residents look towards for amenities, work, post-sixteen education and leisure. It is only twenty miles away, but the journey through the rural hinterland of the Borough of Flintonprice, an ancient borough within the County of Woldenshire, takes place on narrow, bending country roads. The journey time is uncertain, and weather conditions, agricultural vehicles, and timid drivers unfamiliar with the tight blind bends can conspire against one's schedule. One can hope to reach the city of Haxton in 35 to 45 minutes by car, but one should plan for much longer. Slow-moving agriculture vehicles, weather and a usually half-empty double-decker bus service can impede progress. The hourly bus, of course, is much slower, and there is no train. The capital of Woldenshire, an old market town, Whorley, is even harder to reach by car, being approximately just under an hour away, but the journey takes around two hours by bus.

At the start of the 19th century, Skelsend and its neighbouring village, Holdthorne, which it later absorbed, were small fishing villages with a combined population of 200 inhabitants (Whitehead, 1988). Then, in the 1840s, a Woldenshire entrepreneur, George Mulgrave, resolved to cite a seaside resort to the east of Haxton by connecting the growing city with the coast with its railway. The line's opening the following decade promptly facilitated the development of Skelsend, enabling the transformation from a tiny fishing village to a popular seaside resort (Whitehead, 1988). The loss of the railway in the 1960s is now beyond the living memory. However, a collective memory remains of the lifelong residents and older visitors who still lament its loss. The railway line was the town's artery through which the touristic economic capital once flowed into Skelsend. Indeed, old Victorian train timetables show that public transport between Skelsend and Haxton was quicker over a hundred and fifty years ago than today (Craven, 1972).

Despite attracting significantly fewer visitors than in its heyday, Skelsend and tourism are synonymous; the town was born as a seaside resort. Like many small seaside resorts, tourist decline has been accompanied by economic decline and social disadvantage for many of their residents. There are no large employers besides the two supermarkets, Tesco and Aldi. There are no other industries to fall back on; Skelsend's other traditional industry, fishing, employs very few people now. Consequently, with the steady net depletion of tourism, residents report that the town is left to fade and wither. Tourist decline brings to bear an existential question for Skelsend.

The following is a fieldnote excerpt written following a visit to the Railway Pub in Skelsend, a venue popular with locals. Just the place to learn about some of the issues at large in the town. The conversation detailed below was with older residents who had moved to Skelsend from other parts of the north with one man from Scotland. They all had lived in Skelsend long enough to be considered as long term residents.

> *As soon as I walked into the pub lounge, armed with the Skelsend Gazzette as my prop, the patrons had clocked me as someone new and stared intently. One older woman shouted, "You're new" followed by, "What are you doing here". This was not the first time I had been asked*

about my intentions after being identified as someone new to town. I tried to explain my research, and as soon as I mentioned health, two customers shouted out, "There is none". Meaning, there is no health. This was not the first time first time I had heard this. There was no hiding behind the latest copy of the Skelsend Gazette. I had been caught. We convened an impromptu and informal, late afternoon Skelsend Pub Focus Group across this pub's lounge …Christine tells me that the tourists that come here are rough "we get all the rough ones here, and they have no money". She says this more than once to emphasise her point. She was very keen to tell me this. They are called "Sand-diggers" says Christine. Bev behind the bar, interjects and says they are "not all rough, there is a mixture". Christine, humphs and says, "they are rough", nodding he head and glowering eyes. Carol told me, "it was when they closed the line down, that was the beginning of the end"". But "that was a while ago now", said Eddie. Eddie told me that the "heart of Skelsend was lost when they closed the market[1]". Christine said, "there used to be a boating lake, and an outdoor pool, which was popular, but we lost that". I asked if anything positive had happened here over the past few years. They pause, genuinely think for a moment, and reply, "no"; almost in orchestration with each other. However, they like the "slow pace" and feel that there is a community here. Eddie remarked, "you can come in here if you were in bother and people would help you out". Don told me, "We've have had people like you come here before, but nothing ever comes of it". He says this in a friendly way with a knowing smile. [Fieldwork Diary extract, March 2022]

[1] The popular market at Skelsend attracted many visitors every weekend. It was held on the site of the station. The old station buildings were even used as a changing room to try on clothes. The market closed in the 1990's. Many residents and regular visitors would like to see it return.

Skelsend used to be a happening place!

Many long-term residents fondly remember the concert hall lost to the town in the late 1980s. The concert hall had northern England's largest sprung dance floor and was a popular venue for dancing and socialising. There used to be a weekly, evening weekend train that took people from Haxton to the dance hall and back, taking about forty-five minutes each way. After the train's demise, Skelsend became popular for rock and heavy metal concerts from the late 1960s to the 1970s and the early 1980s. Legendary artists like Slade, T. Rex, and Suzy Quatro would perform at the hall. Skelsend also hosted bands that pushed back the boundaries of acceptable sound, including the influential New Wave of British Heavy Metal (NWBHM), bands such as Iron Maiden, Diamond Head and Def Leppard. Curiously, several long-term residents told me they especially enjoy recalling a gig by an unusually named NWBHM group called Ethel the Frog, a band that has since faded into obscurity along with Skelsend's rock and roll past.

Alice, a lifelong resident in her early fifties, was typically nostalgic about Skelsend's seaside past. She told me she would never leave the town and has many fond memories of growing up in Skelsend. Many people like Alice spoke with pride and warmth about Skelsend's history as a place of fun and leisure. However, she accepts those days are now long gone. Like many parents I spoke to with grown-up children, her daughter had left the area due to a dearth of opportunities, a reoccurring theme that was articulated by residents with young adult children. Throughout the two interviews, Alice would talk informatively about when Skelsend was a "…proper seaside town" and the town was "heaving" in the summer months. Alice also spoke affectionately about the annual summer carnivals in the town, which had floats, majorettes, and steam engines that paraded through the town. The tourist infrastructure, the boating lake, the lido, the gardens, the dance halls, and the popular outdoor market all helped foster a sense of pride and belonging, yet, incrementally, have been lost over decades of decline.

> *"There were two cinemas. I mean, I can only remember there only ever being one, but there used to be two cinemas. There were eight bingos. You know, it was a proper seaside town. Where pier monuments are there*

used to be, like, little huts there. There used to be a hut that sold seafood, you know, like cockles and muscles, like proper seafront stuff, and another one that sold rock, and another one that sold buckets and spades. And, you know, proper stuff that should be on the seafront. Yes, but nothing now." [Alice, Resident Interviews]

The stalled promise of regeneration

Residents of Skelsend have become used to false dawns, promises of regeneration and investments that never meet expectations. When collecting online data, I noted two significant attempts at regeneration in the town that failed to materialise. The first was a Millennium Plan in 1999 sponsored by the town's diminutive town council, the lowest tier of local government administration, poorly resourced, like a parish council in a rural village. This plan was featured in a BBC documentary on Skelsend just before the turn of the century posted on Youtube, which discussed the economic redundancy and the resorts' steady decline (Norman, 2021). The report was depressing and portrayed the town as a decaying shadow of its former self. The following quote, from a young teenage boy resident in Skelsend, was particularly sad.

> "I think Skelsend will always be forgotten now, I think it has gone past the stage when anyone is going to help it anymore. It's just going downhill." (Norman, 2021)

However, the concerns identified in the report centred around the loss of purpose and lack of opportunity, remain to this day. The attitudes I heard from many people, especially those who need work opportunities, and lifelong residents, exemplify this entry on the comment's wrapper connected with the report.

> "Meanwhile, 20 years down the line the town's is still in the doldrums, a state that seems terminal" (Norman, 2021)

In 2011, the Woldenshire Council published a Skelsend Renaissance Plan (Woldenshire County Council, 2011) that identified the need to improve the facilities for visitors near the seafront and amenities for residents down the high street. The report spoke of the town's collective loss of confidence and identity. The potential

attractiveness of the townscape was felt to be negated by incongruent buildings, tired shop frontages and street furniture cluttering the high street and unkept properties, such as the tired iron-clad shed arcades and utilitarian brick pumping station just off the promenade being prominent examples of the former. The Skelsend Renaissance Plan 2011 builds on the Parish Council's Plan formulated in 2009. Its vision statement was to build a sustainable community and economy, providing employment opportunities and a better quality of life for residents (Woldenshire County Council, 2011).

The Skelsend Renaissance Plan envisaged a town that provided residents with opportunities; however, a common complaint I heard was that, a decade on, the residents continued to report a lack of opportunities. A decade later, during fieldwork, it was apparent that the much-heralded transformation plans had been quietly shelved. Skelsend's long-term and lifelong residents have become accustomed to unrealised promises. During fieldwork, it was commonplace for residents to communicate resentment about the lack of resources invested elsewhere in the county.

However, more recently, the town was boosted by the prospect of a new pier installation replacing the original, torn down over 100 years ago after ships crashed into it during storms. At the time of my fieldwork, the construction of a new pier for Skelsend was a genuine prospect, and there was a real sense of anticipation amongst the residents involved in the project. Residents formed the Skelsend Pier Society, which raised the necessary funds by securing numerous grants and undertaking local fundraising ventures. They raised sufficient funds to construct the first stage of the new pier, the viewing platform. I met many volunteers from the Skelsend Pier Society at the Follies, and they were very committed to this project to help revitalise the town.

Work on the pier was scheduled to commence in the autumn of 2021 after planning permission was granted. This was a popular project in Skelsend, involving many volunteers from the town. Most people I spoke to did not think it a panacea to the town's difficulties, but it did provide many people with real purpose and a sense of optimism and civic pride. Barbara, a committee member, was hopeful that the pier

would attract more visitors and encourage residents to “go get out around the town again” and help “wake the town up”. However, she was concerned that the Woldenshire County Council was so “pedantic” and slow. Their involvement, although necessary, had, she felt, only served to delay and escalate costs.

However, the long-awaited construction that many volunteers of the Skelsend Pier Society had strived for tirelessly, overcoming many barriers, faced further difficulties that ended their inspirational project. Unfortunately, before work began, Woldenshire County Council demanded further changes to the plans, escalating the costs in May 2021. Changes were made, and work was about to proceed after this initial delay in 2022. However, council officials from Whorley halted the construction of the viewing platform, citing restrictions on the use of heavy machinery during the tourist season. Then, because of this further delay, planning permission expired, leaving the project unviable after seven years of hard work by local volunteers. The volunteers had run out of money and energy to continue the project in the face of such intransigence (Simpson, 2023). A spokesperson for the pier committee was quoted in the local paper as follows:

> “We have been working on this for seven years, put our hearts and souls into the project, and are now back to square one. We no longer have the funds to proceed, and the board and steering group members are fatigued by the endless battle with the council. It is therefore with sadness that we have to admit that the rebuilding of the Skelsend Pier is no longer a viable option.” (Simpson, 2023,1)

These disappointments significantly impacted long-term and lifelong residents, many of whom had developed a resigned, pessimistic outlook in connection with their home town and place within it. It seemed to them that the town’s assets were slowly being stripped with no replacements to compensate. Josh, one of the younger participants, told me:

> “*I’m old enough to know what it was like, you know, it used to be a thriving town, there was all sorts to do – we had funfairs, we had everything and now, like everything with Skelsend, has gone. The way I would compare*

it, it's like Coldenthorpe, Hotonshore,[2] *all their historic features have been preserved, ours have been pulled down, and you know, you just have nothing.*" [Josh, Resident Interview]

Regeneration in Skelsend is like a sea fret, a thick fog slowly advancing towards the town from the sea, only to fade and dissipate forlornly into the ether before it reaches the shore. An ever-distant promise on the horizon that invariably fails to materialise.

Figure 2: Skelsend's regeneration: the sophistry of promise

Figure 3: The site old pier.

[2] Coldenthorpe and Hotonshore are the larger Woldenshire seaside resorts to the north of Skelsend.

Relative deprivation statistics

As a small town with a population of around 6,000, Skelsend does not have its own ward councillor at the local government level. Its needs as a left-behind place can be overlooked, with information about demographics and the local economy conflated with its much wealthier rural hinterland of Flintonprice. Even the granular data provided by the IMD (Gov.UK, 2019c), which I have used to acquire quantitative details on Skelsend's challenges, is conflated with the wealthier disparate rural hinterland, thereby diluting the measurements of disadvantage.

The IMD detail neighbourhood areas referred to as Lower Super Output Area (LSOA). These LSOAs are ranked on overall deprivation out of 32,844 neighbourhoods and other socio-economic domains, including health and disability. The health and disability domain rankings are based on data relating to reported morbidity and preventative mortality levels (Gov.UK, 2019b). Each neighbourhood is given what appears to be artificially delineated boundaries to ensure that each population is approximately like typical neighbourhood boundaries based on neighbourhood environmental shared commonalities (Gov.UK, 2019c).

These neighbourhoods, covered by the IMD, typically do not neatly cover Skelsend. There are two LSOAs within Skelsend; Skelsend's residents comprise only part of the LSOA's population, with the southwest LSOAs mainly consisting of residents from the wealthier villages. The western LSOAs consist of slightly more Skelsend residents than the wealthier hinterland it comprises. However, three LSOAs are entirely within Skelsend's boundaries; I name these neighbourhoods as northern, central, and southern LSOA.

Using the most recent available data, the table below details the overall deprivation ranking and the health domain for Skelsend's LSOAs in 2019. Ranking and Decile 1 are measured as the most deprived LSOA in England. To protect Skelsend's identity, I used an approximate ranking figure within a margin of 50 LSOA rankings. The data provides a comparative indicator across social domains and details how the three neighbourhood LSOAs that are fully contained within the boundaries of the town are, by comparison with other

neighbourhoods in England, significantly disadvantaged, with the southern LSOA being within the most deprived 5% in England (Gov.Uk, 2019). Interestingly, health deprivation is not as prominent as overall deprivation; perhaps this is indicative of some of the protective environmental factors in Skelsend in contrast to areas of urban deprivation.

Table 2: Indices of multiple deprivation LSOAs of Skelsend.

	IMD Rank Overall and Decile	**Health and Disability**	**Income**	**Employment**	**Crime**
Northern area	2000-1 2800-1	5700-2 4600-2	1300-1 2400-1	800-1 1200-1	4300-2 6500-2
Central area	2200-1 2200-1	4500-2 3900-2	3100-1 2800-1	1100-1 1700-1	980-1 1200-1
Southern area covering the main estate	900-1 1000-1	2500-1 1200-1	700-1 900-1	500-1 400-1	1600-1 9000-3

Western fringe and hinterland	12,300-4 13,400-4	15,300-5 16,900-5	12,700-4 12,800-4	9800-3 10,100-4	6700-3 11,700-4
Southwest fringe and hinterland	10,300-4 11,900-4	15,800-5 16,000-5	14,900-5 17,100-5	7600-3 11,500-4	25,100-7 20,400-6

(Gov.UK, 2019)

Prevalent illnesses and neighbourhood transitions

Health professionals working in the town drew my attention towards the growing tendency for people in Skelsend to develop serious illnesses earlier in life, such as COPD, high blood pressure and diabetes. Not only were they seeing younger people presenting with what some professionals referred to as "lifestyle diseases" at a younger age, but they also reported the prevalence for some diseases as being twice the national average. This observation is consistent with observations made across England in locations measured as being comparatively deprived, particularly in coastal deprivation areas (Marmot et al., 2020; Whitty, 2021).

> *"Well, if you're looking at prevalence rate we've got double the national rate of diabetes, double the national rate of ischaemic heart disease, double the average rate of hypertension, it tends to be all the sort of illnesses associated with poverty. And the other thing is they get them at a younger age. So, you tend to find that people have these things in their fifties and sixties, so they've moved to places like Skelsend because they're ill. A lot have got bad arthritis, they've often worked in heavy industry… So, you'll find that coastal resorts such as Skelsend have probably got about double the national average on most things."* [Guy, Health Care Professional]

Elizabeth provides a broader point: the effects of illness and multiple health conditions at a younger age have a profound social effect beyond the individuals involved.

> "*The prevalence of multiple health conditions is obviously quite high and quite noticeable for our population… you'll find that you're seeing people with what are – what would traditionally be associated with an older population I guess – long-term COPD, history of stroke, high blood pressure, diabetes, and suddenly we're seeing what I would class as young people, you know, in their forties, and they are suffering the ill effects of that. And because they are suffering with it at a younger age, the effects are longer lasting and more profound, and that can put strain on all systems really, health, social care, housing, everywhere you look*." [Elizabeth, Health Care Professional]

Within Skelsend itself, areas were consistent with the broader national picture of health inequality, with residents of poorer neighbourhoods living longer with poor health and lower life expectancy (Marmot et al., 2020). Health professionals and community workers told me that the sizeable post-war council estate, Seaville, within the southern LSOA of Skelsend, tended to present a higher prevalence of illnesses associated with financial hardship – or, as some health professionals described, "lifestyle illnesses". The estate is within the southern LSOA, the foremost relatively deprived town in Skelsend, including for health deprivation (Gov.UK, 2019). Both Guy and Elizabeth noticed a difference in the health problems presented by the more affluent areas in Skelsend, its outskirts, and rural hinterland. Elizabeth referred to the estate as having a clustering of illnesses related to deprivation.

> "*Yes, so the Seaville estate is the most deprived area of town. You definitely see clusters of illness associated with deprivation. So, mental health and high blood pressure, obesity, smoking-related illnesses, yes, definitely. And I think the other thing to consider is – probably because we cover quite a wide geographical area, you know, the difference between some of them – we've got some quite affluent areas as well that we cover and you do notice the difference."* [Elizabeth, Health Care Professional]

Guy, who had worked in the town for several decades, noticed how the town's composition had changed, with more residents with social problems concentrated on the estate, an observation explicated by several other community workers I spoke to. The Seaville estate, perhaps, is a typical micro-scale example of the trend towards relocation to the coast, the tendency towards people moving into Skelsend with social and health problems, like other seaside resorts, replacing the long-term residents who have either died or moved away (Houghton, 2023; Smith, 2012; Ward, 2015).

Guy also spoke about a cluster of older terraced streets that ran down towards the southern promenade, which, like Seaville, had fallen into decline, and this was reflected in the prevalence of illness he had witnessed in that area. This housing cluster was on the other side of the main road running through Skelsend, opposite the Seaville estate. The tendency was for traditional family

homes to be bought up by private landlords and suck in residents with vulnerabilities attracted by an affordable seaside abode. The areas Guy talks about hosting pockets of neglect are within the most deprived LSOAs in the town.

> "*Seaville interestingly has changed, when I first came to Skelsend it was probably a mixed population and a lot of people on that estate had actually been there since they built it just after the war… and often they'd have reasonable jobs, you could tell because they had nice gardens at the front… I remember a man who had beautiful rose beds… as they died off, people then moved in from away, you know, often with like you say more problems both socially and medically... So, you get a pocket on Seaville and then the terraces up towards the seafront are quite deprived on that south side; those few avenues, they're quite poor. But again, they've gone down, you know, I think again often they were quite elderly and as they've died off… the houses are actually fairly worthless, so even though they were quite well-kept houses and everything, they've been sold off. They're often bought by absentee landlords who rent them out to whoever they can get in them so they're relying a lot on sort of Social Services, you know, housing benefit people and things like that... And again, it sucks in people with problems. I think it just tends to be the same old COPD, diabetes, heart disease, blood pressure, smoking, mental health…well, they tend to be more of them in those bits (of town) than, say, the newer private estate, which is sort of on the nice edge of the town…"* [Guy, Health Care Professional]

Chapter 6 Spatial Calm: Seaside Relocation, Restitution and Finding Community

Introduction

This chapter focuses on residents with multiple health conditions who have moved into the town of Skelsend. As fieldwork unfolded, I was struck by how many people I encountered who had moved into the town over the last two decades. Indeed, I seemed to meet more people who had moved into town over the last couple of decades than those raised there. For most residents who had moved into Skelsend, especially for those experiencing mental distress, the town provided an opportunity to break from difficult events in their past to a calm space conducive towards achieving a sense of biographical renewal. Although features of spatial redundancy impact some residents, as we shall see in the next chapter, there is a tendency amongst people who have moved into Skelsend to benefit more from the spatial calmness of the environment.

Skelsend's affordability enabled many people to relocate to the town. Its inexpensive housing costs allowed a broader geographic range of people to abandon their urban lives in favour of the relative calm and tranquility of Skelsend. Many residents who had a history of mental distress as part of their multiple health conditions left their city environments, not wanting to return. They contrasted the calm of Skelsend with the fast-paced intensity and aggression of their former urban environments, and generally concluded that Skelsend was much better for their mental health and overall well-being. Few residents with working-age multiple health conditions disagreed with the sentiment that living near the sea significantly improved well-being, regardless of how long they had lived in Skelsend. For these residents, Skelsend's peaceful, relaxed environment, spatial calm, and the town's friendly feel played an important part in their pursuit of well-being, despite the challenges posed by their health condition.

I found that residents who moved to Skelsend under the age of fifty were more likely to be significantly influenced by experiencing a disjuncture, a trauma and lifestyle disruption in their choice to relocate to the town than older residents. Conversely, the older working-age cohort, although they also desired a quieter and slower life, like the younger incomers, had a motive to move, which was

less likely to come from a critical disjuncture. For older residents, the pull of the environment of Skelsend tended to appeal as a more decisive factor than their health condition or trauma. For others, the decision to relocate was, in several cases, influenced by partners or family already living in the town.

Welcome to the seascape of Skelsend: the calming benefits of blue spaces

> *"I don't know how people can live without being near the sea."*
> *[*Annie, Knitting Group, The Little Gem Café]

The long promenade at Skelsend runs from the south of the town through to the north and is easily accessible for residents. It runs adjacent to the neighbourhoods on each side of the town and stretches for a mile and a quarter. These neighbourhoods are measured by the ONS (2019) as the highest decile for deprivation in England. Yet, access to the promenade and the sea appears to ameliorate negative characteristics associated with social deprivation. The extensive promenade accommodates both walkers and cyclists, bringing pleasure to many residents throughout the year. The usually quiet beaches and promenades are places of exercise and visual pleasure, promoting a sense of calm. The overwhelming majority of residents spoke of the pleasure and benefit to their well-being brought by their proximity to the sea. The promenade was an instrumental infrastructural feature facilitating visual access to this blue space.

A further fundamental characteristic of Skelsend that assisted residents in deriving benefits from the town's seascape was its tendency not to attract large numbers of tourists. Therefore, it is often a quiet, sparsely shared communal space, and there are always places where relative solitude and calm can be found. Having access to this space, not having to share it with noisy visitors, and enjoying the expanse before them brought a sense of calm and tranquility to troubled minds. When walking in Skelsend, I would often pause on the upper reaches of the northern promenade and look down towards the central promenade at the two follies, remnants of the long-gone, ill-fated Victorian pier, and look out across the sea. Several residents would comment on the same view, a scene of perpetual motion and change. The seascape of Skelsend is an impermanent stage. The seascape is especially pleasing from the northern end of town, with the long promenade, the old sea-beaten and gnarled groynes, and

the vast sea stretching into the distance, meeting the skies. When I indulged in enjoying the seascape, I would venture onto the beach and find a comfortable boulder. On occasion, with a pen and notebook in hand, I would try contemplatively to describe the mental impression before me.

> *"I managed to spend some time looking out over the promenade wall across the sea. The sky was interspersed with brilliant white clouds set against a deep blue background. The clouds were constantly shifting, it was quite a windy day with the sea roaring in. Not in a manner that was threatening, but it was forceful, and one could feel the power of the waves in front of you as they crashed onto the shore to greet you in all its glory before receding away. The sea was ever-changing in colour, with three broad discernible colours: brown, green, and blue. It was a patchwork of colours and constantly moving. The sea was brown and green at the front, and the further out you went it was blue. I could feel salt on my upper lip and the wind in my hair. The combination of faint sun and strong breeze refreshed my face. The sound was omnipresent, but the noise of the waves was also reassuring and rhythmic. It was a very mindful experience. The feeling of being grounded washed over me. It had a cleansing feel; the layer of dirt and grime of life became thinner, and my mind became lighter and more expansive."* [Ethnographic diary, July 2022]

Almost universally, the study participants extolled the benefits of having the sea as their constant neighbour, especially, although not exclusively, those residents who had moved into Skelsend. The seascape afforded the opportunity not just for contemplation; it encouraged gentle physical activity and incidental conversations with people who soon became familiar. Some people were discouraged by the often-brown sea colour caused by the stirring of clay sediment. Others were repelled by the family of rats that lived in the giant boulders that had been shipped in from Scandinavia about twenty years ago, to defend the town from the seas that people admired. However, this was a minority view; the blue space of Skelsend's seascape was, in most cases, never

far from people's minds when they thought of the positive local uplifting impacts on health and the ability to manage long-term health conditions.

Bernie is one of the long-term residents who appreciates the sea, recognising its positive benefit on his mental health. Bernie worked locally as a chef, but retired early due to ill health and work stress. He lives with diabetes and the long-term repercussions of surviving cancer, including fatigue, and requires a urostomy. Bernie lives on a terrace that runs down to the promenade; he can see the sea from his house and walks up the southern side of the promenade every school morning with his youngest child. "*It makes you feel good,*" Bernie says. The sea is "*just therapeutic, you don't have to go in it".*

Figure 4: Welcome to seascape

There was a tendency towards people who had always lived in the town, or long-term residents who, for example, may have lived in the town for more than twenty years, to become so accustomed to the presence of the sea that it was a part of their customary landscape which they paid less attention towards. However, this was not the case for Bernie, who was born and raised in the town; he left for a career in the forces before returning to the town, where he felt a strong sense of connection.

> "*I love being near the sea. It's, you know, I thank God every morning when I wake up and I walk into my kitchen and I can see the sea. I can see the sunrise every morning.*" [Bernie, Resident Interview]

Bryan explained that his health had improved vastly after relocating to Skelsend and cited the sea and the beach as prominent, ever-present features that provide significant therapeutic benefits. Bryan also lives near the beach on the northern side of the town. Bryan, who has struggled with depression ever since the onset of a neurological condition, told me that access to the sea provided a boon for his mental well-being.

> "*I've got literally a 100-yard walk to the beach. Gosh, do you know that expanse, that, I can go— If I want to… In the winter, if I get really pissed off, pardon the expression, I can go to the beach and sit there, you know. And yes, and just get my head together, you know. Yes. And it works, it just works."* [Bryan, Resident Interview]

I asked Sam, who also struggled with mental health and a neurological condition, if she felt there was anything specific about Skelsend that promoted her mental well-being. She told me that the town's surroundings, specifically solitary access to the sea, provided an essential therapeutic resource. The sea is reliably accessible whenever she needs to assuage a low mood. Sam, who lives a short five-minute walk away from a quiet section of the beach, explains the sea's calming influence and describes its restorative tendency to reflect her fluctuating moods.

> *"Even now that I'm stable, I still hit lows, and I still have highs. But my lows. I like to go sit on the beach. There's just nobody around, and I can sit there, and it doesn't matter if the weather's— If it's a mill pond or it's a storm. I prefer the storms, it just invigorates you, I think. But I can just sit and just do nothing… Well, if it's summer time, everyone sticks to the town side of the beach. They tend not to go further up. So, we have got real secluded peace and quiet, and you can literally just sit and do nothing. Nothing interferes with it, nothing bothers you, and you can just sit and relax… It's calming. And it's not a conscious calm, it's just sit and watch the water. And it is just, naturally, a calming effect. And I've noticed that, I have noticed when I'm feeling quite stressful, I like it when it's stormy. I think it reflects how you're feeling. And you sit and you watch… It just sort of goes away with the weather." [Sam, Resident Interview]*

Many residents talked about how the proximity of the promenade and beach to their homes encouraged them to be more active and how it benefited their physical and mental well-being. Florence moved to Skelsend with her husband about two years ago. She wanted to get away from the urban environment of her hometown and was planning for a future retirement by the sea. She appreciated the environmental qualities of Skelsend, which encouraged walking. The attraction of walking was primarily centred around the sea and the town's extensive promenade, although parks that provided green space complemented their appreciation of the seascape.

During our recorded walking conversation, Florence told me of the locations in and around the lengthy Skelsend promenade she routinely walks around for leisure with her husband. They often leave their home with drinks prepared and purposefully walk down the promenade to sit down on a bench with a drink, enjoying the sea view. As we ventured along the most peaceful section of the southern promenade towards the lifeboat station, we came upon the four, colourful, large wooden shelters with benches, from which one can sit comfortably and look out to the sea.

> *"You know like we walk a lot down here, down to the south side, we sit here because it's peaceful and quiet and it's nice and then we carry on down to the bottom and then we go back down onto the street and then walk back down. And that's a sort of little walk that we do. Then we will go odd times the other way, like down to the other end. But we do like walking round here."* [Florence, Residents Walking Interview]

The footfall is sparse on this part of the southern promenade, even in the high summer season, but it is a quiet place to spend time, reflect, and be undisturbed. One can sit on the benches in these shelters and look out to sea, watching ships slowly inch past the distant offshore wind turbines standing proudly on the horizon.

> *"We sit in there and chat. Sometimes he'll put a little can of beer in his backpack and I'll have a coffee. Well, that's my husband. He loves his beer. But it's nice, it's just nice and quiet... I see a lot more*

people going for walks, you know. And it clears your head, you feel better when you get home. You've had the fresh air, you've thought about things, it clears your head, and you go home, and you feel a lot better." [Florence, Residents Walking Interview]

The promenade was a source of inspiration to many residents I spoke to, and it was usually those residents who had moved here who seemed to be more ready to extol the virtue of Skelsend's seascape viewed from the promenade and beach, which motivated them to leave their homes and be more active, through walking, cycling and, for Gary and Mick, sea swimming. What struck me during fieldwork was how residents, especially those who had moved to Skelsend, took time to observe the sea environment momentarily; the sea obliged an indulgence in calm contemplation. Gary lives on the caravan site, close to the end of the northern promenade. During the photo interview, he commented on the temporary bird sculpture on the northern promenade; he told me this was where he always stopped and took time to appreciate the view.

"*As we pull out of our caravan site we can see the sea bird sculpture right at the end of the prom, and if you stand there and look all the way down you can see the whole of the beach of Skelsend, all the way down, and on a nice sunny day you can see past the follies and all you can see is the sea, sand, when the sea's out all you can see is pure sand.*" [Gary, Photo Interview]

Lucy, a long-term resident of Skelsend, has a combination of physical and mental health conditions. Although the autoimmune condition she lived with caused her physical pain, in recent years, her mental health difficulties usually had a more profound adverse impact on her well-being. When I visited her at home for our recorded conversation, Lucy reported that her mental health had improved over the last few months. Lucy said being more active helped; she had been walking and biking around Skelsend. Recently, she purchased a discounted bicycle and described her enthusiastic rediscovery of cycling. When Lucy was having a bad day, walking, or getting her bike out and cycling down the promenade was an excellent way to keep active and physically more resilient, but also prevented her from ruminating further, risking becoming more anxious or depressed.

> *"I'll try and make myself do something like go for a walk, or, I just bought myself a bike, so I've been going up and down prom on my bike like, yes, which is helping."* [Lucy, Resident Interview]

During our conversation, Lucy explained how cycling in a pleasant environment significantly impacted her well-being. Lucy frequently takes her bike onto the promenade, incorporating it into her ride when visiting friends.

> *"Well, when I first got on, I thought, oh my Lord, what am I doing? I haven't been on a bike for about thirty years. But then I loved it. I absolutely loved it. It hurt, it hurt my knees at first, and it really did hurt, and it hurt like getting the coordination and I was a bit nervous I was going to fall off, but when I actually got going, I thought, You know what? This is brilliant. Why haven't I done this years ago? And it helps, it helps. It helps with your mind. And I've got my little dog. My husband walks with the dog and I whizz up and down [the promenade] on my bike, and it is brilliant."* [Lucy, Resident Interview]

For many residents, walking the dog along the beach was a popular pursuit that encouraged activity in a pleasing environment. Even old-fashioned seaside fun can be enjoyed on Skelsend's beaches for younger working-age adults. For Amelia, a younger lifelong resident who lives with a mental health and neurodevelopmental condition, the combination of access to a quiet beach and friendships means a great deal to her well-being, encouraging exercise and pleasant distractions from any stress she might be experiencing.

> "*The beach, every day I can meet up with friends and because I have a dog, I can take the dog on the beach as well… You can draw pictures in the sand, you can find fossils, you can make sandcastles. Cos when I was a child, I could make a massive sandcastle and I made them with a moat around it*." [Amelia, Resident Interview]

Affordability

Crucially for many residents, because the cost of housing was comparatively low, it was one place where they could financially afford to be away from the stressful city environment they had experienced earlier in their lives. Phil, a

community worker who moved to Skelsend several years ago, told me there had been an increase in the number of people moving to Skelsend from the southeast. Skelsend provided a very affordable opportunity for people living on moderate budgets in the south.

> *"The town hit number one on a website some years ago to relocate, we have been getting people from the southeast who can't afford to buy down there but can here. People are paying huge amounts on their mortgage, but they can come up here and buy outright. One chap I knew moved from the southeast, and works from home, but his firm is down there. It's working well for him. People who have limited budgets can afford to move here, they want to be by the sea and here is affordable."* [Phil, Community Worker]

Moving to Skelsend meant participants could live without high mortgage costs and work fewer hours. Dennis was from an urban town in southeast England; his relocation story exemplifies this trend. Dennis always appreciated what he perceived to be a slower pace of life in the north and the pleasant environmental pursuits he enjoyed when visiting. A mild heart attack prompted him to evaluate what he wanted from life, and he decided to find a lifestyle that allowed him to work less and live in a more peaceful environment. Not only was Skelsend cheaper but it was better for his health, too.

> "*I had a £900 monthly mortgage before I moved here. If I brought back home less than £2000 a month, then something was wrong, so you get used to it. But when I was fifty, I had a mild heart attack and life changed for me… I just love Woldenshire, the people are friendly, property is cheap, so we sold up and moved up here and it's a different way of life… I didn't want to live in a city. I worked in a city, I lived in London at one point when I was kid, but I just didn't want to do that, so I said what I want, I want to live near the hills or the beach, but I would like to live near the beach because it's just appealing… It was up for £115,000. I paid £113,000 for it. So, I cleared my mortgage down south, the plan was to buy this one outright… people have said to us, 'Why did you move, because it's cheap.' You get a better quality of life,*

it is cheap up here. But why have you moved up here? Because it's a better way of life." [Dennis, Resident Interview]

Mary also moved from southern England, looking for a quiet, affordable space by the sea. Affordability is a crucial enabler for people relocating to Skelsend for a new beginning. Unlike so many coastal spaces, Skelsend was accessible for people of moderate means living in relatively deprived urban areas, like where Mary had moved from.

"*I came here from London three and a half years ago because it was affordable. I could buy property outright and wanted to be by the sea. I had £100,000 so I put that in a search engine and Skelsend came up.*" [Mary, Resident Interview]

Moving to the coast was an aspiration for many of these residents, whether to escape environmental conditions, memories of trauma or the desire to be close to the sea's natural environment and the town's rural hinterland. The affordability of Skelsend, in part a reflection of its economic malaise and spatial disconnection and redundancy, facilitated the realisation of these aspirations. The low cost of housing broadened the town's accessibility to homeowners struggling to maintain mortgages in more expensive parts of the country.

Onset of illness, trauma and moving to Skelsend

Several of the younger incomers into Skelsend had experienced some trauma before they had moved into town. Life events had exacerbated or caused mental ill health and critical dislocation in their lives, prompting a desire for a significant lifestyle change. Here, we discuss Sam, Jason, and Kim's relocation stories, which involved traumatic life events. Sam moved to Skelsend from an estate of notoriety in a prominent northern city fourteen years ago with her young family, after her baby boy had died. Before losing her child, she had lived with an enduring mental health condition, which, at times, could significantly affect both her and her family. Several years following her relocation to Skelsend, Sam developed a neurological condition that resulted in her experiencing very severe and debilitating headaches. Several months after her son's death, Sam felt compelled to live somewhere else, preferably where she

was not known and where she could commence a restorative new chapter in her life, away from the painful reminders of her loss.

Sam's family was from a large northern city; she lived on a close-knit estate, was a long-standing resident and was well known. The desire for anonymity and a fresh start contributed towards her decision to leave her urban home and relocate to Skelsend with her family. To Sam and her family, Skelsend was familiar, often taking caravan breaks on the town's outskirts. Skelsend, for Sam, represented an opportunity to seek restitution and a new start in life. Her decision to move away from what had been a secure home and environment happened abruptly following a weekend in Skelsend.

> *"I wanted a complete fresh start, I just wanted somewhere where I wasn't known. Because being home. Everybody knows me as, oh, 'She has just lost her baby.' And that is I felt like everything was crumbling on me…. Fourteen years I've been here… And, yes, I totally lost the plot, packed us up, and moved us here. And never been back since. It was – Yes, I didn't know it at the time, that I'd had a breakdown. It was – I had a little boy that I lost at eleven weeks old, and that was Christmas, and then it was like hitting the grief, hitting the grief, and then come the Easter at – Yes, I'd had a breakdown. But I'd just put it down to grief. So literally packed us up and moved us here, and it was like, okay. Everyone thought I was losing the plot slightly, but it was a blessing in disguise… and it was just literally a weekend away, came for the local campsite, had no intention of doing anything, just needed a different change of four walls, basically. And it was like, let's go. And we were there for the weekend, I went home, I'd seen a house to let, I'd phones them up, done it, loaded our van, and turned up on the doorstep two weeks later. And got on and just did it. No conscious decision, no nothing, I just packed us up and went."* [Sam, Resident Interview]

Sam's relocation to Skelsend proved successful. Indeed, the town's slow pace and spatial calm were most beneficial to her well-being and provided space for her to work on herself, as later discussed in this chapter.

> *"If I lived in the city now, I would probably be dead. Suicide would have got me a long time ago. But moving, even though I moved for all the wrong reasons, moving here has literally saved my life because there's outlets for me here, and – not always the medical side. A lot of it is just because of where I am. The environment and the people. It is very olde worlde here, as well, that's the hard one to get used to. But personally, it's what I needed."* [Sam, Resident Interview]

Jason was in his forties and had moved to Skelsend two years ago. He had a skin condition and a mental health condition, both of which had resulted at one time or another in him having to take time off work. Jason told me that his arrival in Skelsend had not involved much planning; being single, he had no relationship or family constraints. He just wanted to find somewhere for a fresh start and put a difficult period behind him. A combination of pre-existing mental health difficulties, increased work stress and a severe skin condition had combined to cause an intensive period of mental distress from which he was still recovering.

> "*I was living in another part of the country, and I had a job which became very stressful and it was making me ill, so I decided on a fresh start, I put a finger on the map and it landed me here, so this is where I came."* [Jason, Resident Interview]

Before moving to Skelsend, Jason lost his job as a recovery driver because he had taken two weeks of sick leave when medical treatment for the skin condition necessitated two weeks in the hospital. The stress of the job and his subsequent dismissal, combined with a lifelong propensity to experience significant anxiety in the form of obsessive thoughts and behaviours, induced a mental health crisis.

> *" I've always had problems but not like this, you know. I had a psychiatrist when I was a kid but I was only young, I never really took much notice of it because I didn't know what he was on about. And I've always sort of struggled but I've never had any help for it, you know. I've always just gone to work and got through it, but now I've*

got older it must have built up into my system that bad that I felt like I was having a breakdown. It was awful, so basically, I just stopped everything, you know." [Jason, Resident Interview]

After being dismissed, he did not work for twelve months before taking work as a self-employed truck driver. However, the time pressure of the job was not conducive to his mental well-being. He continued this work initially when moving to Skelsend, but the lockdown and his deteriorating mental health resulted in him leaving the labour force again. Jason gave an example of his compulsive thoughts.

"Then I started self-employment through an agency, and I was doing a lot of hours. And that was stressful but it wasn't too bad, but I started counting lines in the road (when driving)*. So, if I went to London and back, I'd count all the white lines in the road, and by the time I got to London I was that shattered, I'd just be wiped out for hours, asleep in the cab. Because that's what I was doing, I was doing stuff like that, but every time I got in the truck or the van, I was counting these lines constantly, for hours and hours and hours. And obviously when you speed up on the motorway the lines get faster, you lose count, you can't count them anymore so I was having to start again. One, one, two, three, four, counting lines in the road."* [Jason, Resident Interview]

Jason arrived in January of 2020, before the first lockdown. He recalled no one being about the town. It was winter, when Skelsend could appear quite bleak and empty. Some residents joke about the tumbleweed blowing through the town, especially during winter. Jason told me that when he first came to Skelsend, he felt "*stressed and confused"* and found his first winter here particularly difficult, and his outlook did not immediately improve. He recalled how his mental health deteriorated; he described to me in quite a matter-of-fact and calm way how he contemplated suicide that winter.

"I mean, when I first moved here, I did think about committing suicide a few times. I was sat on the cliffs up there one day and I thought – Yes, it was winter. I think it was January and it was really bad, and

the weather was really bad and it was crashing up (the waves against the clay clifftops). And I was stood right on the edge of the cliff, you know in the mud, and any of those waves could have taken me off and I wasn't bothered. I was at peace, you know, and I did think for a moment, Shall I just fall off? And I thought, No, I'm not ready yet, so I went home. Yes, that was strange, but I felt at peace, you know. I don't know why. I threw my grandma and grandad's ashes in the sea when they died, at Scarborough, so I wonder if they were calling me? 'Come in here, everything's alright,' you know. I don't know." [Jason, Resident Interview]

Jason ultimately accessed support for his fragile mental health in Skelsend, and his overall well-being improved considerably after being signposted towards cognitive behavioural therapy by a GP in the town. Jason told me he was supposed to get three months of support, which turned into six months. This treatment proved to be the most supportive and beneficial. Accessing mental health services was integral to several residents' relocation stories, which I will return to in Chapter 9. For Jason, though, Skelsend provides an environmental outlet that helps defuse his anxiety and stress. Through beachcombing, he has made friends with another man who moved to Skelsend for similar reasons.

"*Go fossil hunting, that's all I do. Because I stay on the beach, because there's nobody on the beaches that way or that way… So, I go with Jim, you know, that works for the museum. Yes, he comes with me every day nearly, but I met Jim on the beach strangely enough, because he has mental health and stuff. And we just got talking and we've got a good friendship now so I just go with him… But I did it today. After I phoned the housing today, I was really stressed. I didn't know what to do so I made a coffee and went on the beach, and I just started walking. Before I knew it, I was in the next village*." [Jason, Resident Interview]

Kim's relocation to Skelsend is a particularly harrowing example of the need to move from unsafe environments. Kim's primary health condition, a severe and enduring mental health problem, was, in her view, directly due to being a victim of an assault and other intimidatory incidents in her northern city home sixty

miles inland from Skelsend. The trauma and subsequent illness were instrumental in her moving to Skelsend sixteen years ago from the large northern city once her home. The assault occurred in Kim's front garden; her assailants knocked her unconscious, beat her, and ransacked her home. This assault occurred after a break-in and, on a separate occasion, a brick through her window, narrowly missing her infant child. These events precipitated a mental health crisis that necessitated admission to the hospital for six months. The 'attack', as Kim continually referred to this traumatic moment causing disjuncture in her life, has left a lasting mark on her. She has received treatment for a severe and enduring mental health condition ever since.

> "*After the attack, it destroyed me, but I'm still here, and that's the main… I was walking down me garden, I was carrying burgers for the kids, and, as I remember it, these people came into me garden and started shouting. I said, 'Go away you've been drinking, I'm having a get-together with me children, just go away.' And she just carried on, storming down, she pushed me on the shoulder like that, then boom, straight across my forehead. I lost consciousness, for three minutes, she was beating me up on the floor in front of them all* (her three children). *So that's how I got me condition. It were horrible. They put me in another hospital for the next three months. When I did get discharged, I had to rebuild my life again. I had me own home, but they (the attackers) destroyed everything. They took all me furniture, I can replace everything, I've done it before, but I can't replace –* [long pause] – *they ripped up me baby photos on me wall."* [Kim, Resident Interview]

Whilst in hospital, Kim discovered she was pregnant. However, her husband had become estranged during this turbulent period. Kim could no longer settle back home, where the assault took place, so she moved to Skelsend to be close by her parents, who had already moved across to the coast.

> *"I had me little baby boy, he were a miracle, but I couldn't settle back there… I got everything together and me dad came over with a friend with a van and just brought me over here… I'm not looking over my shoulder all the time living in Skelsend."* [Kim, Resident Interview]

Before long, she was offered a four-bedroom council house, where she has lived ever since. Kim said firmly, *"It's my home"* followed "*I feel like I'm protected in there."* Kim reported feeling much safer in Skelsend and has no intention of returning to her home city, even though she has relatives there. Many of the people I met who had relocated to Skelsend experienced mental health challenges as well as many other long-term conditions. Like Sam and Jason, they were looking for peace and a fresh start following life experiences elsewhere, which had severely impacted their well-being.

Escaping the city and feeling safe

> *"I moved here on my own two months ago. I didn't know anyone and family and friends are 2 hrs. away. I would feel very safe walking about on my own and made friends. Love this sleepy town and would never move back."* [Skelsend Community Facebook Group]

Many residents came to Skelsend to escape urban environments that they felt were bad for their mental health. The intensity, noise, and fear of crime, including, in some cases, physical danger, were things they wanted to leave behind. In contrast, Skelsend, although not without its problems of antisocial behaviour, represented a calm oasis compared to where they had moved from. A theme that strongly emerged from the interviews was the fear that the city environment held for several residents who had moved from Skelsend and who came from intense urban environments. Gary told me,

> "*I would never go back there – I have friends now in Skelsend living round the corner from us from there, they won't go back either. You can walk the streets safely here… Wouldn't get me back to there. We are going not next week, the week after. We got to see relatives, but I've been back to there a couple of times. As soon as I get to junction 22, I start getting palpitations."* [Gary]

Mary acknowledged the poverty people experienced in Skelsend, the deprivation and the lack of opportunities for younger people. However, despite this, she felt there was not the same virulent aggression in Skelsend, which resulted in unease, anxiety, and hypervigilance.

> *The whole area of this place is much more relaxed, there's less aggression, it's the aggression that's not here. And I don't think the people that live here realise what it's like to live in a town and be faced with, if you look at someone wrong, you were in trouble in areas that have greater deprivation, there's more angry people and up here, in this area, people are much more relaxed."* [Mary, Walking Interview]

When Mary's daughter, who lives near her former home, comes to visit her in Skelsend, she brings with her the fear of violence. Mary recalled her daughter's reaction when her doorbell rang after dark. Innocuous now to Mary, but threatening to her city-dwelling daughter.

> *"My doorbell rang, and it was about twenty to nine, it was dark, so it was winter, and I said, 'Oh, someone's at the door, let me just go and see.' She said, 'Mum be careful.' And I went, 'Be careful of what? There is nothing to be careful of.' And yes, where she lives, she – well, she would look out, well, she's got cameras there." [Mary]*

When visiting Haxton or returning to other large towns or cities, to see family or tend to business, many residents reported that the pace and the concentrated density of amassed people caused them to feel agitated or panicky, even though they were returning to places familiar to them.

> "*If I lived in Haxton now, I think my health all the way round, my pancreas, my mental health and my asthma would be a 100% worse. I don't like people being close to me. I don't ever go shopping in Haxton city centre because I can't stand it. I can't stand people walking at you. I can't stand the fact that everywhere is so busy. There's no fresh air there, there's no sea air to take any heebie-jeebies out of the air and I think they live a chaotic lifestyle, they are not relaxed in any way.*" [Cheryl, Resident Interview]

After leaving a stressful and sometimes dangerous job and an urban lifestyle to take early retirement in Skelsend, Mick, in his mid-fifties, although recognising living in a seaside town such as Skelsend does have

logistical challenges, namely its isolation and lack of amenities, the health benefits to its environment make it all worthwhile.

> "…*no looking back for that no, but there are obviously the issues that come with a small seaside town…. I like living on the coast and I like it that it's a small town with a good community. I wouldn't like to live in a big town or a big city anymore to be honest. I find it much more relaxing here. Obviously it does have its pressures, but it's better here for me, and my wife*." [Mick, Resident Interview]

Likewise, although originally from the city, Paul found the busy urban environments challenging to bear, a discordant confrontation to his senses. Paul has a mental health condition that predisposes him to experiencing overwhelming anxiety, as well as an autoimmune illness that leaves him feeling fatigued. Due to poor access to services in Skelsend, such as banking and shopping, and the need to visit his mother, who is dependent on his support, Paul, despite the stress it causes him, must visit Haxton. Although Haxton is his former home, he finds its environment very stressful. I asked him, hypothetically, how he would feel if he had to move back to Haxton; Paul replied by drawing a contrast between his old home and his current home just outside Skelsend. During our conversations, Paul described how access to green and blue spaces made a difference to his well-being.

> *"I wouldn't be able to cope, I can barely cope going into Haxton, I have to pick up Mam and take her shopping in Haxton sometimes. Sometimes, I go into the shop with her but can't stand it, I get real irritable at checkouts. I've left her in the shop and gone out cos I can't stand it. Yeah, acute, it's not that I'm angry, it's just the way things affect me. I don't like Haxton, I hate it. I can't handle everybody, the mad rush you know what I mean, I get really wound up. Round here, and where I live in the next village, I've got fields in front of me, fields round the back and round the side. My two neighbours are fantastic. I think, so living somewhere like this, it does my mental health a world of good."* [Paul, Resident Interview]

As my time in the field progressed, I felt similar sentiments to Paul's about the town. Even though I had a job to undertake in Skelsend, I usually felt calmer within its environment than back in my city home, which started to feel more oppressive in comparison. I could see why Skelsend was conducive towards mental and physical well-being. A place that had the capacity to soothe illness rather than exacerbate. On reflecting whilst journeying home on the conclusion of fieldwork, I wrote the following,

> "*The longer I spent in Skelsend, the more I shared the residents' sentiments. Indeed, when returning to my city home after time spent in the field, I could feel my bodily tension build as I turgidly progressed through the city's congested streets and grey trunk roads. The intermittent and startling sirens of emergency response vehicles, the impatient and aggressive driving, the carelessly abandoned accumulation of litter, the interminable roadworks, and the frustrated urgency of two lines of disconnected people, separately encased in their vehicles, trapped in creeping traffic. The taste of contamination that hung in the atmosphere compared to the sea air of Skelsend often became more palpable. I would feel the oppressive weight of the city and could appreciate the motives of people moving to Skelsend, despite its reputation and the challenges that might accompany living in a comparatively remote, small, and materially poor town."* [Fieldwork Reflection on leaving the field, October 2022]

The spatial calm of Skelsend

I noted during fieldwork that, for most of the time, the town was tranquil, especially by mid-afternoon when the footfall, aside from the school holidays, was very thin. The pace of the town felt slow; even the beaches in summer were comparatively quiet. Skelsend is not a place people pass through on the way to somewhere else. There are no large retail stores, just medium-sized Tesco and Aldi, and a small Factory Shop stores for clothes. The arcade precinct can be heard to zip, beep, and chatter across the promenade gardens, but the area is usually sparsely occupied unless it is the school holiday. By mid-afternoon, most shops are closed, and some do not even open if the weather is inclement. Apart from Friday and Saturday nights in some of the pubs, Skelsend is a quiet, sleepy town next to a garrulous sea that keeps gnawing away at the land to the north and south of the town.

Although, for many, this may appear to be spatial redundancy, as I discuss in Chapter 7, to many residents, especially those who have moved from stressful environments, the slow pace can be restorative and conducive to managing one's health, especially with response to mental health. That is, providing one can adjust to the town's idiosyncratic nature. It is this environment, in combination with the sweeping seascape and low levels of economic activity, I refer to as spatial calm. During fieldwork, I noticed that the main high street usually drifts into a slumbering torpor by three o'clock in the afternoon.

> "*You could go around at three and they're shut. And it'll be like, oh, they've had to do something at school, and oh, the weather's rubbish, they've gone home, or they're just bored. And because – In winter, you can see the tumbleweeds in this town. So, it's like, they're not sitting there all day, they've gone home. They're bored. And that's how it is*." [Sam, Resident Interview]

I noticed how many independent traders operated unpredictable part-time hours. Ben, who lived with multiple health conditions, his primary condition affecting his spine and mobility, ran a small shop on the high street – although, due to deteriorating health, he was closing at the end of the season. He was from a large city where the shops are open until late; whereas, in Skelsend, shops, cafes, and other amenities are open at erratic times and never stay open

into the evening. It is not unusual to see shops closed for an hour or two during the day, even on weekdays. Moving to Skelsend was a culture shock for Ben; he compared urban retail life with this small seaside town.

> *"…say it's not open (in the city), you'll go to the next shop. You won't care. It's like you won't go to your regular shop as such because everywhere's open basically. If it's not, it's tough. You go to the next place and no one worries about it… but then a lot of the small businesses didn't shut till seven, eight o'clock. Here it's three o'clock in the afternoon. I can understand it because it's like there's no one coming in, so there's no point staying open. It's like the town just dies."* [Ben, Resident Interview]

Sam further reflected on this ad hoc aspect of life in Skelsend and saw the benefit of shops not opening and life being so much slower. This was largely because Skelsend has, as she says, "*its own time zone and weather system*". In contrast, the major northern city where she came from never slept. In contrast, there was access to the shops and other amenities day and night, but in Skelsend the "*shops just shut, and you just have to wait*". Sam acknowledged that Skelsend was far from affluent, but she thought, through its environment and gentle pace, it was "*rich in ways money can't buy*".

Just getting to Skelsend from somewhere like Haxton is unpredictable. It contributed to a loose, flexible relationship that residents may have with time. Sam described with some mirth the problems one encounters getting to and from the town, with tractors, "*Sunday drivers*", weather conditions, and the winding, narrow country roads combining to make journeys somewhat capricious.

> "*So, it doesn't seem to matter how long you leave for your journey. You never get anywhere on the right time, you're either early or late. There's no in between... think once you put your head around the fact that timings round here just don't work, and you can say you're going to be somewhere at a certain time, but as long as you're close enough, then that's acceptable over here.*" [Sam, Resident Interview]

Sam reflected on the vast lifestyle change moving from the city to Skelsend involved Although, at first, she struggled to adapt to the change of pace, as she became more accustomed, she firmly believed that ad hoc timings, the reduced general activity and restricted opening times, that contrived a much slower pace of life, had benefited her mental well-being. Instead of feeling rushed, she had time to reflect, work on herself, and learn greater acceptance. The environment helped her to embed the workshop skills she had learnt when receiving talking therapy from mental health services.

> *"You actually take time for your life, where before, you always had a million and one things to do. I speak to family that live over there, and they never have two minutes to do anything... And I think that's the biggest thing, because we're sort of out of the way, we can actually stop. And because we have our own time system, everything does stop, and it's like, come five o'clock the town's asleep, literally. But that's a good thing because you get time for yourself. And I think that's been a big thing health-wise, because you actually get time to sit and work on yourself rather than everything else.*" [Sam, Resident Interview]

The stark environmental contrast between the slow rhythms of Skelsend's seascape and the intense urbanicity, where many incomers have come from, is reported by many working-age adults with multiple health conditions to have vastly improved their quality of life. Mary could not praise enough the health benefits of living in Skelsend more, especially compared to her previous urban home, where she did not feel safe.

> *"I've just had a health check and I got the results two weeks ago, and all of my bloods and my sugar levels, everything, fine, first time ever. And it is, I think really, for living with peace and not having stress."* [Mary, Resident Interview]

Supportive spaces, community groups and volunteering

The friendly neighbourhoods and network of communities within the town made for a friendly environment, something I encountered in Skelsend. People soon recognise your presence, and impromptu greetings and conversation will flow.

Given the town's geography, this helps provide a more trusting environment where people can relax and helps counteract the potential of social isolation. People are encouraged to leave their homes, exercise, and get fresh air because they usually have opportunities to connect with others on the high street or in and around the promenade. As Janey says,

> *"I love being here anyway, because it's the people. Yeah, I mean there's one or two people, but the majority of people – if you're out it's very difficult to be lonely in Skelsend."* [Janey, Photographic Interview]

The friendly atmosphere and the supportive spaces of Skelsend created by its residents spill onto the streets. After a few months of fieldwork, I found it hard to traverse from one side of the town to another due to impromptu meetings with friendly new acquaintances. Mick runs one of the many community social groups that nurtures solidarity and belonging, helping to build the town's social capital. He explains how this social cohesion is found on the streets, too.

> *"I live probably five minutes from the prom, and if I walk it'll take me five minutes but it doesn't. It takes me half an hour because there'll always be somebody going, 'Morning, morning, morning,' d'you know what I mean? Then you'll, like, stop and have a conversation, and you'll go another couple of hundred yards and then you'll stop and have another – I've never had that before anywhere we've lived so it is good… There's the Services Club, which I like doing. I like just going, and I'll do the serving of the teas and coffees rather than get involved with the chatting on the tables. And I like to just stand back and just watch it all."* [Mick, Resident Interview]

The community centre had become an important place for many residents in Skelsend. It was essential for people experiencing difficulties arising from a mental health condition. However, the community centre was one of those essential spaces that gave people a sense of security and confidence to leave the house and interact with the world in person. Without the support available in Skelsend, Paul told me that he would not come into town and would likely become more isolated at home.

> "*I have had more support in Skelsend than I could wish for. I don't think I'd have had this support if I lived in Haxton, cos when I lived in just outside East Haxton, when I was well, I lived there thirteen years, I never got to know anybody. Here (Skelsend), I know everybody at my two support groups, and I have safe places. I can come into Skelsend, relaxed now. Because I know if have a blip I got somewhere to go, whereas if I didn't have, you wouldn't get me in* [to town]." [Paul, Resident interview]

Across the road from the Social Supermarket was the base for the local Pear Tree charity, where I also volunteered during fieldwork. From the outside, the Pear Tree looked like a shop; indeed, assorted donated items were displayed and could be bought for a reasonable charitable donation. However, the primary purpose for its presence on the high street was the drop-in service; it was a place where anyone from Skelsend could call in and receive support. It also provided a space for people to connect with others.

> *"That's one thing about this place, it's a good thing. It's a good thing that it's here because there are a lot of people that could do with a hand, people who've got nothing, you know what I mean? People who've got mental issues and things like that who have nothing, and they've come out of hospital or something and they've got a place with nothing. It's a good idea, you know what I mean?*" [Bertha, Resident Interview]

While I volunteered with the Pear Tree, the organisation helped numerous people, many of whom had relocated into the town after being housed elsewhere by the council. Mark was recovering from a period of severe mental distress and, following being made homeless, he had been given a flat in the town. When he came to Skelsend, approximately one year after we had met, he knew nobody, and it was a challenging time. When Mark came across the Pear Tree, he was feeling very low in mood, but felt he must find a connection with others, even though he wanted to remain withdrawn. Referring to his reaching out to the Pear Tree for support, Mark told me,

> "*But I was just, only just managed to drag myself along. I did not want to go. I didn't want to do anything. I just wanted to, I didn't even want to go shopping (pauses)… Sheer grit and determination, I think really, knowing – Yes, knowing that I have to, I suppose somewhere deep down you just knew that you've got to have some kind of connection with people… I'm beginning to feel more at home here (referring to Skelsend). And, of course, the people here are very, they're very sort of cohesive in some ways I think*." [Mark, Resident Interview]

Finding connection through the space provided by the Pear Tree charity has played an essential role in Mark's recovery. The contacts he made there provided emotional and practical support and assisted him in embarking on a new venture, which aided his recovery by providing him with more social contact, purpose, and achievement. Apart from volunteering at a charity shop on the high street twice a week, he used his art and design skills to start designing shop and street signage. His newly found connections at the Pear Tree provided support to get going. When we met for an interview, he had just designed a sign. He hoped to contribute towards improving the look of the high street, which had become, according to many people, "tatty".

> *"I mean I'm only charging the guy peanuts for the design, just to get me going so that I've got something up in the town. I can say I did the sign at so and so. A friend at the Pear Tree is going to measure up and put the signs up for me."* [Mark, Resident Interview]

Indeed, volunteering often became part of their social support. Paul had lost his job due to a period of severe mental distress. This period of illness was like a fracture in his life from which he was tentatively recovering. His connection with the community centre and the voluntary work he regularly carried out there, using his trade skills from his former work, was an essential part of his gradual recovery. For Paul, volunteering helped him to maintain a positive outlook and reduce feelings of stress and anxiety, which can impede his ability to manage an autoimmune condition.

> "*I do the volunteering now. Instead of being a client, I go and set up all the tables in the room, I get the tea and coffee ready, and I sit in on the groups, I can then relate my story to them. So, they know it's coming from somebody that has been there and done it… Volunteering gets me out of the house… I can come here and switch off… it helps me, helps them, everybody is happy. You get back what you put in. When people ask me to do things, I'm happy to help them for nothing, cos they will be one day when I might be asking them for a bit of help*." [Paul, Resident Interview]

Several residents found that voluntary work was a safe way of maintaining a sense of purpose without the pressures of paid employment, which they felt they could not cope with at this stage of their recovery.

> *"I'm happy doing voluntary work, because I've got no boss and no pressure, but the minute you put pressure on me I dip. I start worrying, and I will spiral back to where I've come from. Whereas, if I'm doing it voluntarily, I can drop out anytime, because I know that there's no one putting me under pressure. Cos when I get put under pressure, that is when my head goes, I start getting ratty, I start ticking, I start marching up and down, I get so frustrated… best to come in and do a few* [hours]*, then call it a day when I feel the tension in my head. Then come back another day and do another few and do it in small sections that I can manage."* (Paul, Resident Walking Interview)

During ethnographic fieldwork, I encountered many community groups in Skelsend, undertaking various activities, from walking football and craft groups to a gardening group. Several of my cohort of interview participants contributed significantly toward the development and sustainability of these community groups; by seeking connection with others and sources of social support, they helped build the social capital of the town. Volunteering was often therapeutic and sociable for several residents and helped provide an important sense of purpose.

Summary

Skelsend was, for many, an affordable sanctuary away from the stressful harms of their former urban environments. The affordability allowed a broader range of people to relocate to social and physical spaces of the town and its natural environments, notably its seascape. These residents do not seek economic opportunity or employment, but rather a chance to make a fresh start and renew after the onset of illness frequently accompanied by traumatic life events. The natural environment of Skelsend benefited the mental well-being of working-age residents with multiple health conditions. The soothing influence of the sea, the slow pace and safety of the town compared with previous environments, helped provide residents with a sense of calm and, ultimately, a better platform from which to manage physical health conditions. The ease of access to blue spaces encouraged people to engage in outdoor activities, whilst interacting with others in what appears to be a laid-back location.

The sea, the activity around the sea, and the camaraderie on the streets encouraged people away from the sedentary lifestyles that risk a deterioration of physical health conditions. Further bolstering residents' feelings of well-being were groups and networks of social support, facilitated by organised groups and the regular encounters on the streets of Skelsend. The town's environment and its people contributed to a sense of security beneficial to reducing stress and anxiety, once more building an increased capacity to tend to both physical and mental health, thereby beneficial to acquiring a sense of well-being, despite living with multiple illnesses. For many relocating residents, Skelsend, through its spatial calm, provided an opportunity to renew, forge a new start, and improve their well-being, despite the detriments of living with long-term health conditions.

I found there was a tendency for residents with health conditions who had relocated to Skelsend to benefit more from the environment of Skelsend than the lifelong residents. Aside from the length of residency, there existed a further tendency for those residents not dependent on Skelsend's physical and social space to acquire access to necessary financial capital to have a greater appreciation of Skelsend and its contribution to their physical and mental well-being.

The next chapter juxtaposes the benefits to well-being of the spatial calm of Skelsend, with a sense of spatial redundancy and loss of purpose. Those people needing economic opportunities to thrive, or who struggle with poor connectivity, may experience a detrimental impact on their well-being caused by underlying social structures of disadvantage and a shortage of personal resources to overcome them.

Figure 5: Its not a bus shelter!

Chapter 7 Spatial Redundancy and the Dissolution of Purpose

Introduction to spatial redundancy

This chapter stands in contrast to the preceding chapter. Instead of narrating Skelsend's beneficial experiences of spatial calm, this chapter discusses the experiences of spatial redundancy and the dissolution of the purpose of place and people. Much of the qualitative data gathered during fieldwork, complemented with online sources about the recent history of Skelsend, depicts a seaside town incrementally shorn of purpose by the gradual decline of tourism. I define spatial redundancy as referring to a specific inhabited location in which the intrinsic purpose for being the primary industry has largely dissipated. In this chapter, I consider how the loss of purpose within Skelsend intersects with health conditions and geographic isolation, shaping the experience of working-age residents living with health conditions.

As conveyed in the previous chapter, the spatial calm of Skelsend, significantly generated from the town's spatial redundancy, benefits those seeking tranquil spaces conducive towards restoration and well-being despite the challenges of living with health conditions. Spatial redundancy helps to keep prices low and housing more affordable for a broader range of people from other parts of England. Those seeking to exploit spatial calm usually do not need to work and wish to preserve the quiet and maintain only a subdued tourist industry. Therefore, within spatial redundancy, a paradox is found: the biographical restitution of many of its residents, especially those who have relocated to Skelsend from intensely urban environments, as described in the previous chapter, contributes toward the reproduction of the spatial redundancy that impacts on other residents with poor access to economic capital and requiring work opportunities.

The adverse effects of the erosion of purpose, through ongoing spatial redundancy, tend to disproportionately impact longstanding and lifelong residents, especially if they feel economically insecure and need to access work opportunities. Without large employers, the local economy rarely produces secure work that can accommodate the vicissitudes of fluctuating health conditions. In Skelsend, most employment opportunities are fraught with insecurity, often seasonal, and usually consist of physically demanding work not

conducive to many people with health conditions and restricted physical functioning. The work available is more likely to exacerbate symptoms of health conditions, whilst the tenuous security of work, for many, invites financial distress and consequent damage to health. The long commutes caused by poor transport connectivity to and from Skelsend prevent many living with health conditions from accessing work opportunities in Haxton or larger towns in Woldenshire. Consequently, many residents become more dependent on what the local economy can generate.

The conditions of spatial calm host a plethora of challenges characterised by the same redundancy that facilitates the environment of restoration. Therefore, the needs of those seeking and maintaining biographical restitution, often driven by past experiences and circumstances that demand restitution, can conflict with those who require economic opportunity, especially younger adults. Additionally, there are those incomers, whilst seeking to take advantage of the restorative characteristics of Skelsend, still need access to employment and other opportunities and, thus, can be materially threatened by the very spatial calm that might ameliorate propensity towards harmful stress and anxiety.

The redundancy of place contributes to the experience of spatial calm. Those residents seeking relief from redundancy and needing to extract opportunity from the social space of Skelsend, have needs contrary to those who wish to maintain a spatial calm, the quiet, slow pace from which they extract conditions conducive to restitution. Meanwhile, as tensions unfold, the seaside nostalgia and yearning for a lost golden age ripple under the surface through the narratives of paradox.

The existential crisis of Skelsend

Throughout the fieldwork, there were frequent comments about how many visitor attractions were lost to the town. “Skelsend loses everything” and “Skelsend is dying” were phrases I often heard from locals, especially younger residents, who felt nothing is left for them in the town, a place full of pessimistic gloom. In the words of Selina, whom I volunteered alongside, Skelsend had become a place “where people come to die”. Likewise, when marshalling a

summer event in the town with another marshall, she remarked, during a tea break that Skelsend is “god’s waiting room”.

People still visit Skelsend, and holidaymakers arrive at the caravan parks on its outskirts during summer. However, the infrastructure to entertain visitors appears absent or stale, tired without the sustaining nourishment of lasting regenerative initiatives. During my ethnography, I detailed walks around town across the seasons, high and low, noticing, even in peak season, the stark contrast with busier resorts further up the coast, the footfall being discernibly sparse in comparison. The caravan parks in summer do host regular seasonal visitors, usually familiar with Skelsend, but the town does not attract the crowds it once did.

Skelsend was developed as a seaside resort town, hosting holidaymakers who were escaping their city lives; this provided the town with its purpose. Mass seaside tourism is a thing of the past, and, in Skelsend, it is reduced more than elsewhere. With no replacement industry, the town’s economic life has ebbed away with little returning flow. The progressive diminution of resort life is central to the slow intensification of the conditions of spatial redundancy that influence the social context, which, in turn, influences the experience of multiple health conditions in this small seaside town. A community worker based in Skelsend, whose occupation was in community development initiatives, sketched out the challenges faced by the town.

> “*In the other seaside resorts nearby, there is a higher footfall, but Skelsend is a very quiet place. It can get busy at certain times of year but then drops off dramatically. So, because people aren’t spending the money in the town, the economy can’t regenerate itself. Other towns have longer tourist seasons that attract more visitors. The quiet nature of the town may attract more people wishing to settle somewhere that is not busy or built up. However, this can have a negative impact upon the economy, because it fails to attract sufficient numbers of people to generate the necessary income to provide the economic opportunities for the people living and looking to work in the town.*” [Tanya, Community Worker Interview]

During fieldwork, I soon found the owners and staff of cafés were like the barometers of Skelsend, observing the changing weather, the moods of the town's residents and their fortunes. They gauged the tourist activity and absorbed the town's collective talk, misgivings, and aspersions. With this in mind, I ventured into all Skelsend's cafés, fish and chip shops and bars, apart from the two clubs requiring membership to enter.

Dan's Café is a cheap and inexpensive small café that offers a good breakfast. It was one café amongst many where I enjoyed a breakfast. Sadly, this was the morning that Dan made the difficult and reluctant decision to close due to a lack of custom and escalating running costs. He was one of three café owners during the peak July and August 2022 tourist season that closed. I heard other local business owners dependent on the tourist trade complain that visitors no longer have money to spare, and what they did spend tended to be on the facilities within the caravan sites. Stressed budgets meant that more visitors were getting food from the Aldi supermarket than visiting cafés like his. The economic environment meant that cafés and other small businesses, like Dan's, were operating on tight margins. I talked with Dan, and he was happy to share his thoughts.

> '*Dan, a café owner, saying he is closing in three weeks; there is just no business. He points to the scene outside his café, which is in the main tourist area of the town. Despite its centrality, it's empty. It's the middle of the season, it should be high season with the school holidays, but it is empty. He looks like a mixture of dejection and resignation. He is sitting at a table across from me in his empty café… Invariably, when I have visited, the café had few if, any, customers, today is no exception. He tells me he sees other café owners standing outside their premises looking into space because nobody is around. Last year, the streets were full, but this year, "Business has dropped off a cliff," he tells me. He tells me that Skelsend is a "budget resort", and people would visit the cafés here*, *but now they are empty, whilst Tesco and Aldi are full of tourists. The visitors just don't have the money. He tells me he has another place on the caravan site, but they are not breaking even there, either.*

Referring to this café though, "*With you, we have two tables and yourself all morning, and that's it." He tells me the "streets this time of year should be brimming, there should not be room on the pavement, but instead it's dead*". [Dan, Café Owner, Fieldwork diary]

Dan sits with me longer, redundant in his own café, with a tea towel slung over one shoulder, hunched over an empty dining table across the empty room from me. He shares his sadness about the town's long-term decline and its effects on the people in the town.

"There are no opportunities for people", he tells me. "You must move out of town; there is just nothing here work-wise for people..." He talks about his siblings; he is one of six. They all needed to move apart from a sister who works in the primary school as a teacher. He is glad his daughter is moving to Manchester University to escape "this bubble". He tells me people become "stuck here and feel they can't move on". He tells me there is much apathy, the "town breeds apathy" because there are so few opportunities here. [Dan, Café Owner, Fieldwork diary, August 2022]

Tensions between competing needs: spatial redundancy and calm

Tanya, a community worker involved in community development, had considered the tension of the competing needs of residents in Skelsend. She was very familiar with Skelsend, both living and working in the area. Tanya identified the contradiction between the benefits of being a quiet town for many residents and the need to secure more inward investment and attract more visitors. She reflected upon the difficulties of accommodating an apparent juxtaposition of needs and aspirations.

"*I think one of the difficulties as well is the residents of Skelsend, they like the town quiet. Which again is a positive in terms of accessibility. So, for sensory (impairments) and things like that, it is quite nice because it's not too busy, it's not too built up, and it is quiet. However, it then has a negative impact on the economy because if they like it quiet, they are quite averse to new things being brought in,*

which may attract a higher footfall. So, sometimes it's a bit six of one and half a dozen of the other, because they need the footfall to generate the income for that income to be put back into the town to make improvements. But at the same time, they do not want the footfall." [Tanya, Community Worker]

Tanya further reflected that the tensions between the needs of the residents are characterised by the three generations she describes below. The locals, the relocators or incomers who benefit from the peaceful environment, and the *young* who require more opportunities. These segregations broadly corroborate my ethnographic observations, although they are tendencies, not constant conjunctions.

"And it seems to be that the ones who are born and bred here, are still living in the view of how Skelsend was originally. So, you're talking when the train was there, when there was the outdoor swimming pool. Even generations dating back to when the leisure centre was actually the dance hall. And they will quite happily tell you all about how Skelsend used to be, and they're very much in favour of the train coming back or a bus route being made to a different town, like a Whorley bus route, for instance. They're not really opposed to having those transport links made because they are very aware that they have missed opportunities and haven't been able to expand a lot of their life experience from being in the corner of Woldenshire, if you like. Whereas the ones who have moved here later on have moved here because of how quiet it is, because it is the end of the road, so people don't really pass through Skelsend. If you're going to visit Skelsend, you're going to visit Skelsend for a reason. It's not a town that you drive through to get anywhere else. So that's what's attracted the secondary generation of people, they've moved there because it's quiet. Whereas the younger generation that we are also working with are really keen to broaden their horizons." [Tanya, Community Worker]

I found that lifelong residents are more likely to see redundancy within Skelsend's social space than calm; the degree to which they feel materially insecure tends to intensify perceptions of redundancy. Meanwhile, there is a tendency amongst incomers, and especially those who do not need to undertake work or work-related activity, to perceive the town as spatially calm. However, this is not universal; incomers with insecure access to capital are more likely to experience the adverse effects of redundancy.

Mary is typical of Tanya's second generation, representing the many people who have relocated to the town, seeking peace, and appreciating the town's remote existence. During our two interviews, she conveyed an insight into the competing needs of the residents.

> *"I've spoken to, or I meet a lot of people, that are longstanding residents, and their memories of what this place was like, they feel that their – the enjoyment of the place has gone. They lived here when it was a thriving seaside resort, and to me even the funfair being here is too much."* [Mary, Resident's Photo Interview]

Mary had previously admitted, in our first interview, that she did not want visitors flocking to the town like they once did. She firmly concurred when I suggested that might not be to her liking.

> "Yes, exactly. *That's what I, because people keep saying, 'Oh, we want the railway back,' and I say, 'No, we don't want the railway back.' And they say, 'Of course we do.' And I'm like, 'No, keep it as it is.'"* [Mary, Resident Interview]

In contrast, Bernie, a born and bred resident, was saddened about how the town had faded over the recent decades and the attenuation of its touristic attraction. He laments the loss of the railway and views it as a pivotal moment in Skelsend's history, heralding the town's decline. I asked him what he thought of Skelsend in 2022. Bernie's outlook on Skelsend as an older lifelong resident was typical of a view shared by many long-term residents.

> "Terrible. Absolutely awful. I don't know, you know, it'll never be like it was. The people are trying to get it back. They're trying to get it back to being a seaside resort again. But it will never be like it was in the 1960s… I blame Mr Beeching;[3] he got rid of the train, and when the train went, it (Skelsend) started to gradually go down." [Bernie, Resident Interview]

Lacey, in her late twenties, felt the decline of Skelsend had a real impact on people's mental health; the town's loss of purpose and its lack of amenities resulted in a lack of opportunities. As Lacey remarked, "*If you're struggling, you're going to struggle more in a place like this,"* reflecting the potential difficulties of those with mental health difficulties and poor access to economic capital. Her explanation of the negative impact included the phrase 'feeling stuck', which I often heard concerning younger long-term residents during fieldwork. I asked her if Skelsend was good for her mental well-being.

> "*No, definitely not. There's nothin' here, is thee. Lots of restaurants and arcades, and that's about it. If you're struggling, you're going to struggle more in a place like this. Like, job-wise, there's no jobs is thee, and once you're here, you're stuck. Once you move to Skelsend, it's hard to get back out... It is what it is here, when people come here, and holidaymakers come here, there's 'like nothing here', cos there isn't… you hear people say 'we've wasted a day haven't we', cos now't here for them to do, cos there is nothin'…"* [Lacey, Residents Interview]

The feeling of being stuck in Skelsend repeatedly came to the fore. The young need to move out to avoid becoming stuck. As a community worker and longstanding resident, Phil advises,

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[3] Dr Beeching being the Chair of the British Railways Board and author of the report published in 1963, *The Reshaping of the British Railways*, which instigated the removal of thousands of route passenger miles from the rail network, including the branch line between Haxton and Skelsend; the railway line instrumental to George Mulgrave's aspiration to transform a remote small fishing village into a seaside resort (British Railway Board, 1963; Whitfield, 1998).

"Other than seasonal work, there just isn't employment here, to a point that if you want to get ahead and you've gone to Skelsend High School, you have to leave the area. You can't stay here. There's nothing for you here." [Phil, Community Worker]

A mother at one of the craft groups I attended during fieldwork told me that she impresses upon her children, "*The world starts at Tenley crossroads; you have to cross it*." This is the main crossroads one needs to go straight on and head south out of town. This lack of opportunity for young people was especially disheartening for many residents facing the prospect of their children having to leave Skelsend. This was a reoccurring theme during interviews, especially among mothers who had mental health conditions. The flight of the young is an example of how spatial redundancy of place can weaken family and social bonds, further layering the social context as a backdrop to the lives of working-age people living with multiple health conditions in this seaside town. As Sam further explains,

"Well, my daughter's left. She's twenty-one at Christmas, and she's coming home for Christmas… she was struggling (here)*… She's worked and she qualified for childcare and all the rest of it. Then COVID hit. She spent six months online retraining for caring for the elderly, and that's what she did for the entire COVID. She worked seven days a week caring in the community. And then COVID finished, and she just packed up and left… She never wanted to do caring with the elderly in the first place… And then she moved down there and she's now getting into admin and customer services. And she said, 'I can't do that up here. There's no work on it… There's no job opportunities, there's no career prospects.' For her to stay here, she'd have to stay at home, because she wouldn't be able to afford to live in her own place and commute to work all the time… I'm lucky if I see her three or four times a year now… It breaks my heart, she's my little girl… It is hard."* [Sam, Resident Interview]

Dissolution of purpose, place and people

A prominent section of my conversation with Sam was the town's loss of purpose and decline of the town as a resort. Sam connects the loss of touristic infrastructure and declining visitors with the overall local economy and how this impacts residents' well-being. The resulting depletion of people present in the town can result in fewer services being available for the resident population as overall demand wanes.

> *"When I used to bring my kids here, it had a huge big market, there were all these things on, now they have nothing. There is nothing to do for kids, there's nothing here… This* [town] *has got nothing anymore. It's so run down in everything about it that as a holiday resort it just doesn't work anymore. And that is a shame… Because the less money comes in, tourism-wise, the less money spent on the town. And I've seen it, over a few years, of things vanishing. Even from just like— You know, from the cottage hospital. 'There's no need for it,' (they might say). Well, there really was a need for it, and— But as the summer numbers dwindle— Because the visitors used it a lot because you could just walk in and use it. But as the visitor numbers are dwindling, then the need for it got less and less and less, and they've lost the service now. And that has a knock-on effect on people that live here."* [Sam, Resident Interview]

Many residents are primarily confined to Skelsend's redundancy through insufficient access to economic capital, their health conditions, lack of access to a car and a paucity of public transport conducive to people impacted by physical and sensory impairments resulting from illness. Restrictions caused by health conditions often influenced their ability to drive and their access to work opportunities. Chronic pain, restricted mobility and experiences relating to mental distress dissuaded people from the long and less-than-smooth bus journeys across rural Flintonprice. A life with multiple health conditions and poor access to capital predisposed residents towards reliance on activity within the physical space of Skelsend.

However, the increasing shortage of amenities within the town resulted in the need for many residents to venture into Haxton, even though the journey, for many, can be fraught with difficulty, costly and anxiety-provoking. This can reinforce a sense of purposelessness for residents, causing logistical difficulties in accessing goods and services needed for well-being. The lack of banking facilities was a particular problem for many residents.

> "*Everything is all in Haxton, not here, including the hospital. It's a pain having to go into Haxton, and the traffic in Haxton is terrible – this why we want to move."* [Florence, Resident Walking Interview]

> "*I think people that do come and live here don't realise how difficult it is to live here*." [Janey, Photographic Interview]

Paul, who struggles with mental health difficulties, really dislikes going to Haxton. The congestion, noise and urban intensity elevate his anxiety, but he often has no choice but to use Haxton services in the absence of amenities in Skelsend. It leaves him feeling vulnerable; it is a journey he must mentally prepare for. Similarly, Paul felt that the closure of bank branches and the reduction of Post Office services indicated a town in decline.

> "*Everything is in decline* (pauses briefly), *or it seems that way at the moment. We have walked through and we have seen quite a few businesses that have gone recently, I mean that one was open only two year ago, it was a betting shop, I don't go into betting shops, but then at least it was in use.*" [Paul, Resident Walking Interview]

Bertha, who lived with a respiratory and a degenerative joint condition, moved to Skelsend three years ago to be closer to her family. Although Bertha appreciated aspects of the town, such as its compact layout and the seaside environment, she had come to find the place somewhat 'drab' and lacking in leisure opportunities. Bertha seldom had the opportunity to benefit from leisure activities outside Skelsend due to her mobility and her stressed financial situation, which, like many people, had deteriorated due to the unfolding 'cost of living crisis'. Bertha enjoyed swimming, but was prevented from using the local

council swimming baths as they lacked the requisite equipment to facilitate safe access. Bertha was told she would have to go to Coldenthorpe up the coast; however, she could not easily get there due to her mobility problems and lack of access to transport. Bertha found the lack of leisure opportunities in Skelsend depressing. I asked her if she felt she had something to look forward to. Bertha replied,

> "*Personally? My son is coming around on Saturday night, other than that not really. No, because it's the same old, same old, you know what I mean? It's the same old faces, same old shops, same old, same old*." [Bertha, Resident Interview]

For many residents, the perceived lack of opportunities to socialise other than at the pub and undertake activities that appeal to them negated the potential for restitution. The situation becomes worse in winter. With the visitors almost absent, the town goes into a state of hibernation; its economic pulse becomes enfeebled. In winter, many places close, the nights draw in, and the returning familiar lacerating chill wind frequently whips across the town's sea wall should one attempt a bracing promenade walk. Often, solace is found in the pub, a place, paradoxically perhaps, that simultaneously might reduce loneliness but also nurtures an increased consumption of alcohol.

> *"I do sometimes feel of an evening would be nice if there was somewhere to go, some group or something... The pubs are open. But then that is all there is, and there are a lot of pubs. Yes. When you think about, I counted them, and I can't remember how many. I counted, and I think it was about eight.*" [Mary, Resident Interview]

There was, perhaps, a kernel of truth to Cheryl's tongue-in-cheek remark about the lack of leisure opportunities amidst the many bars and pubs in Skelsend.

> "…they just go from being unsociable to being an alcoholic!" [Cheryl, Resident Interview]

Some residents, like Catherine, see the winter through at home.

> *“In the summer I’d say there are more people, and it’s nice in the summer, but in the winter, there’s nothing for people to come to, is there? You just put up with it, don’t you. Just sit and watch TV.*”
> [Catherine, Resident Interview]

This experience speaks to the paradox of Skelsend, locating personal restoration for many within the context of spatial redundancy. With the reduced footfall, the town becomes quieter, a blessing for some seeking spatial calm, but for those needing to secure income or engage in a greater variety of leisure activities, this apparent blessing is inverted to a lack of opportunity and personal purpose. Therefore, the dissolution of purpose within the town can produce a sense of inertia and fatalism among residents. This pessimistic framing of outlook predisposes one to developing further health conditions and exacerbating them through lifestyles injurious to health that are influenced by the environmental context of spatial redundancy.

Public spaces of neglect

Many residents, including those who had moved to Skelsend recently and enjoy living in the town, universally accept that the town’s high street, its main retail thoroughfare, was tatty and depressing. The shop’s frontages along the street, running through the town from north to south, stood in sad contrast to the natural seascape. Indeed, interspersed pockets elsewhere in the town looked neglected, including the tourist areas near and around the promenade and the central gardens. Residents’ proximity to these sites of neglect can undermine the beneficial aspects of Skelsend’s environment whilst deterring the potential investment needed to ameliorate the adverse consequences of spatial redundancy.

> “*Get rid of all the tat shops off the front. Shut the tat shops on the front; there should be no tat shops whatsoever. It should be all seaside shops, burgers, rock shops, souvenir shops. Anything to do with Skelsend but not all secondhand shite, should all be shut down and I would shut it down.”* [Cheryl, Resident Interview]

Mark, who had only been a resident in Skelsend for ten months when I spoke to him, commented on what he describes *as "dire shop fronts"* and the independent traders' apathy towards improving their shops' appearance to the public. Of course, appearances matter, and the visible neglect on the high street confirms the widely disseminated assumption that the town is in steep decline with deep social problems. This can deter new investment and prevent new developments, opportunities, and purposes.

> *"It's like, 'It's good enough. What's wrong with it?' But it's because, we're so far from anyone, if you were in, even nearer Haxton I suppose, you would have the competition… But here (in Skelsend), it's just like people will come anyway. We can just hang anything outside and people will still come, which to be fair is true, but it doesn't do the image of the town much good."* [Mark, Resident Interview]

During our walking interview, Paul and I walked down a neglected alleyway through the heart of Skelsend. It is between the back of the eastern side of the high street and the arcade precinct. For Paul, this cut-through was a refuge from meeting people when he was feeling low. He could traverse central Skelsend without encountering anyone to reach the community centre, where he found plenty of support and felt safe. Few people tread here; it looks like a woe-begotten place despite being in the centre of a seaside town. I often used this path after Paul pointed it out to me, I never once passed anyone. In winter, it becomes a quagmire.

As we walked down the path, which was strewn with litter on the day, Paul said it was an "eyesore". Halfway down the alley, the air was thick with the smell of cannabis. He bemoaned the lack of care taken, which undermined the quality of the town's environment and undermined the restorative aspects of the town. I thought of the alley as the bowels of Skelsend, but it was Paul's refuge amongst spatial redundancy. Perhaps, analogous to the paradox of Skelsend: where there is calm and sanctuary, there is neglect and redundancy.

"I use this quite a lot to avoid the main street, but sometimes you can come down here, and the rubbish is absolutely appalling, some of it is the business… when I walk down here and everywhere overflows water jets, see that there (back of the arcades we are now) that's like a waterfall… You can see how it has been neglected, I mean it's terrible really, you have got to watch what's under your feet." [Paul, Walking Interview]

Figure 6: The bowels of Skelsend

The cut-through between the back of the high street and the arcades, right through the heart of the centre of the resort town. Although not too bad on the day of this photo, rubbish often accumulates here and it becomes a quagmire when it rains. Once upon a time, it was a road, although now it is a rarely used alleyway.

Another place on the promenade that speaks of spatial redundancy is what remains of the once-popular nightclub and bingo hall, Cleggie's. Florence and I paused and considered the its remains during our recorded walking conversation.

"*It used to be a nightclub, and it burnt down. But fancy leaving it like that. But at least now it looks so much better; they took all the broken boards down and put this bit of fencing around it. It looks like it's altered a little bit because there were armchairs and settees on here.*

It's a bit dangerous because I've seen the kids go over into it, and it is a bit dangerous, it's not safe at all… What a shame, it could be a lovely café, couldn't it: ice creams, cakes and coffee and just sit here, all the old people would come in, sit here and look over at the sea. That'd be lovely, wouldn't it… Yes, it's really ugly, isn't it. It spoils Skelsend as you're walking down to that end, you come to this and think, oh, this is so horrible. Like unkept and not loved, and it's just neglected." (Florence, Residents Walking Interview)

Figure 7: All that remains: the dancefloor of Cleggie's

The remains of Cleggie's and Skelsend's once-thriving nightlife. Now, a septic furuncle that has stubbornly festered away for over a decade on Skelsend's promenade. Ironically, over time, the damage caused by vandalism and arson has made the site somewhat less ruinous and disorderly. Still, it is a sad reminder of the past.

Housing and pockets of spatial disturbance

For several residents, the benefits of living in Skelsend were negated not just by spatial redundancy and geographic isolation but also by crime, the fear of crime, and antisocial behaviour. While in Skelsend, I undertook several field walks alone or with residents, complementing the recorded narratives of residents. The residential areas were pleasant to stroll around, including the main post-war council estate, but there were distinct pockets of neglect and signs of potential antisocial behaviour. These were pockets of spatial disturbance in an otherwise quiet town, which disproportionately affected the Seaville estate and pockets around the southern and northern neighbourhoods of Skelsend.

Living in and around these pockets predisposed residents towards experiencing incidences of antisocial behaviour and occasional crime. Although most residents I spoke to were not affected by antisocial behaviour, the adverse effect on the well-being of a significant minority necessitates reflection. Several residents reported instances of antisocial behaviour, problematic drug use and intimidation in their neighbourhood, which had affected their well-being. Other problems, such as littering and dog fouling, caused upset among residents living near these spaces.

Some of these problems might be considered micro stresses. Nonetheless, they accumulate and influence residents' outlook, relationship with their neighbourhood, and consequent dissatisfaction with life. Being routinely subject to environmental factors that either promote anxiety or feelings of malaise and alienation from one's neighbourhood can reduce one's capacity to maintain a lifestyle conducive towards physical and mental well-being in the context of living with physical and mental health conditions. Environments such as this may predispose one to seek remedies that provide short-lived gratification, but they also predispose one to an increased likelihood of illness (Barta, 2017; Bourdieu, 1984). Additionally, Larrabee and Sonderland et al. (2019) provide evidence of how the accumulation of daily stressors, described as 'allostatic load', increases the propensity towards cardiovascular illness.

I was made aware by several community workers that the Woldenshire County Council housed people with addiction problems from other towns in the county and Haxton. During broader fieldwork activity, I met several people who had been housed in Skelsend from elsewhere who struggled with poor mental health, addictions, homelessness, and domestic violence, which were the predominant underlying reasons why they needed rehousing in the town. These residents were typically housed in flats on the Seaville estate and elsewhere in the town.

Many residents commonly complained about this; they felt that people rehomed in the town brought with them a host of challenging antisocial behaviours. Josh, living with recurrent mental health difficulties and a bowel condition, felt

saddened about what had happened to the Seaville estate, the town's post-war council estate, a space which, for him, resonates with emotional and nostalgic personal history, a space that once provided a childhood home. He directly connected the relocation of vulnerable people from elsewhere and the decline of neighbourhoods, which added to the sense of malaise he felt in connection with the town where he was raised and remained rooted within.

> "*In the last five years, we have had a lot of people who have been dumped in the area that have caused the area issues, which has had a massive impact on the dynamics of the area. The estate I grew up on, the council estate you know, like all council estates had its problems, but it was a lovely area to live, everyone knew everybody, kids could play out and you wouldn't have any worries. Whereas it's not the case anymore, with the people that are now there, they have just absolutely destroyed the area. The block of flats that I used to live in, got burnt down. You know, yeah, it's not what it used to be, all the memories that you get just aren't there anymore… you see the synthetics like spice and MCAT, and that sort of thing, you know. The people that have been dumped in the town, I don't like to talk about people like that, but it's like we've got issues here."* [Josh, Residents Interview]

Mandy, a community worker, and resident, who worked on a community health engagement project, was aware of the problems residents on the estate faced.

> "*There's some flats that were* (ex) *prisoners in there for years and they basically evicted them all. Evicted them, found them other places to live. Knocked the flats down and built new flats and then filled those flats with people from local cities with drug problems and things like that. But there's always been relocation to seaside towns for people with problems. You take someone out of prison for drugs, you want to take them away from where that was their life... It's always happened.*" [Mandy, Community Worker]

The change in composition in these neighbourhoods particularly impacted people with vulnerabilities resulting from illness and made them feel less secure. The residents whose well-being was threatened by living in proximity to these pockets of spatial disturbance were invariably people who had insecure access to social or economic capital. Jason and Nicola both live in flats within pockets of spatial disturbance. Nicola, now in her early 60s, had mobility problems due to a combination of respiratory illness and arthritis. She told me that she had been subject to ongoing harassment by a neighbour that had affected her mental health. Nicola had lived in Skelsend for over forty years; her family moved here after her father stopped "*working down pit*[4]" in the 1980s.

> "*Every time my grandson stops with me, it's bang, bang, bang. He lives upstairs, I live downstairs. I've had problems ever since I moved in there, this is the flats, warden controlled. Now he is not allowed to approach me in the streets, he is not allowed to press my bell, knock at my door, press my buzzer, talk to me in the garden or talk to me in the doorway and that's it. It sets me off and me anxiety and me panic attacks. It's been going on for eight years since I moved in… he verbally harasses me, yeah, like he will stand across the street outside the hospice charity shop and stare me out. It can't continue, because my grandson loves stopping and when I took him to the police station, I told him don't be frightened… the other week he was clinging against me (*her young grandson*). Its affecting me gran-bairns, cos I've got five." [Nicola, Resident Interview]*

Meanwhile, Jason, who lived in another block of flats, was also being impacted by antisocial behaviour. He moved to Skelsend, searching for a quiet location conducive towards recovery from a severe episode of mental distress that had prevented him from working. However, his neighbours included a drug dealer and a known paedophile. He felt tainted by his proximity and was worried about the safety of his sister's young family when they visited. The antisocial activities around his flat were threatening his project of well-being, feeding into his social

[4] The coal mines.

anxieties and obsessional compulsive ruminations. This was further predisposing him to an impulse of social withdrawal and self-isolation. After spending all his savings on making his council flat a pleasant living space, it was starkly bare when he moved in, and he didn't want to move again because of his neighbours.

> *"I just want to live in peace; that's all I want, really. A bit of stability, and I want to live in peace, where there's no bloody scumbags about annoying me… there seem to be more people in society that are not nice people, so I try and avoid them… Quarter past seven, I woke up, and I thought, What's that smell, you know? I don't know if it was that that woke me up. And I went outside into the communal. As soon as I opened my door, because our doors are next to each other, a waft of cannabis smoke came into my flat. I shouldn't have to live like that… I can't live next door to basically— well, he's a paedophile* (referring to next door, a different neighbour)*, you know. I can't have family coming. My sister can't come with the children because— well, they can't… I feel it's not nice if your family come, is it?…but you feel like a scumbag that's living next door to them. It drags you down…"*
> [Jason, Resident Interview]

Jason's neighbours' reputation and nefarious activity have contributed towards a re-emergence of obsessive thoughts and behaviours that increase his anxiety and interfere with his life.

> *"I try the handle* (when leaving the flat)*. If you ask Johnny* (his friend)*, I try it, count. Sometimes it goes up. It used to be three times, and then about a month ago, it got to about fifteen. Trying the handle fifteen times... I've got seven cameras up in my flat, four facing inside, all on a hard drive, recording, and three, one facing out of each window outside. I shouldn't have to have any of them. When I was putting them up, I was, like, Why am I doing this? Why should I have to do this? But because of the environment that I'm in, it's made me do it, you know. And that 200 quid, I could have spent that on my bills for the winter, so I've had to spend money on something that my*

brain's telling me to spend it on, and I shouldn't have to do, should I?" [Jason, Resident Interview]

Consistent with the spatial calm, Jason, like most people I became acquainted with during fieldwork, who had relocated to Skelsend with multiple illnesses, found, for the most part, that the town met their needs in terms of their quest for security and restitution. However, living in a location that has become a spatial pocket of disturbance, Jason's peace and security feel threatened, reducing his capacity for trust in his neighbourhood. This insecurity was predisposing him to return to checking compulsions and doubting the security in his environment and his actions in relation to his neighbourhood environment.

During fieldwork it was clear that many vulnerable people were being housed in around these areas of Skelsend, especially on the Seaville estate. I could not help but notice the bleak living environments people had been placed in. Usually bare and broken floorboards, peeling paint, no curtains, or fittings. Not suitable places to rehome people who were made homeless, especially when people were struggling to survive due to mental distress. There was clearly a shortage of quality social housing. I heard several stories during fieldwork. Lacey was made homeless after a difficult relationship break-down and ended up living with her mother in a caravan whilst waiting to be rehomed. She was finding her situation very stressful impacting on her health and habits. Such as an increased propensity to smoke and consume energy drinks.

"There is no houses to house anyone, there is no flats, there is no houses, and for bonds as well, they are wanting three or four months bonds at a time. So where are you going to get a couple of grand from to move into a house… I'm classed as homeless, but the waiting list is horrendous. Just got to wait…Stress! if there wasn't a day when I didn't feel stress it would be a miracle, really a miracle. I mean sleep, I don't sleep, what is sleep, three four hours a night, is not sleep is it... I just smoke more when I'm stressed. And the more I like try to quit, it's hard. I like Red Bull as well, as you know I'm addicted to Red Bull. You get off it, but then I go back to it all the time." [Lacey, resident interview]

Mark's story though was particularity upsetting. Mark had become homeless following a relationship breakdown and a severe mental health crisis which had warranted a stay in hospital. Despite being particularly vulnerable at the time Mark had been moved into an area known for antisocial behaviour. However, for Mark, it was the internal environment of the council flat he had been placed in that contributed to a further admission to hospital due to another mental health crisis a few months after his original discharge. He was new to Skelsend, he did not know anyone and was placed in an empty flat, with no furniture, carpets, curtains, and hardly money to get by, let alone furnish a bare flat. Building relationships with workers and volunteers at the Pear Tree charity and eventually receiving a moderate sum of money through an inheritance helped him to improve his circumstances. However, his first six months in Skelsend was harrowing. He told me the following,

> "*I came here, and felt like I was a cod that had just been landed on a fish dock. Horrendous for me… the place looking like a —hole, and my mental condition as it was. It could not have been bleaker than it was… And then autumn come in, winter coming up, getting darker. I went back into hospital, because this was all too much for me, and it just did me in, I went back for a long stay. I was there from October until January and just dreaded the thought of coming back here*."
> [Mark, Resident Interview]

Meanwhile, the antisocial behaviour in these pockets of spatial disturbance resulted in visible deterioration of the environment in and around these areas of the town. The apparent signs of neglect and general environmental deprivation take several forms, from rubbish and discarded household items accumulating in front gardens, littering, and dog fouling to particularly poorly maintained buildings. For several residents, this not only undermines any sense of pride they might have in their town and neighbourhood but also can undermine their sense of well-being because of the negative emotions prompted by the visual signs of neglect and lack of care.

How neglect and disturbance can impact well-being and the ability to manage health conditions is exemplified by Clare's experience of moving to Skelsend. Whilst she takes great pleasure in the town's seascape, the visible neglect of public spaces produces negative emotions. Her intention to improve her mental well-being by relocating to Skelsend is undermined by her proximity to spatial disturbance and neglect. When we held our recorded conversation, she spoke about the distress caused by someone intoxicated by alcohol aggressively hammering on her door in the middle of the night, before lamenting the lack of care around her neighbourhood. Rubbish and "*dog muck*" were recurring themes mentioned by several residents living near these pockets of spatial disturbance.

> *"Friday evening, when I was woken quarter to midnight. Sounded like someone tried to come from the front door, battering it. They made me feel slightly unstable, I didn't know what it was and when I eventually opened the door, I was quite fearful; there were two women who identified me as someone called Sally. They were quite aggressive and angry. I just thought, what the hell am I doing here*?... *It's quite an unkept little place, and I know everyone's going on about it. There is dog muck everywhere, and I am fed up with it! I really am. It's really depressing. I hate it. There's no bins. It's depressing, erm, the rubbish in people's front gardens is depressing*… *I hopscotch through dog shit every day coming to work."* [Clare, Resident Interview]

Territorial stigma: "If the planet had piles, Skelsend is where they'd be!"

Although the troubled spaces of Skelsend were very localised, Skelsend, like many seaside towns, has a reputation for widespread deprivation and crime. This was reflected in the local media and online social media. Despite the narratives of transformation from relocating residents, Skelsend, over several decades of decline, had reputably, according to public opinion in nearby Haxton and Woldenshire, become, in the words of Wacquant (2007), who has written extensively on sites of urban stigma, "a place of territorial infamy"; a bounded space of 'territorial stigmatisation' that was routinely subject to "…discourses of vilification" (Wacquant, 2007: 66/67).

When reporting on Skelsend, the dominant regional newspaper selectively focused on social deprivation, crime, and dereliction issues. Correspondingly, external negative attitudes towards Skelsend percolated through public imagination, as exemplified by the vitriolic abuse the town and its residents were subject to in the comments section of Haxton News articles and social media. It reflected, albeit in hyperbolic caustic tones, the narrative of the "broken society" propounded by political adherents of moral conservatism (Hayton, 2012) that portray parts of the UK as being blighted by welfare dependency, idleness, and personal irresponsibility (Hancock and Mooney; 2013).

There were fears, particularly among relocated residents, who had benefited most from the spatial calm of Skelsend, that the media attention on the 'cost of living' crisis in the town unfairly and selectively depicted the town as disadvantaged and a site of daily struggle to access the necessities of life. The town, repeatedly associated with deep deprivation in the regional media, was positioned in uncomfortable contradistinction with the residents' perception of their adopted town and their relationship with and use of its space. Association with the "blemish of place*"* (Wacquant, 2007:67) threatened aspirational identities. Relocated residents of Skelsend expressed concerns that the unfair representation damaged the public image of the town; other long-term residents expressed a weariness that their town, their shared space, had, for decades now, been subject to exaggerated depictions in the media. Several lifelong and long-term residents lamented that their town, a town with which they closely identify, gets "*blamed for everything*" and was demonised.

In stark contrast to the experiences of many residents who had relocated to Skelsend, the town's stubborn reputation for social deprivation feeds into a popular public discourse around Haxton and Woldenshire that Skelsend is a place to avoid. This is exemplified by the local newspaper's comment wrappers that cover Woldenshire and Haxton. It is the only news outlet that covers this area of the north of England. Articles on Skelsend invariably attract unflattering remarks in the comment's wrapper ridiculing Skelsend.

> “Skelsend the town where tumbleweed goes to die.”
>
> “It’s been portrayed as a poverty-stricken dump because it is a poverty-stricken dump. The best thing that could happen to Skelsend is being swallowed up by the sea.”
>
> “If the planet had piles, Skelsend would be where they’d be.”
>
> “Skelsend has got to be the dregs of places to visit. It was bad when I was a kid, even worse now.”
>
> “The best thing that could happen to Skelsend is for it to collapse into the sea, taking the banjo pluckers with them.”
>
> “Hell by sea, aka Costa del Turdhole.”
>
> “The pubs in the town are a joke, most shut at 9 to 10 pm (worse than World War One hours). They try to attract daytime drinkers, which is quite easy as most of the town are unemployed anyway.”
>
> “The place is like a zombie apocalypse at the best of times.”
>
> “The parents won’t care as they will be drugged up or drunk out of sight out of mind…” (A report involving children in Skelsend playing with rotting whale carcasses on the beach)
> (Haxton and Woldenshire News, comment wrappers, 2020–2022)

The intense degree of othering on these comment boards is visceral and represents a vitriolic invocation of moral conservativism based on a facile supposition of indolence, generalised to cast aspersions on the communities and neighbourhoods of Skelsend. This contrasts with the message given to prospective property investors or relocators from southern England by commercial agents who promote the potential of Skelsend as an affordable escape from an intensively paced materialistic life, highlighting a struggle between competing discourses.

Spatial redundancy: work and illness

The paucity of work opportunities in Skelsend is a central feature of spatial redundancy, playing a prominent role in the lives of many residents. While employment opportunities are found in Skelsend, the work available often involves various degrees of manual labour and tends not to be conducive for people with physical health conditions. There are no large employers in Skelsend. Aside from the caravan sites, most businesses are pubs, cafés, and small independent retail outlets, often subsisting on thin profit margins. Many of these small businesses struggle to accommodate the needs of people with health conditions and whose fluctuating symptoms may disrupt their productivity. Other employment sites are care homes, the two small supermarkets, a small council leisure centre, and primary and secondary schools. There are also three discount chain stores, but these are by no means large outlets.

When gathering online contextual data on the town, I searched for vacancies between October 2021 and April 2022. I used two search engines for this task: indeed.com and the DWP. I undertook this task intending to gain an appreciation of the type of work available within the town of Skelsend itself. I acknowledge that, in Skelsend, some work becomes available via word of mouth; therefore, not all opportunities are advertised, which is often the case with cafés and shops. Consequently, I considered the data gathered to indicate the type of vacancies available rather than the exact concrete situation.

During the six months, I listed ninety-two vacancies within Skelsend or its immediate village and rural hinterland. Consistent with spatial redundancy, I found little variety of work available. It consisted overwhelmingly of care, retail, and seasonal work on the caravan sites. Care work was the most ubiquitous employment sector, although there were some opportunities for local primary and secondary school teachers. Zero-hours contracts were commonplace, while 64% of vacancies advertised wages below £10 an hour, with only 10% advertised above £17 an hour. Strikingly, there was an absence of clerical working opportunities available in the town.

During fieldwork, I interviewed 29 working-age residents living with multiple health conditions. Seven had resolved, for different reasons, that they need not take paid work again. Eleven were currently working, including two who ran their own small business in Skelsend. The other residents aspired to work shortly or believed they would be required to complete a work-related activity to receive continued financial support from the state. It was also worth noting, consistent with Skelsend as a whole,[5] that most residents interviewed did not have reliable access to a car. This was due to several reasons, such as never holding a licence, being unable to finance a car's running and not being able to drive due to their health condition. The absence of access to a reliable vehicle significantly curtailed opportunity.

Many residents working locally were reliant on seasonal summer labour, which forced them to claim Universal Credit after they got laid off each year. With seasonal work came a periodic reliance on tenuous and hard-to-obtain state support. Josh, who worked for a charity that, amongst other things, supported residents to improve their employability, told me,

> *"Yeah, we have a hell of a lot of caravan sites in the area, which does hold the tourism, and it's great for the local businesses and stuff like that, but unfortunately, a lot of the time, it is seasonal, a lot of people that work there they work for nine months of the year, sort of get laid off for three months, then they go through the selection process again the year after… the vast majority would be unemployed at that point, probably claiming UC* (Universal Credit*)... you know you're laid off at the end of the season, you have to go through that process again and I know it's quite a painful process to just claim it in the first place."* [Josh, Resident Interview]

Helen, a resident living with long-term health conditions who, like Josh, also worked for a local community-based charity, spoke of the precarious nature of

[5] Car ownership in Skelsend is well below the national and regional average (ONS, 2021).

employment in Skelsend and lamented that the insecure work is not confined to tourism, but also retail.

> *"They hire when the season's going to get busy and then they fire when it goes slow again, even Tesco's do. Tesco's, Aldi and Heron all do the same."* [Helen, Resident Interview]

No place for me here

Many residents complained about the lack of work opportunities in the town and the need to travel to Haxton for work; the commute was beyond the capacities of many working-age residents with multiple health conditions. The inability of the local economy to afford opportunities for people with an impaired work capacity was evident within fieldwork. For example, Ben lived with a congenital spinal condition, which caused several health difficulties that impeded his mobility. Ben could not undertake the physical tasks required by most employers in the town. He could not drive and struggled to use the bus to Haxton regularly. He walked short distances using crutches and had poor balance, which often caused him to fall. Despite this, he managed to run a small independent shop that sold clothes, toys, and traditional seaside items. He found that self-employment allowed him the flexibility to work around his disability. However, before becoming self-employed, Ben applied for many retail jobs locally. He found this a demoralising experience, with his applications not even acknowledged.

> *"I applied for, what's the place called down here? There's that paper shop down there. Never, got told I didn't get it, I just didn't get it. I applied at a shop on a caravan park. There's a little shop on Wright Street. Didn't get an answer. I think as soon as they read that I was disabled, I was rejected, without them telling me that. Because, you know what I mean, I applied at* (inaudible) *shop, never got an answer. So, being no answered to things, you can't even come up to me and go, 'Alright, no.' You're just giving me nothing. I'm not hearing anything, and it's like, well, is that my disability?... same with Tesco's, because I think I tried there as well, and it's, like, that's the problem I have. I can't sit down for too long, I can't stand up for too*

long because it starts to hurt. Like now, my back's starting to hurt… I'm pretty much the only one that I know of that is in work, proper work-based work..." [Ben, Resident Interview]

Ben's story was consistent with Sandra's observations, a community worker involved in employability. Sandra stated that it was not just the physicality of the work available in the town, but also the lean profit margins for local businesses that reduced their capacity to make allowances for workers' needs arising from health conditions. Skelsend's poorly financially resourced customer base partly accounted for this challenge, amplified in 2022 as food and other necessities became more expensive, with galloping inflation taking hold that year.

"I've done café shifts, and you know, on a particular day, if you've got a counter on, you can do 15 to 18 thousand steps easily, just within pacing up and down that short space… there's no break. It is often a ten-hour shift on your feet all of the time. So you need to be physically fit to cope with all of that; even if you were to look at part-time opportunities, such as covering one element of the shift or a half shift, etc., it's still a physical job because it is non-stop, and from a business point of view it needs someone who can maintain a significant pace to then be productive, because the profit margins they are working within are once again very limited. What you find is people come on holiday here because it's cheap, but the same cost implications apply, of the heating, staffing costs, etc. are all similar, you know, to more affluent areas. When I've done events here within the area, we have monitored and examined where footfall is coming from as in the geography… there was a high volume of visitors from West Haxton, another poverty area. So, poverty then attracts poverty… they don't want to go to the resorts up the coast because it's too expensive." [Sandra, Community Worker]

Sam, who volunteered to help in one of the markets, has a fluctuating neurological health condition and an enduring mental health condition; she receives ongoing treatment for both conditions. She understood the difficulty as described by Sandra and had tried to work in a local pub.

"It's all right and very well the government saying, 'Oh, they have to have these rules where they have to employ people,' and it's like, 'Yes, but that's not your business. They can't afford it.' In the real world, the things that are in place don't work. And unfortunately, it's just the way life is. And I have accepted that; it still irritates me. But I've tried before, when I first moved up here, I went and worked in the local pub. I just— It wasn't fair to them. Because, they're a local independent business, they can't afford, if I'm not in work, for them to hire more staff and still pay me. It just doesn't work." [Sam, Resident Interview]

Spatial amputation impacts on work prospects

The prospects of work are so much better in Haxton, and this was universally accepted, with many people resigned to the commute. The barriers to commuting can be hard to surmount for people who are fit and healthy, let alone those with health conditions that could impact daily functionality. Not being able to drive due to illness severely disadvantaged people needing to find work in Skelsend. This became a reoccurring theme with working-age participants living with health conditions. Even though the nearest city of Haxton was only twenty miles away, the transport infrastructure around this part of southeast Woldenshire is especially precarious with its narrow, winding roads.

Commuting by bus into Haxton centre would take up to at least three and a half hours daily and cost £210 a month for a full-time job. Often, a further connecting bus from Haxton town centre to their place of work is required,[6] further escalating the time taken[7] and adding another £96 a month. For many people receiving low wages and those who may have caring responsibilities, whilst living with health conditions that restrict physical or cognitive functioning, this

[6] The tendency for economic activity to move away from the centres of small cities like Haxton makes this now more likely (McGough and Thomas, 2014). The prospects of Haxton have an impact on residents in Skelsend.

[7] It is possible to be only twenty miles away from one's workplace in Haxton but have to endure a four-and-a-half-hour return journey.

was not a sustainable lifestyle. The combination of the isolation caused by the town's disconnection from its economic hinterland and the impaired functionality caused by life with chronic illnesses resulted in many residents being trapped within Skelsend's iron cordon of precarious, poorly paid manual labour.

As Helen's story exemplifies, reliance on the bus, because of health conditions, can disintegrate career opportunities. Helen lives with several health conditions: a sleep disorder, an autoimmune condition and diabetes. She also cares for her partner with a degenerative muscular condition. Due to her health conditions, she was required to surrender her driving licence and, consequently, became dependent on the bus. However, one day, she found an excellent job in Haxton where she could use her specialist IT skills to their full effect, a rare opportunity for her following the onset of illness and moving to Skelsend. However, the commuting logistics were a nightmare for her.

> "*I was getting up at half five, walked my dog, you know, breakfast, dressed, showered, changed, dressed, get my lunch ready, my dog sorted out for the day. And then, like, the half-six bus to get into Haxton, to then get another bus to get up to the business park to do nine till five. On the second day, I walked from the business park to the bus station in Haxton because it was quicker than getting the bus. Three-quarters of an hour's walk is quicker than the bus in rush hour. And then you had to wait for the next Skelsend bus back, and then it was get in, walk the dog, tea, get ready for bed. I never saw my partner*. *I did that for two and a half days… So, on the third day, I was on the bus, and I rang and I said, "I can't do this anymore."*
> [Helen, Resident Interview]

Working in a location near the Flintonprice area can be even more complicated than commuting to Haxton. Dennis temporarily lost his licence due to cardiovascular illness while working in a village up the coast. Reliance on the bus nearly cost him his job. Fortunately, a temporary car share was available, coinciding with the time he was without his licence.

> *"It's twelve miles away from where I work. I can get a bus, but most days, I start at eight in the morning until five because of the bus situation. I wouldn't get on site until half nine, and I would have to be gone by four…it's only twelve miles up the coast."* [Dennis, Resident Interview]

Jimmy lives with a spinal condition that causes him chronic pain and a recurring mental health condition. The latter is the lasting consequence of being a first responder to a major terrorist incident when working abroad. Jimmy has persevered with commuting to work at a distribution warehouse in a small town on the other side of Haxton. He borrows his mother's car to get to work. There are no evening buses from his workplace to return home. Jimmy says the commute is very stressful, long, and expensive, especially given the escalating fuel cost. Jimmy tried to find work locally in the stores, but these positions were filled quickly due to the local demand for work. Jimmy used to work on the caravan site, but this was only low-paid seasonal work that failed to provide him with the security he needed. Jimmy enjoys the work, but getting to and from his workplace is challenging.

> *"I've been trying to find somewhere to work because I used to work for the caravan park. I would work in Aldi or Tesco's, but every time I go on their site it's always filled up… The commutes is worse, especially for people who want to get from Haxton to here, and you're waiting for buses and sometimes, they break down, and God knows what… I finish at ten o'clock at night, there's no buses because the buses stop at seven from Smeltone going back into Haxton… it's really stressful. The only thing is I love what I am doing."* [Jimmy, Resident Interview]

The unpredictable drive through the winding roads of rural Flintonprice in winter can be particularly hazardous when icy. During my journeys to and from Skelsend, I could not help but notice the fairly common sight of abandoned cars, wrapped in police ticker tape, in ditches at the side of the road. Trying to get to and from Skelsend under the pressure of a punctual work imperative typically demanded by paid employment can be stressful and even dangerous

to commuters from Skelsend. Other than Haxton, there are two nearby Woldenshire towns with approximate populations of 30,000, though the bus journeys are removed into the distance. Worley, the capital of Woldenshire, is twenty-six miles away and takes two hours to reach by bus. A trip to the coastal town thirty-one miles to the north of Skelsend, Hotonshore, would take two and a half hours by bus.

Spatial redundancy, opportunity, and mental health

Many community and health workers in Skelsend reflected on how the high prevalence of people presenting with mental health difficulties was related to the geographic and socio-economic characteristics of the town itself. Jordan and Archie,[8] two healthcare professionals in their twenties who grew up in the town, explained how younger adults of Skelsend often feel "stuck" and experience low self-esteem. Jordan discussed how poor opportunity structures, especially for younger people, contribute to an all-pervasive negative outlook on their health and future career; Jordan gave the example of working in a "chippy" with "little sense of achievement" and little prospect of advancement. Undertaking such work on a long-term basis and experiencing "the same old thing every day" could generate disillusionment with life. Jordan felt that the meagre prospect of change and aspiration for the future can have "a corrosive effect" on people and nurture an intuitively negative mindset. The resulting negative mindset serves to reinforce the likelihood of living a lifestyle that might expose one to both poorer mental and physical health.

Similarly, Archie explained that, for many low-income households in Skelsend, young people are pressured by their families to take on low-skilled paid work to contribute towards household income rather than take apprenticeships that would improve their prospects. Meanwhile, many more academically gifted young adults missed out on higher educational opportunities because their families did not have the financial resources to support them through higher education. Archie explained that their pessimism grows when they see their

[8] An unrecorded interview with a group of health professionals based in Skelsend, notes taken with permission from Archie, Jordan, Terrie and Janice.

better-resourced peers advance in life, whilst they feel “stuck” in low-paid jobs in Skelsend. They felt that the resulting despondency, in response to their environment, predisposes people to develop poorer mental health, and encourages lifestyles that often result in the development of health conditions at a younger age than otherwise would have been the case.

Meanwhile, Guy, another health professional, talks about manual workers in their middle years, with illnesses like severe arthritis caused by their work, who also become “stuck.” Their purpose is lost, along with their productive potential. Subsequently, lasting financial difficulty entwined with a pervasive sense of being “stuck” can generate a pernicious pessimism. Guy noted this was especially the case for lifelong residents in later working life who were living with health conditions.

> “ *…the residents that have always lived in the town, there seems to be amongst some of them an almost resignation and an apathy and a feeling of being stuck, that’s what I’m getting when I’m talking to people because of the opportunity structures are so poor like that I would imagine, and its generations of that… think often you get the sort of person who is in their late fifties, only ever done manual work, they’ve no computer or IT skills so no one actually wants them. You know, and it’s sad really, they’re on the scrap heap really*.” [Guy, Healthcare Professional]

The pessimistic outlook nurtured by the less advantageous characteristics of Skelsend had the potential to undermine some residents seeking a fresh start in life who had moved to Skelsend. For instance, Claire told me that she had moved from a large seaside resort town on the south coast to find solace in a peaceful location where she could rebuild her life. However, unlike most people discussing their relocation, Claire’s move to Skelsend has resulted in limited success. Although the environment, the sea, fresh air, and green hinterland pleased her and were beneficial to her mental well-being, the lack of opportunity, isolation and what she perceived to be backward attitudes made her feel uncomfortable and fed into her pessimism, which she had moved to the town to address. However, a more significant impediment was the negativity

she felt from the people she encountered daily, including at work. For instance, she wanted to adopt a healthier lifestyle, which included stopping smoking, but the environment she found herself in when working in the town she found to be often damaging and not conducive towards the transformation she had sought, especially in the context of the mental health difficulties she experienced. When I asked Claire what had motivated her to move to Skelsend, she told me,

> *"Just to be somewhere quiet and where I can heal from my past life. But here, it's to be a long process (laughs)… I keep trying at least once a week to give up smoking, and it's like the negativity [referring to people around Skelsend]. But come on, people, I want to change. I want to change my life. I came here to change, but I'm whirling round in a vicious circle. So, yeah, I came here to change things."* [Claire, Resident Interview]

Returning to the group of community health professionals in Skelsend, I was told that smoking was seen as the norm in the town, and they had requested support to stop smoking from as young as eleven. Janice felt the town existed in its own "time capsule". The idea of going out and purposefully exercising seemed an anathema or just culturally at odds with residents' way of being. Terrie, guided by her experience of working in the town, explained that she felt harmful behaviours such as smoking resulted from boredom and loneliness; this was especially the case in winter after everything in the town closed and people just sat inside their homes. This view corroborates the interviews with several residents, who said that, in the evenings in Skelsend, and throughout the long winter offseason, the only places open are the pubs, which involved socialising with the assistance of alcohol consumption. My experience of several 'pubs' popular with locals in Skelsend gave an impression of a culture that frowns upon those avoiding or reducing alcohol intake. The Railway pub struggled to find me a half-pint glass. Indeed, the bartender seemed a little flustered by the experience of a man asking for a half, while, over at the Corner House, the bartender served me a coke from a two-litre plastic bottle; of course, it was served flat and disapprovingly observed by the room full of locals.

Controversially perhaps, Terrie felt that there was a tendency towards learnt helplessness generated through community projects that might alleviate social and health problems without addressing more profound causes of problems, which this group of workers felt was rooted in lifestyles. This was a similar view expressed by community worker Phil, although he did feel that underneath the causation of lifestyles and outlooks was a wider systemic oppression.

> "…the system beats people down… *a lot of people also feel that they're not part of the system. 'Nobody cares about me.' There's that emotional baggage that goes with it, and so then it becomes, like, 'How do I work the system? What do I do?' And it actually helps people, I think, to be disabled or ill or unwell, because they get more back from the state… They literally extenuate or lay it on a bit heavy. They've got underlying problems, genuinely. They play to that rather than say, 'How do I live my life to improve that and get around that situation?*' (Phil, Community Worker)

This was a refrain I heard repeated amongst several people working in the community of Skelsend. However, other health professionals reported that their lives were too stressful to consider and act to improve their health, either because of caring responsibilities or poverty-related issues. The prevalence of smoking is a prime example cited by numerous people working in Skelsend. As one community worker told me, it was a form of self-soothing. Nonetheless, I was struck during fieldwork by how many people I encountered on the streets smoking, especially outside the pubs and arcades. Pressures of life can crowd out the capacity to act on one's health, and people can disproportionately bear these pressures with fewer resources to overcome environmental difficulties. A reduced capacity to care for one's health risks accelerating the deterioration of existing health conditions, and predisposes one to accumulating more chronic illnesses detrimental to one's quality of life. This tendency is reflected in the research literature. Residents of poorer neighbourhoods accumulate chronic illnesses earlier in life and live longer in poorer health (Marmot et al., 2020; Mercer et al., 2012).

"…*they've got so many other things, and smoking is probably… they know they should give up, but they've so many other pressures in their life that it's the one sort of pleasure they've got that, you know, that they want to carry on with*." [Guy, Healthcare Professional]

A further perspective was provided by Elizabeth, another health professional working in Skelsend. She felt that people struggle to attain lifestyle change when they are under stress, or lack the mental resources due to their environment to sustain change for the benefit of their health. Elizabeth refers here to women in caring roles at home.

"…the thing that people struggle with, in my experience, with the ability to self-manage is having the mental capacity to do that… They're struggling financially, and they're trying to balance the books. What then gets pushed to the side is her own health. So, she then doesn't have the kind of, mental capacity wrong, but actually, time, capacity, whatever you want to call it. So, she then doesn't come for her annual review appointments, she doesn't come for her smears, she doesn't come for, you know, she doesn't have the capacity to want to stop smoking..." [Elizabeth, Health Professional]

Elizabeth felt the prevalence of some chronic health problems was likely to be higher than is acknowledged in areas of deprivation because people were less likely to come forward for help. Elizabeth felt residents in poorly resourced neighbourhoods tended to be more accepting of physical deterioration as inevitable than those with better access to support and resources.

"…we do talk a little bit about fatalism and the fatalistic attitude sometimes… I think some of it is just, you know, an association of, 'Well, here I am at 70, and my dad died at 60, and my brother died at 60…' They just kind of accept it, so I do think you do get those patterns within communities… So we'll know that people will, for example, just put up with their breathlessness and not come and see you, and they'll just be like, 'Oh, that's just because I smoke,' rather than considering that there is something that the doctor could do or

that this could be COPD. So, people will put up with stuff and won't be diagnosed with it." [Elizabeth, Healthcare Professional]

With health resignation being a prevalent barrier to managing one's health, being in the right place and having the mental health reserve to take on the challenge of changing one's lifestyle is another barrier, especially in an area that is spatially redundant.

"…the other thing I think is self-esteem, if I'm honest with you. I think in order to put the effort into your own self, people have got to be in a mental position to want to do that... You can't just go in (in a consultation) and say, 'You really need to lose some weight,' because they're just, like, not in a process to even think about that at the moment. And so, there are kind of multiple issues around that…" [Elizabeth, Healthcare Professional]

Summary

The vastly diminished tourist industry is central to spatial redundancy. Local people's needs are neglected without the demand to cater to visitors' needs. Meanwhile, spatial redundancy and spatial calm are a mutually reinforcing nexus of one another. Spatial calm disproportionately attracts further inactivity, resulting in intensifying conditions of spatial redundancy. Although the disconnected, struggling economy of Skelsend and the resulting spatial calm of its seascape provide opportunities for those moving into Skelsend to renew their identity and achieve restitution in the context of multiple health conditions, those people with poorer access to capital may not have the resources to transcend the inherent geographic challenges and the difficulties of living within a largely redundant local economy. This is particularly the case for residents in Skelsend who have insecure access to capital, are spatially bound to Skelsend because of their conditions and experience mental health challenges.

Those residents who require work opportunities, with insecure marginal access to capital, may struggle within this nexus that provides opportunities for restoration but few opportunities for accessing the material means of maintenance from an insecure personal economic base. Therefore, the

dissolution of purpose within the town's social space, characterised by the fading business infrastructure, can, for many, result in their dissolution of the purpose. This has consequences for working-age residents in the town with multiple health conditions who need to improve their access to economic capital to improve or ameliorate mental and physical health concerns.

Chapter 8 Accessing Financial Support: Precarity on the Edge.

Encounters with social insecurity

Previous chapters detailing the inward migration of working-age residents with multiple health conditions partially explain why Skelsend has a much higher proportion of residents who receive Personal Independence Payments (PIP). In Chapter 7 which expounds upon Spatial Redundancy, I discussed how the local economy and geographic features combine to predispose working-age residents with multiple health conditions to rely on state support. During fieldwork, I was shown statistical granular data, the collation of which was commissioned by a local charitable trust, that recorded the number of Skelsend's inhabitants claiming PIP in 2019. The report identified that proportionately, almost twice as many people received PIP in Skelsend than across the region (Skelsend Insight, 2019). Of the twenty-nine working-age residents with multiple illnesses I interviewed, fifteen received the Employment Support Allowance (ESA), PIP or had been placed in the Support Group of Universal Credit. Four residents considered themselves retired and no longer economically active, whilst ten were in paid work, either part time or full time. Accordingly, engagement with the DWP provides a prevalent source of discussion during interviews and broader fieldwork activity.

It was clear from the interviews with residents and community workers that the processes involved in accessing support impacted adversely on mental health and well-being. Not only was the process found to be beguiling in its complexity, but assessment decisions also seemed confusing, often seemingly arbitrary, and failed to reflect the realities of residents' lives. Residents were often left feeling that they were being accused of making fraudulent claims, and this was especially the case amongst those residents who lived with illnesses or disabilities that might not be necessarily immediately apparent. Prejudicial insinuations and vocalised judgements from other residents in the neighbourhood, arguably informed through the prevalence of moral conservative public discourses, further contributed towards a perception of embattlement. Meanwhile, real motivation to take on paid working opportunities that might accommodate their illness experience was undermined by the

inflexibility and lack of timely responsiveness in adapting to nonlinear fluctuating health trajectories and ability to perform paid employment.

Furthermore, the recent transfer from DLA to PIP was reported by most residents as a traumatic experience. All residents, apart from one, I spoke with who had previously been awarded DLA, reported losing their award or one of its components, considerably reducing their income and placing them into financial difficulty. The Work Capability Assessments (WCA) further stressed residents, who appeared to be subject to multiple assessments that scrutinised their eligibility and worthiness for support. This struggle, though, could be beyond the capabilities of residents, especially during periods of mental distress, which in several circumstances resulted in social withdrawal and marginalisation.

Meanwhile, residents were required to compile considerable evidence to access and maintain their financial support: a process that many found difficult and threatening because mistakes or omissions resulted in financial penalties. Accessing the correct information from medical professionals was reported to be fraught with difficulty. It could be expensive to obtain and not necessarily accurate. The delay in reviewing long-term health conditions due to COVID-19 often meant that there was no recent evidence available for people to use in support of their claim.

The narratives of residents convey a struggle to acquire the means to maintain a rudimentary quality of life, or even subsistence. This struggle, though, can be beyond people during moments of acute vulnerability, such as when experiencing a mental health crisis. Without access to appropriate support and advocacy services, many of the residents I encountered in Skelsend would have fallen into an avoidable crisis caused by financial hardship that magnifies mental distress and results in social withdrawal and marginalisation.

The chapter's first theme, 'Aspersions of Indolence', highlights the impact on residents from prejudicial accusations and insinuations from DWP administrators during assessments and other residents living in Skelsend. The middle section outlines the insecurity and work caused by regulative conditionality imposed on residents, including collating evidence to support claims. This section also discusses how several residents who previously

claimed DLA had lost support following the transfer to PIP. The lack of acknowledgement of fluctuating conditions that might not be immediately apparent often threatens residents with severe financial penalties. Concerns regarding how conditionality reconditions people with pernicious consequences detrimental to well-being are also discussed through the experiences of community workers and residents. The final section describes how the current system lacks flexibility and responsiveness, resulting in an oppressive barrier that erodes confidence, security and dissuades people from availing themselves of potentially achievable work opportunities. Therefore, the 'benefits system' not only undermines many residents' recovery from mental distress but it is also often self-defeating, undermining their potential for future employability.

State surveillance and aspersions of indolence

It was apparent from the recorded narratives that being confirmed as living with multiple health conditions by medical practitioners did not prevent residents' health status from being invalidated by DWP administrators. Many residents spoke about how representatives of the DWP insinuated that they were exaggerating health conditions. Jason, whose health conditions resulted in him losing his job, was not reticent in expressing his frustration at how he was treated when being assessed for PIP and during a WCA. The questioning of his integrity and the lack of acknowledgement of his circumstances left him frustrated and more insecure. Jason's experience was typical of residents, especially when their primary health condition involved a mental health condition. Jason underwent the bureaucratic procedure by phone during a period of social withdrawal and anxiety that prevented him from leaving his flat during the day. Jason recounted his experience with some vehemence.

> *"…they were calling me a liar, and they were trying to catch me out… and she said, 'So, how do you get all your stuff?' I said, 'Well, my mate brings me some shopping in.' I was going out a little bit, but I'd have to go out really late, you know, to the supermarket, maybe half past nine, you know, to Aldi because I know there'd be nobody in there because I was trying to avoid people as much as possible. And you know what one of the questions was? She said to me, 'So what would you do if your friend came round and said, 'I've got some*

tickets to go to the cinema[9]. You want to come?' I said, 'Well, what sort of a question's that? I've just told you I don't go out round people.' So she was trying to catch me out, you know. I said, 'I don't go. I don't go near people, so I won't be going to the cinema, would I?' ... And then the other guy from the DWP, he says, 'So what do you do for a living?' I say, 'Well, I was a driver.' He said, 'Well, why aren't you at work then because there's a shortage of drivers in this country.' I said, 'I'm not at work because of people like you talking to me like that.' I think I called him a dickhead or something. I'd had enough, and I ended up putting the phone down on him." [Jason, Resident Interview]

Jason regretted having to put up with this "crap". He told me he would prefer to work and not be subjected to insinuations of being a "skiver". The accusation of indolence had been levelled at Jason more than once, perhaps because a surface-level judgement on appearances alone might have given the impression of work capability. The accusatory nature of the contact with the DWP impacted his already fragile mental health, for which he received support from the Community Mental Health Team.

*"...I wish I didn't have to go through all this crap, to be honest. You know, I wish I didn't have all this crap in my head all the time and I could just get up and go to work, but unfortunately, I don't know. Something's happened hasn't it, and this is how I am. Hopefully I won't be like this forever… I'm shattered every day because I don't stop. Just thinking and doing stuff. I never stop." (*Jason, Resident Interview)

Bryan has lived with a neurological condition for over two decades after experiencing a physical assault while at work; he has a degree of cognitive impairment, which is accompanied by sporadic depression. He also lives with arthritis. He felt vitriolic about how the staff from the DWP would judge his lifestyle and assume that he was undeserving. He previously had been awarded

[9] There are no cinemas in Skelsend. The nearest one is a 75-minute drive away.

a lifetime award for DLA. Bryan explained that DWP assessors presumed there was a particular way of being concordant with receiving eligible support. Any divergence from this lifestyle, a presentment of paucity and relative inactivity, was perceived as a potential indicator of being a fraud. Bryan prides himself on keeping a presentable, nicely decorated home. However, based on prior experience, Bryan knew this lack of assumed congruence counted against him, as he told me of his experience of state surveillance undertaken to prove indolence and fraud. According to Bryan's experience, an assumed precondition for financial support for disability and illness is demonstrating an impoverished lifestyle.

> *"...I've been assessed through my benefits time and time again. And I've had people come out to my house, and I've said to them, 'You're going to now go away and give me no points, aren't you?' And they've gone, 'Well, I can't say anything, that's for the decision maker.' I'm like, 'Well, where's he sat?' And he was in Scotland, in Glasgow somewhere. He doesn't even know me. So, he's going look at a form and go, no, no points for him, right there you go... They've come into my house, I'm a single bloke, I don't live in a shithole because I couldn't. My house is a nice house and I live in a nice place and I don't care. But they think because I live in a nice house, I'm a single bloke, it should be a shithole... You know, if you've got a bit of something about you, then you're fucked… You have to be real careful what you're doing. You do, yes, anything. 'Oh, what are you earning? What are you doing?' I've had guys round here, round pubs in black suits, you know, coming in and saying, 'Do you know blah, blah, blah?' That's me. 'Has he been playing guitar in here?' Honestly!"* (Bryan, Resident Interview).

Local aspersions of indolence

The aspersions of indolence also appear to operate on a neighbourhood level. Residents living with health conditions experience judgement from fellow residents for their failure to work. For instance, many long-term or lifelong residents who work, including those with health conditions, like Alice, feel that

people relocate to Skelsend with no intention of working but just live off benefits because, isolation aside, it is a very inexpensive place to live.

> "…*because it's a cheap place to live, a lot of people who don't actually work move here and they want something for nothing. Only a few people down my street actually work.*" [Alice, Resident Interview]

Assumptions of indolence and fraud are quite prevalent, and there was a tendency for many people to reach conclusions based on surface-level impressions.

> *"Yes, there's a lot of disabilities and doom and gloom and a lot of people on benefits. So many people on benefits… I've seen one guy abroad pedalling on his bike yet he's here on a disability scooter claiming. He goes abroad and he gets a bike and pedals on his bike everywhere to sing in pubs."* [Florence, Resident Walking Interview)

Janey has a neurological condition, as well as muscular and skeletal conditions and has not been able to work for several years. She is frustrated by the attitudes of some residents she encounters in Skelsend who do not understand the limitations a life with illness have placed upon her. People question her need for a mobility scooter, not understanding the fluctuations in symptoms she experiences.

> "*This scooter does cause a lot of trouble and because sometimes people see me walking around they think I don't need it. But I do need it really.*" [Janey, Resident Photo Interview]

Janey's physical activity might be achievable during small, concentrated periods, but this cannot be sustained. Her need for rest after activity is not appreciated by other people. She faces further criticism for not working.

> "*Yes, it is, and it kinda annoys me a little bit, because people say you don't work, but I do, I work at living. That's the best thing I can say, is that I work at living…They think I'm having a great time; they don't understand how restricted my life is in respect of time… People don't see that if I get tired, I have to go to bed for a couple of hours. I time*

it. I know if I've done this much, that I will at some point have to have a nap." [Janey, Resident Photo Interview]

During our conversation, Janey and I discussed the daily routine work involved in managing her condition, the chores required to keep symptoms at bay, and the activities other people who live free of serious illnesses may not appreciate. For instance, she described her complex medication regime and how the extraction of pills from their packets caused her already swollen hands further pain. She described her morning medication routine as commencing a "shift*"* and related this to work*.*

"*My shift on a morning starts about eight o'clock and I will take some tablets and take a banana, you can't not eat, you have to protect your stomach as much as you can, mine is already not well after years and years of doing it (taking medicines), I think I've been doing it since I was twenty-seven, it's a long time."* [Janey, Resident Interview]

Sam is also sensitive to other residents' pronouncements of indolence. Sam felt that accusations and insinuations have more potency, given that the symptoms of her health conditions are often not visible. She encounters negative judgements from other residents of Skelsend, who feel her illness claims or impaired functionality to work are erroneous.

"Because it's not something people can see, then people just think there's nothing wrong with you. Then that makes me feel worse, because it's like, well, there are things wrong, it's just that you can't see it. And then you'll get, 'Oh, just get up and do it.'" [Sam, Resident interview]

This judgement in the form of unsolicited advice about working, which she confirmed as not infrequent, left her feeling *"*crappy". During our conversation, Sam compared the potential to receive criticism from local people in Skelsend with the urban neighbourhood from where she relocated over a decade ago.

She felt the smaller community, where nothing goes unnoticed, can leave one open to greater misinformed scrutiny.

> *"Especially in a town like this. It's hard. Because people see you day after day, and it's like, they just-sort of chalk you up to being lazy. And it's like, I'm really not lazy. I'd do anything. But realistically, I can't, because it doesn't work like that in my world.*" [Sam]

Sam's symptoms resulting from the health conditions she lives with, an enduring mental health and a neurological condition, fluctuate unpredictably. Moreover, they are not visible in the same way physical impairments might be. Sam feels that the lack of a visual marker means she attracts moral disapproval, especially when she is seen undertaking supportive tasks for her husband. Like Janey, she says people do not realise that it is hard work just to be present in the world.

> *"If I was in a wheelchair, nobody would look at it twice. But because I'm not, they say, 'Hello, yes, you're just fiddling the system, or you're doing this and that.' Or it's like, they'll see me when I'm having a good time as far as they're concerned, but what they don't realise is I'm working so hard to just do this at the moment*." [Sam]

Several residents I spoke to found they were forced to defend themselves against state and local suspicion and the implied accusation of indolence. They found the process exhausting and often coming at a time when their resources to fend off accusations and build a defensive paper trail were most depleted. This was the case with Paul, when he understandably elected to remove his last remaining capital, £2000, from a private pension fund, from which he was paying exorbitant administration charges. Meanwhile, poor management had left his pension fund vastly diminished. Paul declared this to the DWP, which instigated an investigation into his financial situation. Paul provided all necessary evidence regarding this withdrawal of money to the DWP, but this was not registered in the database correctly, resulting in an administrative error threatening his financial lifeline. He received further written instruction demanding information, which he had already provided, whilst under the potential threat of sanction, causing him considerable anxiety and stress.

Eventually, the situation was resolved, but the lack of care left Paul angry. This incident was not long after Paul's dire financial situation after losing his job due to a severe mental health condition and which caused him great distress, which left him suicidal.

Before becoming ill, Paul had worked all his life. He was no "shirker", as many people who are suffering from sickness-related benefits are portrayed (Garthwaite, 2011). This stressful situation was made worse by the DWP's lack of reassurance, which threatened a return to crisis. Paul told me he intensely fears any communication with the DWP and is left angry about how people are treated. He recalled how stressful the situation was to resolve. Just getting to speak to someone from the organisation who was prepared to listen was difficult.

> *"I get in a real bad state with things like that. But you know they never replied to me, I never got a letter, they never came back to me after that point… no reassurance, not a thing. And every day, I was waiting*. *They don't realise how much pressure they are putting on people. It's awful. I agree they have to be careful, because there are a lot of people who, thingy, but they should be respectful, because you're not guilty until you're proven guilty, but they treat you as if you're guilty before you have even started. And they never answer the phones, and that is a stressful situation… Whether it's the system or the people, the benefit system don't treat you properly, they treat you like a bag of* (Paul uses frustrated facial and hand gestures to avoid swearing on tape). *Every time I get a letter from them my heart drops, I can tell the typeface, I dread opening it, I honestly do… But I get angry with them, I really do, cos you feel they are like hammering you, they try to hammer you for everything and leave you with nothing. You know, when you're on hardly owt as it is, you'd think that they were giving you a bar of gold the way you get tret. Yeah, I can't handle 'em.*" [Paul, Resident Walking Interview]

The discipline of non-work

Although, welfare conditionality eased during the COVID-19 lockdown and subsequent restrictions, community workers reported during the latter part of my

fieldwork in the summer of 2022, that there were signs of a gradual return to the austere conditions that existed before the pandemic. Moreover, the fear and threat of sanctioning remained. Community workers and residents often told me of the obligatory work involved in maintaining financial support and the work of non-work, which, if not undertaken, results in sanctioning and severe loss of income. As Phil, one of the community workers who must respond to a personal financial crisis caused by sanctioning, advises,

> *"We always are having to subsidise people who have been sanctioned on benefits. There seems to be a government policy to sanction first and ask questions later, and most of the cases where I hear people have been sanctioned it's hugely unreasonable. Okay, I hear their side of the story, but I actually believe that a lot of the sanctioning is unfair and unreasonable… they send you a letter but the letter goes missing, and because you didn't reply to the letter within so many days, or phone up or deal with it, then you're just automatically sanctioned after two weeks."* [Phil, Community Worker]

Residents spoke of the difficulties of obtaining necessary information, usually written medical assessments, needed to make a claim or to justify the continuation of their support. Their testimonies and reflections from community workers in Skelsend reflected the unacknowledged work involved and necessitated by one's relationship with the DWP. Indeed, securing one's financial means of maintenance involved work without paid work. Meanwhile, several community workers advised me that people could quickly lose their income without support from a specialist advisor independent of the DWP. Often, people with mental health conditions lack the personal resources to be able to navigate through the complexities of accessing support and may struggle to access support.

> *"Sometimes we find they are unable to reach actually the services, for example, or to get evidence from their GPs… There's difficulty with accessing these services, but I'm referring basically to mental health because people with mental health issues they have more difficulty with accessing, actually with initiating this contact even, or with reaching for help, asking for help… they tell you that they are*

physically and emotionally drained, so if they don't have someone to encourage them or to help them, they might not themselves actually ask for help." [Zania, Community Worker]

Residents and community workers also spoke of the perils of completing complicated long forms. A straightforward mistake, no matter how easily rectified, would invalidate a claim, and one would have to embark on the same process from the beginning, placing people in financial distress.

"…*if you're disabled now, every three years you have to give them all your information again. Everything. It might be that much paperwork... they make you fill a whole form out which is forty pages, yes. And if you get one question a little bit wrong or a little bit, word it, your money's stopped and bang, gone*." [Bryan, Residents Interview]

Sandra's charity encountered many situations like this. She explained how some people struggle to cope and try to ignore problems related to accessing financial support because of their anxiety and poor health, only for their difficulties to accumulate and grow. Meanwhile, the regime of conditionality through mandatory work-related activity can be particularly onerous and high stakes when living under the threat of sanction. The whole process of applying for work online is difficult for many people lacking contemporary IT skills. The community centre did obtain a grant to fund a welfare rights advisor, but this was for only two days a week, and, although this was better than no service, the supply of support could not meet demand. However, these support services were vital to help residents overcome oppressive structures. As Sandra describes,

"*…when you've got individuals who are challenged financially that they haven't been able to attend, erm, er, a computer course or can't even afford a computer to even go through that learning journey themselves. So, then to suddenly jump on to a public computer in the library or anything else, to then access a public computer such as at the library etc., sitting thinking, 'What the hell do I do?' When they haven't got them underpinning skills, their literacy and IT literacy is*

not up to speck, their current health conditions are accelerated by the anxiety because mistakes are made etc. You're back to the beginning… Then trying to get hold of Citizens' Advice. And people struggle, so all it does each day goes by and the problem escalates and escalates. That's why so many people put their head in the sand because obviously trying to address these issues just keeps building on the anxiety. …You know, some of them have thirty-hour job search commitments, per week. And then to evidence thirty hours of job search, when the job coaches know that they got no transport, they'll never earn at full minimum wage because limitations of skills and abilities. That for them to get a job cos of limited numbers of jobs in immediate locality and they would have to work in Haxton. That then has a cost implication and a time implication…" [Sandra, Community Worker Interview]

However, the long commutes, as described by residents, are often unsustainable for many. Lucy, who is in her 50s, has struggled with a long-term mental health condition, asthma, and arthritis; she describes the arduous nature of the mandatory job-related activity. Skelsend had also lost its job centre, resulting in residents making the journey to Haxton, which many residents with illnesses found challenging.

"*Horrendous. You had to fill in all your job searches, you had to look all the time, you had to go for interviews, you had to do everything, and it was just a nightmare. It was a nightmare, absolute nightmare. My anxiety and my depression, it did (impact), because you'd be, I'd be panicking all the time. I mean I've gone in there; I've actually gone and signed on before and I've actually sat and cried because I was in such a state with myself. I had to go into Haxton. And then that must have cost me £10.10 on the bus and they never used to give it you back. An hour there and hour back. And then I had to walk from station to the dole office. So, it was just a nightmare. Yes. So, by the time I got home I was in agony.*" [Lucy, Resident Interview]

Pernicious systemic effects of reconditioning

Service users claiming support must apply for a fixed quota of vacancies as a condition of continued financial support, even if this means applying for jobs in which they lack the prerequisite skills and experience. This naturally results in ongoing application rejections. Over time, the repeated, predictable rejection has a pernicious effect on one's outlook and one's mental health. Sandra's observations exemplify this: Sandra is a community worker whose charity, amongst several functions, supports residents with employability. The charity supports many residents searching for work and applying for jobs as a precondition to receiving DWP benefits. The process of applying with genuine purpose and effort is knocked out of people by rejection. However, many of the jobs applied for were not suitable, but to prevent destitution, people are mandated to apply regardless. Sandra describes this demoralising exercise.

> "*I think the individuals come into negativity because of how being forced to apply for something you know you haven't got hope in succeeding with. Well, going there to have to say you're not suitable. [then] Go over there and told you're not suitable. Go over there and they'll tell you you're not suitable. It becomes a bit like white noise to many individuals. That's the process. But when people first start this journey, to adhere to those requirements, it's, yeah. 'I was trying but now I can't do it. But I was trying.' And then that mindset is being knocked a bit more, knocked a bit more… Characters change. Well just imagine you doing that. Day in, day out, then for a year, of saying, no go away, no go away… you've been reconditioned.*"
> [Sandra, Community Worker]

During my time in Skelsend, further pernicious reconditioning in the face of DWP regimes could extend to maintaining healthy activity levels. I learnt of instances whereby residents living with long-term health conditions were financially penalised for trying to improve their fitness. In some cases, this resulted in people becoming deliberately less active because they could not afford the subsequent loss of financial support. Catherine and Gary told me that they had lost part of their PIP award on assessment because they had told advisors they had attended classes at the local council leisure centre. They had wanted to improve their health, but were subsequently penalised as their activity was taken

as evidence of their improved mobility. For example, Catherine enjoyed chairobics; she wanted to keep attending classes, but the loss of benefits after declaring this deterred her from continuing.

> *"Sometimes I can get tongue-tied if I get stressed or anything. They just didn't want to believe what I was saying. And because I'd mentioned I go to this chairobics because the doctors had sent me there, that seemed wrong... If I told them that I didn't go anywhere and I've got mental health issues, what would they have done then? I'd rather tell the truth than lie. If I didn't tell them I went to this chairobics… I feel like not going, but my husband says, 'Keep going. Your doctors have told you to go to help with your knee.' I can see when I'm there I'm more happy, but it's when I don't go. It's only twice a week. I need something to interact* [with]." [Catherine, Resident Interview]

The healthcare system and DWP work in contradiction to each other. As Rick explains, as a healthcare professional who supports people with health conditions to improve their mobility and fitness, the financial penalties some people face should they improve their health dissuade them from engaging with his service. He is often viewed by the residents referred to him with some suspicion and as part of an undertaking to remove their benefit.

> *"People feel trapped and you can see it. They're in like a vicious Catch 22. I'm unemployed, I'm on benefits. I might have some kind of benefits help me with a medical condition. If I start improving that and I go back to the doctor, and the doctor says, 'Oh yes, yes, you're doing fantastic,' what's going to happen to my benefit? Is that going to make me poor then? Physically, am I going to lose money while I'm still in the same position? I haven't got a job, I've still got no chance of getting employed. All I've done is make myself poorer by becoming a bit healthier. And you can see that cycle going round. I mean, I gave you the example about the lady in the wheelchair, and we engaged with her, found out she didn't really need to be in a wheelchair. We got her out of the wheelchair, we got her exercising,*

she was loving it. Then she stopped coming and then we saw her again a few weeks later, back in her wheelchair. And her husband quite pointedly said, 'We're not going to lose benefits,' and with the best will in the world we can't cure that." [Rick, Health Care Professional]

Rick told me that some people view him with suspicion as being part of a system that wants to cut their income, and it is a significant barrier to engagement. Sharon, a café owner, whom I spoke with during the ethnography, was, like many café owners, a fountain of local knowledge. She talked about the very same thing, fear of people in authority and being forced to relinquish control. She had seen how people endure daily struggle but avoid contact with services. This observation was shared by Mandy, a community worker. She found this barrier especially with residents of the Seaville estate.[10] Whether this has been influenced by the years of engagement with DWP, which has contaminated perceptions of other governmental organisations, is unclear. However, Rick's experiences are shared by other community workers.

"*Well, that's the thing that we got from that estate. We did the work there in conjunction with public health and that they don't engage with the town... We can put it on social media, we can put it in newspapers, they just don't engage.*" [Mandy, Community Worker)

The precarity of PiP

A pressing concern of many residents that I had interviewed was their relationship with the DWP and how this impacted their well-being. The interview findings demonstrated that this relationship was often suffused with precarity, confusing complexity and seemingly negative prejudicial assumptions. Six of the fourteen residents I interviewed received social security payments for working-age benefits, and those who were not working lost a significant

[10] The estate is in an LSAO, which is within the most deprived 5% in England according to the Indices of Multiple Deprivation.

proportion of their income during their transition from DLA to PIP.[11] Other residents were concerned they would be forced into work they could not manage and described feeling materially insecure. Consequently, eight residents had, or were, enduring financial distress that impacted their mental health and overall well-being. This included social withdrawal, escalating anxiety and difficulties coping with household tasks. Residents told me reviews were very stressful and worrying experiences. The likelihood of financial hardship, with all the consequent stress that comes with it, is unfortunately quite high, seemingly regardless of one's actual circumstances and ability to work.

Community workers and residents spoke of how easy it is to get lost in the system and not understand what is required, or how to satisfy some of the more complex processes involved in maintaining one's financial support. They, the community workers, strongly advised that people seek advice and support before being reviewed to avoid falling into any concealed discursive traps that may await them. However, independent welfare rights advisors are thin on the ground in Skelsend, and it is common for people to have to wait up to a month before they can see an advisor.

Zania, a community worker who supported people with problems related to debts, housing and benefits, explained that when being assessed, people must draw attention to their physical and emotional difficulties and not try to continue stoically. The system was such that people had to "sell" their illness and physical and mental limitations; otherwise, disability and the symptoms resulting from health conditions would be overlooked. In the post-COVID environment, reviews have been increasingly undertaken over the phone. According to Zania, this disadvantaged residents further because the visual element of the assessment was absent, necessitating residents to work harder to sell evidence of the symptoms of their illnesses.

[11] DWP decisions overturned at tribunal between October and December 2023: Personal Independent Payments (PIP) 70%, Disability Living Allowance (DLA) 58%, Universal Credit 54%, Employment Support Allowance (ESA) 49%. The highest proportion of decisions was in regards to PIP and accounted for 67% of total appeals (Gov.UK: 2023).

> *"… If they don't give supporting evidence, there is this risk that the whole award will be reassessed, so it's going to be as if you are making a fresh claim. And even when they go to the tribunal, if they don't really have good advice and some clients, they don't know to express themselves… They* (her service users) *don't really understand that, if you don't really feel good, if you need a break, if they are in pain then don't say okay, say I'm standing up now because I cannot sit on the chair for a long time. They will not go through those details over the phone, so an assessment over the phone is not really an efficient way to assess the needs. And especially if they (the claimant) don't really provide supporting evidence. And you know how difficult it is even now to get supporting evidence. You must pay for this sometimes. A client paid £30 the other day for getting a report from her GP.*" (Zania, Community worker)

Zania's advice of demonstrating one's physical and mental limitations during assessments was pertinent to Ben's situation. Ben, aged 40, has a lifelong disabling spinal condition that severely impairs his mobility; he walks slowly with crutches and often experiences falls. This condition causes Ben pain around his hips and back and leaves him doubly incontinent. He receives continence aids from the NHS, however, the provision is inadequate to maintain his hygiene and dignity. He has no choice but to purchase his needed additional continence aids, but they are expensive and take a sizeable chunk out of the household budget, which is already under pressure due to him losing half of his award. Ben has a congenital condition; it is lifelong, and there is no prospect of improvement. However, for Ben, demonstrating the daily reality of his difficulties constituted a personal indignity. He was not prepared to adopt this strategy, although he told me others did. Ben recalls his assessment for the transition to PIP.

> *"I went from DLA to PIP, and they rejected me to get the PIP. I fought like hell, I even went to the advice surgery here, and they said, 'Because of your incontinence, qualifies you straight away,' because you have to have, I think a minimum of, like, seventeen points or whatever it is. It's a specific number of points, and she goes, 'But the*

incontinence of bowels and bladder automatically qualifies you full stop, on the high rates on both.' But because I didn't piss myself basically in the interview I was rejected... It's like when I went for my interview there were people there, and fair enough they had a stick there, I'm not saying they didn't have anything with them. And all they did was sat in the room and pissed themselves, and I'm thinking, I could do that but I've got dignity. I'm disabled, doesn't mean I've got to sit there and stew in my own mess. But because I think like that, I get punished for it. Like, they say because I don't have many accidents, but then if I didn't have a pad on I'd be wet… because I don't have that accident I'm penalised, but I'm having that accident, just the pad's saving it." [Ben, Resident interview]

Ben faced further disregard for his circumstances during his WCA. The assessor compared him to her son, who had a different condition and used him as an example of the work activity she felt he should be undertaking. Ben was left feeling incredulous and frustrated by this approach.

"… the nurse I think it was… did my assessment was comparing me to her son who had cerebral palsy. I'm like, 'But your son's disability and my disability could be two different things...' And she kept doing it, so I think that had a factor in my not getting it because she's, like, 'Oh, my son can do it, why can't you?' I'm not your son for a start, and my disability affects my spine, not just my brain neurons, my spine and I can't control certain things… Your son should have nothing to do with my interview." [Ben, Resident interview]

Bryan and Janey, both of whom live with neurological conditions impacting their cognition and other health conditions, lost the lifetime award on being assessed during the transition from DLA to PIP. In Bryan's case, he lost all the financial support that he had previously been guaranteed under the previous benefit, DLA, because the change in the qualifying criteria disregarded his disabilities resulting from a neurological condition caused by a physical assault. The consequent stress from the loss of income had a significant impact on his mental health; had it not been for family support, he would have been left

destitute. It took several years of specialist support from a charity to overturn this decision in court.

> *"…they took all me money, took me car off me and everything, everything gone. Yes. They went, no you're getting no points, zero on everything. So went to court. He took nearly three years to go to court. Yes. They didn't turn up to one meeting and one interview. They had a judge's chamber thing that he had to do (his advisor), they never turned up to any of them (DWP). Honestly… I won the case. I got a year and a half's back pay." [Bryan, Resident interview]*

Janey lost an element of her DLA on the transition to PIP after her consultant provided incorrect information regarding her ability to get to and from a hospital appointment to a hospital to the west of Haxton. The consultant informed the DWP that she had made her own way to the hospital when in fact her friends supported Janey to get there. Janey had previously received a lifetime DLA award, but lost the mobility component on its transfer to PIP. Janey's experience highlights how at the mercy people are to get the details about their functioning right.

> *"The neurologist that did this put down in one of my letters that I was capable of finding and whatever that is, you know, doing your own thing to get to the hospital. I didn't do any of it. Somebody organised a taxi for me. Somebody took me to the place. I didn't do any of it. I can't do buses. I can't actually physically do buses but… And you see people judge me on different days because to be honest yes I have that stick, but I could walk a bit down there (centre of town) but it causes me pain… I was downgraded because I did used to have… I was on DLA and I had DLA for life... And they started with the PIP, and you had to be reassessed. I've had… The last time I was reassessed I had people helping me at the community centre, yes, a nice lady helped me there. But they can only help you so much. And the fact is because they'd put that down in a letter, I lost money*…"
> [Janey, Resident interview]

Janey told me she did her best to avoid becoming stressed by the prospect of DWP assessments, which had the potential to provoke stress that brought on the debilitating limb tremors, a recurrent unpredictable symptom which she particularly dreaded. Janey further confided that she was sometimes inclined to avoid medical appointments, finding them stressful and, therefore, a potential trigger for worsening symptoms, especially involuntary tremors. However, when engaging with the DWP, she recognised this reticence detracted from her ability to collect the evidence she needed to build an argument justifying her continued support. I developed a good rapport with Janey at the Craft Club and through our impromptu chats on the high street and around the central promenade in Skelsend. I quipped that she did not play the "sick role" in avoiding medics. Janey laughed and replied,

> "*No, I don't play the sick role. No, but I'm playing the, I think it's the pointless role. And it'd probably stress me more if I (did)… And the trouble with stress… I don't do stress. Don't get stressed because it will bring your tremors on and that's why I'm avoiding. I've been doing this avoidance thing.*" [Janey, Resident Interview]

Fluctuating conditions and assessments

Adding to the sense of precarity was the fluctuation in the presentation of residents' symptoms, with all residents reporting a lack of understanding from DWP about fluctuating symptoms. Perversely, having good days can be costly and result in residents losing their financial lifeline. Residents reported that the situation was particularly precarious if one's good day coincided with contact and assessments from the DWP. Both Janey and Ben, who lost an element of their award, lamented that assessors did not account for the rest and preparation taken days before their assessments to cope with the ordeal of travelling to Haxton and during the assessments themselves. Nor did they feel any consideration was given to the fatigue afterwards.

Janey reported that her symptoms fluctuated considerably with no discernible predictive pattern, although she knew that there would be consequences for being active; for instance, should she walk to the community centre or into town from home, the following day she would likely experience fatigue and muscular and back pain preventing her from leaving her home. Should Janey prepare

herself as if the assessment was a crucial examination instead of reflecting her usual daily capability, her dedication would be punished. Generally, she felt that was unable to replicate the concentration needed for an assessment on a daily predicable basis.

> *"I have phases, that's the trouble. Because at the moment, I'm quite good. And I'd love to be like this all the time. But I don't know when it's going to happen (fatigue /onset of tremors/debilitating pain). One day I can be able to walk and the next day I can't get out of the house, you know. And I'll be so tired that I can't get around… And to be honest if they do an assessment on me and yes I'm having a good day, and I'm concentrating really, really hard like I am today… they don't see that I have to go to bed for… Like I didn't get up till twelve."* [Janey, Resident interview]

Like Janey, Ben's experiences of being assessed corroborate with Janey's; preparing sensibly days before an assessment only seems to increase the likelihood of financial support being removed, regardless of illness and accompanying symptoms and limitations.

> *"Yes, and that's the thing. Like, that day I could have been having a really good day. The next day could barely walk. It hurt. I get a pain, like my legs ache everywhere so it's like I am in constant pain. But they don't see that. They just see me for that day which I'm building up for, so I might take it easy for a couple of days to do it, which they don't see."* [Ben, Resident interview]

Furthermore, to protect oneself, being fully honest and open was not always seen as a successful route to maintain one's well-being and financial stability due to this lack of accommodation on behalf of the DWP processes. Residents also knew that reintegration into the workplace was incredibly difficult for employers, who could not accommodate the resident's fluctuating symptoms. The sense of insecurity is further intensified by the difficulty of getting financial support from the DWP should the residents attempt work, only to find they cannot manage this on a sustained basis. Sam exemplifies this by reasoning

that she should not disclose her then-current, but likely short-lived, period of symptom abatement.

> *"I have to fight tooth and nail to stay on benefits. Because there are times when I'm okay, to a point. But it never lasts long. And that's where it's hard, then, because trying to get that through to people that have got absolutely no knowledge of how you live day to day is really, really difficult… So, it is hard. It's like my clusters* (severe intense headaches)*. I've had three months where they've not been too bad, but then they'll start building up. Now, if it wasn't for the mental health side of it, they'd have probably taken me off PIP again. Because I've got this little break. Yes, great, but we don't know if that break's going to be two days, two months, two years. There's nothing to sort of accommodate the fact that there's things wrong with me that can change on a daily basis. And that's a constant battle… but I haven't told them this time that I'm in a lull from my clusters* (intensely powerful headaches)*. I'm in a quiet period. Because they'd have just stopped everything, and then I'd have had to start all over again. And then getting back into PIP's hard work. And it was like, this time, I said, 'I'm not doing it. I'm not*.'" [Sam, Resident Interview]

Consequences of losing support

Kim, whose relocation to Skelsend was discussed in Chapter 6, has a severe and enduring mental health condition, PTSD and osteoarthritis. She had come to Skelsend after experiencing a brutal assault, which appeared to have triggered a severe and enduring mental health condition. Kim reported this as the primary health difficulty that has the most impact on her quality of life, causing her to experience debilitating social anxiety and agoraphobia. She had been receiving DLA and then PIP for well over a decade; however, three months before we met at the community centre to record an interview, Kim was reviewed by the DWP via a telephone interview. She found the review over the phone much more challenging than in person, felt much more anxious, and had trouble answering the interviewers' questions.

Several residents complained that reviews were overdue due to an inability to access their usual medical appointments due to the COVID-19 pandemic and

the subsequent backlog. Kim was no exception; this further penalised her by reducing the evidential support she used during the assessments for the transition. However, the assessors did not recognise the difficulty in accessing evidence. Like Bryan, despite previously being awarded DLA, she was now judged as ineligible for PIP. With the support of a welfare rights advisor, she started the appeal process against this decision. In the meantime, the financial hardship caused by the loss of support had severely impacted her mental health. Kim was often tearful during our interview, but determined to record her experience and difficulties. I found her testimony to be a powerful demonstration of the real anguish experienced by people living with illnesses and disabilities when losing financial support.

> *"I've been having really bad episodes of panic attacks and anxiety and that. Yes. It's only because I'm fighting my case with PIP… When I had the phone consultation, face to face, my daughter she was with me. And she saw how anxious I was and everything. And how I did panic, she held my hand through it. And I had two anxiety attacks. But they said, 'No, I was fine...' It's not that I'm lazy, not willing to go out to work. It's that I can't be in… I can go and prepare* (inaudible but tearful). *But it's the being out in the environment in places where I panic and I can't… My anxiousness takes over and then… I just get nervous being around so many people. It's always been there. I mean, even if they didn't stop my payment, I'd be still in the same boat, you know, as I am. But it's triggered it more. It's because of stopping it. And not being able to get these appointments* (medical). *It's triggered it, triggered it, triggered it* (tearful)*… And I've kept myself locked in a lot.… now my letters are piling up, piling up because I just feel like my brain is not taking it all in. It's too busy, it's too busy… I'm in the middle of getting all my medical records from hospitals and doctors and stuff. Get as much evidence as I can. And I keep thinking, right I've got to think positive. I spread my money out less each week... if I don't win the case that means the Universal Credit will stop my, it's called capacity, not being able to work. They'll stop all that and I will have to go get a job and that I can't. I'd have to work from… I'd have to cook this year from my own kitchen to send*

them out. Because I can't go into this… I can't… I've got all the qualifications and everything, I run my own kitchen but I can't do it now and that hurts. I used to drive, but I can't drive no more. [crying]" (Kim, Resident Interview)

Catherine, who lives with epilepsy, type two diabetes, asthma, osteoarthritis, and depression, told me that she lost the daily living component to PIP and, as a result, her husband lost his carer's allowance. This was an abrupt and massive blow to the couple's finances, and the consequent financial difficulties caused her to feel more depressed and anxious. Like Janey, after becoming acquainted with Catherine, we would often see each other on the high street and stop and talk. When mobilising, she used her wheeled walking frame to help her balance and prevent falling. Her assessment was also over the phone. Catherine, too, was in the process of being supported to challenge the decision at a tribunal, but the stress was having a real impact on her quality of life and mental health.

"I just don't want to do anything. I just don't want to do anything at all… The DWP took my daily living off me, so he was getting Carer's (Allowance)… it's money worries I think that's mostly getting me down, because they've taken half of my PIP and then I've got my ESA. But it's still money worries, isn't it? Your bills have got to be paid. I think that's what's doing it, money worries… I know we're on the pay-as-you-go system on the gas and electric so I watch what I'm spending. Smart meter I mean. I just don't put the lights on as much… I just don't want to put the heating on... If I'm stressed about anything it can trigger blackouts…" [Catherine, Resident interview]

Jason was turned down for PIP and subsisted on Universal Credit and his dwindling savings. To improve his well-being and combat his tendency towards social withdrawal, he was advised to mix amongst people; the therapist from the Flintonprice Community Mental Health Team told him to try to sit in cafes to build resilience against social anxiety. However, living from such a meagre income, provided by Universal Credit whilst the cost of living was escalating, rendered this an unaffordable social prescription. Jason was not even receiving

the additional income from being positioned in the Universal Credit Support Group to which he was entitled. Not having access to additional funding being the real barrier to recovery left Jason feeling exasperated by his situation:

> *"… the therapist says you need to maybe go somewhere and have a coffee or something and sit and read a book maybe in a coffee shop, or I don't know. You know, just where there are people around so you can get used to sitting with people and talking to them, but you can't. You can't afford to... So, he's telling you what he wants you to do to try and get better but you can't do it. So, the system isn't helping."* [Jason, Resident interview]

Rigid intransigence of support

When residents reflected on the capacity for paid work, several tentatively conceded that there were times when they might be able to undertake limited employment. However, how the system operated, namely the lack of flexibility and responsiveness, undermined the resident's sense of security. Should residents take on a work opportunity but find that they cannot sustain the work schedule, they could not be confident that the system would respond quickly enough to prevent them from sliding into very hard financial distress or even destitution. They also worried that any small amount of work, or even voluntary work, would be mistaken for an ability to undertake sustained employment. Residents often reported being caught between a "rock and a hard place", with little mediating mechanisms for them to engage in paid work during periods when they might be able, even for a minimal time. This is exemplified by Sam, who would like to be more active, maybe undertake a few ad hoc hours of work where she could, or embark on volunteering for a charity, but a rigid system, cynically punitive, prevented this.

> "*But then there are times when you think, well, actually, I should be able to go and do this. But the system doesn't allow that to work. If I'm feeling good, I will go and do something. Even if it… The amount of times I walk past the charity shop and poster has said, 'You want volunteers?' And it's like, I might try that. Don't know if I'd do it, but I might try it. Because I don't want to be sat at home twenty-four hours*

a day. I'm not… You know, I'm not that poorly that I'm sat in my bed. I want to be able to go and do things. It's just that I can't commit to certain things. And I think there's no flexibility in the system that allows me to do that. Go and, you know, work a shift in a pub. Our local bar, they've had times where they've had staff on sick and it's just… If you say to me, 'Oh, I could do with you… Would you do a shift?' I should be able to say yes."

I asked Sam whether volunteering several days a week might jeopardise continued financial support through PIP, even though it might be good for her well-being, contribute to the community and potential employability.

"Yes, because then they could see that I can do three and four days, 'Well, why can't you get a job?' Because what you've not seen is I'm doing three and four days in one month. And that's what they don't allow for. And I think that… Especially on PIP I think there needs to be some leeway, and… And I say, it's different when you've got a mental health condition. You should be allowed the leeway. Because having the leeway actually makes you better in the long run. And that's what I've noticed. Keeping busy keeps my mental health better." [Sam, Resident interview]

Meanwhile, returning to Jason, his mental health recovery was tentative and fragile, and he knew that he was not ready for work. He expressed concern that his recovery had recently halted and was sliding backwards; financial and DWP pressures were contributing factors, among other difficulties he was experiencing. With each communication from the DWP, he felt the weight of the pressure and the imperative to take any work. Given his state of mind, he was worried that he would be unable to cope and could envisage himself just walking out on a job regardless of the serious consequences.

"So, if they push me into a job, I'm not going to be able to stick it. And if someone is on my case, I'll just walk out. But then you can't go back to the Job Centre because they'll say, 'Well, you're going to have to wait six weeks to get any money again.' They might push me into work when I'm not ready, or a job that I can't do or don't want to

do. Maybe not, not want to do, because I'd probably do anything to be honest. And then if I fall back after a week or two to how I am now, they're not going to… It takes six weeks for them to help you again, doesn't it? And then that's a fear then, because you've gone back, then what happens? How do you pay your rent? How do you pay your bills? How do you heat your house in the winter, and food? How do you do it… It's just a bloody vicious circle is this country, and I don't know what they're trying to do to us, to be honest… You know, the Universal Credit won't pay for everything. I'm not a stupid person, this is why I need to get back to work so I can afford to live, but they don't see it like that. They don't help you to get to that point, which is bizarre isn't it?" [Jason, Resident interview]

Summary

Taken together, the negation of mental well-being, the lack of acknowledgement of daily hardship, and prejudicial assumptions felt by most residents when encountering the DWP, can cohere to have a deleterious impact on the lives of residents with pernicious implications for the health and well-being through the reduction of activity. Residents living with multiple health conditions, or conditions whereby limitations are not immediately apparent, are more predisposed towards a loss of income and a subsequent struggle to secure their means of maintenance.

Chapter 9 The Health Landscape of Skelsend

Accessing health services

This chapter focuses on the challenges study participants experienced accessing health and care services. The subsequent section will discuss the broader contextual health landscape in Skelsend and the challenges faced by health professionals tasked with meeting high public demand. The paucity and diminishment of services experienced by residents have gathered pace over the last decade and have caused considerable anxiety, which, in some cases, has resulted in anger directed at the services essential to maintaining their well-being.

The rationalisation of health services resulted in provision being pulled away from the periphery, despite high levels of need in towns like Skelsend. The consolidation of services had resulted in fewer services being offered in Skelsend. Residents felt that accessing GPs and hospitals had become increasingly difficult because of the journey and availability of appointments. They found it particularly difficult to access services because the town is connected poorly to urban areas that increasingly host the services they need. The effects were felt hardest by people with mental health conditions and those people with poor access to finances.

This chapter concludes by discussing a different aspect of maintaining health and well-being, which speaks more to preventing illness and encouraging healthier lifestyles concerning food consumption. Skelsend has a high density of takeaway food outlets, which is typical of an area that is measured as being relatively deprived. Access to affordable, fresh, healthy food is often unreliable, especially for those residents on low incomes, who are spatially bound and are impacted further by mental health struggles.

Spatial amputation and dislocated health

Consultant appointments and diagnostic procedures were invariably situated at the Haxton Royal Infirmary or the Woldenshire General Hospital to the northwest of Haxton. Many appointments were situated at the Woldenshire General Hospital, and a return journey without a car would require four buses that would take someone approximately four to five hours of journey time. Florence, someone who had relocated to Skelsend, partly on the assumption

that there was a local hospital in the town, was one of several residents who struggled with severe anxiety and found this journey challenging.

> *"…it's just trying to get appointments at the hospital, it's really getting on my nerves trying to get to the hospitals… all the way to Haxton for your appointments just to do check-ups and things like that. It's two buses, it's such a hassle, you end up just leaving your health problems… it's so stressful and upsetting trying to get appointments and getting the treatment because they are all at the end of the earth as they say." [Florence, Resident Interview]*

This sentiment was echoed by a health professional, who felt many residents were disadvantaged by the town's poor connectivity, with many people moving into Skelsend with illnesses but unaware of the difficulties in accessing medical facilities.

> *"One of the biggest challenges we face here is our isolation. The journey people have to get to the hospitals can be challenging, it's bad enough by car, but by bus it's very difficult and long. I think people who run services should try the bus route, they might be more understanding then. Many people see Haxton as a distant place and they didn't sign up for Haxton, they signed up to Skelsend."* [Guy, Healthcare Professional]

Ben, over recent months, had been experiencing severe pain in his hip. He was losing his balance and falling more often. He felt that there had been a deterioration in his physical functioning connected to a lifelong spinal condition. Following repeated appointments at both surgery and hospital, he was referred to a private hospital outside Haxton, under the auspices of the NHS. The journey to the private hospital, like Woldenshire General, required buses. Aside from waiting at the hospital, the journey time would consume most of his working day using buses when reliant on two crutches. Ben felt this long, tiring journey on multiple buses was fraught with stress, especially given his tendency to lose balance and fall. Ben was concerned about not coping with the journey; also, having dyslexia, he found reading and understanding the information

about the buses at the interchange problematic, and usually there are now no transport staff around to ask for support.

> *"I think I have got a three o'clock appointment, or a quarter to three appointment, something like that, so it's like an hour and half on the bus there (Haxton Station) and an hour and a half back afterwards. And that's not travelling from the bus station to the hospital… And then it gets busy, and then what if I get knocked over because I've got a crutch now. It's, like, there's worry in the aspect of these things could happen… Yes, because I'm not good at reading, so it's like trying to work out what buses I've got to get isn't exactly easy, because I've got dyslexia so it's sort of like my reading isn't… I can read, but sometimes understanding what I'm reading could be an issue."* [Ben, Resident Interview]

For many people, travelling to the hospital was so frustrating, especially given that many residents would walk past the Community Hospital building, which, over the years, provided fewer health services. From consultations to rudimentary diagnostic services to CCT scans, residents complained that they were routinely required to travel further afield. Residents without access to financial resources to overcome transport difficulties, those with mental health difficulties, and those without access to a car found accessing hospital services from the periphery of Skelsend most stressful. In several cases, I heard of residents disengaging with services and not attending appointments because of the logistical difficulties involved.

> "…*we are all being sent further away Woldenshire General* (beyond Haxton to the west). *I've been sent there for breast screening, but I cancelled, it is just too far away and stressful. I've been speaking to other people and especially older people; they feel the same. It's just too upsetting trying to get to appointments now… but there is a hospital just down the road, but I will end up not getting that treatment due to travelling all that way. For me I can't do it, I can't do the travelling. It's not that I'm lazy, it makes me very anxious and stressed travelling all that way on two buses, especially on my own, it is too far.*" [Florence, Resident Interview]

During the subsequent walking interview, Florence later turned down an appointment for keyhole surgery on her knee, which caused her discomfort, especially at work. However, the anxiety provoked by travel had become too much for her to endure.

> *"I'm not going all the way up there, so you put up with your aches and pains."* [Florence, Resident Walking Interview]

Florence decided to leave her job soon after my last meeting with her, the physical exertion causing her too much pain. Florence is indicative of the many thousands of people with long-term health conditions leaving the workforce because of an absence of accessible services. This disengagement was further evidenced by healthcare professionals, who accepted that the lack of available local health resources and the distance and time taken to reach the hospital were significant barriers to managing health conditions effectively. Timing of appointments and a lack of regard for the practicalities of travel dissuaded many residents of Skelsend from attending appointments.

> *"You know, people who are suffering with cancer who have regular appointments at the Oncology Unit at the Woldenshire General, getting across there is even more of a pain. So the buses – there are buses, they'll will go into central Haxton so it's not too bad for an appointment at the Haxton Infirmary, but if you get an appointment for Woldenshire General, then you got to get another bus across town and yeah… often I'll hear all the time, and patients will say, you know when I say you have missed an appointment and they will say, 'Yes, because they gave me an appointment for nine, half past nine, and I just can't get there for that time.' I hear it all the time.*"
> [Elizabeth, Health Professional]

Another anxiety-provoking issue for many people on low incomes was the cost. Even with a car, the cost of travel has escalated due to a recent spike in fuel costs. The return bus journey to the hospital outside Haxton would cost £15, an expensive appointment on a low income should it become a regular requirement. I was told by health professionals that transport costs for hospital appointments could be claimed back; but, as Paul, who lives with mental health

difficulties and an autoimmune condition, explained when he tried to claim, it was not that simple nor reliable.

> *"I've tried it, it was too stressful. You have forms to fill in, receipts to put down, then you have to pay for the postage, I've got to photocopy it... And then it takes months, by which time you have racked up more expenses, so you get further and further out of pocket. One occasion when I did do it to save money, I posted four off at one time, and guess what happened? I heard nothing so I rang them up, then they said they had never received it. So, I just gave up. I can't do with all this hassle. On top of everything, everything is a pain, it's hard work. I think they have made it that way to put people off."* [Paul, Residents Walking Interview]

Patient transport

Despite difficulties travelling to the hospital, patient transport services had become notably more restrictive. Indeed, several residents felt they were actively discouraged from booking a service that would reduce their stress and worry when travelling to major medical hubs. The paucity of transportation services for people with physical and sensory impairments was a further reflection of how services fail to serve the needs of people living on the periphery. Janey, who moved to Skelsend several years ago, told me that she had found it much harder to reach the hospital since she had moved to the town. Janey's cognitive impairment caused by a neurological condition, poor sight and restricted mobility prevented her from driving and catching a bus and was highly challenging for her. Catching four buses, which a return trip to Woldenshire Hospital would entail, was not tenable. Despite this, her difficulty was not sufficient to warrant support.

> "*Yes, well it's quite difficult medically wise because if I need anything for any of my stuff it's all Woldenshire General now. It's not even Haxton. I usually have to beg, steal and borrow kind of thing. I mean I have; you see there is a difference between where I lived and living here because where I lived you could get transport. They didn't ask you twenty million thousand million questions and try to prove that you didn't need it, you know*." [Janey, Resident Interview]

Securing transport to the hospital did not guarantee a return journey to Skelsend. Should transport back home not materialise, taxis, even if a person could afford the considerable expense, are not always an option, with drivers reluctant to take people back to Skelsend due to their drive back to Haxton without a fare. Rick, a community worker, who does not live in Skelsend, told me about a situation involving a Skelsend resident when he visited the Woldenshire General Hospital for a procedure as an outpatient.

> "*It's about three o'clock and we're all recovering, all going to be discharged four, five o'clock time. And the lady who's next to me, I knew her. Lives in Skelsend. I'm talking to her on the bed. I said, 'Alright, how you doing? Yes, yes, yes.' She said, 'Oh, I'll be going home soon.' I said, 'Alright,' never thought any more about it, and then the nurse came to her and said, 'Patient transfer won't take you home. Have you got another way of getting home?' So, she said, 'No. I've got a car at Skelsend but I got told I couldn't drive, so I had to get patient transport to bring me from Skelsend to Woldenshire General.' And so, the nurse said, 'They're saying they won't take you back.' So, the woman said, 'Well, how do I go home to Skelsend? I'm expecting to get taken back in an ambulance. I've got next to no money, I'm not in a fit state to go and get God knows how many buses.' So, I'm sat on the bed next to her waiting for my wife to pick me up and I'm thinking, Jeez. And the nurse said, 'Okay, ring up the general ward. We'll have to admit her overnight.' So, I said, 'Well, I know the lady. I'll get my wife to drive her to Skelsend,' and the nurse said, 'No, patient transport. It's their job to do it. They are refusing. I've notified my consultant, the consultant at so-and-so ward's been notified. She's going into that ward and she's going to stay overnight…' And the woman was sat there all confused. 'I've got to go home, I've got my cat.' And they said, 'Well, we can't get you home*.'" [Rick, Community Worker]

The fading community hospital: an inverse care law

Universally, residents expressed dismay at the attrition of services provided at the local hospital. The current building opened in 1998 and replaced the old community hospital, which had been converted from a Victorian hotel. Previously, aside from hosting outpatient appointments, there was a community ward that afforded rehabilitation close to where people lived. However, over the years, services have been withdrawn from the hospital. Situated on Skelsend's High Street, residents now walk past the half-empty, underutilised building to catch the buses to Haxton and beyond to attend hospital appointments.

> "*We could do with a hospital instead of going to Haxton all the time and overwhelming them. We've got a hospital there doing nothing, you know what I mean?*" [Bertha, Resident Interview]

Previously, access to a local hospital was important to several residents who had moved to Skelsend. Sam described how responsive services in Skelsend had hugely improved her life after moving to the town over a decade ago. However, she felt the overall support had increasingly diminished, and the effective dissolution of the community hospital had a real impact on her well-being.

> "*Skelsend at the time, when I moved here, had everything we needed. Good schools, dentist, doctors, hospital, everything. And that was what made me decide here over Coldensea.*[12] *Because Coldensea didn't even have the community hospital and all that had been closed, so here had everything we needed… and when I first moved up here it was brilliant because the doctors were accessible if you had small injuries or anything, and especially my mental health, I did a lot of self-harm. But I could walk into the little hospital, get treatment, no questions asked, come away. All that's gone…*" [Sam, Resident interview]

[12] The next seaside town up the coast.

Sadly, the relatively new building now largely stood empty, or at least this was the common perception. The health professionals based in Skelsend confirmed that funding and services had been withdrawn over several years. For many residents, the hospitals' slow disappearance was symptomatic of a broader malaise that many long-term or lifelong residents felt had become embedded in the town. As alluded to by Bernie,

> "…*we had a maternity hospital and a convalescence place – and it was a good place to convalesce. Anyway, it all got knocked down and I don't know what the new one does. It all went downhill like everything else*." [Bernie, Resident Interview]

Residents also complained that facilities in Skelsend could no longer deal with unforeseen eventualities requiring swift treatment. The local hospital building ostensibly hosted a minor injuries unit, but, overwhelmingly, resident experiences would suggest that this service did not function when needed. Most residents were diverted to either a minor injuries unit on a North Haxton estate or the market town of Worley. Both locations required two buses and would take 2-3 hours to reach from Skelsend. Officially, however, the minor injuries unit remained open between 8 am and 5 pm at the Skelsend Community Hospital. Residents must ring 111 before attending. However, according to the many conversations I have had with residents in Skelsend, people are usually diverted to the Haxton North Estate Medical Centre or the Worley Community Hospital. Several residents told me that they thought this was a deliberate attempt to manufacture a justification for closing the hospital altogether due to a lack of use. There appeared to be little trust in Skelsend towards the decision-makers who distributed public resources, mainly concerning local health infrastructure.

> *"Well, you will ring up 111 and you will say, 'I've had this done.' 'Yeah, you can go to North Haxton or Worley.' 'Well, what about Skelsend?' 'No, you can't go to Skelsend.' 'Well, why? It's a minor injuries unit. It's open between 8 and 5.' 'Yeah, no we haven't got it on our list.' So, even 111 haven't got it on their list, so it makes you*

think, is the CCG trying to close it and then say to us, 'Well, it's not being used.'" [Mick, Resident Interview]

The lack of prompt access to emergency care was especially worrying for several residents. In some instances, especially for people concerned about the prospect of a heart attack, they were considering moving out of Skelsend to live closer to shorten emergency response times.

"*My worry now is that if I have a heart attack, I can't get to the hospital. So, in sixteen months of living here, we are both talking about leaving, but I like it here, I love it in Skelsend, but we are thinking of moving*." [Florence, Resident Interview]

The surgery and GP access

During my time in Skelsend, considerable public disquiet remained about access to the local surgery. Complaints about lack of access to the surgery and the local hospital abounded frequently in the local media. A few years ago, the GP practices around South Flintonprice, a rural borough of Woldenshire, merged into one practice covering a large geographical area. Consequently, Skelsend lost one of their surgeries; the remaining surgery was on the hospital site run by the Clinical Commissioning Group (CCG), now the Integrated Care Board (ICB), but separate from the new South Flintonprice primary care service. One of the main reasons for closure was the inability of the old practice to recruit GPs and other staff to work in Skelsend. Distance and isolation, once more, a particular problem.

"…*there's hundreds of job applicant vacancies in Haxton, for GPs, for example. You could go another twenty miles past that, you know* [to get Skelsend] …*because people don't live on the patch anymore, you're actually going to get people to come from away. So, the old practice… I think we advertise for two or three years for a doctor and didn't even have an applicant... this is why the practice merged because the practice was just on its feet, you just couldn't carry on.*" (Guy, Healthcare Professional)

Janine, a health professional working in South Flintonprice, hypothesised that because residents in Skelsend are so used to having amenities removed from their town, they frame any change in a negative context. Residents reported worsening access difficulties to primary care since the merger. Increasingly, residents were being diverted from the town when seeking appointments and told to attend surgeries in the outlying villages of South Flintonprice. This was causing difficulty given the high number of residents in Skelsend who do not have access to a car and poor transport connectivity across the borough. Residents decried the long waits for appointments, the dearth of in-person appointments in favour of telephone consultations, and being sent away from Skelsend for routine medical procedures and consultations that were once accessed locally.

> "…*it's terrible to try just get an appointment. There will be no appointments here because they will be all gone. And because they are all joined together, they will expect you to go wherever, to Haventon or the villages. Wherever they have gotten appointments at. Which you know isn't feasible with people that don't drive, so you could be two to three weeks without an appointment*." [Dawn, Resident Interview]

> "*It's an absolute nightmare trying to see your GP. Even getting past the phone lines is a nightmare. It takes days, or they do the online thing which you fill this form in online, that goes off to the doctor, and it can be about three days before you get a text to say the doctor will ring you in maybe about two weeks*." [Gemma, Resident Interview]

Residents reported that the chances of seeing a doctor in Skelsend promptly had become remote. Additionally, the loss of local hospital services and the merger of GP practices meant typical routine healthcare functions were no longer performed in the town, requiring residents to go further afield.

> "…*just to get a contraceptive injection, they will send me all the way to Haventon. I go for my appointment in Haventon and the woman in front of me in the queue is booking the exact same appointment, she's got to come all the ways to Skelsend… We've got a perfectly*

fine hospital that used to do your blood appointments, it used to do x-rays, it used to have a minor injury unit so that you weren't having to travel all the way to flaming Worley. And it's just not being used." [Jennifer, Community Worker– also a resident of Skelsend]

Several residents were disillusioned by the services available and had become less likely to seek support for health conditions. Other residents are encouraged to seek other avenues of support.

"*…you know, I just get to the point now where I just write the doctors off, if I'm feeling poorly, I just grin and bear it now. That's where I am with it.*" (Josh, Resident Interview)

"*They are signposted to pharmacists, anywhere, but the doctors... I was told that, to see you, the pharmacist. So, I went to see the pharmacist. And be completely misdiagnosed what I have, what was wrong with me. So, I was taking wrong tablets for about a month actually. That's me. How many people? How many other people going through the same thing*?" [Sophie, Community Worker and Resident of Skelsend]

The shortage of local services heavily impacted residents who struggle with travelling through mental health, poor mobility, or lack of social and economic resources. For instance, Sam, whose symptoms of her mental condition can be quite severe, finds busy spaces confrontational and anxiety provoking. Travelling to Haxton or beyond for medical appointments was something she dreaded. The lack of local provision forces her to make journeys into Haxton, a much busier city with a large busy hospital, just the type of place from which she had moved to Skelsend to escape.

"*I have to fight tooth and nail to get my ECGs done at the local doctor's because I haven't done it for three months because of the medication. And the amount of times… And I've stood and I've been screaming in the practice, because it's not something they do routinely. But my hospital requested them to do it because we have the ECG centres there. There's no point in dragging me all the way to Haxton Royal to have something done that takes five minutes that*

they can do here. But it's a battle to have it done here, because they don't see why they should do it. And they've had me in floods of tears in the reception. And they just look at me, and… But they know how I am, and they know what my conditions are, and yet they still challenge it." [Sam, Resident Interview]

Increasingly, appointments were conducted over the telephone. I was told by an administrator of community health in the borough that the increase in telephone appointments had become essential to meet demand. Without recourse to telephone appointments, waiting times would be much longer. Many residents I spoke to felt telephone consultations provided inferior consultations and possibly resulted in health issues not being thoroughly addressed. Several residents told me that they struggled to talk openly about health troubles on the phone and wanted face-to-face contact.

"Yes, and when you are talking about personal problems, you want a human face. Certainly, when I've had anxiety problems and IBS problems, and you don't want to be talking to someone you can't see. Yes, I think better if I can see that person, if I'm on the phone, I would explain the problem properly, I wouldn't explain how I feel, I would want to be able to see them and see if I can trust them and look into their face, and you know that person if you look at them, but you can't trust someone at the other end of the phone." [Florence, Resident Interview]

"*There is the odd one, like some of them, telephone appointments, you know they're rushing it. Because they're on a time thing and then there's a couple of them, it's as if they haven't got no time, you know, just carry on, you can't talk to them about stuff…*" [Gemma, Resident Interview]

Often residents' sentiments descended into frustration and anger. The practice had faced severe criticism on social media and, regrettably, staff had been subjected to verbal abuse from upset patients. Before my fieldwork commenced, there was a public demonstration in Skelsend about access to healthcare. Residents marched on the hospital with placards and chanting

slogans expressing their wish for improved access, especially the return of in-person appointments with GPs.

In response to the protests, the management of the embattled practice posted a letter to residents on their Facebook site, hosted a public question and answer meeting, and published the proceedings as information to residents. Residents were informed that more face-to-face appointments would reduce the number offered. They accepted that COVID-19 had caused backlogs, that the telephone appointment system needed adjusting, and that more support was needed so that residents could use it more easily. The South Woldenshire practice posted a communication on their Facebook page to residents addressing their concerns. The posting highlights a set of circumstances, just after the COVID-19 restrictions had been lifted, that depicted the service and the staff being close to breaking point.

> "*We feel incredibly disappointed that residents feel the need to protest against the NHS at a time when it is under such severe pressure. Setting the scene as a battleground between doctors and patients is distressing and destructive. Yes, there are problems. Yes, many of these are difficult to fix. But we are willing to talk and to come up with solutions together. Like practices across the country, we admit that we are struggling to cope. Our team is exhausted and has worked under immense stress for 18 months. We can clearly see the impact on the well-being of our staff and fear that they will choose to leave the profession. We are desperate for additional resources (staff and space), particularly for our reception and administrative teams, but recruitment is becoming increasingly difficult. When we put this alongside some of the highest staff sickness absence rates we have experienced since the start of the pandemic, it becomes increasingly difficult to maintain services let alone extend them even further to cope with the increased demand. That increased demand for access to general practice is coming from a number of different areas. We are dealing with the impact of 18 months of on/off COVID lockdowns and restrictions which have taken a severe toll on both physical and mental health. At the same time, we have patients suffering from COVID and long-COVID. And those for whom their*

treatment or operation in secondary care has been delayed and who now require substantial ongoing management in general practice to help cope with their pain and symptoms whilst they are waiting. We have a higher number of general infections circulating in the community now that we are all mixing again. We have all the catching up on things that we were instructed to suspend during 2020 such as smears and joint injections. These all involve patient consultations and they are all important. We also have the seasonal work that must be accommodated." [South Woldenshire Medical Practice, Facebook, posted September 2021]

Personal resource and social capital

Throughout fieldwork, it was apparent that those able to assert themselves, or who had someone to be persistent on their behalf, tended to be more successful in obtaining the required support. The need to be persistent and assertive, sometimes insistent, when accessing support for one's health was a recurring theme throughout fieldwork. Residents said they had to walk into the surgery in person because telephone calls were often ineffective. Being proactively assertive was often essential to being seen by healthcare professionals. This was particularly the case when chasing up reviews for health conditions.

"*I think they just deal with things on a day-to-day basis, but not with people who have got the issues, they are not like following up, it's up to the patient to know what's wrong with them, you know, You have to ask for the blood test and ask why, whereas they should actually be checking all that*." [Dawn, Resident Interview]

Having knowledge about one's rights and being able to assert them was seen as necessary by several residents, but this capacity was restricted to only a few residents I encountered. Mick described the difficulties he had in receiving treatment for his knee. He resolved them only after his wife, a nurse, told him what to say to get treated quicker. Mick asserted his 'right to choose', where he received treatment and chose to go to a hospital eighty miles away, near his home town, which was then able to refer the work to a private hospital in Haxton. This would not have happened without his wife telling him about his

rights and having a helpful contact at a hospital where he used to live. Residents did not like asserting themselves in this way, but felt it necessary to receive treatment. Those without access to information about how the system works and lacking confidence tend not to fare well.

> "*I said to them, 'Actually, I can choose where I want, can't I?' They were not very happy that I know what I'm doing, but I chose to go to Thirlkirk and the gent that did my left knee works for them, and obviously the NHS do it. So, I got an appointment within three weeks to see him, only because I know because my wife said, 'You need to do this…' If that was the NHS or through the doctors doing it, I'd be waiting years, but it's still NHS through the private hospital*." [Mick, Resident interview].

Alice asserted herself differently when trying to access a GP. A relative told her that the surgery would get fined if she presented at Accident and Emergency twice in Haxton with the same condition before seeing a GP.

> "*Well, it's not even so much getting to see the doctor, it's even getting to have a phone call with the doctor… 'There's no appointments,' and I'd say, 'Well, I'm having an asthma attack. I know my chest's bad and it's my asthma.' I think they would maybe find an appointment for me. Because years ago, I had an asthma attack. My partner at the time took me through to Haxton's hospital and they gave me some steroids, some strong steroids, and got it sorted. And they said, you know, 'You need to go and see your doctor next week.' So, I rang up, couldn't get an appointment with a doctor, so I just said, 'Oh well, that's fine. And if I have another asthma attack, I'll just go back to A&E again.' And with that, they found me an appointment.*" [Alice, Resident Interview]

Dennis found himself in a similar situation; he could not access a doctor's consultation appointment, which he needed to get his driving licence back after an illness. He needed to get his licence back to be able to work; his job was under threat. Dennis was told by someone in the practice that to get an appointment, he should use his title, which carried symbolic capital. He tried this

in desperation, and it worked. He was happy to get the appointment, but how he did this was totally against his values.

> "*I went the first day half past eight, no appointments. Went in the second day eight o'clock, lady in front of me got an appointment when I got there, no appointment so I was told by somebody internal to use my title that's as a XXXX walked in there, declared I was a XXXX and got offered an appointment. That's totally wrong."* (Dennis, Resident Interview)

Mental health access

Like Jason, I had met many residents who had relocated to Skelsend over the last decade or so with a history of mental health conditions. They reported that the support they had initially received here was much more responsive than in their previous city home. Six relocated residents spoke very positively of the support they received on moving to the town. However, this experience was not universally recognised; several residents have expressed fears that accessing mental health support had deteriorated since the COVID-19 pandemic. Before COVID-19, Josh, a lifelong resident in his 30s, informed me that he had to wait three to four months to access the IAPTs[13] therapeutic service. It seemed that when services could deliver timely support, this resulted in positive outcomes with broader benefits, especially given the residents' role in developing social groups through volunteering in Skelsend. However, a timely response to mental distress was not always available.

> "…*in 2019 I had a major, major, downfall in the mental health. I went there to get some support, and the first thing that I was offered were antidepressants. Which is just a case of putting a plaster over wound. But on the counter side of it I did get the number for IAPTs. So, then I called them and three to four months later I got access to therapy. But it was a long process*." (Josh, Resident Interview)

[13] Improving Access to Psychological Therapy.

Dawn, a resident with physical health conditions, felt mental health support was particularly poor in Skelsend during the COVID-19 pandemic, with the usual support groups not operating. This lack of access had affected a family friend in Skelsend and had left her with little confidence in the responsiveness of local services.

> "…*the services are very lacking in Skelsend, definitely lacking. I've got somebody with mental health issues (inaudible)… during COVID the support groups didn't run, but I said to them why are you not doing something on online? There's still people suffering with mental health issues, especially now in COVID and there were no support for that. He's finally getting it now* (help), *but he was getting to the point, that he was that way inclined, he would have committed suicide, but we managed talking him down you know, giving him the support he needed, but there were no services for them at the time*." [Dawn, Resident Interview]

Nonetheless, for many residents, the responsive support they received was a significant positive factor in their move to Skelsend, which was successful, with real improvements to their well-being. Mary acknowledged that, on moving to Skelsend, she was drinking too much and had successfully sought help for this in Skelsend and other emotional difficulties. Mary told me that she had started drinking as a child during a difficult upbringing; her siblings had similar lasting addiction problems. Mary recalled how she used to be on a short fuse and quick to anger before moving to Skelsend. However, combining a different, less stressful living environment and receiving psychological support helped her cope with life better and maintain an improved sense of equanimity. For Mary, moving to Skelsend from an intensely urban area of social deprivation in southern England had proved transformational.

> *"Because I used to be so aggressive. I was up here with anger, and as soon as anybody upset me, I would just explode. And I don't do it anymore."* [Mary, Resident Interview]

In Skelsend's calmer environment, she addressed these issues to improve her physical and mental well-being. The move to this small, remote seaside town

manifested a combination of beneficial factors for Mary: time, space, and access to local support for her mental health. Mary was now no longer working, had more time, and was in the right frame of mind to access support from services she felt were responsive and non-judgmental. Mary felt it was the first time she had been listened to by a service. Previously, when she tried to get help, she felt judged. Instead, she discovered, with support, both validation and confidence to take the treatment further and learn to manage difficult emotions more compassionately.

> "*I never used to admit that I drank too much, and it was only when I came here and I realised if I don't be honest and if I don't do it properly, I'm just wasting the opportunity… The therapist asked, 'What is it that you find is so different?' And I said, 'Well you're actually here talking to me.' She said, 'We do like to talk up here.'… I went through my history and everything, and she went, 'Well no wonder why you drink.' And I thought, 'Well actually yes, you're right.' Because I've been drinking since I was a child. And my brothers, and their drugs. I've never done drugs. But that's how they survived. We didn't live. We just survived."* [Mary, Resident Interview]

Mary described how she got further support in Skelsend through local organisations providing support groups for mental health and alcohol dependency. She received telephone counselling throughout the lockdown and support from the local Community Mental Health Team. Before moving to Skelsend, Mary told me she had been referred to the local mental health many times, but had never been able to change her habitual ways of thinking and acting.

> *"I learnt* (previously) *why I behaved the way I did and what caused it, but I didn't learn any methods of how to change my behaviour. And it's here that they've told me…* [Mary, Resident Interview]

This support and change in the environment have benefited her physical health. Mary was supported in developing a sense of inner calm, which assisted her in enjoying some of the benefits of living in Skelsend as described in chapter 6.

After settling in the town, Mary became very active in the community, playing a supportive role in running activity groups based at the community centre. Like many of my interview participants who had moved to Skelsend, Mary contributed to building the town's social capital. Access to compassionate support was crucial in helping her contribute to community life.

Before the traumatic loss of her son, Sam had struggled with a severe and enduring mental health condition for many years for which she had not received a formal diagnosis. Sam felt that services had not addressed the root cause of her problems, nor did they consider the difficulties holistically by looking for patterns over time. She reported being labelled as having depression, and her condition was left to dominate her life adversely. However, the practitioners in the local mental health service in Skelsend identified a distinctive patterning of symptoms, resulting in a diagnosis. Following diagnosis, treatment efficacy and ongoing management improved significantly for Sam.

> *"So, I'd have the really big highs and then I was bottoming out low to suicidal type, and then flying. And they just never sort of saw the two together until I moved over here… It was always treated as an individual issue every time there was something wrong. So, it was always, oh, you're depressed, and it was like… As I got older, it was like, yes, but you've lost your son, you've lost your mum, there was always a new reason behind it. Where, when I came over here, they looked at it from start to finish, and realised that, no, I've got this pattern going and was able to diagnose me. And that's what I say, one of the best things of me moving over here was they managed my mental health… The mental health team when I moved over here was fabulous. They had such good funding, they had everything I needed, and I said, I've benefited from that, really brilliant. Because without it, I'd have been no better and I'd still be doing the really dangerous lows and the really reckless highs."* [Sam]

However, Sam, like Josh, had noticed that the service was now struggling to meet demand. Anyone without access to a car would have to catch a bus to

Haventon[14] and then walk around twenty-five minutes to the medical centre on the outskirts of town to receive in-person support.

> "*As the years have gone on, it's dwindling, like it is everywhere. Funding's being cut everywhere. And we struggle a bit more now. But I still say I'm one of the luckier ones because I'm in the system. So, if I do need the help… Can't go instantly like you used to be able to, but I'm there, and I'm already part of it, which means I get to sort of avoid a lot of the waiting times… We're lucky because we drive* [to the centre in Haventon]. *If you don't, you're a bit*— [stuck]*."* (Sam, Resident Interview)

Nonetheless, like several other residents, Sam reflected very positively on her move here, despite living in a town that she feels is now visibly declining, and adjusting to the difficulties of residing somewhere remote. After we had finished our recorded discussion and I had turned off the voice recorder, Sam told me what might have happened had she stayed in the city; it was striking. She agreed that we could turn the recorder back on to capture her sentiment about moving and living in Skelsend, regardless of the challenges of living in a poor, rural, small seaside town whose primary industry, tourism, had been declining for several decades.

> *"If I lived in the city now, I would probably be dead. Suicide would have got me a long time ago. But moving, even though I moved for all the wrong reasons, moving here has literally saved my life because there's outlets for me here, and… Not always the medical side. A lot of it is just because of where I am."* [Sam, Resident Interview]

Sam reflected on the vast lifestyle change that moving from the city to Skelsend involved. Although, at first, she struggled to adapt to the change of pace, as she became more accustomed, she firmly believed that ad hoc timings, the reduced general activity and restricted opening times, which contrived a much slower

[14] A small town just to the east of Haxton.

pace of life, had benefited her mental well-being. Instead of feeling rushed, she had time to reflect, work on herself, and learn greater acceptance. The environment helped her to embed the workshop skills she had learnt when receiving talking therapy from mental health services.

> *"You actually take time for your life, where before, you always had a million and one things to do. I speak to family that live over there, and they never have two minutes to do anything. …And I think that's the biggest thing, because we're sort of out of the way, we can actually stop. And because we have our own time system, everything does stop, and it's like, come five o'clock the town's asleep, literally. But that's a good thing because you get time for yourself. And I think that's been a big thing health-wise, because you actually get time to sit and work on yourself rather than everything else*." [Sam, Resident Interview]

The food desert of Skelsend

Several community workers raised concerns that there was a profusion of unhealthy junk food readily available in the town. Many people complained that there was a shortage of reliable, healthy, fresh food despite two medium-sized supermarkets in the town. However, only one supermarket, Aldi, was accessible to all, being located in the centre of town; the other supermarket, Tesco, was on the southern fringe of the town, and for those living in the north of the town, a car was needed. There were no greengrocers, but many takeaway outlets. It was apparent during fieldwork that inexpensive but unhealthy, calorie-dense and nutritionally low foods were easily accessible. However, access to affordable fresh and nutritious food was, at best, unreliable, especially for people with insecure or poor access to economic and social capital, who were more likely to be spatially bound to Skelsend's food environment.

The Consumer Data Research Centre (2022) reflects the paucity of healthy food choices, which measures Skelsend as a food desert with insufficient access to affordable and healthy food. Even recourse to online shopping was minimal, with many stores unwilling to travel to this town on the periphery. Many residents complained that the fresh food they could access did not stay fresh for long. They felt that being on the end of the line reduced the supply of fresh

produce. They said that this problem had become worse since the COVID-19 pandemic.

> "*When I was at Tesco the other day it was the watermelons and oranges that there were empty trays, and lettuce. Lettuce was another thing, empty trays again. Mushrooms don't keep. Potatoes is the only thing I think we keep that seems alright. There's always potatoes… Yes, fruit and veg we don't have a good choice, we don't have a butcher's anymore. So, we don't have, like, a nice deli counter where you can get proper ham from, not with that watered meat that's got water in it. The square stuff that has all been… It's not regurgitated as such but it's awful. They want people to be healthy but there are no healthy options here.*" [Helen, Resident Interview]

Residents felt that the unreliable food supply was down to their position at the end of the line and, consequently, was always last to be serviced by big companies.

> *"It's like we are on the end (*of the line*). It's one of those things isn't it, that Skelsend will be the last thing. And if they haven't got it, it'll be taken off before, won't it, in Haxton or wherever."* [Mick, Resident Interview]

The tenuous reliability of the local supply and the absence of some food products led some residents to shop further afield. Other means of obtaining inexpensive food, such as the Social Supermarket (SSM) and Heron, were described by residents as being unreliable for healthier food purchases. Heron stocked largely unhealthy processed foods, whilst the social supermarket was very ad hoc in what food was available.

Food access in Skelsend was particularly stress inducing for people with health conditions who struggled to cope in crowded places. Several residents living with mental health conditions, along with a physical health condition, told me they found the supermarkets too stressful to enter; they were too noisy, pushy and busy, and they struggled to cope with that environment. They avoided them

altogether, or visited them late at night just before they closed, but that affected access to perishable products. Paul struggled with noise, and he found that the tannoy announcements in supermarkets heightened his anxiety. He told me about the time when he was required to shop at Aldi as part of an activity set by his mental health worker and then another stressful time at Tesco.

> "*I get real irritable at checkouts... Yeah, acutely, it's not that I'm angry it's just the way things affect me. I do have a problem with Aldi in Skelsend, because the tannoy announcements, they are always opening and shutting tills, and it's tannoy announcement after tannoy announcements. It just really, really, I get angry. I went in once, cos they put me on a mission to buy a couple of items, and then come out, that was like, to see how I would cope. I knew where these items were, I went, and by the time I got to the checkout I counted nineteen announcements and I let rip at the checkout operator. I said, 'For God's sake, do you have to keep pressing these buttons, we are opening till one, we are closing till three, assistant required, manager required.' I said I counted nineteen announcements, I've only bought two things, I said I can't stand it… I have had a flip in there as well (Tesco). I got told to calm down, that was before I realised I was having a panic attack. But they don't realise what was, you know, happening in my head at the time."* [Paul, Resident Interview]

Paul struggled to budget on his low income; there was little money for food, and they needed to shop at the cheapest outlets. However, as Jason explains, he, like Paul, was on a limited budget and often could not shop at Aldi for the same reasons, and shopping at the cheapest outlet would usually result in returning home with unhealthy ultra-processed foods. Jason complained about gaining weight since moving to Skelsend and blamed this on his consumption of ubiquitous poor-quality foods in the few shops he could afford to visit.

> "*I don't think the cheap shops help, like Herons and stuff like that, where they sell loads of crap, crisps and stuff. Because you can go in and get something, you end up coming out with bloody— I think, oh, I'll get some of that and some of that, you get home and you've*

bloody got, you know, half a bag full of crap." [Jason, Resident Interview]

Skelsend's café culture

Meanwhile, during the day, the food landscape in Skelsend is saturated with cafés selling unhealthy foods, such as all-day breakfasts, burgers, sausage rolls and chips. As Lacey told me, finding healthy food on the streets of Skelsend was difficult. "…*it's hidden under a rock*," she said. The predisposed tastes of residents and visitors on holiday appeared to reinforce a food landscape not conducive towards maintaining a healthy diet. The seaside holiday environment arguably nurtures an unhealthy food environment, catering to an inexpensive tourist indulgence. During our walking interview, Helen said that she had to prepare meals when she was at work; otherwise, she would have to resort to unhealthy street food. Given her gluten-free diet, this was particularly difficult.

"*I find that if I don't bring my own dinner, it feels very lacking in choice of what do you have, it's always… ends up being a sandwich, which is bread, the filling's never that good either, there's not a lot of choice there… The market on the front here, they had a salad bar and you could get like sweetcorn and lettuce, peppers, all the stuff you'd want in a nice healthy salad box, but nobody wanted it so it closed down*." [Helen, Resident Walking Interview]

Several health and community workers felt that the seaside food landscape of Skelsend, permeated with takeaway outlets and cafés, constituted an environment which nurtured a predisposition towards obesity.

"…*you look at the amount of kind of fast-food places there is around this area. The availability of quick easy food, normally that's unhealthy. And so, you find that the general population of Skelsend does have a higher BMI.*" [Jack, Healthcare Professional]

There was some evidence that local tastes also influenced the supply of foods in Skelsend. Barbara told me that she had asked the managers of the local supermarkets why they did not stock the vegetables she wanted for her cooking, and was informed that customers do not purchase the items she was

looking for. I was also aware of a couple of small local independent businesses trying to provide healthier food options, but soon failed due to a lack of custom. I was told by one business owner, who had tried to sell healthy alternatives, that people predominantly wanted the unhealthy bacon, sausage, cheese, and onion paninis. Her health alternatives did not sell, no matter how good they looked.

> *"Nobody bought anything. But they like junk, they should open a McDonald's around here, it will go down a storm!*" [Sharon, Café Owner]

I tried to visit all the cafés and bars in Skelsend. It was undoubtedly the case that there was a copious quantity of beige food available with very similar menus. The other cafés in Skelsend tended towards being inexpensive and provided generous portions, but limited healthier options. Among the cafés dotted around the high street were five fish and chip shops, two of which were especially popular with residents. On Fridays, they frequently boasted queues stretching outside down the side of the shop. Evening restaurant choices were confined to an Indian restaurant, and four pubs that served traditional pub-style meals. In Skelsend, I counted the following food and drink outlets.

Thirteen cafés (excluding the fish and chips cafés) – two of which are in the arcades and one in the leisure centre. One café had a licence to serve alcohol. Only one of these closes during the winter.

Three ice-cream outlets – one selling inexpensive pints of lager.

Seven pubs – excluding the snooker club bar, an arcade bar, and two members-only clubs (four pubs sold traditional pub food).

Four Pizza, burger, and kebab takeaways.

Five fish and chip shops – two with a café section.

Two Chinese takeaways.

One Coupland's bakery.

One Indian restaurant.

Perhaps the most inexpensive place was the arcade café[15] near the promenade gardens; I enjoyed pie, mash, and mushy peas, followed by rhubarb crumble with lashings of thick, sweet custard for pudding. All ingested to a background cacophony of arcade tunes, whistles and machine gun fire and washed down with two large mugs of coffee. I recorded this unique food environment in my journal.

> "*The café is in the same giant corrugated tin structure as the arcade, outside on its forecourt, people congregate and smoke, the young and the old. The café is sectioned off from the main arcade by a temporary panel that looks as if it has been in place for decades. The man behind the counter, who seems to be coordinating the operation, is very effusive with customers. Altogether mine came to something like £7.50, two mugs of coffee, pie, mash, and peas, not forgetting the rhubarb crumble. There does not seem to be much veg on offer. It does taste a little saltier than I am accustomed to, but all the same it is satisfying and enjoyable. The service friendly and warm hearted. From behind the counter a woman in her team's colours shouts whether I wanted the peas processed or mushy. "Mushy," I reply over the heads of my fellow patrons. One of staff then exalted in song the benefits of mushy peas. This café is always busy, it's perhaps the cheapest in town. The thin hardboard partition walls keep giving way as they lean backwards and to one side towards the arcade area. This little arcadian café is drenched with incessant electronic sounds; of whirls and beeps, I can hear space invaders and the rattle of a machine gun. It is very nostalgic and reminds me of those childhood computer games of the 1980s, like ZX 81 or 48k Specky (Spectrum). Ahead of me I can see Noah's Ark covered by a transparent dome, sat on a red plinth, providing refuge to an assortment of nodding plastic animals. From where I am sitting, I can see a giraffe, an elephant, a lion, I think a pig – but also an*

[15] There are two arcade cafes in the town, one near the promenade which sold a variety of meals, many of which are cooked from frozen, and one on the main street which opened early for breakfasts.

incongruently menacing T-Rex. Amongst the dozen or so people here I see differing ages, combat and sportswear predominate and morbid obesity prevalent. I see one man, maybe in his 50s, round in body, struggling with clothes fittings, and his legs, red, swollen, and turgid with oedema, helping his wife whose exertions made her breathless on sitting. I see people coming into the cafe, older people with their carers and people with physical disabilities, including someone on oxygen. They negotiate the immovable stationary plastic tables and red plastic chairs screwed to the floor, McDonald's style, but much more crammed into a small space and regimented into rows. We are all close to each other, I can smell the older customers that have walked in, a smell of damp fusty clothing. At one point, I hear someone choke. I turn round to see if help is required. Thankfully not, help is at hand from carers, the choking momentarily stops only later to be repeated." [Fieldwork diary, February 2022].

Cooking skills

Not only is the town awash with food outlets offering unhealthy but convenient fast-food meals, but community workers and health professionals reported that many residents they worked with lacked the rudimentary cooking skills to prepare meals and consequently become over-reliant on convenience foods. Jennifer, who works at the Pear Tree charity, concluded that people need support in learning cooking skills to improve their finances and health.

"…*we found more and more and more with the food parcels that we're doing that people just generally don't know how to cook, and that's what we're talking about, simple things, like frying an* egg*, for example, or cooking spaghetti bolognese or just cooking fresh fruit and vegetables. So, the plan is here to grow our own fruit and vegetables and then to teach them how to cook it in the kitchen."* [Jennifer, Community Worker]

Several workers felt that the inability to cook was driven by an intergenerational attitude, increasing the likelihood of people overusing takeaways and cafés.

"…*if the parent's eating unhealthy food you find that the children's kitchen skills as they grow up, so when they become 14,15,16 onwards, they don't have the knowledge or understanding on how to prep a healthy meal. But because you've got seven or eight takeaways down the road, and the convenience, they would rather go there.*" [Jack, Healthcare Professional]

Guy, a healthcare professional, considered this dynamic and propensity towards a poor diet that they frequently encountered in Skelsend. He the underlying causes were complex, including intergenerational culture, access difficulties, poor material and emotional resources, the obesogenic environment, and stressful lives, all contributing to a predisposition towards fast food and poor diets.

"…a lot of people don't even have an oven. You know, there's a lot of people rely on microwaves, if that. So, they tend to eat junk food… I suppose then these deprived areas have far more fast-food outlets than affluent areas. …there's nothing wrong with going for a pizza once every couple of months or something, but I think people live off that… it's probably also what people are brought up with as well..." [Guy, Healthcare Professional]

Skelsend's social supermarket

The Community Resource Centre, the main community charity in Skelsend, ran the Social Supermarket in the town (SSM) and was one of two local organisations with which I volunteered. People who shopped there had to become members and needed to live either in or around Skelsend. It was set up to provide dignity to residents on a low income, who could purchase heavily discounted surplus food stock rather than resorting to the food bank in the first instance. The SSM also hosted a food bank that operated on a referral basis, and sufficient food was held back to keep the food bank well stocked. They received two weekly deliveries from a company that sourced surplus food products from supermarkets and redistributed these across other social supermarkets in the region.

The food items brought by the distribution company varied greatly, but the store usually received two weekly deliveries. The store staff were unaware of what was coming until it arrived, such was the apparent ad hoc nature of the delivery. Some of the food items needed chilling on delivery, and some things needed to go into the freezers, challenging the ability of the shop to find space to store these products. The fruits and vegetables varied in range, quantity, and quality significantly. Often, the vegetables did not sell because they were past their best by the time they reached the social supermarket; this was often the case with long-stem broccoli and spinach, which often arrived already wilting.

At times, it felt like supermarkets used Skelsend as a place to discard unwanted stock. I recorded an oversupply of Uncle Ben's rice following its rebrand to Ben's Original rice. At one point, Uncle Ben's rice had taken up a third of the stock cupboard space. Usually, vegetarian and vegan products were delivered in more significant quantities than meat, fish, and poultry, with red meat being exceedingly scarce.

> *"The refrigerators were stocked up on processed vegetarian meat substitutes, vegan mushrooms burgers and mince, they take up a lot of space in the fridge but sell very slowly. The mushroom burgers, which look appealing to me, are largely overlooked, and invoke disapproving looks from several shoppers. Apart from the vegan meat-free substitutes, the fridge is crammed with pizzas and mince pie-flavoured ice cream. However, that has not prevented today's delivery from providing more ice cream and pizzas and it becomes quite a task to find a home for more mince pie-flavoured ice cream."*
> [Fieldnotes, March, 2022]

Other random products for which there was no demand in Skelsend included large quantities of white tea and vanilla oat milk, the latter laced with sugar. We struggled to sell products like sachets of cooking sauces and vast quantities of loose herbal tea bags, even for a few pence. For several weeks, there was an oversupply of radishes, which people rarely bought, but the delivery company reliably provided them. Of course, other products flew off the shelves; they included various cereals, waffles, ubiquitous pot noodles and chocolate biscuits. Meanwhile, I noted that greens which could comprise a salad were infrequently

delivered, or the shop would receive one item, for instance cucumber, rather than several different items to make a salad. This was often the case; one often found bits of meals instead of ingredients for a complete meal.

> "*Well, the carrots were bagged up again to be taken away, as well as the radishes. True, there is an oversupply of radishes, but people just aren't buying them. Carrots I would have thought should have sold, but not so. Although the organisation that sources and provides the produce, there seems to be insufficient attention to their shelf life. For instance, the crate of carrots is covered in a clear, sealed plastic. As a result, they sweat and start to rot. I try to rescue as many as I can. I need to wipe down the remaining good edible carrots, wiping off the rotting fluid juice-like substance which oozes from the decaying carrots. The store is also full of oat milk; more was delivered today. The fridge is packed with the stuff and mozzarella. It's cheapest mozzarella in the world 20p, 20p for the oat milk. A lot of the mozzarella will go to waste, I'm not sure what will happen to oat milk, it has a long shelf life. But this is the problem, they get too much stuff which only a few will use here*." [Fieldnotes, March 2022]

Many of the items received by the social supermarket are not necessarily typical household food or drink items. For instance, whereas herbal tea was delivered to the SSM in large quantities but sold poorly, popular tea bags commonly taken with a spot of milk, such as PG Tips or Yorkshire Tea, rarely materialised during my time at the SSM. Likewise, mozzarella was more likely to be delivered than cheddar cheese or other more common cheeses.

Despite the variability in the quantity and usefulness of the delivery, many of Skelsend's residents benefited from the SSM, and some people referred to it as a lifeline. As the cost-of-living crisis deepened towards the end of fieldwork, the number of members of the SSM rose steeply. However, most of the food provided was heavily processed, with the fresh fruit and vegetables having a short shelf life. Besides, it was common for customers to convey their disinclination in taste towards vegetables and often an apparent unease about preparing vegetables such as sweet potatoes, courgettes, butternut squash and celeriac, being unfamiliar to the Skelsend culinary palate. Any vegetable with

soil on tended to be rejected. When I asked Bertha if she could purchase sufficient fruit and vegetables, she told me,

> *"I don't eat a lot of fruit and veg to be fair, so I can't say yes and I can't say no because I don't, because it's all in mine, in my food what I get. You know what I mean? Like, I get microwave meals and stuff. I don't cook anymore."* [Bertha, Resident Interview]

This was a typical sentiment amongst many Skelsend's residents, especially those who are financially less well resourced.

Skelsend on wheels

> "*It's the buggy capital of England is this, you know what I mean. Have you seen Monty Python, it's Hell's Grannies."* [Bryan, Resident Interview]

Bryan's comparison may not accurately depict the demographic characteristics of Skelsend's mobility scooter users, many of whom are younger than he suggests and are both male and female. Nonetheless, the element of peril, albeit tongue-in-cheek, has validity. I was nearly mowed down one summer evening by a young man careering along the pavement at a belting pace on a residential street. Mobility scooters are ubiquitous in Skelsend. At the end of the main road coming into the town from the hinterland, there is a mini roundabout where a sizeable shop is dedicated to selling mobility scooters. A smaller mobility scooter shop with a sizable billboard display is visible from the main southern coastal road into the town.

Some mobility scooters that abound around town are large and elaborate, for instance the imitation Harley Davidson or a 1980s retro-looking mobility scooter that reminded me of the Sinclair C5 tricycle. I have observed people gathering admiringly around them outside the arcade on the main high street. This arcade has a little front courtyard on the main street and a meeting place for older residents in the morning. It appears like an unofficial social club, where people meet in the morning for a very inexpensive breakfast and a smoke. Venturing into the arcade café is a journey back in time to the 1970s, and it has a dilapidated tatty charm.

Mobility scooters feature on the large cartoon mural covering an entire wall inside another popular and inexpensive café. The mural depicts life in Skelsend and, weaved in amongst the typical seaside characters, is a speeding mobility scooter.

Figure 8: A rampant Hell's Granny of Skelsend

During interviews with health and community workers, there was a tendency to view mobility scooters with scepticism. Their understanding was that, for most users, it had become the standard way to move around regardless of actual capacity for mobility. These workers contended that it had become another lifestyle choice that was injurious to health. Several workers in Skelsend associated mobility scooters with smoking, obesity, and poor diet.

> *"There is such a high availability of them here and affordable, it encourages a reliance on them which, in some cases, might not have been necessary and self-defeating, leading to a more sedentary lifestyle and further mobility issues, accepting that for some it does allow them to be more active… Half of the people on that protest march to the hospital were on mobility scooters, the other half had a cig in their hand. If they walked on the march every day the health benefits will be enormous."* [Jack, Health Practitioner]

> "*I was driving through the town with a student once who was from Skelsend, and there was a woman, about 40 years old, who was obese, sat on a mobility scooter with a fag in her mouth. He said, that*

> *just about sums up the town, doesn't it? Some of them need one, but for the majority it's a way of getting round."* [Guy, Healthcare Professional]

Phil, a community worker, linked mobility scooters with the dietary environment saturated by inexpensive, poor-quality food.

> *"If I ate the food that predominated around here, I would be in a mobility scooter."* [Phil, Community Worker]

However, the experiences of several residents I met portrayed a different reality than those outlined by health and community workers. Four residents I interviewed used mobility scooters: Gary, Janey, Nicola, and Bertha. Given the significant mobility problems caused by their respective health conditions, they would often struggle to leave their homes if they were denied access to their scooters. This was especially the case with Gary and Bertha, whose mobility was severely restricted. For Gary, a mobility scooter meant he could enjoy access to the long promenade and the town's seascape. As discussed in Chapter Six, this provided much pleasure and benefited Gary's well-being. Bertha told me how the scooter allowed her to visit the Pear Tree, where she volunteered, and that it meant she could access the high street independently of her carers.

> "*It got me freedom with me scooter, it's given me a bit of freedom yes*." [Bertha, Resident Interview]

The presenting symptoms Janey lived with tended to fluctuate. Therefore, Janey did not always use her mobility scooter; it depended on how she was that day and the amount of shopping she needed. However, Janey's striving to remain mobile when she was feeling able resulted in her being questioned about her genuine need for a mobility scooter.

> "*This scooter causes me a lot of trouble and because sometimes people see me walking around, they think I do not really need it. But I do really.*" [Janey, Resident Interview]

> "…*one day I can be able to walk and the next day I can't get out of the house, you know. And I'll be so tired that I can't get around."* [Janey, Resident Interview]

I asked Janey what difference not having the mobility scooter would make to her life, should she not have access to one. Janey replied,

> *"I would be tired all the time, I wouldn't get out, and I can't do the carrying anyway (referring to shopping). I hate being in the house if I can be possibly out. People don't see if I get tired, I have to go bed for a couple of hours."* [Janey, Resident Interview]

Janey's experience demonstrates the importance of not arriving hastily at judgmental conclusions based on surface-level impressions concerning lifestyles; the underlying reality could differ significantly from the one initially perceived.

Summary

Although many health benefits derive from Skelsend's pleasant environment, there are several barriers to accessing the support needed to optimise well-being in the context of a life with multiple health conditions. Service reorganisation tended to be experienced by residents as an intensification of scarcity of provision. This affected all residents, but especially amongst working-age residents with multiple health conditions and those with the least social and economic capital, many of whom struggle with mental distress, making it more challenging to overcome these barriers of access. Meanwhile, the food environment of Skelsend, combined with the struggles of daily life for those predisposed to be spatially bound, having insecure access to capital, including intergenerational cultural capital influencing dispositions regarding food choice, is not conducive towards long-term well-being. There was a distinct tendency for people with lower volumes of capital to be more affected by the poor food environment of the town, which had implications for long-term health and well-being.

Chapter 10 Discussion and Conclusion

Introduction to discussion.

The primary research question of this study endeavours to identify the prominent social structures impacting working-age residents living with multiple health conditions in Skelsend. Although it is impossible to elucidate on all social structures and relationships between social agents, it is possible to identify salient underlying social structures and contingent causative mechanisms that produce emergence; that is, the social phenomena experienced by residents that intersect with the experience of illness and well-being. The study considers the social structures of the town as stratified through laminated scales, from micro to macro levels of reality, to assist in identifying causative mechanisms as products of interwoven social relations (Bhaskar et al., 2018; Houston, 2010; Layder, 1997).

Several studies have considered the influential socially contextualised associations predisposing and impacting multiple health conditions (Mercer et al., 2012, 2018; O'Brien et al., 2014; Singer et al., 2019). More recently, Woodward et al.'s (2024) qualitative research considered structural barriers to effective self-management of multiple health conditions in two urban neighbourhoods measured as socially deprived, one in London and the other in Sheffield. However, this study of Skelsend is unique in considering the intersectional layers of social structure that percolate through the lived experience of working-age residents living with multiple health conditions in a small, remote seaside town that has experienced decades of decline.

The core findings from fieldwork describe how residents' access to capital within the social and physical spaces of Skelsend significantly contributes towards residents' potential to achieve their anticipated projects of well-being. I have considered capital in the Bourdieusian sense of meaning, which exists in economic, social, cultural, and symbolic forms (Bourdieu, 1990). Whereas the differential access to capital is determined by the struggle of social relations within the hierarchical intersecting subfield positions contained within social space (Bourdieu, 2018), how one uses social space in Skelsend, often by necessity, determines how residents perceive their town and benefit, or not, from its environment.

Findings suggest that how working-age residents with multiple health conditions perceived their town was significantly influenced by their relationship with the labour market, specifically their need and ability to secure work that accommodates their health conditions. How residents use physicall space is considerably determined by their relative access to capital and the resources needed to optimise well-being, despite the existence of restrictive health conditions. For some residents, usually long-term residents, the use of space in the town is determined by their need to extract the economic capital through work necessary to secure their means of material maintenance. However, for many well-resourced relocating residents, the so-called incomers, access to economic capital is not dependent on place; instead, they use place, the social space of Skelsend, to cultivate access to social capital.

To illustrate, residents moving into Skelsend to retire were more likely to extol the virtues of the town's peace, solitude, and natural environment, as opposed to any concerns about the weak local economy and poor opportunity structures. Those residents enjoy and derive considerable feelings of well-being from what I refer to as the spatial calm of the town: the slow rhythms of the town and its omnipresent, yet ever-changing, seascape. In contrast, there was a tendency for those residents required to work or concerned for their children's prospects to see the town as isolated and without reliable opportunities to access the material security required to realise well-being. The contextual background to the relative absence of opportunity is decades of declining infrastructure and investment and the erosion of its primary purpose, namely seaside tourism. I use the metaphor of spatial redundancy to describe how this is experienced. Poor connectivity, the town's spatial amputation, compounds its relative redundancy of people and place.

These distinct contrasting experiences, though, do not present as a neat binary; some incomers subject to the vagaries of occupying a liminal social space between work and non-work, in the context of often complex and fluctuating illness, feel exposure to both elements of the relative positions I have outlined. Their insecurity in terms of access to capital through the DWP and relative spatial immobility bounding them to Skelsend necessitates either actual extraction of economic capital from the town or the preparation for the extraction process, despite any apparent impairment resulting from their health conditions.

These projects of accessing capital necessary for well-being are undertaken within the insecurity of the local labour market, and the social relations that have been temporally generated by spatial redundancy.

Two further salient factors tended to reinforce this divide, as mentioned: one's access to capital based on relative field positions of advantage and disadvantage and, very often, the longevity of residence. Lifelong residents, typically called "Skelsend born and bred", and many longstanding residents, were likelier to lament the conditions arising from the temporal and attritional dissolution of purpose within the place. In short, the use of physical space segregates residents between those seeking to satisfy projects of renewal and restitution through relocation and, thereby, benefit from the calm, slow environment, and those who pursue projects of daily necessity involved in coping and attaining material necessities to realise relative well-being, despite the constraints of multiple health conditions.

Spatial redundancy and spatial calm rest alongside other salient impacts on well-being emerging through fieldwork. This thesis does not cover all aspects of social structures and their relationships with residents within the town, as this would not be realistic. However, the two most apparent difficulties were accessing health services and financial support from the DWP, as discussed in the findings chapters. I use these two concerns to complement the theme of struggle and intersection between experiences of spatial calm and redundancy within place. Security of access to capital may mitigate access difficulties to services and protect people from recourse to dependency upon the vagaries of the DWP.

The relationships between residents and the DWP can threaten to absent[16] residents' ability to acquire the essential economic capital required to secure what I refer to as the means of material maintenance necessary to secure well-being. The increasingly tight process of eligibility criteria for accessing PIP from DLA invalidates the residents' experience of illness and, in doing so, contributes significantly to mental and financial distress. Meanwhile, conditionality and

[16] Absence being an integral causation of phenomena in Bhaskar's (1993) dialectical critical realism.

perverse assessments potentially trap working-age residents with multiple health conditions into sedentary lifestyles contrary to medical advice.

The difficulties in accessing health services due to a combination of post-COVID-19 capacity constraints, service rationalisation and centralisation and poor transport connectivity can, to a degree, be mitigated through being able to access local economic and social capital. However, this mitigation is curtailed by the fragile mental health of many residents living with multiple health conditions. There was evidence of the 'inverse care law' (Tudor-Hart, 1971) reallocating services away from Skelsend to more prosperous parts of the county. The insufficiency of local resources that resulted in access difficulties reinforced a perception of abandonment and neglect of the residents' needs.

I conclude with a reflection on how some residents with insecure access to capital are predisposed towards poor food environments and are situated in proximity to spaces notorious for anti-social behaviour. These considerations further highlight how intergenerational insecure access to capital across the social fields of Skelsend can negatively impact working-age residents with multiple health conditions. Further, the overall findings demonstrate that the differential capacity to overcome structural and geographic barriers to well-being reveals the insufficiency of explanations for health inequalities based upon 'lifestyle drift', explanations that are integral to the responsibilisation agenda within government public health policy (Brown et al., 2019; Williams and Fullagar, 2019).

Relocating and finding spatial calm

A prominent feature of the findings was the volume of working-age residents, referred to as so-called incomers, who had relocated into Skelsend with illnesses compared to the sedentary locals or lifelong residents. In concordance with the literature on relocation to seaside or coastal towns, the role of retirement in combination with desired lifestyle change is emphasised (Andrew and Kearns, 2005; Leonard, 2016; Walton, 2000). Like the notion of 'biographical repair' (Locock et al., 2009; Sanders et al., 2024), at the core of residents' motivation to move was, all too often, an opportunity to renew, rebuild or regain identity of and control over their lives in a quieter environment.

However, at variance with much of the literature, these findings suggest that although older working-age residents who had moved into Skelsend did so with retirement in mind, a significant proportion of so-called incomers of working-age and living with multiple long-term health conditions had moved to Skelsend long before retirement had become a prospect. A distinct counter-urbanisation theme was conveyed within residents' ambitions to achieve renewal through relocation, such as the need to escape the city environment. Counter-urbanisation resulted from a need to distance oneself from intense urbanisation circumstances relating to social deprivation. This counter-urbanisation provided an impetus towards social change and the use of space within Skelsend.

Counter-urbanisation, rather than gentrification, is identified by Markham's (2024) study of rural English pubs and Willet's (2023) study involving a Cornish village as driving social change in these locations. Willet's (2023) study on relocation as counter-urbanisation in rural villages details how some well-resourced relocators use their capital to facilitate lifestyle change away from prosperous urban spaces to access the perceived rural idyll and draw some parallels with Skelsend. However, whereas Willet (2023) identifies well-resourced relocators, her research is not in the context of living with illness, and, in contradistinction to Skelsend, her residents who sought relocation seeking spatial calm were not, unlike Skelsend's relocators, overwhelmingly from working-class backgrounds. Although residents moving to Skelsend had differentiated access to social, economic, and cultural capital, generally, people could relocate because of the town's affordability, which resulted from the town's relative economic decline.

The spatial inequality across the UK creates significant geographic house price variations, resulting in the affordability of Skelsend's property (Dorling, 2014). This affordability then facilitates the realisation of the aspirations of people migrating into the town. Increasingly, people with multiple health conditions were moving into the town from the south of England and the Midlands, whereas previous inward migration was confined mainly from the north. The relocating dynamic of Skelsend was consistent with Goodwin-Hawkin and Jones' (2022) study of Swansea, which, like Skelsend, was perceived to be a "left behind" town by many of its residents. Swansea's depressed economy resulted in the low house prices that afforded the middle-class lifestyle, which

had become less affordable in the more prosperous locations from which the residents hailed. Similarly, with Skelsend's relocating residents with multiple health conditions and limited access to capital, the local low-wage economy of the town is matched by low house prices, generating Skelsend as an affordable seaside location for a broader range of people, including those seeking escape from the conditions of intense urbanicity.

This finding offers a different context to the negative narrative of the relocating of vulnerable adults to seaside towns who might have addictions and mental health challenges, sometimes oppressively labelled as "social dumping" (Houghton, 2023; House of Lords, 2019; Smith, 2012; Ward, 2015). Although Skelsend is not immune from this phenomenon, it has the potential to impact residents' sense of well-being. The other narrative in the research literature focuses on people relocating to retire and be close to the sea (Leonard, 2016). Once again, this does happen in Skelsend; however, many people moving into Skelsend are working age, and many are under fifty.

I found that the lived experience of intense urban environments was a causative mechanism driving much of the relocation to Skelsend. The mental health detriment of sensory overload from heightened vigilance and being required to respond to the city environment is also acknowledged to exacerbate the tendency towards experiencing harmful stress (Berman et al., 2008; Halpern, 1995; Mubi Brighenti and Pavoni, 2017). Several residents living with illness spoke of hypervigilance, having to always be on one's guard regarding their former urban neighbourhood, a micro stress that can accumulate with other environmental stressors to the detriment of health (Larrabee-Sounderland et al., 2019; Marmot, 2004).

The fear of crime and mistrust in the urban spaces from whence they had arrived was a prominent consideration, especially for those residents who had experienced mental health difficulties. The chronic stress resulting from the fear of crime predisposing one to further illness has been acknowledged by several sources over several decades now (Halpern, 1995; Jackson and Stafford, 2009; Kruger et al., 2007; McGarvey, 2017; Skogan and Maxwell, 1981). The fear produced by the social disturbances generated within intense urban spaces contrasted with relocating residents' newly found sense of community and

access to friendly, supportive spaces and comparative safety. This security is at variance from the negative narrative of decline applied to many socially deprived seaside towns depicted elsewhere in the literature (Burgart et al., 2013; House of Lords, 2019).

Benefits of the natural environment.

The combination of relative safety, slow pace, and the therapeutic value of blue spaces was fundamental to residents' sense of restitution. A plethora of literature demonstrates the value of green and blue spaces to improve self-reported well-being. Nichols' (2014) overview of the emotional and physical health benefits of being near water contrasts with urban lifestyles, which can expose people to mental exhaustion and fatigue. The extent to which the town's rhythms and slow, quiet pace facilitate reflection necessary for residents' projects of renewal and well-being is reflected in Bell et al.'s (2015) mixed methods research, which explores the therapeutic benefits of interacting with the coast across two Cornish towns. Incorporating 'go along' interviews, analogous to the walking interview method in this study, Bell et al. (2015) reported that participants, adults aged between 25 and 85, highlighted, amongst other therapeutic benefits, that the rhythms and pace of being near the sea were all part of a relaxing ambience.

Skelsend is a place wedged between the natural environments of its green rural hinterland and the sea. Many residents and visitors extol its relaxed ambience despite the apparent areas of faded resort neglect. Similarly, White et al. (2013) and Thompson et al. (2012) studied natural environments in connection with mental health and found that urban areas with higher concentrations of green spaces are associated with improved well-being and lower mental distress. Other research has concluded that living near blue spaces can significantly reduce health inequalities (Mitchel et al., 2015; Wheeler et al., 2012). Meanwhile, Nichol's (2014) systematic overview of the benefits of blue spaces argues that the absence of the natural environment increases the likelihood of mental unwellness. The absence of the natural environment in urban spaces is a causal mechanism, among others, that provided several participants with the impetus to relocate to Skelsend.

Within health research connected to place, there appears to be increasing interest in accessing blue spaces, either living by the sea or visiting it. Skelsend's residents reported that the therapeutic benefits of being close to the sea are reflected in the literature. Bell et al.'s (2015) study documents the immersive and sensory experience of the sea. The feeling of expansiveness, experiencing the cognitive cleansing and calming of the mind, are consistent with the reports of most residents of Skelsend, but especially those that had relocated. Illness permitting, residents moving to Skelsend cited that access to the sea and other green spaces encouraged and facilitated more physical activity, mainly walking, benefiting mental and physical well-being. For instance, this finding is reflected elsewhere in Pasanen et al.'s (2019) Health Survey for England data analysis, which suggests that the mental health benefits from living by the coast are partly mediated by increased physical activity, especially walking. Thompson and Wilkie's (2021) qualitative study of activities on the coast further corroborates Nichol's (2014) assertion that fostering a connection between people and water has significant mental healing benefits.

A further health benefit of blue spaces, including other natural environments or green spaces, is the tendency to foster social connections between people. Both Pool et al. (2023) and Bell et al. (2015) found that the ambience of the coast not only encouraged increased physical activity but provided a conducive environment for people to connect and build friendships. This friendliness is apparent in Skelsend, both around the sea and in the town, cafés, and pubs. A prominent place for people to incidentally meet was the promenade, demonstrating how blue spaces encourage many to exercise and meet people and, in doing so, develop those informal social networks that contribute towards collectively shared social capital. Nichol's (2014) overview of the health benefits of blue spaces argues that an absence of access to natural environments increases the likelihood of mental unwellness. Therefore, I contend that the absence of access to natural environments, such as green and blue spaces within urban areas, in the context of this study was a causative mechanism towards relocation and subsequent restitution following trauma and the onset of illness.

The development of social capital.

Residents' access to social resources through social networks and family, and access to community groups, was a principal determinant of the capacity to acquire and deploy the social capital necessary to ameliorate structural constraints infringing upon quality of life. This study partially addresses Willet's (2023) contention that there is insufficient regard within the literature on how people relocating to rural areas from urban areas contribute to social capital formation. Furthermore, elements of this study reflect findings from Potter's (2023) qualitative study on women living with both diabetes and depression. Potter's study demonstrates how people utilise access to social resources to transcend the biographical disruption caused by illness originally defined in Bury's seminal study (1982). In Skelsend, residents able to access social resources were able to improve the acquisition of social capital, which could be deployed to mitigate the effects of illness and structural constraints upon achieving well-being. Further, whilst benefiting from the acquisition of social capital, many residents who had relocated to Skelsend were fundamental to forming social capital. In Skelsend, incomers often undertook volunteering after being connected to social resources. The subsequent acts of solidarity through voluntary activity provided the means by which these residents could convert access to social resources into personal and shared social capital, later utilised as support networks.

This dynamic is evidenced elsewhere, for example Strong's (2020) ethnography of a food bank in Wales. In this study, the volunteers at the foodbank, who struggle with financial distress through unemployment, find connection with others and purpose and restore esteem through the work to which they became committed. Jordan's (2022) qualitative research found that volunteering improved connectivity between people, establishing a sense of solidarity with others in their community. Jordan (2022) also found that men with mental health conditions found volunteering fundamental to recovering self-identity through renewed purpose. In Skelsend, it was apparent that several residents with mental health and physical health conditions were able to improve their social connectivity, access to capital and esteem through autonomously acquired voluntary work.

Tomaney et al.'s (2024) case study is based on a former Durham mining village, which, through an attritional process of deindustrialisation and austerity, has lost much of its social and economic infrastructure upon which residents rely to realise aspirations and build social connections. Tomaney et al.'s (2024) case study describes "root shocks", or critical disjunctures in the community, such as the closure of the primary school, which cause fractures within the social infrastructure that such communities rely upon (Tomaney et al., 2024). Tomaney et al. (2024) describe the work of residents who develop "moral communities" to build alternative social capital, albeit perhaps with less formalised infrastructure, to ameliorate the long-term effects of "root shocks' in left-behind places in which the life chances of residents are inhibited by structural and spatial disadvantage.

Similarly, long-term and lifelong residents of Skelsend have experienced what Tomaney et al. (2024) describe as "root shocks", such as the closure of railways, the closure of the market, and the effective closure of the hospital, to name a few. In Tomaney et al.'s (2024) study, the attachment to place and motivation to address local unmet needs prompted locals to rebuild the village's social infrastructure, which had declined over the years following deindustrialisation. The community groups of Skelsend, which I noted through fieldwork, were usually run and supported by people who had moved into the town and provided supportive spaces for residents living with chronic illness, especially those with mental health struggles, to rebuild narratives and find restitution. Deficits in some areas of social capital were being addressed by migrating so-called incomers, many of whom were working-age residents with health conditions. Through their need for connection, these residents play a critical role in developing and disseminating social capital.

Aside from the benefits to the community and individual residents derived from the many community groups I encountered in Skelsend, a reoccurring complaint was a lack of leisure activities in the evening. Reportedly, the lack of activity became more apparent in winter. Several times, I was told that people stay indoors while others just go to the pub to meet others. In winter, many community groups continued, but they usually operated during the working day and, by default, excluded many working people. A regular moan communicated to me during winter and evenings was that there was not much to do other than

go to a pub. Although, for many, this was not necessarily such a bad thing and did not spoil their enjoyment of the town, for others, it was further evidence of the town's malaise.

Nonetheless, the lack of alternative leisure amenities and spaces facilitating social connection arguably contributed to residents becoming regular patrons of pubs, bars, and cafés. These places are undoubtedly crucial for the community, as they provide convivial fellowship, support, warmth in winter, and opportunities to share helpful information. However, reliance on these public spaces, with beige foods and copious quantities of alcoholic beverages, providing the fuel of conversation and companionship, can have a long-term detrimental impact on health. Moreover, if one was trying to give up smoking, the omnipresent haze or aroma of cigarette smoke around the entrances to pubs and arcades provided a negative encouragement towards relapse. This also needs to be considered in a cultural context that does not encourage abstinence and restraint, a theme I return to concerning reflexive dispositions.

McGarvey (2022) observed a similar tendency, researching the disconnect between the people living in working-class communities and the people who contribute towards public policy they are subject to, including public health. Mirroring my observations, McGarvey (2022) reflects on an evening in a Glasgow pub in a local neighbourhood community where health conditions commonly truncate lives. He writes:

> *Perhaps the saddest aspect of life here is that the places many people associate with happiness, pleasure and connectedness also play a role in their needlessly abbreviated lives*. (McGarvey, 2022: 148)

Spatial redundancy

The experience of spatial redundancy contrasts with the propensity of other residents, usually those who have relocated to Skelsend to seek biographical restitution and enjoy more secure field positions, to benefit from spatial calm. However, residents with illnesses and insecure field positions in the social space of Skelsend are at risk of being bound to the town by their insecure access to capital and health; spatial redundancy represents their dissolution of

purpose within space. Further, how residents experience the social circumstances of living in a town that has lost its raison d'etre largely depends on their location within the field, relative security, and access to resources. Those residents, often young or lifelong nostalgists, are more likely to perceive their town regarding its relative redundancy.

The insecurity of access to capital for those residents who need employment is intensified by their tenuous relationship with work, which is generated by the residents' health intersecting with the inherent economic insecurity of an ailing seaside economy to which they are bound. As with Simpson et al.'s (2021) ethnographic study of male manual workers in Blackpool, the conditions of the place, the inherent insecurity of the manual work to which they were confined, crystalised into inescapable consternation, a sense of perpetual precarity. Simpson et al. (2021) use Bourdieusian theoretical insights to convey how precarity inherent in the social relations of the local labour market, in which manual workers often have little leverage, influences the outlook of those workers in the town. Ultimately, the precarity experienced by manual workers has a spatial context and is constituted through the social space and field positions within the town, which Simpson et al. (2021) refer to as 'place precarity' (Simpson et al., 2021).

Correspondingly, residents of Skelsend, adversely affected by spatial redundancy, tended to hold positions of disadvantage across the social space of Skelsend. This disadvantage, a significant consequence of illness, often reduced their ability to commute and undertake work. Spatial redundancy and geographic spatial amputation, that is, geographic amputation through the remoteness of the town's location and poor transport connectivity, reinforce each other, a dynamic that impacts the opportunities and well-being of residents, especially those younger residents and those seeking economic opportunities. In a similar vein, Simpson et al.'s (2021) study of Blackpool manual workers shows a tendency for perceived redundancy to crystallise into pessimistic schemas, which are presented as a habitus.

Spatial amputation

The remoteness of the town, its poor connectivity, combined with many residents' lack of personal access to capital and health-related physical and mental restrictions, predispose residents with multiple health conditions to be spatially bound. Agarwal et al. (2023) and a House of Lords (2019) report cite poor transportation links as a prominent barrier to employment for people living in seaside towns. In Skelsend, the spatial disconnection with other regional economic hubs impacted residents' ability to acquire material means of maintenance through work. Residents frequently described a lack of opportunity to make a living in Skelsend, often feeling trapped in the town due to lack of opportunity and disconnection. A prominent barrier to work included the arduous commute into Haxton, where most of the quality work opportunities were available. However, those residents with poor access to capital were more likely not to be able to access a car.

Indeed, many residents in Skelsend complained of the cost of commuting by public transport as a barrier to taking up low-paid work available in Haxton and other areas, a difficulty attesting to the broader 'rural premium' of spatial amputation paid by residents in remote rural locations (May et al., 2020). The lack of transport connectivity, common to rural places, including small seaside towns (Barrett, 2022; Frost and Hobbs, 2024; Houghton, 2023), increases competition for low-paid work available within the town. I later revisit the effects of spatial amputation when discussing key findings concerning the difficulties of accessing health services from Skelsend.

The absence of accommodation for illness in local workplaces

Residents reported an absence of accommodation of their needs that resulted from nonlinear fluctuating health conditions within workplaces across Skelsend. As the literature and research demonstrate, people with long-term health conditions experience the daily reality of fluctuating physical, emotional, and cognitive symptoms, which unpredictably curtail their ability to work (Coyle and Atkinson, 2018; Price et al., 2019). As reported in Chapter Eight, the economic infrastructure in the town precluded the accommodation of employees with fluctuating health conditions. The diminution of the resort, lack of alternative industries, and thin profit margins of small businesses that predominate in the town generate weak foundations for the local labour market, whereby room to

accommodate the flexible working practices that help sustain people with more restrictive health conditions in work become marginal.

Lloyd and Blakemore (2021) and Walton (2000) argue that seaside towns like Skelsend are like former industrial towns. Many have lost their equivalent to an industrial town's manufacturing base, that is, their tourist industry, and have been unable to develop alternative means to attract and generate capital (Farr, 2017; Lloyd and Blakemore, 2021). Skelsend's remoteness appears more acute due to this loss of purpose, especially in winter, when the residual tourist activity is absent. Rural remoteness from poor connectivity results in seaside towns cut adrift from the labour markets that provide broader opportunities (Lloyd and Blakemore, 2021).

Like many seaside towns, and especially mono-sectoral ones like Skelsend, there is a tendency towards the local economy to generate temporary, poorly remunerated, and insecure manual work (Agarwal et al., 2018; Beatty et al., 2011; House of Lords, 2019; Lloyd and Blakemore, 2021). Given that residents living with multiple health conditions with poor access to capital were more likely to be spatially bound, they experienced an increased propensity to be subject to insecure and physically intensive labour that was available in the town. Moreover, insecure work predominates in Skelsend, a typical feature of seaside towns (Beatty et al., 2014; House of Lords, 2019). Even though evidence propounded by the government and other organisations that paid work is conducive towards positive mental health (Lelliot et al., 2013), there exists evidence that insecure employment conditions may have a detrimental impact on health (Frayne, 2019; Lloyd, 2019; Virtanen et al., 2013) and be a significant factor in the onset of chronic stress and anxiety (Bobek et al., 2018; Dieker et al., 2019; Watson and Osberg, 2019). However, residents with multiple health conditions are subject to these labour conditions, especially given the predominance of temporary work in seaside towns.

This vocationally related experience of many residents in Skelsend concurs with Simpson et al.'s (2022) recent study of male manual workers in a seaside town comparable to Skelsend, located on England's south coast. For Simpson et al. (2022), the precarity of their subjects' economic situation necessitated close family ties. However, maintaining those ties intensified the workers' spatial

immobility, further constraining their potential to avail themselves of opportunities elsewhere. Finding security in a weak, disconnected local economy was challenging (Simpson et al., 2021, 2022). For several residents in Skelsend, family ties provided social capital; however, this tied them closer to the redundant space of Skelsend. Therefore, residents with limited economic capital, by relocating out of Skelsend, lose their social capital, which they are more likely to be reliant upon because of limited economic capital. Consequently, a decision to move away from family and friends becomes increasingly fraught, especially in the capricious nature of many health conditions, which may necessitate access to sources of trusted support that these established networks provide.

Therefore, workers with health conditions in Skelsend face insecurity on many fronts. Their insecurity of access to capital, the insecurity of illness and the unsympathetic conditions of locally available work combine to form a causative nexus towards harmful stress and pessimism. For those insecure workers with health conditions, the lack of responsive state support in response to future worklessness, caused by further illness or fluctuations in health status, or when their labour becomes superfluous in winter, deepens the insecurity they live with. This insecurity, resulting from a combination of personal circumstance, illness, and prevailing social structure, prevents participation in the workplace and embeds the normality of inactivity. Stahl et al.'s (2022) explication of the "disability trap" faced by workers with health conditions, evident in Western welfare systems, describes this entrapment in disempowering inactivity in similar terms.

Within this environment, there is a lack of capacity to accommodate the flexible needs of workers living with health conditions presenting with fluctuating conditions. The insecurity of work in Skelsend and other seaside towns further reinforces the insecurity of the health of residents living with multiple health conditions, who must work to attain secure access to the capital needed to acquire the means of maintenance necessary for well-being. Meanwhile, subjection towards material insecurity predisposes people to an increased likelihood of accumulating further illness (Hanson et al., 2020; Virtanen et al., 2013).

The habitus of purposelessness

Several studies within the relevant literature discuss how the lack of opportunity structures for younger residents in seaside towns generates negative dispositional attitudes about their future (Asthana and Gibson, 2022; McDowell et al., 2022; Reid and Westergaard, 2017). In Skelsend, the sense of malaise and paucity of optimism for the future was more pronounced among spatially bound younger local lifelong adults aged under forty with multiple health conditions. When discussing the town with younger adults, it was common for them to denigrate it automatically. Reid and Westergaard's (2017) qualitative research with young adults in coastal towns of southern England similarly reflected this sense of deep malaise felt by young adults in Skelsend, specifically the lack of opportunity structures related to macro-social and economic trajectories, which embedded the structural disadvantage of their social positioning (Reid and Westergaard, 2017).

The experiences of younger adults in Skelsend also resonate with those of Wenham (2020), who studied young adults in a much larger coastal town traditionally associated with the seaside. Wenham (2020) observed how investment in tourist infrastructure did not meet the needs of young residents, who lacked the capital to access the benefits of such investment, resulting in a further sense of being overlooked and forgotten. A similar dispositional outlook permeates through McDowell et al.'s (2022) qualitative study of marginalised working-class young men in three large English coastal towns – the loss of spatial purpose transmutes to many residents, forming part of their felt malaise.

In Skelsend, I often heard the phrase "stuck" in relation to people's weak field positions in the town. These experiences cohere into a felt sense of malaise, which is apparent in the way the younger adults of Skelsend living with multiple health conditions referred to Skelsend. Their explanations were framed by a dispositional, almost automatic, pessimism about their future, the town's future, and their position within the town's space. In Skelsend, the habitus of the spatially bound young is a dispositional cognitive schema of pessimism, a defaulted outlook regarding one's prospects and the collective prospects of the town. The outlook of pessimism is generated by living in a space subject to decades of decline, spatial redundancy, and diminution of purpose. The seemingly automatic refrain of younger residents referring to their town as a

"dump" is also replicated by McDowell et al.'s (2022) interview research with young men trapped in a poorly valued, low-paid, precarious and repetitive work cycle in coastal communities. This dispositional cognitive schema is akin to what Scambler (2013) calls a "vulnerable fractured reflexive" of a persisting mode of pessimistic and fatalistic outlook, predisposing the individual to act and think in a manner harmful to long-term well-being.

Causation of spatial calm and redundancy: economic and cultural change and use of space

As discussed in the methodology chapter, many underlying causative mechanisms that reproduce the conditions of inequality are not empirically observable, either as narrated by the participant[17] or acknowledged as an event.[18] Instead, tendential causative mechanisms operate below the visible surface level of reality through social structures and their institutions.[19] Residents of Skelsend living with multiple health conditions, whose perceptions of the town are broadly consistent with the metaphor of spatial redundancy, strongly tend to be residents with insecure access to capital, which, in combination with illness, predisposes them to be spatially immobile and, therefore, confined to extracting the necessary, but often limited, resources from Skelsend. In this section, I focus on the interplay between spatial redundancy, spatial calm and disturbance, and consider underlying causation that influences the residents' experience of their town. In particular, I focus on the causative mechanisms that produce the relative experience of spatial redundancy.

The spatial redundancy of Skelsend and its loss of purpose resulted from the dramatic changes in leisure time consumption, resulting from the economic changes of the 1970s and 1980s, during which the processes of production and accumulation of capital shifted decisively away from modernist Fordist methods to post-modern, flexible accumulation of capital (Agarwal, 2005; Gale, 2005). According to Harvey (1989), in contrast to Fordism's rigidities and long-term financial commitments, the move towards flexible accumulation liberated capital

[17] Domian of the empirical.
[18] Domain of the actual.
[19] Domain of the real.

from restrictive regulations and long-term financial commitments towards industries. The subsequent era of neo-liberalism ensured that profit extraction was increasingly derived from the financial and service sectors rather than the manufacture of goods (Glyn, 2006; Harvey, 1989, 2005; Tomlinson, 2020). This change within the means of accumulation generated a significant change in cultural disposition and consumption (Gale, 2005; Harvey, 1989).

The resulting decades of transformation of the labour market from blue-collar to white-collar employment, from industry to financialisation and services, Gale (2005) argues, weakened class identities and precipitated a shift in culture and dispositional tastes and preferences in the consumption of leisure and holidays (Gale, 2005). This is particularly exemplified by the transition from blue to white-collar employment during the 1980s and beyond (Gale, 2005). Digitalisation and a temporal-spatial contraction further embedded changes in attitudes towards leisure consumption (Harvey, 1989), leaving the seaside resort holiday incongruous with people's changing aspirations and leisure time (Gale, 2005). Erstwhile holidaymakers underwent a dispositional change in their attitude towards the seaside, with many new white-collar workers developing novel holiday habits (Gale, 2005). The traditional seaside holiday became increasingly unfashionable and even unpalatable in the face of considerable cultural change (Agarwal, 2005; Gale, 2005).

The globalisation of holidays, becoming more accessible as package holidays from the 1970s, and the increased competition and choice of holidays within the UK, such as bespoke holiday parks and countryside retreats, increased competition (Agarwal, 2005; Gale, 2005). Therefore, the economic transformation reproducing and expanding monetary capital has led to cultural changes that negate the appeal of traditional seaside holidays that once appealed to people seeking an escape from the oppressive urban environments (Gale, 2005). Seaside towns have struggled to adapt to the changing realities and increased domestic and international competition (Walton, 2000), resulting in attrition of the purpose, especially in mono-sectoral towns built around tourism (Lloyd and Blakemore, 2021).

The built environment of seaside towns, many like Skelsend being mono-sectoral and dependent upon tourism (Lloyd and Blakemore, 2021), developed

around the tourist economy, which has since diminished, with spaces and tourist labour becoming increasingly redundant (Kennell, 2011). This is a similar experience faced by other towns dominated by declining or disappearing industries, notably towns once founded on mining and steel (Lloyd and Blakemore, 2021; Telford, 2022; Walkerdine and Jimenez, 2012).

Consistent with the shift towards flexible accumulation and the ideological adherence to the small, largely non-interventionist state, successive governments since the 1970s have maintained a laissez-faire approach to regenerating seaside towns (Farr, 2017). State intransigence has persisted for decades towards the plight of seaside towns that have lost their primary industry (Houghton, 2023; Kennell, 2011). Houghton (2023) argues that the state has abrogated its responsibility to local governments that cannot, due to treasury rules, borrow to invest in undertaking the scale of investment needed for comprehensive regeneration. For residents who need to remain economically active and use the social space of Skelsend to find working opportunities to access capital, the resulting lack of purpose causing spatial redundancy forecloses aspiration. The remaining work in the town is consistent with the hegemonic mode of production of flexible accumulation, being further disadvantageous towards vulnerable groups (Harvey, 1989). This results in a tendency towards dispositional despondency.

Meanwhile, the maintenance of redundant conditions in Skelsend and the lack of housing regulations from the state to mitigate significant disparities between locations reproduce spatial inequality, resulting in low house prices for Skelsend compared with elsewhere (Dorling, 2014). The availability of comparatively affordable housing preserves Skelsend as a financially accessible destination for people of moderate means to relocate to the coast and escape from urban environments they find stressful. Walton and Browne (2010) contend that retirement migration has supplanted the resort industry in seaside towns, whose needs ran counter to holidaymakers seeking family activity. Further, as Leonard (2016) observes, a lack of economic activity and tourist growth in a seaside town maintains the town’s peace. This is desired by most incomers and, thereby, optimising the conditions of spatial calm.

The migration tendency of people who are predominantly economically inactive moving into Skelsend can reinforce the spatial redundancy of those seeking employment opportunities that do not involve the care sector. For instance, Beatty and Fothergill's (2003) study of the seaside economy concluded that the impact of inward migration distorted and undermined the seaside economy for more than three decades in respect of foreign holidays. Walton (2000) further explains that developing seaside towns as locations conducive to retirement has reduced consumer demand by having a higher proportion of residents living on fixed incomes. Indeed, in Skelsend, the proportion of people identified as being economically inactive in the census of 2021 is well beyond the national average (Gov.UK, 2024).

This inactivity reinforces the spatial calm and spatial redundancy paradox. The lack of opportunity and decline has created a space for spatial calm to develop and be enjoyed by inactive residents, many of whom have long-term conditions. The tensions between those who perceive spatial calm and those who perceive spatial redundancy parallels Leonard's (2016) study on the effects of midlife migration to the seaside town of Bexhill-on-Sea, albeit a more affluent migration. Leonard (2016), as with Skelsend, discerns that the people who moved into town do so without seeking to exploit working or business opportunities. The desire of most incomers I encountered, namely to keep the town quiet, "keeping a lid on vibrancy" (Leonard, 2016: 116), serves to reinforce the redundancy for younger people and those needing economic opportunities to extract the economic capital needed for material security through employment or learning new skills that may improve opportunities. This attitude was present among many people with health conditions whom I encountered who had moved into Skelsend and no longer needed to work. The prospect of attracting more tourism or visitors to the town was often not entirely welcome, even though it may provide more employment, albeit seasonal. For these residents, the thinly spread footfall of visitors was, grudgingly, tolerated as necessary to keep the town functioning, but the prospect of returning to Skelsend's popular resort past was not at all palatable.

Indeed, Bell et al. (2015) reported that residents moving from urban areas to quieter coastal areas wanted to share the spaces with other people seeking calm and restoration, rather than sharing space with people seeking the

traditional seaside holiday experiences that are more hedonistic ephemeral pleasures that people found draining. This sentiment was certainly reflected among many of the so-called incomers in Skelsend. This represents the struggle within the field of social space in Skelsend. The struggles within social space produce the physical spaces of a locale. This struggle within social space also reproduces the appropriation and domination of those spaces, thereby, generating a segregation of people (Bourdieu, 2018; Harvey, 1989). In Skelsend, social segregation manifests through competing needs and how people use physical space. For some residents, this involves acquiring access to capital through their need to be economically active to secure the material conditions required for their well-being. Often, these residents have low capital resources and feel 'stuck'. Their interests collide with those seeking spatial calm, fundamental to their idea of restitution and renewal in the face of illness.

Accessing financial support in a hostile environment

Residents living with restrictive health conditions, which impacted their ability to work, faced the challenge of maintaining financial support from the DWP. Recourse to the DWP often resulted in residents being subjected to surveillance, harsh conditionality, and seemingly arbitrary eligibility decisions. Nearly all residents I spoke with who required financial support due to long-term ill health struggled to attain material security through their relationship with the DWP. Often, pernicious assessments and rules trap residents in comparative inactivity, whether trying to improve their mobility or, perversely, improve their prospects of sustaining work.

The amplification of conditionality and tighter eligibility criteria applied to social security access over the decade preceding my fieldwork in Skelsend was built on the foundations of previous Labour and Conservative governments (Barker and Lamble, 2009; Driver, 2013; Macleavy, 2011). However, following the financial crisis of 2008 and the subsequent election of the Coalition Government (2010–2015), there was an intensification of these pre-existing social relations influenced by the ideologies of neo-liberal political economy and moral conservatism as applied to the welfare state (Barford and Gray, 2018; Gamble, 2016; O'Hara, 2020). The entrenchment of moral conservatism – or, as Morris (2016) prefers, moral economy, significantly contributed to the framing of welfare within public discourse. The promulgation of the moral economy has,

since 2010, been intensified through a re-assertion of a more aggressive neo-liberal agenda, characterised by the ideology of the small state and economic laissez-faire (Barford and Gray; 2022; Berry; 2016; Hutton, 2024). These mutually reinforcing ideological precepts were facilitated through a state-driven financial imperative of austerity in response to the ostensible fiscal crisis of the state, which resulted from the financial crash and the so-called Great Recession of 2008 (Barford and Gray; Berry; 2016; Hutton, 2024).

Therefore, the historical trajectory of flexible accumulation has intensified, resulting in punitive social relations involved in welfare support (Barford and Gray, 2022; Garthwaite, 2011; O'Hara, 2020). The consequent programme of welfare reform, predicated on a moral panic, responsibilisation and a work imperative that threatens to invalidate illness, has pervaded through public policy with the DWP as its instrument of application (Braint et al., 2013; Brown et al., Garthwaite, 2011; Patrick, 2017). These measures, contends Barr et al. (2019) and Jensen (2014), have become a commonsense, doxa-dominated public discourse. Within this narrative, many residents of Skelsend must navigate their lives and means of support.

Residents' experiences in Skelsend accorded with qualitative literature on welfare reform throughout public sector austerity (Braint et al., 2013; Garthwaite, 2011). The consequences of austerity-driven welfare reform impacted many residents living with health conditions in Skelsend. It threatened their projects of well-being, despite the conducive restorative environment. The findings derived from the experiences of working-age residents living with multiple health conditions in Skelsend broadly reflect the qualitative research literature, which attests to the pernicious effects of intensifying conditionality, surveillance, and stricter eligibility, whilst there exists a lack of acknowledgement for invisible conditions, like mental health and fluctuating illness trajectories.

Aspersions of indolence and invalidation of illness

Public discourses depict service users as lazy and undeserving, a view promulgated in much of the media and through government policy. These discourses frame the relationships that residents of Skelsend have with the DWP, the institution on which their material security depends (Briant et al.,

2013; Garthwaite, 2011, 2014; Larsen, 2013). In Skelsend, several residents reported feeling that DWP staff regarded them contemptuously, assuming they were undeserving of support and trying to avoid working. Indeed, the experiences of residents with multiple long-term conditions lend further weight to the body of research on the subjection of service users to a moral conservative ideology and a blame culture that frames them as indolent and untrustworthy (Braint, Watson and Philo, 2013; Garthwaite, 2011; Larsen, 2013; O'Hara, 2014).

Jensen (2014) describes the mutually reinforcing rhetoric of the governments and the media that has produced a doxa, an ostensible commonsense belief that worklessness caused by personal failings is rooted within the welfare system itself (Jensen, 2014). Morrison's (2021) analysis of social media comments, specifically of landlords, demonstrates the prevalence of this doxa in public discourse (Bourdieu, 1990). A doxa is predicated upon an embedded assumption based on the cynical notion that service users are "scroungers" (Briant et al., 2013; Garthwaite, 2011; Morrison, 2021). Several residents in Skelsend, reliant on state support, knew that some people in the town judged them negatively for not working. Residents spoke of their dismay about the local prejudice they might encounter in the town, a prejudice influenced by public discourse that could contribute towards a tendency of socially withdrawing. Garthwaite (2014, 2015b) writes about how the stigma of receiving state support can incline people to distance themselves from their social networks, family, and friends. More generally, prevalent public discourse has adverse psychosocial effects on service users, leaving them feeling stigmatised with consequent effects on their mental health (Garthwaite, 2011, 2013; O'Hara, 2020; Patrick, 2017; Saffer et al., 2018).

Research conducted by Citizens Advice provides evidence of service users being inappropriately sanctioned and compelled to apply for physically difficult jobs that result in deteriorating health conditions (Miller and Rose, 2023). Service users with vulnerabilities resulting from health conditions, mental and physical, can be especially vulnerable to regimes of sanctioning and surveillance (Fletcher and Wright, 2018; Ryan, 2019). The research literature further resonates with the experiences of Skelsend's residents, who talked of their anger, frustration and anxiety caused by surveillance and a feeling of being

criminalised (Fletcher and Wright, 2018). This is further exemplified by Matthey et al.'s (2018) research on DWP practices during austerity, and the impact on mental health service users resonates with Bryan's experience of assessors coming to his home. The haven and sanctuary of the home are no longer sacrosanct once recourse to claiming financial support has been undertaken (Matthey et al., 2018). Additionally, Fletcher and Wright (2018) recognise the stress caused by DWP work coaches monitoring progress on the online work journals, a virtual panopticon of authoritarian surveillance. The move to online surveillance in the UK invokes what Wacquant (2017) terms the "centaur state", when the laissez-faire of neo-liberalism and upholding the supremacy of free markets is transformed into authoritarianism when dealing with its consequences, the people who lose their place within the productive economy.

The precarity of accessing financial support

I encountered many service users who had a significant portion of their income removed after having their eligibility for PIP reviewed. Consistent with a considerable body of research, residents of Skelsend transferring from Disability Living Allowance to PIP were particularly vulnerable, especially residents with mental health and fluctuating conditions. Machin and McCormack's (2023) qualitative study with people living with a mental health condition as their primary condition found, during the transition from DLA to PIP, that the assessment process no longer acknowledged serious issues related to mental health to the detriment of people with severe and enduring mental health conditions.

Allen et al.'s (2016) study on the effects on service users with chronic fatigue syndrome transiting across to PIP details the increased exacerbation of symptoms as people found the assessment adversarial. Woodward et al.'s (2024) study of barriers to managing multiple health conditions also found that the difficulty in acquiring and sustaining PIP was itself a barrier to well-being. The anxiety caused by attempting to access PIP exacerbated mental health, and, as with Skelsend's residents, the process was found to be particularly punitive for those residents with hidden disabilities or impairments (Woodward et al., 2024). Accordingly, these findings concur with Dwyer et al. (2020) and Scholz and Ingold's (2020) qualitative research, which found that assessments

focus overwhelmingly on physical health to the detriment of people with mental health conditions.

Several residents informed me that assessors failed to account for how they had prepared especially for their assessment, resting for days beforehand to ensure they could make the journey into Haxton: resting in a way that would not be possible if they were regularly required to work. Moreover, they felt the potential for fluctuation in symptoms was not acknowledged. The DWP's unwillingness or inability to consider a nonlinear illness trajectory is well documented in the literature and corroborates this experience (Coyle and Atkinson, 2018; Geiger, 2018; Price et al., 2019). Wright et al. (2022) state that medical information provided by health professionals for service users with mental health difficulties is routinely not considered in assessments. Allen et al. (2016) report that the amount of evidence and validation of proof of disability that people need to convey to assessors is both dehumanising and disempowering. Once again, the literature resonates with residents' experiences.

Amongst Skelsend's residents, the lack of accommodation for any fluctuation in residents' ability to work meant that some residents felt they could not be open about what they could achieve, for they knew that neither employers nor the support were flexible or responsible enough to ensure material security. For instance, self-reported improvements in physical activity, including attending an exercise class as recommended by a GP, no matter how gentle, risked the loss of financial support. This finding, which potentially could foster alienation from support services, I found to be particularly pernicious and so detrimental to long-term well-being.

Further detriment to residents' well-being was caused by the punitive sanctioning system, which threatened to "recondition" people into cynicism and passivity by forcing them to apply for inappropriate work opportunities for which people were predictably rejected. This futile process is evidenced in other studies, such as those by Patrick (2019) and Wright et al. (2019). The response of community organisations in Skelsend and elsewhere to personal crises caused by sanctioning, as evidenced by Butler (2023) and Watts et al. (2014),

exemplifies Strong's (2020:211-219) contention that state abrogation has enforced upon communities the "localisation of responsibility".

Community workers advised me that service users needed expert support before attending an assessment to avoid the unnecessary loss of income. Unfortunately, the demand for support could not be matched by the support available in Skelsend. This is consistent with Allen et al.'s (2016) findings regarding the experiences of people with chronic fatigue syndrome, who reported how crucial professional support is when being assessed. Indeed, Pybus et al. (2021) conducted qualitative research concerning WCA and found that people were more likely to lose support without professional advocacy when undertaking the WCA.

Additionally, the complexity of the system invites mistakes when completing required documentation. There is little accommodation for this, nor a mechanism to help amend mistakes; instead, service users, some of whom have difficulties with literacy, must recommence the process of claiming from the beginning. This effectively results in a financial penalty due to delays in receiving eligible and needed support. Benefit delays are one of the main reasons people are compelled to use food banks, which are becoming accepted as a normative and institutionalised means of support in the UK (Caraher and Davison, 2019; Garthwaite, 2016). Community workers in Skelsend concur that benefit delay was a significant reason residents struggled and required emergency food parcels.

The experiences of service users in Skelsend reflect the existing research literature demonstrating the pernicious workings of a system ostensibly designed to promote independence and security. The experience of Skelsend would, though, suggest otherwise; rather than an enabler, supporting residents to achieve well-being in the face of illness, the administration of welfare reform, informed by ideological precepts, through the auspices of the DWP, was a barrier to achieving projects of well-being. As Öğütle (2013:493) writes, institutions are "executors" of causal mechanisms and leave their mark on the embodied individual. The residents' narratives in Skelsend speak to the impacts caused by ideologies, themselves an influential causative mechanism of emergence operating through state institutions.

Accessing health services from the periphery

Woodward et al. (2024), in their research on the multiple health conditions of residents of socioeconomic disadvantage in Sheffield and London, found transport accessibility to be a salient factor in the self-management of health conditions. The paucity of accessible and affordable public transport in rural areas is documented by Allen (2020), Frost and Hobbes (2024), Houghton (2023) and Ward et al. (2013). Following Allen's (2020) methodology, Skelsend is classified as a 'transport desert' with no rail service and is only connected to Haxton by a long bus journey. In Skelsend, the lack of transport options and the centralisation of services severely disadvantage residents, especially those with unreliable access to a car.

Despite the concentration of need in peripheral spaces like Skelsend, the rationalisation of public services during prolonged austerity has increased the centralisation of services and amenities to the detriment of rural locations like Skelsend (Shucksmith et al., 2023). The withdrawal of community-based services is not unique to Skelsend during an era of public service retrenchment (Davison et al., 2019, 2022; Youle, 2019). However, its impact has been more keenly felt in the town than elsewhere, given the remote location and the shortage of capital at the disposal of many residents to overcome the disadvantages of spatial amputation. Typical of the inverse care law (Tudor-Hart, 1971), the former Woldenshire Clinical Commissioning Group's decision to consolidate services in Whorley removed resources from a town measured as deprived only to be reallocated to another town measured as one of the least deprived. The distancing of services away from patients in rural and peripheral coastal communities can result in tangible adverse impacts on patients, as evidenced in the findings of this study.

Kelly et al. (2016) undertook a systemic review of the literature to consider the impact of travel time to health facilities in the global north. The review concluded that 77% of studies found a "distance decay association", a tendency that suggested that the further away from health facilities a patient lived, the greater the likelihood of a poor outcome to their health and was evident across all geographies, at a "local level, interurban and intercountry" (Kelly et al., 2016:6). The review acknowledged that most studies assumed patients had access to a car and were not reliant on public transport (Kelly et al., 2016). The findings on

accessibility difficulties of residents of Skelsend perhaps highlight a need for a broader study on the health impacts on rural residents with problematic access to public transport.

Dobson et al. (2020), in a study of oncology patients accessing healthcare from a rural area, found that difficulties in accessing hospitals resulted in delayed diagnosis and poorer prognosis. Dobson et al.'s (2020) study produced results like those of an earlier study based in northeastern Scotland concerning the difference between urban and rural diagnoses of lung or colorectal cancer (Campbell et al., 2001). The study concluded that the greater the distance from an oncology treatment centre, the greater the likelihood of late diagnosis, resulting in a poorer prognosis (Campbell et al., 2001).

There is a paucity of research detailing the impacts of community hospital closures or significant service withdrawal on residents in socially disadvantaged and remote areas like Skelsend. Palmer and Rolewicz (2020) further contend that there is a lack of research detailing residents' potential difficulties with extended journey times to access NHS services. Highlighting the benefit of maintaining local resources, Davison et al. (2019, 2020) identify the benefits of community hospitals via qualitative data on patient experience, illuminating the missed positive contributions community hospitals provide to local well-being. For instance, patients felt that local hospitals provide a more person-centred, familiar, accessible, and reassuring service than larger acute hospitals (Davison et al., 2019, 2020). A report by Youle (2019) on the closure of a community hospital on Devon's coast describes similar patient experiences as communicated in Skelsend; the difficulties caused to patients with painful chronic health conditions by having to travel ninety minutes to attend appointments that were, until recently, hosted at the local hospital.

Accessing primary care

Accessing health services was a difficulty experienced by all working-age residents with multiple health conditions. The removal of services, like the community hospital, and the difficulties experienced were a cause of anxiety and distress. Residents with poor access to capital and those predisposed to it were particularly affected. Meanwhile, the lack of GP capacity within the town was also a significant barrier to residents self-managing their health conditions

and achieving well-being. However, those with greater access to social capital were more able to exercise self-advocacy and persistence, which helped facilitate access to support from primary care services.

Working-age residents living with multiple health conditions in Skelsend did not just speak of their difficulties in travelling to hospital appointments but also conveyed deep frustration about accessing GP appointments, especially if they could not travel easily to the outlying villages elsewhere in Flintonprice. However, access difficulty was not just about physical location but also a shortage of available local appointments, a problem not unique to Skelsend. According to the Nuffield Trust (2023), just over a third of people had trouble accessing GP surgeries across England during my undertaking fieldwork in Skelsend. Fieldwork spanning 2021 and 2022 occurred when post-COVID-19 demand for primary care was still placing primary care services under considerable demand, with its workforce emotionally and physically exhausted (Seidu et al., 2022).

Accessing primary care in Skelsend, especially GP appointments, was almost universally reported as a barrier to residents managing their health conditions. This emergent theme is consistent with the Nuffield Trust's (2023) findings that access to primary care is more difficult in areas measured as socially disadvantaged. When accounting for increased workloads in deprived areas, given the higher levels of morbidity, GP practices, according to Fisher et al. (2020), receive 7% less funding than those in more affluent areas. A similar pattern unfolds regarding the ratio between patients and GPs, with GP coverage being poorer in deprived areas once adjusted for increased demand in poorer areas (Fisher, 2020). According to Fisher et al. (2020), GPs working in disadvantaged areas must care for 10 % more people than their counterparts in less-deprived areas.

Meanwhile, towns like Skelsend face double jeopardy, as Whitty (2021) observes: disadvantaged towns on the rural periphery are often overlooked or occluded by their wealthier hinterland, resulting in funding allocations that do not reflect local needs. Furthermore, according to Palmer et al. (2019), the Carr Hill Formula for primary care fails to account for extra costs incurred from operating within a remote location. These factors are further impacted by

recruitment difficulties in rural and coastal areas (Fisher et al., 2022; Palmer et al., 2019), a problem highlighted by health professionals in Skelsend.

Moreover, Mercer et al.'s (2018) study of GP consultations with patients living with multiple health conditions found that consultations in affluent areas were longer and the experience more empathetic and person-centred than in deprived areas. The inferior service in poorer areas is despite evidence confirming that the prevalence of multiple health conditions is higher in areas of deprivation (Mercer et al., 2012). This provided further anecdotal evidence from residents' narratives of an 'inverse care law' (Tudor-Hart, 1971; Mercer et al., 2012, 2018) but from within Flintonprice itself, although I could not quantifiably confirm this. Indeed, it was clear that many residents living with multiple health conditions, especially those that included a mental condition, tended to lack the economic and social capital restricting their access to the hospital; also, long journeys were anxiety-provoking, and transport costs were potentially prohibitive. The reallocation of resources from the periphery towards larger urban areas had a disproportionate impact on residents with mental health conditions and/or those budgeting on restrictive low incomes. In several cases, the anxiety and expense caused by access difficulty have resulted in disengagement and people forgoing medical appointments in Haxton and elsewhere.

Reflecting this tendency, Allen (2020) claims it takes rural residents in England 54% longer to access a GP surgery than urban residents. Service retrenchment in rural areas during the era of austerity (Shucksmith et al., 2023) and poor transport connectivity, resulting in spatial amputation (Allen, 2020), combine to impact residents with multiple health conditions in Skelsend, especially those people more reliant on public transport, who tend to have fewer economic resources at their disposal. The reallocation of resources had a disproportionate impact on residents with multiple health conditions who have insecure access to capital and who struggle with severe anxiety resulting from mental health conditions. Murage et al. (2019) considered the impacts of geographical access to primary care and found that poorer access resulted in poorer engagement and an increased tendency towards disinclination to present symptoms promptly. This resulted in poorer health outcomes overall and an increased risk of emergency admission to the hospital and late diagnosis.

Although it was clear during fieldwork that accessing primary care was a challenge experienced by most residents, it seemed apparent that some residents could better secure consultations with GPs than others. Findings suggested that residents with greater personal resources and social capital were more likely to be assertively persistent in advocating for their needs and, thereby, were more likely to access the required services to support well-being. Meanwhile, other less well-resourced residents were more likely to become resigned to poorer health and disengage from services. The emergence of this finding within Skelsend corroborates Woodward et al.'s (2024) study of barriers to self-management in socially deprived urban areas. Having the personal resources to find relevant information and the confidence to ask for referrals is essential to self-management, especially when faced with services that fail to work seamlessly to provide holistic support (Woodward et al., 2024).

In contrast to accessing support for physical health, several of the residents who had relocated to Skelsend reported that mental health services, including talking therapies, were instrumental in the success of their move to the town. However, concerns were emerging during fieldwork regarding an increasing lack of availability. Having access to talking therapies and learning strategies to cope with threatening emotional states, whilst having access to spatial calm and the seascape of Skelsend, helped residents reclaim their identity and find restitution.

According to Clark (2018), access to talking therapies significantly improves the overall well-being of service users, with more than half of patients recovering or reporting improvement. However, according to Krekel et al. (2024), residents living in areas of social disadvantage and people with disabilities were less likely to benefit from talking therapies provided by the NHS. There was a tendency for some residents with insecure access to capital, including younger lifelong residents, to be more likely to feel resigned to poor health and to disengage from services. However, more focused research is required to establish barriers to achieving well-being goals for talking therapy, the causes of poor engagement being an area of potential interest.

Furthermore, the combination of therapy with immediate access to the natural environments and the calming space of the town complemented each other.

Considerable qualitative and quantitative literature exists about the self-reported health benefits of living close to the coast or having access to blue spaces (Bell et al., 2015; McCartan et al., 2022; Pasanen et al., 2019; White et al., 2013). However, further research on the potential relationship between therapy and place may reveal a fresh understanding. Although Krekel et al. (2024) contend that therapy is less effective in areas of social deprivation, perhaps Skelsend's natural environment is a mediating factor facilitating improved outcomes.

Mental health and spatial disturbance

In Skelsend, small areas within the neighbourhoods had been measured as being within the most deprived decile in England, harbouring small areas known for disorder and anti-social behaviour. These spaces consist of houses clumped down a terraced street or a small block of flats on the main council estate. In contrast to spatial calm, I refer to these areas in the findings as pockets of spatial disturbance, arguably areas that have developed into being through the growth of spatial redundancy over several decades of the town's declining purpose. These areas were bestowed with notoriety and symbolically devalued spaces (Keene and Padilla, 2014).

Residents with insecure access to economic capital were predisposed to live within or near these pockets of spatial disturbance. Several residents experiencing these circumstances spoke about how elements of their neighbourhood were detrimental to their mental health; these elements included drug-related activity, littering, dog fouling, low-level harassment, and burglary. McCartan et al. (2023) considered the potential benefits of living near blue spaces and acknowledged that these benefits are undermined by living in areas with a high prevalence of anti-social behaviour.

Such conditions increased the likelihood of social withdrawal, and there was some evidence of this in Skelsend, with residents taking different routes when walking around town to avoid these spaces. In severe cases, actual social withdrawal leads to reinforcement of a tendency towards agoraphobia. Consequently, living in and around pockets of spatial disturbance could undermine the therapeutic benefits of residents' proximity to the seascape. This association between fear of crime and reduced activity and social withdrawal is evident in several studies (Jackson and Stafford, 2009; Kruger et al., 2007).

Impoverished levels of community trust and hypervigilance in response to community threats have been identified as having tangible adverse impacts on both physical health and mental health over time, elevating risks of non-communicable disease (Larrabee et al., 2019; Marmot, 2004; Ross and Mirowsky, 2001) and mental distress (Wilkinson and Pickett, 2018).

Residents who are renting and primarily residing in social housing were more likely to be subject to spatial disturbance. Like other aspects of social life in Skelsend, differentiated access to capital and material security influences one's capacity to avoid devalued spaces. According to both findings and available literature, the more contact with spatial disturbances one has, the more likely it will predispose one to experience a resulting detriment to mental and physical well-being.

Health in the 'food swamp'

Health professionals advised how the challenging life circumstances of many residents in Skelsend made lifestyle changes advantageous to health and well-being difficult. Social disadvantage, social stress and lack of material security can result in a fatalistic outlook regarding health, as previously discussed in relation to a pessimistic outlook regarding employment and overall prospects of well-being. These social characteristics, along with the poor food environment and low cultural capital, are apparent amongst some of the lifelong spatially immobile residents, and they combine to influence dietary habits that have adverse long-term implications for health and well-being. These residents tend to have poor access to economic capital; the combination of poor health, geographic isolation, and shortage of money results in spatial immobility. They are, therefore, more dependent and embedded within the physical space of Skelsend and its poor food environment.

Meanwhile, health professionals advised that these features ran alongside a particular fatalistic view about health prospects, an acceptance of accumulating health conditions in the context of their social, economic, and cultural heritage. Health fatalism is demonstrably associated with socioeconomic stress in several studies, such as Dumas and Stuart's (2013) study of men from socioeconomically disadvantaged backgrounds undergoing cardiac rehabilitation; or, for instance, Garthwaite and Bambra's (2018) ethnographic

study in Stockton, a town in the north east of England, which, at the time of the study, had the largest health inequalities in the country.

The food environment of Skelsend is a food desert; that is, there is insufficient reliable availability of affordable, healthy, fresh food, leaving people to resort to heavily processed food regardless of dispositional tastes (Consumer Research Centre, 2022). Meanwhile, the cafés in Skelsend reflect the wider food desert environment; food might be accessible and affordable, but unhealthy foods proliferate, and the outlets selling foods with low nutritional value were densely concentrated within a specific area. According to Dimbleby (2023), access to convenient, fast foods makes places like Skelsend not just food deserts but "food swamps", a typical feature of areas of high social deprivation (Dimbleby, 2023; van Tulleken, 2023). In Skelsend, healthy, affordable foods are proportionally marginalised and confined mainly to an Aldi, which, according to residents, does not always reliably stock fresh fruit and vegetables. In Skelsend, residents most likely to be harmed by the food swamp are those with the least money who are spatially bound. The propensity to be spatially bound is apparent when one considers that 40 % of the lowest-income households in the UK do not have access to a car (Dimbleby, 2023). However, throughout Skelsend, and despite its remoteness, the figure is 30 % including the more prosperous areas around the fringes of the town (Gov.UK, 2024).

According to Goudie (2023), healthy foods are more than twice as expensive per calorie as unhealthy food, the latter being foods many residents I met living with multiple health conditions had become reliant on due to a shortage of money and lack of spatial mobility. Indeed, the lack of capital and fixity within an obesogenic environment could be argued to nurture a dispositional dietary-related habitus. This is alluded to in Chapter 9*,* for instance the account of the social supermarket, the observations of health professionals and the community workers providing support in the town. People in Skelsend, including those with lower access to economic, social, and cultural capital, were more likely to depend on heavily processed foods. When monitoring tastes and what was popular, fibrous fresh food was often overlooked in favour of ultra-processed foods.

These dynamics influence food choices, and access to affordable, healthy food can be difficult. Arguably, residents' poor access to capital and poor supply of healthy food products temporally shapes a reflexive habitus (Elder-Vass, 2007), a disposition towards dietary taste, which develops by necessity and is imperative to satisfy immediate needs (Bourdieu, 1984). Dispositions of taste are integral to lifestyles, and, as Bourdieu (1984:164) writes in his influential work, *Distinction,* "Lifestyles are thus the systematic products of habitus". As with the fatalism described by health professionals, those who feel they have little future are more likely to seek food behaviours that provide immediate self-gratification. Furthermore, like the social connectivity found at the pub, solidarity and belonging can be derived from partaking in the satisfaction of immediate gratification in an activity such as drinking alcohol or group eating habits (Bourdieu, 1984). A later Nordic study by Øygard (2000) found that not only did economic capital help foster a habitus, but also that intergenerational cultural capital could have a decisive bearing on dietary disposition, leading to those with poorer capital levels. Low economic and cultural capital may predispose a preference for functional foods that satiate, rather than leaner and lighter foods (Bourdieu, 1990).

Corwin (2011) argues that it is not so much that people become addicted to sugary and fatty processed foods. Instead, the combination of the social context of material insecurity, an abundance of unhealthy foods, and physiology predisposes people towards immediate gratification through food choice. There was a tendency for residents with low economic and social capital to accord with Barta's (2017) and Wills et al.'s (2011) findings on the habitus of working-class families in eastern Scotland, whose tastes are influenced by the immediate need for gratification necessitated by their external disadvantaged social conditions. The need to address immediate needs, often without secure access to capital and combinations of circumstantial environmental stresses, can overwhelm regard for long-term healthy lifestyles, including food choices (Barta, 2017). Similarly, in Skelsend, for people spatially bound with low levels of capital, the combination of the intergenerational forgetting of cooking skills and the stressful lives of financial precarity nurture a compelling imperative of satisfying immediate needs.

The contribution of this study

This ethnography provides an original, novel study of how the specific intersecting characteristics of a remote seaside resort town that has experienced decades of economic decline impact the well-being of its working-age residents living with multiple health conditions. It uniquely frames how the well-being of residents with multiple conditions intersects with a specific place. The study sheds light on the contrasting needs of residents, particularly between residents who have relocated to Skelsend to find restitution and those sedentary residents who feel disadvantaged by the town they are spatially bound within.

The research further elaborates on how residents with divergent access to social and economic capital use and experience the social space of Skelsend very differently in the context of multiple health conditions. Because the ethnography focuses on working-age residents with multiple illnesses, the study considers the residents' relationship with the labour market and how this affects the relationship between themselves, place, and illness.

The study contributes a further understanding of how living with health conditions in a remote peripheral rural and coastal town can result in spatial immobility and foreclosed opportunity through an absence of secure access to social and economic capital. The absence of capital, combined with the limitations of fluctuating physical functioning caused by a life with long-term health conditions, can result in residents becoming reliant on the limited resources and amenities within the town. Moreover, this study also contributes to a body of research demonstrating the self-reported physical and mental health benefits of regular access to blue spaces in an area of social and spatial disadvantage within the context of chronic health conditions.

The study provides a unique insight into the difficulties of accessing health services from a remote location and how the rationalisation of services away from the periphery impacts residents with multiple health conditions. The study contributes further insight into how ideologically embedded assumptions transmitted through the DWP impact well-being, revealing how the practices of the DWP often undermine residents' attempts at secure well-being and can contradict health-related activity as promoted by health professionals. The

research contributes to existing qualitative literature describing hardships caused by the application of increasingly exclusive eligibility, inconsistent interpretation, and the intensification of conditionality and surveillance as felt by working-age residents of Skelsend living with multiple health conditions. Importantly, this study incorporates the lived experience of residents accessing support from the DWP and other services from a remote location, which cannot offer reliable opportunities to secure material security through employment.

Throughout this discussion, I draw attention to findings where the intersections between residents' well-being, social structures and place are not well established in the research literature, and where further investigation would contribute to a greater understanding of the barriers to well-being, working-age people with multiple health conditions, in remote seaside locations and more generally, and routinely confront within the day-to-day reality of the lives.

I have attempted,where appropriate, to construct a methodological synthesis between critical realism and a revisionist Bourdieusian framework, to explore resident's connection with social structure. Although recent critical realist theorists have sought this accommodation, as discussed in this thesis, this methodological approach to analysis has not been attempted in the context of English seaside towns and people living with long-term health conditions. Incorporating Bourdieu's (1992, 2018) habitus, capital and field and later work on social space, has assisted a critical realist approach in identifying causative mechanisms and the development of key themes in this thesis. Although the synthesis remains theoretical, this thesis demonstrates how Bourdieu's work can potentially be employed and complement critical realism by identifying cognitive schemas that may contribute towards the emergence of social phenomena whilst not underestimating the impact of human agency on structure.

COVID-19

Continuing to develop this study through the COVID-19 pandemic was a challenge I had to surmount; it cast a long shadow over fieldwork. Although I was incrementally able to build a small network of people who worked in Skelsend remotely, access to the field in person was delayed for approximately six months. When access was gained, many local social groups and

organisations took time to recover their previous functioning, whilst many people living with health conditions continued to shield and did so throughout fieldwork. This was a critical difficulty for a study that relied on building rapport with gatekeepers and residents. Being present in person and becoming involved in the community was essential to the success of this study; this project could not have been undertaken remotely.

The COVID-19 pandemic necessitated my withdrawal from the field for nearly two months, from December 2021 to January 2022, due to a new wave of the virus and consequently falling ill. It also disrupted my ability to invest sufficient time to build relationships and, crucially, a rapport with residents who were reticent about contributing to the study.

Community workers did inform me that a significant number of residents were ‘harder to reach’, particularly on the main council estate, an observation I came to share. Understandably, I generally found that those low in confidence and often material and social resources were less inclined to participate. COVID-19, therefore, delayed identifying and locating people, perhaps those less confident in engagement, impacting my capacity to build necessary rapport. This difficulty was reflected in interview recruitment, with incomers being more readily available. Nonetheless, the broader ethnography went some way to compensate for this effect, allowing me to acquire understanding from unplanned and unrecorded conversations with people I became acquainted with.

Recommendations

Aside from the need for significant strategic investment in towns like Skelsend, including transportation improvements to ameliorate the town’s disconnection to its hinterland and nearest city, I make the following more achievable suggestions.

Further longitudinal research into the impacts of accessing primary care, outpatient appointments and minor injuries units from disadvantaged rural locations, including coastal ones, would be beneficial to identify intersectional difficulties preventing access to health consultation and the long-term effects upon people with long-term health conditions. The value of community health

services needs to be appreciated, and the consolidation of provision away from peripheral towns like Skelsend needs to be avoided, or at least the subsequent adverse impacts must be mitigated. A practical measure to improve connectivity to hospitals might be to ensure that eligibility criteria for patient transport should consider not just the individual's difficulty but also transport implications from where patients live.

The culinary micro-climate of Skelsend reflects the broader lack of amenities, including leisure opportunities, that can restrict social arenas hosting communal solidarity to the pubs, bars, and cafés, especially the pubs. These venues, whilst providing needed conviviality, also reinforce dietary and cultural habits that are injurious to long-term health, reinforcing a likelihood of further declining health and well-being. This is a cultural and spatial health paradox, which I suggest is reflected within many working-class communities such as Skelsend. A qualitative investigation into the social relationships between culture, neighbourhood and personal circumstances may identify a means of combining conviviality and solidarity with healthier, broadly accessible and communicable activity. On a more practicable level, it may identify an investment in resources to support more community services and groups to be available in the evenings, facilitating greater participation amongst the working-age population.

Chapter Eight of this thesis demonstrates a need for a fundamental review of the current social security system that is not based on the moral conservative presumption that shapes public discourse. The need for a system that considers the difficulties manifest in a locality and provides real security for people to achieve health aspirations is evident in this thesis. For many people with health conditions in Skelsend and elsewhere, continued poor health is often seen as the only means of attaining material security. However, this outlook is nurtured by a system that penalises attempts at activity and does not provide a responsive safety net for those seeking employment.

The government should consider investing in pilot schemes that organise flexible, supportive, part-time employment or voluntary activity conducive towards people living with health conditions. Such initiatives should not be coercive and should not jeopardise the financial support people receive. It should be based on the principle of security and self-determination, recognise

fluctuations in health and provide a genuine alternative to being trapped in activity. People should not be penalised, as they currently are, for taking on voluntary work or paid work when they feel able.

Conclusion

Overall, I contend that this study illustrates an intersectional layering of social structures that have prominence in the lives of working-age residents who live with multiple health conditions in an economically and geographically disadvantaged small seaside town. I have discovered tensions and paradoxes within the locally operating structures throughout Skelsend that influence residents' experiences. The research demonstrates that specific structural features of a locality's social and physical space and residents' social and economic position greatly influence the lives of people with multiple health conditions. The reproduction of social positioning within the social space of Skelsend results from combinations of structuring structures, which can transform personal circumstances and, over time, the local context. This results in the emergence of the structural impediments and enablers to well-being discussed in this thesis. Although the natural environment and spatial calm of Skelsend provide restitution for many, the town's depressed economy and geographical isolation pose a fundamental barrier to the well-being of people living within health conditions.

The study highlights differences in what people need from the physical and social space of the town to prosper based on their relationship with their illnesses, employment, and security of access to capital. Their relationship with capital and employment is critical to whether living in a seaside town like Skelsend results in successful restitution or further disadvantage to health and well-being. Fundamentally, I have found that residents with secure access to capital and who are spatially mobile, both in a physical and social sense, are better positioned to enjoy the restorative benefits Skelsend can provide. This is especially true for residents who do not need to work but are materially secure. However, those less well-resourced residents needing to extract economic capital and opportunity from within the physical space of Skelsend may struggle with the town's spatial redundancy, especially given the limitations caused by the health conditions they live with.

For many relocated residents, spatial inequality across England has enabled personal projects of counter-urbanisation, which, for many, liberates access to their economic capital. This liberation of personal capital facilitates lifestyles that are more conducive to managing health conditions and nurturing well-being. This sets up a tension of need, between those who are comfortably resourced and who desire the maintenance of spatial calm, and those, who are materially insecure and spatially bound due to a combination of illness, lack of money, and often, personal mental health struggles. The materially insecure and spatially bound are more likely to need to extract capital from the physical space of a poorly resourced town to maintain both themselves and their illnesses. Amplifying feelings of spatial redundancy and anxiety, is the tendency of those with insecure access to capital to live in close proximity to pockets of spatial disturbance. This can further impact on their well-being and ability to manage health conditions.

A further conclusion drawn from this thesis is that residents with unseen health conditions tend to be disproportionately disadvantaged by the current practices of the DWP, often amplifying mental distress. More generally, residents requiring recourse to the DWP due to living with multiple health conditions are often subject to stigma and trapped in pernicious relations of insecurity, but this is especially more likely for those with mental health conditions. These experiences result from the intensification of the application of moral economy to the welfare state.

Meanwhile, the social relations that operate through the DWP can harm residents' well-being, resulting in health impacts arising from financial distress and being disempowered from attempts to build a more active lifestyle. The lack of appreciation by the DWP of fluctuating symptoms caused by the complexity of multiple conditions, combined with a lack of support for attempts at increased physical activity, tends to ensnare people into a trap of inactivity and passivity. The omnipotent threat of severe financial penalty, limits residents in their aspiration towards improving their health. Improving one's health may have implications for the access of material security and thereby causes further stress and anxiety. The resulting passivity and enforced inactivity to maintain continued financial support serves to undermine any 'responsibilisation' informed policy that is founded on lifestyle explanations for health inequality.

This brings into question the effectiveness of health policy informed by surface level appearances of social life, rather than searching for underlying deeper structural causes of health inequality.

An additional key finding is the role of local social capital within the town and how people engage and access social resources. Access to social capital, often through family and other supportive networks, is particularly crucial in the absence of material security no longer guaranteed by the state. Additionally, many people moving into the town, initially lacking the necessary social capital to thrive, must invest personal resources, time, and emotional energy to foster social capital. This capital can then be utilised to overcome barriers caused by spatial amputation and the paucity of public service provision. This was evident in the community groups across Skelsend. However, people experiencing mental distress need the initial prompt support from services to enable them to build sufficient resilience and confidence to make contact and engage with the town's community groups.

Meanwhile, all residents' ability to benefit from the town's environment is negated by the withdrawal of local services. This is particularly the case with the consolidation of health services away from rural communities to larger urban areas, which amplifies a sense of spatial amputation from the town's hinterland. In some cases, difficulty in physically accessing sites where appointments and treatments are held can result in disengagement from services despite the prospect of deteriorating health and well-being. Moreover, in the case of Skelsend, the withdrawal or reduction in locally based service provision and the consolidation of services towards wealthier parts of the county's hinterland exemplifies the inverse care law. In Skelsend, those lacking in economic and social capital, and those with severe mental health struggles, become further disadvantaged and, in some circumstances, this can contribute towards a sense of feeling bereft and forgotten.

These restraints on well-being are underpinned by causative mechanisms within social relations, such as the transition towards the flexible accumulation of capital, which contribute towards spatial redundancy and the mutually reinforcing ideologies of moral economy and neo-liberalism as applied to the state provision of welfare. Long-term exposure to these structures predisposes

some residents with insecure access to capital to develop a pervasive sense of despondency, which can generate a reflexive habitus injurious to health. Pessimistic cognitive schemas, including fatalism about health, may prevent the adoption of lifestyles conducive towards optimising one's capacity for well-being in the context of living with health conditions.

However, I do not wish to close this thesis on bleak terms. Before I began this fieldwork, I was mindful of the pessimistic research literature and reports regarding declining seaside towns. I had been exposed to the regional and local negative aspersions cast upon the town of Skelsend and the local tropes that evoke territorial stigma. However, what I found in the rich nuance of Skelsend, compounds the misconceptions and ignorance with which external opinions frame the town and its residents. Indeed, I discovered positive networks of communities and hope amongst disconnection, neglect, and disadvantage. I was struck by how working-age people living with health conditions and other residents not only overcame the inherent and embedded structural barriers but were able to use the town's fundamental strengths, its proximity to nature and seascape, its gentle pace, and mostly friendly atmosphere, to find a restorative restitution. For many Skelsend was a place of sanctuary, greatly enhancing their ability to cope with the difficulties of life with multiple health conditions. Indeed, I reflected on the restorative benefits of the calm and seascape compared to my urban life, a journey experienced by many residents relocating to Skelsend.

However, one must acknowledge that the spatial disconnection and paucity of economic opportunities mitigate against the life chances of many residents, especially younger people, and those, who, through a combination of low economic capital and illness, become spatially bound within the town. The conundrum of satisfying the needs of different people in Skelsend, including those living a life with multiple health conditions and their different strategies of achieving well-being, that is, those who need to transcend spatial redundancy and those who need to maintain spatial calm, perhaps should not be viewed as a binary incompatibility. Instead, strategies of promoting spatial calm and restorative retreats, in concert with the town's idiosyncratic, unique spaces, influenced by decades of disconnection and marginalisation, need to find ways of improving spatial connection and opportunity.

However, the decades-long laissez-faire approaches of governments, combined with the constrained absence in the capacity within local and regional governance, have, thus far, been unable to address this conundrum of need within the town. The macro structures of support underpinned by national polity and political economy, as evidenced in this thesis concerning social security and access to local healthcare services, currently appear to be exacerbating disadvantage. Experiences of disadvantage increases the inequality amongst Skelsend's residents' ability to cohere and maintain well-being, in the context of life with restrictive multiple health conditions.

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Appendix 1

INFORMATION SHEET FOR PARTICIPANTS

Resident's Interviews

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study

Feeling Kind of Blue: negotiating working-age multiple health conditions in a seaside community. A study of Skelsend in East Yorkshire.

We want to invite you to participate in a research project which forms part of a PhD research thesis. The research considers how living with multiple health conditions is affected by where people live. This research is focussing upon the experiences of working-age residents living in seaside communities. Therefore, we are asking residents of Skelsend who are of working age and live with two or more health conditions to share their experiences as a part of this research project.

Before you decide whether you want to participate, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me, the PhD researcher, if there is anything that is not clear or if you would like more information. My contact details are shown at the end of this information sheet.

The sponsor for this research is the University of Hull.

What is the purpose of the study?

People are living a greater proportion of their lives with health conditions. Living with more than one health condition is increasingly common. A significant proportion of working-age adults live with many long-term health conditions. Meanwhile, where we live and work can have an impact on our health.

Skelsend, like many smaller seaside towns, has poor transportation links, is affected by seasonality and has been subject to long term economic decline. This research seeks information from Skelsend's residents about their health in connection with their local environment. Similar studies have been conducted in larger urban communities, but smaller seaside towns such as Skelsend tend to be overlooked.

The focus is on working-age adults. The research rests upon people's stories, challenges, adversity, and triumphs. It is hoped that the results of

this research will be informative and help to improve services and understanding of health inequalities.

Why have I been invited to take part?

You are being invited to participate in this study because you are a working-age resident of Skelsend and live with more than one health condition.

What will happen if I take part?

If you take part, you will be invited to a one-to-one interview with the PhD researcher conducting the project. The interview will not be like a job interview, instead it will be an informal discussion with the researcher who will provide some structure. There will be no right or wrong answers. The interviews will discuss how your health conditions affect your life, and what, if any, role doesSkelsend play in your wellbeing. Participants should only talk about what they are comfortable in sharing with the researcher. There will be no pressure to disclose any information.

You can choose where the interview takes place, as long as it is within the Government Covid 19 guidelines. Interviews can be held online, by telephone, in a local office or in your home. The scheduling of the interviews is flexible and will be at your convenience, including evenings and weekends. It is anticipated that these discussions will last between 30 to 75 minutes, but they can be as long or as short as you wish. You can withdraw from the interview at any time or request a break. The interviews are recorded with your consent and transcribed. They are strictly confidential; all data is securely stored and your identity will be protected.

The researcher may ask you if you would like to take part in a further interview which involves a walk around Skelsend. The researcher will explain this further if you are interested, however, it is entirely optional.

All participants taking part in the interviews will have the opportunity to learn about the project's key findings at an event organised by the researcher when the project comes to an end. When interviews are conducted, the researcher will ask whether you would like to attend this event or receive some individual feedback on the project's conclusion.

Consent

If you choose to take part, we will ask you to sign a consent form before commencing the interview, and you will be given a copy of this consent form to keep. If the interviews are not conducted in person, recorded consent can be arranged through email or other means. You will be able to ask any questions you wish before signing.

Do I have to take part?

Participation is entirely voluntary. You should only take part if you want to, and choosing not to take part will not disadvantage you in any way.

What are the possible risks of taking part?

Discussing challenges posed by illness can provoke unpleasant sad emotions. However, it is important to note that you should only share information you are comfortable with. You should be aware that although information given by you to the researcher is confidential, should there be any disclosures involving the abuse or neglect of children or vulnerable adults, the researcher will be required to contact the relevant agencies.

What are the possible benefits of taking part?

There are no direct benefits to participating in the study. Still, this project is an opportunity to share your experiences, thoughts, and aspirations, which may in the future influence service and policy development.

How will we use information about you?

We will need to use information from you for this research project. This information will include your name and contact details. We will keep all information about you safe and secure. Only the PhD researcher and two research supervisors will see your data.

The PhD researcher will record and transcribe the interview. The researcher will be using an encrypted audio recording device. The researcher will securely save the transcription initially on this device and then electronically. Audio recordings of interviews will be transcribed and deleted from the recording device within six weeks following the interview.

Hard copies of consent forms will be scanned, securely kept on an electronic encrypted file. Hard copies will be kept in a lockable filing cabinet at the researcher's home. Consent forms, electronic and hard copies will be securely stored for a year after the research before they are safely destroyed.

Your data will be processed following the UK-GDPR and the Data Protection Act 2018. All identifying information collected during interviews and surveys will be pseudonymised on transcription and confidential. Pseudonyms will be used to ensure that people participating in this study cannot be identified. This means that I will give you an entirely different name and any place or organisational names mentioned, apart from the town itself, will be changed. The researcher will be using an encrypted recording device that is password protected. No one else will have access to this device.

Only the researcher and his two supervisors will have access to any of these documents. You will be allocated a unique id number so that the PhD researcher can cross reference with your pseudonym. The pseudonymised research data, in which no-one can be identified will be securely stored for ten years following the completion of this project.

When you sign the consent form, there will be a question asking for your consent to be directly quoted in the thesis or a subsequent publication. Any quotation will be under an entirely different name from yours. The pseudonym allocated to you will be used. If you don't consent to this request, the researcher will not directly quote you.

What are your choices about how your information is used?

You are free withdraw at any point of the study, without having to give a reason but we will keep information about you that we already have.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

Where can you find out more about how your information is used?

Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx. You can learn more by asking the PhD researcher whose contact details are at the end of this participant information sheet.

Any questions, comments and requests about your personal data can also be sent to the University of Hull Data Protection Officer (dataprotection@hull.ac.uk). Further information can also be obtained by calling 01482 466594 or by writing to the Data Protection Officer at the University of Hull, Cottingham Road, Hull, HU6 7RX.

If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

Data Protection Statement

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights, including rights of correction, erasure, objection, and data portability. The data controller for this project will be the University of Hull. The University will process your personal data for the research outlined above. The legal basis for processing your data for research

purposes under GDPR is a 'task in the public interest'.

The data controller for this project will be the University of Hull. The University will process your data for the research outlined above. The legal basis for processing your data for research purposes under GDPR is a 'task in the public interest.'

Suppose you are not happy with the sponsor's response or believe the sponsor is processing your data in a way that is not right or lawful. In that case, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 0303 123 1113).

How is the project being funded?

This study is being funded by the University of Hull.

What will happen to the results of the study?

The results will be included as part of the PhD researcher's thesis. However, results may also contribute to journal publication and distributed to the research and public health community.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given a favourable opinion by Faculty of Health Sciences Ethics Committee, University of Hull. It has also been reviewed by a research ethics committee of the NHS Health Research Authority.

Who should I contact for further information?

If you would like to participate or require more information about this study, please contact me using the following contact details:

Edward Hart, Faculty of Health Sciences, University of Hull,HU6 7RX.

Email: E.A.Hart-2019@hull.ac.uk

Telephone: (number of a bespoke mobile for fieldwork)

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the details below for further advice and information:

Thank you for reading this information sheet and for considering taking part in this research.

Appendix 2

Interview Guide - 1

Residents semi-structured interviews

- How are things at the moment regarding health and wellbeing?

How long have you lived in the town?

- What are the positive aspects of living in Skelsend – sea, exercise, community??
- What do they like/dislike about living in Skelsend – anything that causes them to feel sad/happy/frustrated/ calm? – does this impact their health well-being.
- Is locality and connectivity a factor? – commutability.
- How well do local services, health or otherwise, support management of their health conditions?
- Are there any issues about the accessibility of support services that impact their well-being?
- Are there any aspects of ‘getting by’ that cause stress and discomfort affecting health conditions (work/benefits) (what work done) (managing illness
- Does the seasonality aspect of living in a small resort town affect emotional well-being?
- Are there any local factors that have magnified or mitigated vulnerabilities to Covid 19?
- Perceptions and stereotyping in the town and outside the town – unfairly/fairly described – does this have an effect on people? Share own exp**.**
- Is there anything that has helped them manage illness in their lives both at home and in the community?
- Is there anything that promotes activity and anything preventing

activity?

- Is there anything in their environment, including work, which may have contributed towards becoming ill? What aspects of life was stressful and may have fostered routines that might not be healthy?
- If you did have a bad habit or routine for health, is there something that compels you to repeat? (smoking, sugar, caffeine) – **my problem** is sugar and caffeine.
- What might be the underlying drivers behind habits and routines that may not be conducive to good health maintenance? For example, are there any coping behaviours regarding long-term management of health conditions, i.e., smoking/drinking to relieve stress, diet.
- Are there aspects of home life and accompanying responsibilities that impact their health and management of health conditions? Positive or negative.
  Does this connect with the local neighbourhood in any way?
- What would they like to see change in their town or neighbourhood?

Appendix 3

Health Practitioners

INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study

Feeling Kind of Blue: negotiating working-age multiple health conditions in a seaside community. A study of Skelsend.

We want to invite you to participate in a research project which forms part of a PhD research thesis. The research considers how living with multiple health conditions is affected by where people live. This research is focussing upon the experiences of working-age residents living in Skelsend. Alongside asking residents who live with multiple health conditions about their experiences, we are also asking health practitioners who currently work in Skelsend about their experiences working in the town and how social and environmental factors may impact on their patients.

Before you decide whether you want to participate, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me, the PhD researcher, if there is anything that is not clear or if you would like more information. My contact details are shown at the end of this information sheet. The sponsor for this research is the University of Hull.

For the purposes of this study, we are defining working age as between 18 and 67. Alongside asking health practitioners and other community workers to share their experiences, we will be asking residents living with two or more long term health conditions about their experiences living in the town.

What is the purpose of the study?

People are living a greater proportion of their lives with health conditions. Living with more than one health condition is increasingly common. A significant proportion of working-age adults live with many long-term health conditions. Meanwhile, where we live and work can have an impact on our health. This research seeks information from Skelsend's residents about their health in connection with their local environment. Similar studies have been conducted in larger urban communities, but smaller seaside towns such as Skelsend tend to be overlooked. The demographic focus of this study is on working-age adults and how social, environmental and locally felt economic factors may affect them.

The research rests upon people's stories, challenges, adversity, and triumphs. It is hoped that the results of this research will be informative and help to improve an understanding of local difficulties as experienced by residents. It is further hoped that the research will also identify positive environmental aspects which may benefit wellbeing. Alongside collecting information from residents in the town, the insights of health practitioners working in the town will be invaluable.

Why have I been invited to take part?

You have been invited to take part in this research because you are a health practitioner practising in Skelsend and have experience of working with residents of working age living with more than one long term health condition.

What will happen if I take part?

If you take part, you will be invited to a one-to-one interview with the PhD researcher conducting the project. The interview will not be like a job interview, instead it will be an informal discussion with the researcher who will provide some structure. The interviews will discuss your experiences of working in Skelsend and how social and environmental factors may affect the wellbeing of the people you work with who live with multiple health conditions. Participants

should only talk about what they are comfortable in sharing with the researcher. There will be no pressure to disclose any information.

You can choose where the interview takes place, as long as it is within the Government Covid 19 guidelines. Interviews can be held online, by telephone, in a local office or in your home. The scheduling of the interviews is flexible and will be at your convenience, including evenings and weekends. It is anticipated that these discussions will last between 30 to 60 minutes, but they can be as long or as short as you wish. You can withdraw from the interview at any time or request a break. The interviews are recorded with your consent and transcribed. They are strictly confidential; all data is securely stored and your identity will be protected. When the researcher transcribes the interview, you will be allocated a pseudonym as will the location of your work base. To further protect your identity, your role or job title will not be mentioned and will instead be referred to generically as health practitioner.

All participants taking part in the interviews will have the opportunity to learn about the project's key findings at an event organised by the researcher when the project comes to an end. There will be separate events health practitioners and residents. When interviews are conducted, the researcher will ask whether you would like to attend this event or, alternatively, receive some individual feedback on the project's conclusion.

Consent

If you choose to take part, we will ask you to sign a consent form before commencing the interview, and you will be given a copy of this consent form to keep. If the interviews are not conducted in person, recorded consent can be arranged through email or other means.

Do I have to take part?

Participation is entirely voluntary. You should only take part if you want to, and choosing not to take part will not disadvantage you in any way.

What are the possible risks of taking part?

Reflecting upon challenging aspects of work can be emotionally tiring. However, it is important to note that you should only share information you are comfortable with. You will be able to ask any questions you wish before signing. You should be aware that although information given by you to the researcher is confidential, should there be any disclosures involving the abuse or neglect of vulnerable adults, the researcher will be required to contact the relevant agencies.

What are the possible benefits of taking part?

There are no direct benefits to participating in the study. Still, this project is an opportunity to share your experiences, thoughts, and aspirations, which may in the future influence service and policy development.

How will we use information about you?

We will need to use information from you for this research project. This information will include your name and contact details. We will keep all information about you safe and secure. Only the PhD researcher and two research supervisors will see your data. The PhD researcher will record and transcribe the interview. The researcher will be using an encrypted audio recording device that only he will have access to. The researcher will securely save the transcription. Audio recordings of interviews will be transcribed and deleted within six weeks following the interview. Hard copies of consent forms will be scanned, securely kept on an electronic encrypted file. Hard copies will be kept in a lockable filing cabinet at the researcher's home. Consent forms, electronic or hard copy, are securely stored for a year after the research before they are safely destroyed.

Your data will be processed following the UK-GDPR and the Data Protection Act 2018. All identifying information collected during interviews and surveys will be pseudonymised on transcription and will be confidential. Pseudonyms will be used to ensure that people participating in this study cannot be identified. This

means that I will give you an entirely different name and any place or organisational names mentioned, apart from the town itself, will be changed. The researcher will be using an encrypted recording device that is password protected. No one else will have access to this device. Only the researcher and his two supervisors will have access to any of these documents. You will be allocated a unique id number so that the PhD researcher can cross reference with your pseudonym. The pseudonymised research data will be securely stored for ten years following the completion of this project.

When you sign the consent form, there will be a question asking for your consent to be directly quoted in the thesis or a subsequent publication. Any quotation will be under an entirely different name from yours. The pseudonym allocated to you will be used. If you don't consent to this request, the researcher will not directly quote you and this will not disadvantage you in anyway or preclude you from taking part in this study.

What are your choices about how your information is used?

You are free to withdraw at any point of the study, without having to give a reason but we will keep information in specific ways in order for the research to be reliable and accurate. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

Where can you find out more about how your information is used?

Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx. You can learn more by asking the PhD researcher whose contact details are at the end of this participant information sheet.

Any questions, comments and requests about your personal data can also be sent to the

University of Hull Data Protection Officer (dataprotection@hull.ac.uk). Further information can also be obtained by calling 01482 466594 or by writing to the Data Protection Officer at the University of Hull, Cottingham Road, Hull, HU6 7RX. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

Data Protection Statement

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights, including rights of correction, erasure, objection, and data portability. The data controller for this project will be the University of Hull. The University will process your personal data for the research outlined above. The legal basis for processing your data for research purposes under GDPR is a 'task in the public interest'.

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Suppose you are not happy with the sponsor's response or believe the sponsor is processing your

data in a way that is not right or lawful. In that case, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 0303 123 1113).

How is the project being funded?

This study is being funded by the University of Hull.

What will happen to the results of the study?

The results will be included as part of the PhD researcher's thesis. However, results may also contribute to journal publication and distributed to the research and public health community.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given a favourable opinion by Faculty of Health Sciences Ethics Committee, University of Hull. It has also been reviewed by a research ethics committee of the NHS Health Research Authority.

Who should I contact for further information?

If you would like to participate or require more information about this study, please contact me using the following contact details:

Edward Hart, Faculty of Health Sciences, University of Hull, HU6 7RX

Email: E.A.Hart-2019@hull.ac.uk Telephone: (number of a bespoke mobile for fieldwork).

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the details below for further advice and information:

Thank you for reading this information sheet and for considering taking part in this research.

Appendix 4

UNIVERSITY OF HULL

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w: www.hull.ac.uk

PRIVATE AND CONFIDENTIAL
Edward Hart
Faculty of Health Sciences
University of Hull
Via email

9th November 2021

Dear Edward
REF FHS362 - Feeling Kind of Blue: negotiating working-age multiple health conditions in a seaside community: The case of XXXX in XXXXX
Thank you for your responses to the points raised by the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

Should an Adverse Event need to be reported, please complete the Adverse Event Form and send it to the Research Ethics Committee FHS-ethicssubmissions@hull.ac.uk within 15 days of the Chief Investigator becoming aware of the event.

I wish you every success with your study.

Yours sincerely

Professor Matthew Hardman
Acting Deputy Chair, FHS Research Ethics Committee

UNIVERSITY OF HULL

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