20-minute neighbourhoods

1. **Climate and Environmental Concerns**.

RCGP Scotland welcomes the opportunity to respond to this consultation. As the membership body for general practitioners in Scotland, we exist to promote and maintain the highest standards of patient care.

Walkable, community centric neighbourhoods can help support better health outcomes among the population. Through encouraging individuals and communities to travel more actively, as well as by reducing the need for short car-based trips through enhanced urban design, the carbon footprint of these communities can be significantly reduced. By encouraging more active lifestyles, walkable neighbourhoods also increase everyday physical activity levels,[1] and as physical activity including walking and cycling is known to reduce the risk of premature all-cause mortality by around 30%[2], this is a welcome benefit of active-centric urban design

Transport itself is now considered a determinant of health, and the mode of transport chosen can have a profound impact upon health on both an individual and society wide basis. Transport based travel is a leading contributor to the UK's greenhouse gas emissions, comprising approximately 21% of total annual CO_2 emissions. Reducing overall levels of car-based travel could have a pronounced lowering effect on the incidence of road traffic accidents, which currently account for almost 26,000 serious injuries p.a. in the UK. Air pollution is also thought to contribute to 28-36,000 deaths p.a., which might be lowered via a reduction of travel-based emissions.

2. **Health inequalities.**

Current community and urban planning reflects and contributes to health inequalities: poorer neighbourhoods often have fewer public facilities and amenities, and they are often bereft of adequate public and active transport options. We know that the poor are more likely to die of road traffic accidents (despite lower car ownership) and tend to have poorer access to green and blue spaces too.[3] They also are subject to more air pollution[4] and the argument is now being made that we need to actively consider "environmental inequality".[5] Implementing a 20-minute neighbourhood policy without accompanying improvements in public transport infrastructure, access to bikes and off-road paths, and better local infrastructure can perpetuate inequalities, including of health. The Scottish Government's policy of free bus travel for those under the age of 22 is very welcome in light of this, and consideration of the possible expansion of this policy may be warranted. Urban and rural planning needs to account for this, as health-based outcomes could be improved by facilitating more active lifestyles.

Lack of digital access can also limit opportunities to work at home, opportunities which may be afforded to others with better IT infrastructure. Many in poorer neighbourhoods, including those who work multiple jobs, are employed in positions which are in-person, and for which they face a significant commute. This was demonstrated by some of the work done investigating the varying

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[1] Editorials: Low traffic neighbourhoods and population health.
BMJ 2021; 372 doi: https://doi.org/10.1136/bmj.n443 (Published 22 February 2021)
[2] Transport and health on the path to a net zero carbon world. *BMJ* 2022; 379 doi: https://doi.org/10.1136/bmj-2021-069688 (Published 12 October 2022). Cite this as: *BMJ* 2022;379:e069688
[3] https://www.scotpho.org.uk/wider-determinants/physical-environment/data/green-and-blue-space/
[4] https://uk-air.defra.gov.uk/assets/documents/reports/cat09/0701110944_AQinequalitiesFNL_AEAT_0506.pdf
[5] https://www.gov.uk/government/news/environmental-inequality-must-not-be-ignored

impact of Covid on the basis of health inequality.[6]. To ensure individuals and communities from deprived areas are not disadvantaged by 20-minute neighbourhood polices, proper recognition of the barriers they face and greater access to digital and other infrastructure is needed.

The Deep End has looked at climate change and health inequalities and outlined some of the structural changes we need to address both.[7] One of their evidence-based recommendations was to *"Support engagement with local councils and community groups to advocate for equitable access to active travel opportunities, green space and non-pharmacological options to improve health and wellbeing"*. The Deep End group also recognised the potential for improving health at a neighbourhood level, given additional Cluster resource: *"GP clusters and Primary care networks can build on the potential of community-oriented primary care teams to engage with schools, families and communities to improve public health on both wider and local levels"*.

3. <u>Access to Primary Care.</u>

The core tenant of the 20-minute neighbourhood concept is that individuals have access to key amenities and services close to them, to underpin a healthier lifestyle and more active communities. General practice is the central pillar of healthcare provision in Scotland, and in order to fulfil the promise of the '20 minute' concept, access to local GPs is essential. The 4Cs of primary care as outlined by Barbara Starfield - comprehensiveness, first contact access, coordination and continuity - require general practice to be accessible, and for many that means local.

The need for ease of accessibility to GPs is especially profound for certain groups, including those with low car ownership, the elderly reliant on carers and parents or carers of young children. Local general practice must be seen as a powerful factor in reducing health inequalities, particularly when we know that patients in deprived settings are more likely to miss hospital or specialist appointments. Deep End GPs outline that many vulnerable patients find it difficult to access services outwith the practice itself and so local access is critical.

Local primary care provision should be seen as underlying both the effectiveness and cost-effectiveness of the NHS. However, we are at risk of losing this: 10% of Scotland's practices now have closed lists, and overall practice numbers are down, despite an increase in the overall population.[8] There are some rapidly expanding populations in Scotland, also outlined in the BMA's analysis, and often those are often not complemented by new GP practices, meaning that existing practices are pushed even further, and the scope for primary care provision narrowed more. All this means that patients may struggle to register with a GP at all, or may have to register with a practice further away. This is difficult enough in urban areas but must be even more so in rural ones.

There are also knock-on adverse effects for the practice team of having unnecessarily large practice areas, or worse - large numbers of patients outwith their boundaries, many of whom remain on lists for historical reasons, and which the practice is unable to remove. GPs report that this is often an ageing cohort, and there is evidence from some that they are more likely to request house calls, which additionally burdens the GP with a longer journey.

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[6] Risky business. Economic impacts of the coronavirus crisis on different groups of workers. Resolution Foundation. April 2020.

[7] https://www.gla.ac.uk/media/Media_819283_smxx.pdf

[8] The sustainability crisis in GP practice in Scotland (bma.org.uk)

More dispersed practice populations can also impose upon GPs and their practice staff the need to liaise with community nursing teams who aren't familiar to them. GPs increasingly rely on a broad range of professionals and other healthcare providers, including link workers, local third sector organisations, and also Hospital @ Home or mental health teams. When operating in this manner, long-term relationships and established channels of communication make a profound difference to teams as well as to patient outcomes. Familiarity between these individuals and groups can also save time by enhanced efficiency through established relationships, freeing up GPs and enhancing their capacity to treat patients. The closure of GP practices or lists is disrupting the network of connections on which efficient and safe care relies. A 20-minute model would help re-focus on what brings the most benefit for local working.