Royal College of Physicians

RCP view on neighbourhood health: planned specialist care

April 2026

Contents

Introduction 3

Recommendations 5

Integrating planned specialist care into neighbourhood health 7

What is neighbourhood health? 7

The case for integrating planned specialist care 8

The role of physicians in neighbourhood planned care 10

Embedding physician expertise in practice 11

Enablers for embedding medical specialist input 13

Integration between professionals 13

Improving digital systems and access to shared records 14

Clarifying roles and responsibilities in pathway redesign 15

Flexible job planning 15

Education and training for neighbourhood working 16

Workforce capacity 17

Strategic commissioning to allocate resources effectively 17

Preparing estates for neighbourhood planned care 18

Summary 19

© Royal College of Physicians 2026

Introduction

The Royal College of Physicians (RCP) has long supported the principle of care closer to home with integrated working between different healthcare professionals across traditional boundaries. In 2025, the RCP and the Patients Association published *Prescription for outpatients: reimagining planned specialist care*, highlighting how physicians frequently care for patients with multiple health conditions or complex needs who are left confused and frustrated by navigating fragmented services, as well as those whose health deteriorates while waiting too long for care. The report called for a fundamental reform of NHS outpatient services – an ambition that was committed to in the UK government's 10 Year Health Plan for England.

As part of this transformation, the UK government committed to shifting most outpatient services outside of hospitals by 2035 – enabled by an expansion of the NHS App – and introducing 'neighbourhood health' as a new model for delivering more integrated, community-based care. A neighbourhood health centre (NHC) will be introduced into every community across England, acting as a 'one-stop shop' with some traditionally hospital-based services – such as diagnostics – alongside prevention and lifestyle support, including housing services, weight management support and tobacco dependence treatment. Funded by a reduction in hospitals' share of total NHS expenditure and public–private partnerships, this model is already being piloted in 43 sites across England with 250 NHCs to be delivered by 2035 – including 120 by 2030.

The Department of Health and Social Care (DHSC) Neighbourhood health framework, published in March 2026, sets out the aims of the neighbourhood model, metrics for success and the priorities for the next 3 years. The RCP supports the framework's overall direction, particularly its focus on improving outcomes for key population groups – such as people approaching the end of life – and delivering more proactive care, **but there are still significant gaps in implementation**. The framework does not offer clarity on how neighbourhood models will improve outcomes and experiences for people living with multiple long-term conditions, particularly those living in areas of higher deprivation who are often least well served by the current system. It signals that integrated care boards (ICBs) will need to enable closer collaboration between GPs and specialists in a new model of planned care, but it does not define the role of medical specialists within this.

Neighbourhood health should build not only on the foundations of NHS primary and community services, but also on existing examples of specialist care being delivered outside hospital settings. This reflects the reality that patients' needs regularly span primary, community and specialist services and cannot often be safely or effectively met by a single provider.

Approaching neighbourhood working as an evolution of established specialist pathways and relationships will enable local systems to embed medical specialist input more consistently and at scale. The RCP is clear that the role of medical specialists must be defined within new neighbourhood models, and especially in planned specialist care, to ensure that patients get timely support from the doctors best equipped to manage their care.

There is notable uncertainty among medical specialists as to what the concept of neighbourhood health entails. In a 2026 RCP snapshot survey, **48% of 414 physicians in England were not very clear, or not clear at all, about how their specialist role would fit within a neighbourhood health team.**

This report sets out the RCP's view on how planned specialist care should be embedded in neighbourhood health and what will be needed to make it successful. It builds on more than a decade of RCP work championing care closer to home, such as *Teams without walls* and the Future Hospital Commission, both of which highlighted the need for more integrated, collaborative models of care. Neighbourhood working offers significant potential to deliver the approach to planned care that the RCP has long advocated for – but only if it brings together the range of services that patients need, including primary, community and medical specialist care.

© Royal College of Physicians 2026

This report defines how physicians' skillsets should be embedded in neighbourhood planned care and the specific conditions required for this to work effectively.

It does not seek to resolve the broader system challenges that continue to shape clinical practice – from acute pressures and rising demand driven by demographic and epidemiological change, to the need to balance generalist and specialist expertise – but these realities form the backdrop against which a new model for planned care will be developed. Instead, our aim is to set out the practical considerations that must be addressed if this model is genuinely going to enable patients to access specialist expertise closer to home. In doing so, we hope to support policymakers and system leaders build a model that brings medical specialist care into neighbourhood teams in a way that is both clinically feasible and sustainable for the long term.

What success looks like

Turning this ambition into reality will depend on how neighbourhood working reshapes the way medical specialists operate across the system. While there are strong examples of planned specialist care being delivered in community settings, the physician workforce remains predominantly hospital based, and integrated neighbourhood teams (INTs) will need reliable access to specialist care, advice, supervision and system leadership. This requires deliberate changes to workforce planning, training, and the infrastructure that enables physicians to work across traditional organisational boundaries.

In practice, success means:

- improving clinical outcomes for patients, particularly those who have complex needs and are living with multiple long-term conditions
- enabling earlier and more consistent access to medical specialist expertise for patients with complex or unstable conditions
- streamlining care pathways with clear clinical responsibilities so that patients no longer experience fragmented health and care services
- equipping the physician workforce with the training needed to manage planned care activity outside hospital settings, with physicians supported to work effectively with multidisciplinary teams (MDTs), provide remote clinical advice and manage risk with less immediate access to hospital-based investigations
- implementing digital systems that enable joined-up care, with interoperable tools supporting communication and shared decision making across traditionally siloed teams.

© Royal College of Physicians 2026

Recommendations

1 NHS England should ensure that its new model for planned care reflects the essential contribution of medical specialists in delivering neighbourhood services.

This means embedding opportunities for physicians to provide advisory support, direct clinical care, system leadership and the upskilling of neighbourhood teams. The model should build on long-standing examples where physicians have delivered care beyond hospital settings, strengthening the quality and consistency of planned care closer to home.

2 ICBs should explicitly define the role of physicians when developing their neighbourhood approach to planned care.

This should incorporate the key requirements outlined in the RCP's report, including flexible job planning, effective digital systems with interoperable shared records, appropriate clinical and estate infrastructure and clear clinical accountability across pathways. ICBs should develop this approach in partnership with relevant professional bodies to ensure that the model is clinically robust, aligned with workforce needs and improves patient care.

3 The National Neighbourhood Health Implementation Programme should publish insights from the 43 pilot neighbourhoods, with learning from their evaluations informing the design and delivery of future roll-out.

Sharing these learnings publicly will help ensure that emerging best practice is accessible across the country. This will enable local systems to apply successful approaches faster and allocate resources where they are likely to have the greatest impact.

4 The DHSC's forthcoming 10 Year Workforce Plan should explicitly reflect the role of physicians within INTs – including direct clinical care, advisory, upskilling and system leadership – in its assumptions and modelling of the workforce needed to deliver the hospital to community shift.

Physicians bring a depth and breadth of medical training that is essential for safely managing increasingly complex patient needs outside of hospital settings, providing sound clinical judgement in situations of uncertainty and non-linear care needs. The plan should therefore model how sufficient physician capacity will be embedded within INTs to support multidisciplinary decision making.

5 The DHSC, NHS England and local systems should ensure that the workforce is equipped for a new approach to planned care by expanding opportunities for consultants, SAS doctors and resident doctors to gain practical experience of the skills needed for neighbourhood working.

The forthcoming postgraduate curriculum refresh must embed the meaningful competencies and structured training opportunities for successful neighbourhood working – from making clinical decisions outside hospital to working with broader MDTs. Local systems should develop integrated consultant posts that flexibly span acute and neighbourhood services, supported by job plans with dedicated time for community clinics, MDT working and advice and guidance.

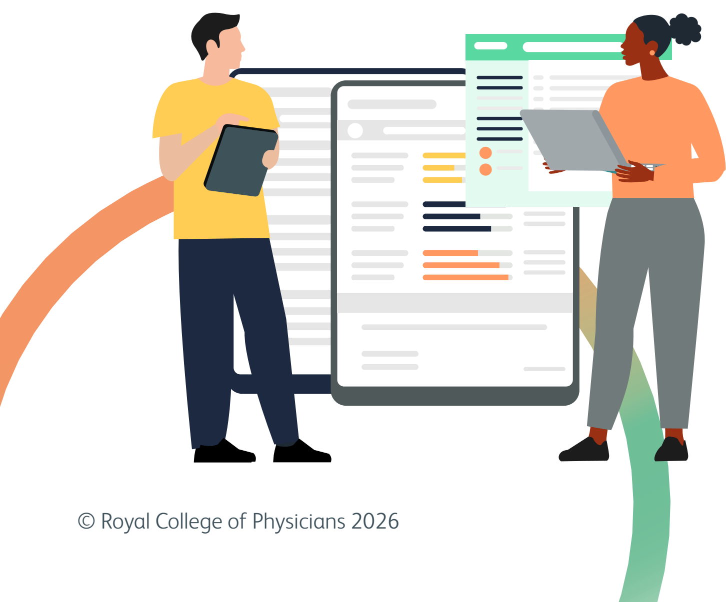
© Royal College of Physicians 2026

6 The DHSC and NHS England must ensure that trusts are supported to maintain safe acute services as both funding and staff shift towards delivering planned care outside of hospital settings.

Hospitals in the NHS rely on consultant medical specialists, resident and SAS doctors to staff and support acute services, making clinical decisions related to admission, treatment and discharge. As more consultants and resident doctors dedicate time to neighbourhood work, deliberate planning and transitional support is needed to avoid creating gaps in acute cover that risk ultimately slowing clinical decision making and increasing pressure on urgent and emergency pathways.

7 Local systems should define clear clinical responsibilities within integrated planned care pathways, including at which stage in a patient's journey direct specialist input is required.

To ensure that planned care pathways are clinically robust and workable in practice, any new models of care should be co-designed by physicians, GPs and wider MDTs, with explicit agreement on when medical specialist oversight is needed, who holds clinical risk at each stage and the triggers for escalation. This level of clarity is particularly important for patients with multiple health conditions, frailty or unstable conditions, who may move frequently between community and hospital-based care. It is also key for care home residents, where responsibility for care is often shared across multiple professionals and services, including care home staff, GPs, community geriatricians, palliative care or mental health teams, and acute services. This approach should support a more effective use of resources by preventing unnecessary referrals, reducing delays in decision making and giving clinicians confidence that risks are being held appropriately across the pathway.



8 Government and NHS England must invest in well-functioning digital infrastructure and prioritise interoperability between systems, including the electronic patient record (EPR), so that clinicians across neighbourhood, primary and hospital services can access and update the same information in real time.

This should include national standards for consistent recording of NHS patient care activities, investment to ensure that records can be reliably shared across all providers (regardless of local systems or organisational boundaries) and training for staff to use digital tools well. Government must set out further detail on its plans for delivering the single patient record promised in the 10 Year Health Plan. Without digital systems that can talk to each other and easily share patient records, clinicians cannot safely coordinate care, manage risk or make informed joint decisions.

9 The DHSC and NHS England should work with clinicians, professional bodies and patients with lived experience to develop clear principles for a planned care pathway for adults who are not older or frail but have multiple health conditions.

This cohort are high users of planned specialist care, yet their care is often poorly coordinated. As a result, many adults with multiple health conditions experience fragmented appointments and unclear referral routes, driving inefficient use of clinical and patient time, as well as diagnostic resources. A clearer, more coordinated pathway would improve outcomes and access to life-changing medical treatment for this group, helping to release capacity across planned and unplanned care.

10 The DHSC and NHS England must support ICBs to implement the strategic commissioning framework so that neighbourhoods are commissioned effectively based on population need and healthcare value.

This includes supporting ICBs to refresh their 5-year strategic commissioning plans to determine how INTs should be configured, including where specialist care is best delivered. To achieve this, systems must strengthen their use of public health, value-based and health economic approaches, and involve clinical and public health experts more consistently to ensure that investment is directed where it will have the greatest impact.

© Royal College of Physicians 2026

Integrating planned specialist care into neighbourhood health

What is neighbourhood health?

Neighbourhood health is the terminology used by the UK government in its 10 Year Health Plan to describe community-based, integrated health and care services. The government plans to roll out an NHC in every community in England – covering a population of up to 50,000 people – where patients can receive diagnostics, rehabilitation and prevention services, as well as support to live with long-term conditions. These services will form part of a wider system in which groups of neighbourhoods work together and are supported by ICBs to plan and coordinate services at scale.

Already, the first wave of neighbourhood health models is being rolled out in 43 pilot areas with the lowest life expectancies and the longest waits to test a wide range of delivery approaches based on local capacity and population health needs.

The government's Neighbourhood health framework provides further detail about the aims of this approach, its metrics for success and priorities for ICBs over the next 3 years. The RCP is supportive of the framework's aims to improve health outcomes and experiences, reduce health inequalities and provide more proactive and convenient care around patients. The framework asks ICBs to implement a series of minimum interventions in every community over the next 3 years, covering the following priority areas to:

- **Improve services for people needing routine healthcare** by making primary care more accessible, strengthening the role of GPs in proactive population health management and diagnostics.
- **Strengthen proactive care** by establishing integrated neighbourhood teams to focus initially on patients with complex care needs and introduce a new model for planned care built on closer collaboration between GPs and specialists.
- **Deliver better alternatives to hospital care** with more community-based options, such as urgent community response or virtual wards, that safely reduce avoidable hospital attendances and admissions.

INTs are MDTs that bring together professionals from primary, community, secondary and social care, alongside wider local authority services, to deliver coordinated, proactive care within a defined local area. As set out in the Neighbourhood health framework, there will be no single national definition of an INT. Instead, their composition and focus will vary according to local population needs and service capacity, with local systems determining the most appropriate model.

The RCP is concerned, however, that the framework does not set out how learning from the 43 DHSC pilots will be captured, evaluated and shared across the system. Establishing a clear mechanism for disseminating this learning will be essential to ensuring that patients can access the care they need from neighbourhood services consistently across the country. It will be important that these insights are actively fed into future roll-out, so the system can design and deliver services based on current evidence, rather than repeating avoidable mistakes. Without this, the framework risks falling short of driving the meaningful improvement that patients and clinicians expect.

© Royal College of Physicians 2026

The case for integrating planned specialist care

Planned specialist care is where patients receive scheduled, non-urgent care without the need for an overnight hospital stay. This care is provided by a multidisciplinary team of healthcare professionals, including specialist consultants, nurses, allied health professionals, pharmacists and diagnostic staff. While this type of care has traditionally been referred to as 'outpatients', that terminology no longer reflects the full breadth and complexity of modern planned care services, which encompass a wider range of specialist interventions, diagnostic pathways and team-based support delivered across multiple settings.

In 2025, the RCP called for reform of NHS outpatient services, and we welcomed commitments to this in the 10 Year Health Plan. A new model for planned care is being developed to meet this commitment, beginning with closer working between GPs and specialists. The RCP is supportive of a new approach to planned care, **provided it integrates specialist and primary care through well-resourced multidisciplinary community teams – all working in a coordinated way to meet local needs**.

The Neighbourhood health framework asks ICBs to start to plan for a new neighbourhood approach to planned care over the 2026–27 financial year. The framework does not mandate what this approach should look like but highlights the need to improve the interface between primary and secondary care. It proposes that:

- GPs will be put in control when it's unclear whether a patient needs specialist care
- GPs and specialists will work more closely together, expanding advice via single points of access, so that by March 2027 one in four referrals is redirected back to GPs rather than a patient being added to the waiting list.
- More specialist follow-ups will be delivered by professionals in the community to reduce secondary care follow-up appointments by at least 10% by March 2027.
- Support will be available for GPs to ensure that these arrangements work effectively within their competency and that they are supported.

While the RCP is supportive of the framework's aims, we believe that its approach to planned care carries significant risks. Greater reliance on advice and guidance, coupled with a lack of joint decision making between professionals about when specialist input is needed, can lead to delays in diagnosis or unnecessary referrals. These delays particularly affect patients with multiple health conditions or complex needs, whose symptoms can be harder to assess remotely and who require earlier medical specialist involvement in their care. The RCP's 2025 member survey found that **over half of the physicians who reported providing advice and guidance did not have dedicated time in their job plans to do so, highlighting the lack of capacity in the current model.**

It is essential that patients who require medical specialist care must receive it from appropriately trained specialists, and that expanding access to follow-ups in a neighbourhood setting does not lead to specialist roles being substituted by non-specialist professionals.

Neighbourhood care should mean that physicians are involved earlier in patient journeys, offering clear clinical direction at the outset and reducing reliance on repeated requests for specialist advice. Without a clearly defined role for planned specialist care in neighbourhood health, and the conditions required for it to be fully embedded, fragmentation between primary and secondary care will persist.

This is even more pressing given the rising number of people living with multiple health conditions, whose care cannot be safely or effectively managed through siloed pathways. The RCP believes that this integrated approach, in which medical and wider health professionals contribute to patient care, is especially valuable for this cohort. An integrated neighbourhood health model should mean that a patient with heart failure and renal dysfunction is supported by an INT acting as the central coordinator of their day-to-day care. The INT should coordinate scheduled reviews or joint case discussions involving the patient's GP, as well as a cardiologist and nephrologist, and a geriatrician or palliative care physician depending on the patient's condition. Through these joint discussions, the INT can collaboratively adjust treatments, while also connecting patients to wider support such as smoking cessation and weight management.

If their condition progresses to advanced heart or renal failure, their care becomes medical specialist led, delivered either in a neighbourhood setting, hospital or remotely, while the INT remains involved to maintain coordination and prevent fragmentation.

The RCP is clear that this model will not work if it simply transfers hospital activity into community settings, expands primary care in isolation or focuses on patients with less complex needs. These approaches would fail to address structural fragmentation across the NHS and the lack of coordinated support required for complex care. Successful neighbourhood and community working requires an entire reimagining of care pathways, including how different services and professionals can better interact with each other, share information and make shared decisions.

> 'It's almost better to define what we think neighbourhood health shouldn't be and that is more of the same somewhere else.'
>
> **– Respiratory consultant, focus group participant (February 2026)**
>
> 'We probably have to think bigger than just shifting people from the hospital-based clinics to community-based clinics.'
>
> **– Sports and exercise medicine consultant, focus group participant (February 2026)**

© Royal College of Physicians 2026

The role of physicians in neighbourhood planned care

Physicians bring a depth and breadth of medical training that is essential for managing increasingly complex patient needs outside hospital settings. It is critical that medical specialists are well embedded in neighbourhoods. Not all patients cared for by INTs will follow a linear care pathway, and it is in these situations that a physician's expertise is critical: they are trained to deal with uncertainty and integrate complex, incomplete information with holistic clinical judgement, combining broad diagnostic insight and medical specialist expertise to make safe decisions for medically complex patients.

Their initial generalist training provides them with an understanding of the whole patient across all systems in the body, while their specialist training then builds on this foundation, adding disease-specific medical expertise to their capacity to see the bigger picture. This is profoundly different to other professionals who may only have a specific narrow technical expertise, even when they are at a senior level. Because of this, relying on specialist input solely through advice in neighbourhood settings is insufficient, as many patients' complex conditions require in-person assessment and specialist clinical judgement that cannot be delivered through responses to advice.

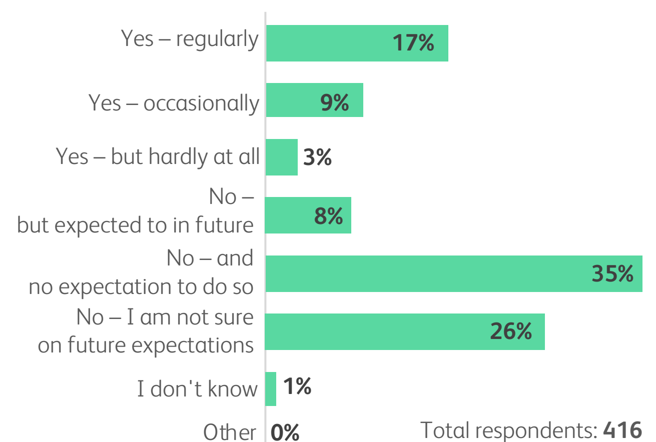
Patients will benefit from the range of skills and expertise that make up an INT, but physicians' training as medical generalists and specialists uniquely equips them to safely exercise clinical judgement – when to treat, and how; how to respond to changing circumstances and new information; when not to treat, or to stop treatment altogether.

> 'I think as consultants you bring a massive amount of knowledge and it's how you sort of fit and slot into neighbourhood working.'
>
> **– General practitioner, focus group participant (February 2026)**

A significant component of medical specialist time is focused on overseeing and advising MDTs who deliver much of the direct clinical care. This includes activities such as case discussions, clinical supervision, joint clinics and ongoing mentorship. Through this work, physicians can support other clinicians to manage specific conditions more confidently and safely, enabling more people to live well at home. Their involvement also helps to embed preventative, coordinated care within communities.

Every part of the health and care system must commit to working in a more coordinated and integrated way to deliver this new approach to planned care. Though often thought of as hospital doctors, many physicians have been developing and delivering planned care in the community for years, especially in specialties such as geriatrics, diabetes, palliative medicine, respiratory medicine and rheumatology. But other specialties do not currently deliver any clinical work in community or neighbourhood settings. Many physicians have had limited training in the skills or ways of working required to practise outside of a hospital.

Do you currently deliver any of your work in community or neighbourhood health settings?



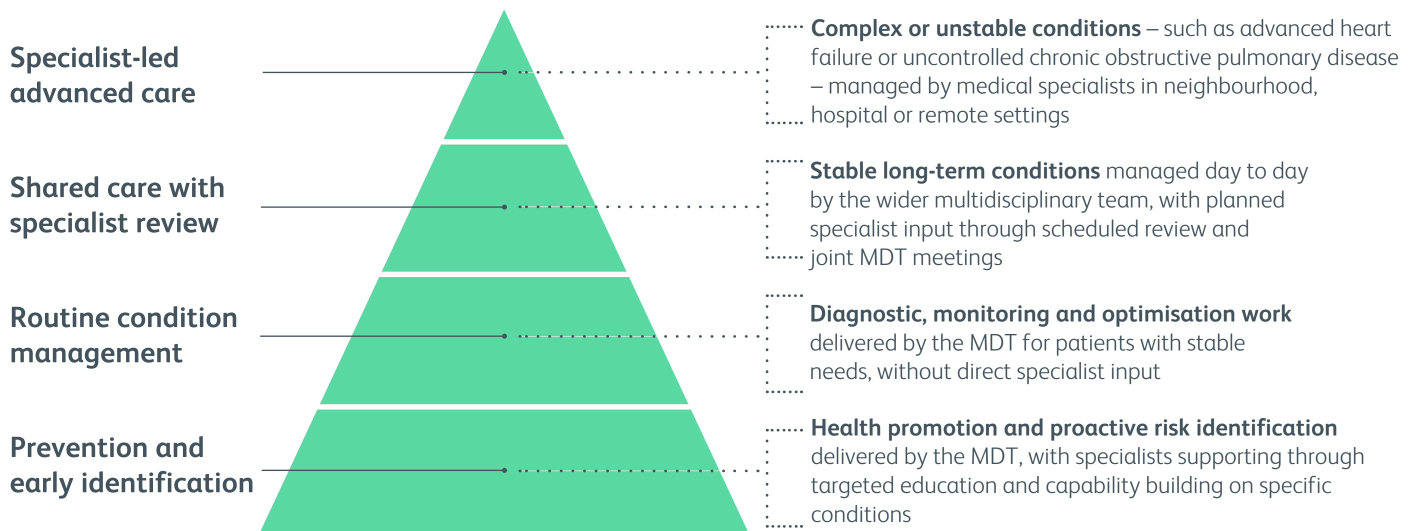
Physicians should be supported to work differently, so that they can confidently embrace clinical pathways that span beyond the hospital, collaborate with a wider range of health and care professionals and develop approaches for shared accountability and decision making.

© Royal College of Physicians 2026

Embedding physician expertise in practice

The RCP believes that new approaches to planned specialist care should be organised into a series of interconnected layers, ranging from prevention and early identification through to medical specialist-led advanced care. This is based on the Kaiser Permanente Pyramid, which shows that most people need routine supported care, a smaller group need targeted management, and an even smaller group require intensive specialist input. While people with multiple health conditions or complex needs may be the smallest group within this model, their needs are more complex and less predictable.

If the model does not work for them, it will not only fail those most in need of coordinated specialist care but also drive additional demand on services, diverting resources away from patients with more routine care needs. Designing the system with this group in mind will ensure that it is resilient and effective for all patients. This is the RCP's interpretation, highlighting how patients move between different levels of support as their needs change, and how physicians should play a role across this whole spectrum.



> 'We don't need to be seeing people twice a year, once a year for a stable long-term condition where there is no decision to be made – so thinking about how better to use us as a resource.'
>
> **– Respiratory consultant, focus group participant (February 2026)**

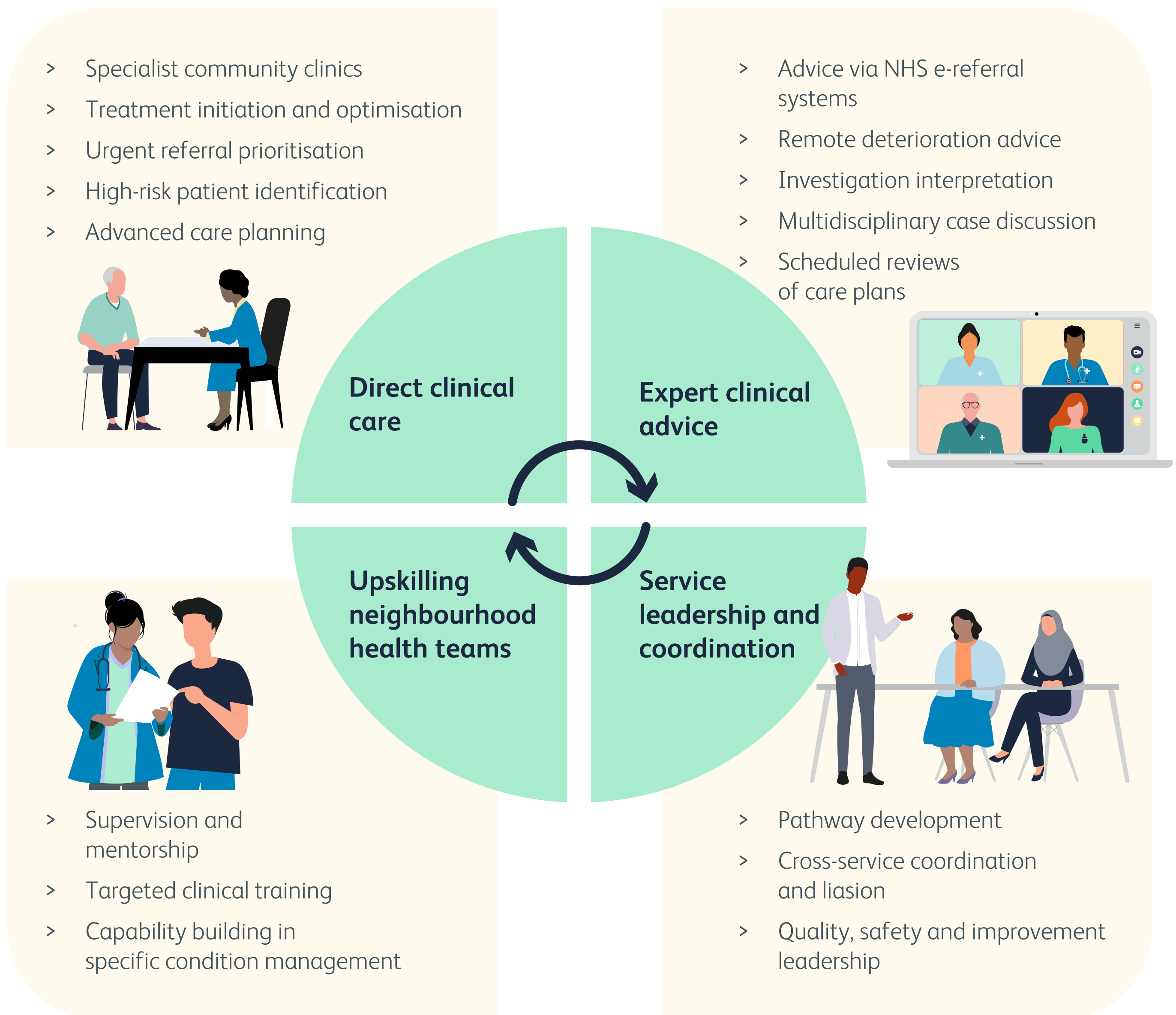
As neighbourhood health expands, physicians' roles are likely to evolve, with more work done remotely, and hopefully, more in collaboration with other healthcare professionals like GPs, nurses and allied health professionals – provided these professionals have sufficient capacity and capabilities to work in a more collaborative way. While remote and supervisory models can extend the reach of specialist expertise, they cannot replace all elements of care, particularly where in-person assessment or diagnosis is required.

Physician involvement in neighbourhood health should be flexible to local needs and will, to some extent, be determined by local services and workforce capacity. The RCP views the role of physicians in neighbourhood planned care as spanning four key areas:

- **delivering direct clinical care** for patients with advanced or unstable conditions, whether in neighbourhood settings, in hospital or remotely, including oversight of rapidly advancing new therapies
- **providing expert clinical advice** to neighbourhood teams to guide safe and effective decision making and help prioritise the most impactful care
- **upskilling neighbourhood health teams** to diagnose, treat and prevent condition-specific issues with confidence
- **offering clinical leadership** and coordination of specialist input across neighbourhood health services.

© Royal College of Physicians 2026

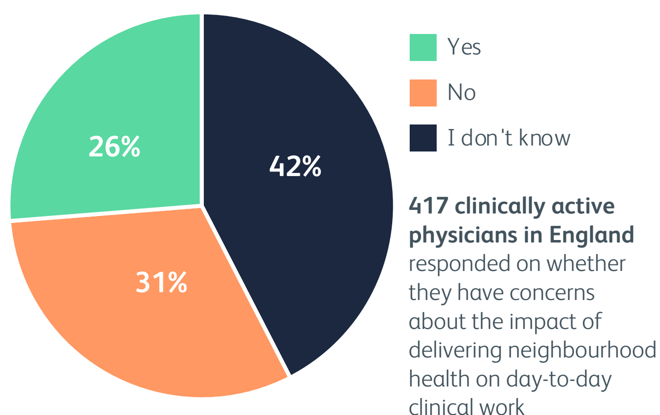
> 'I support a team of inpatient and community-based specialist heart failure nurses who are coordinating and delivering care to patients up to an hour's drive in each direction across Devon. So, while I might not see all those patients directly, I am helping to provide individualised care in the community in this way. And obviously, electronic records and different types of home monitoring data allow us to do this quite nicely. We aim to flex around the patient and escalate/de-escalate input where needed.'
>
> – Cardiologist, focus group participant (February 2026)



Enablers for embedding medical specialist input

We must create the right conditions for planned care to function in an integrated way across neighbourhood and hospital services and local systems. GPs and physicians each play a crucial role in shaping and delivering these services with wider health and care teams, supported by structured opportunities to learn from one another.

Just under half (42%) of 417 respondents to a 2026 RCP member snapshot survey expressed concerns about how delivering neighbourhood health will affect their day-to-day clinical work. These concerns were mostly raised by physicians working in specialties with heavy acute workloads, such as respiratory medicine and acute internal medicine. However, this was not consistent with some respondents in these specialties reporting no concerns and felt as comfortable delivering neighbourhood health as colleagues in geriatrics, palliative medicine and other specialties with long-standing community-based models of care, who were among the highest to report no concerns.



417 clinically active physicians in England responded on whether they have concerns about the impact of delivering neighbourhood health on day-to-day clinical work

Physicians' top concerns revolve around the practical enablers required for this model to work safely and sustainably. The most frequently cited issues in the survey included:

- increased workload without protected time in job plans
- unclear clinical responsibility, accountability or escalation routes for complex patients
- reduced time for specialist inpatient or outpatient work increased reliance on virtual or remote consultations
- reduced access to timely diagnostics, specialist advice or hospital-based infrastructure
- workload pressures affecting wellbeing or contributing to burnout.

Embedding medical specialist input requires considered, system-level action in the form of redesigned job plans, investment in digital technology, clear clinical responsibilities and training pathways that prepare the future workforce for community-based practice.

Integration between professionals

What matters is not the physical location of clinicians, but the shift towards a more proactive, collaborative and integrated way of delivering care, ensuring that medical specialist expertise is available earlier and more consistently to help prevent deterioration and support patients closer to home. This requires inclusive working across professional boundaries, with neighbourhood models built on a clear understanding of the distinct but complementary roles of medical specialists, GPs and community teams. By bringing together medical specialist expertise with the strengths of primary and community care in population health and day-to-day risk management, neighbourhood approaches have the potential to enable coordinated, sustainable care for patients.

With the right conditions in place, a neighbourhood-led model of planned care should give professionals across primary, community and secondary care shared access to population health and patient data. This allows INTs to jointly identify people at risk of conditions such as lung cancer or chronic obstructive pulmonary disease (COPD) and connect them with appropriate support, such as screening or smoking cessation. By integrating information and decision making across traditional care boundaries, clinicians can see the same risk factors, discuss cases earlier

© Royal College of Physicians 2026

and agree coordinated actions. This shared visibility helps teams spot patterns that any single service or professional might miss.

> 'What I find exciting about INTs as opposed to our traditional MDT approach where we come in, give our expertise, we disappear out – who holds that risk? I think coming together on a level playing field where everybody is coming in as equal partners, equal team members, so that we're able to hold a high level of risk in the community than what we could otherwise do as single entities.'
>
> **– GP, roundtable attendee (January 2026)**

If government delivers the enablers that the RCP sets out in this report, INTs should be able to intervene much earlier and more effectively for patients with advanced or unstable conditions. Currently, a patient with uncontrolled COPD might wait months to see a respiratory consultant, experience repeated exacerbations resulting in emergency hospital admissions, and rely heavily on their GP for interim management. With a planned care model that is built around integrated working, patients with uncontrolled COPD could be identified and supported much earlier by an INT including GPs, respiratory consultants, specialist nurses, pharmacists and carers. The INT could jointly review needs, provide rapid virtual or same-week physician input, optimise treatment or help address wider factors such as smoking or housing, enabling early intervention and reducing hospital admissions.

This approach is especially important for people with multiple long-term conditions, who often find themselves navigating disjointed services and unable to get issues resolved in a timely way. For example, an INT might identify a person with type 2 diabetes, uncontrolled hypertension and early kidney disease who has been struggling to manage their condition day to day. Instead of multiple specialist referrals, the GP could trigger an integrated community pathway where a diabetes specialist nurse provides remote glucose monitoring support and the pharmacist undertakes regular medication reviews. A renal or diabetes consultant provides regular specialist oversight, reviewing shared data and advising the GP on treatment adjustments, while day-to-day follow-up remains with the INT, unless a further complex need emerges such as pregnancy or a cardiac event. By sharing information and coordinating interventions, the INT ensures that problems are considered collectively rather than passed from one service to another.

Improving digital systems and access to shared records

Interoperable digital systems are key to supporting staff to work well together and ensuring that medical specialists can contribute effectively to patient care. This includes making sure that digital tools deliver safe care, without adding extra burdens or risks. When these systems operate seamlessly, it allows professionals in neighbourhoods and secondary care to share information easily and better coordinate patient care.

A shared, real-time understanding of a patient's healthcare history is essential to making holistic, timely and safe clinical decisions. Yet the digital tool that should enable this – the electronic patient record (EPR) – is extremely fragmented. Most patients will have data in multiple EPRs, even within one organisation. Primary care EPR data are transmitted poorly into the secondary care record and vice versa. Better, simpler data linkage is needed to target interventions for patients at high risk of complications from long-term conditions and support the delivery of joined-up care.

Ideally, each patient would have a single longitudinal record capturing their full healthcare history, providing one version of the truth for every professional involved in their care. The 10 Year Health Plan commits to a new 'single patient record' to bring together data from multiple sources including the EPR and personal health data supported by the Federated Data Platform (FDP) that can be accessed anywhere in the health system, and over time, will also show a personalised account of health risk. The RCP has expressed concern about the significant optimism bias in the 10 Year Health Plan around the creation of this record.

As well as investing in well-functioning digital infrastructure and up-to-date IT systems so that clinicians have access to digital tools that work, the NHS must also establish robust clinical national standards for the procurement of digital systems and data interoperability. Having a standardised set of requirements should mean that all NHS trusts generate the same data, allowing them to draw better conclusions about patients and services. This should include a requirement for interoperability that allows data to transfer into and out of the EPR and between records, allowing structured data to land in the right place in the record.

© Royal College of Physicians 2026

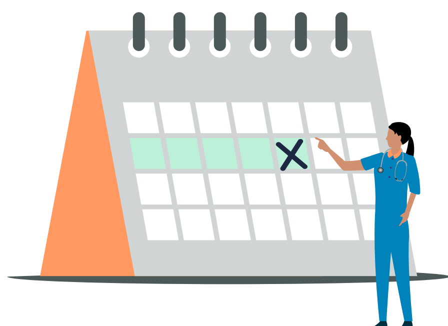
The NHS App also has the potential to play an important role in improving communication between INTs, hospitals and patients. However, government must set out clearly how it will mitigate the risks of digital exclusion and exacerbating health inequalities. A 'digital-plus', rather than 'digital-only', approach is essential to ensuring that people who can't use digital systems can still access care.

Access to professional interpreting must be built into the digital systems used by INTs to ensure provision if in-person services are not available. Many patients whose first language is not English move through primary and community services without any communication in their native language, leading to misunderstandings and delays in care. This disproportionately affects communities with the poorest clinical outcomes, who often present to emergency services because they have not been adequately heard or understood. Embedding rapid digital or remote interpreting services within neighbourhood pathways is therefore essential to ensuring timely and equitable access to care.

Clarifying roles and responsibilities in pathway redesign

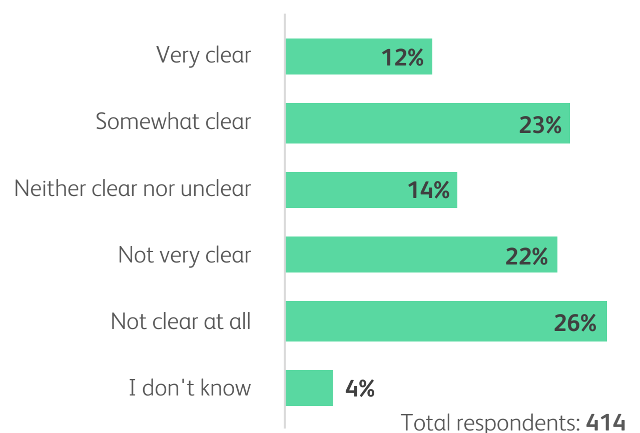
Because neighbourhood health is intended to bring together parts of the system that have traditionally operated in siloes – primary, secondary and community care – it is vital that clinicians have clarity about their roles and responsibilities. This is essential for managing risk, making decisions and escalating care when a patient's condition worsens.

> 'From a patient's perspective, what they'd like to know is two things. One, who has overall oversight about what's going on with the patient? And secondly, how is that all joined up?'
>
> **– Patient care representative, focus group participant (February 2026)**



GPs should anchor INTs with their continuity and strong patient relationships, while physicians bring the specialist insight and clinical judgement required to navigate complexity and risk. We already see this in action – for example, community geriatricians and GPs have a long history of working together to care for older and frail patients – but delivery remains patchy across the UK. Shared care models, joint decision making and clear clinical accountability must be embedded into care pathways.

How clear are you on how your medical specialist role would function within a neighbourhood health team?



Flexible job planning

As opportunities for physicians to contribute to this new model of planned care increase, job planning will need to evolve and protect time for consultants' full range of new responsibilities, including where consultants contribute directly to delivering neighbourhood services as part of an INT. The RCP's 2025 job planning guidance emphasised that even when community-based care is regularly scheduled, job plans must retain flexibility to accommodate work delivered through various modalities such as home visits, supervision, case discussions and remote advice.

> 'The key to successful partnership between hospital and community dermatology services is clinical integration, which should be recognised as dedicated programmed activity in consultant job plans, to facilitate the community liaison work required for an organised and unified approach to intermediate care.'
>
> **– Consultant dermatologist, focus group participant (February 2026)**

© Royal College of Physicians 2026

We must also recognise the potentially significant implications for acute care if job planning is not done well. The same clinicians who deliver outpatient clinics in hospitals also support the acute take (the urgent assessment and management of patients admitted to hospital for unplanned care) through ward referrals and by making decisions about admissions, treatment and discharge. This is particularly true for specialties such as geriatrics, where clinicians continue to make a substantial contribution to staffing acute admissions. If most outpatient clinics are moved out of hospital by 2035 as the 10 Year Health Plan proposes, this raises serious concerns about the potential impact on the workforce available to staff acute services safely.

> 'It's much more efficient to do the outpatient clinic in the hospital and walk down the corridor and do the ward referrals, rather than get in a car and waste an hour.'
>
> **– Consultant neurologist, focus group participant (February 2026)**

> 'There's not a great incentive to be releasing consultant time to be contributing to neighbourhood teams.'
>
> **– Acute medicine consultant, roundtable attendee group participant (January 2026)**

Job plans will need to account for how physicians balance neighbourhood-based work with the demands of the acute take, ensuring that increased medical specialist input in community settings does not unintentionally compromise hospital capacity. To do so, local systems and clinicians need clarity on how neighbourhood working will operate in practice, including expectations for remote and face-to-face activity, and this clarity must be provided in the forthcoming 10 Year Workforce Plan.

Education and training for neighbourhood working

Physicians must be supported with education and training to develop the practical skills needed for neighbourhoods. The 10 Year Health Plan commits to reforming curricula 'to promote the generalist capabilities', but rising complexity means that timely specialist input will remain critical for safely managing multiple health conditions and conditions that require deeper, disease-specific expertise.

Physicians already combine broad generalist training with strong medical specialist expertise. Training and education must evolve to ensure that physicians have the right opportunities to apply and refine these skills, such as through structured involvement in neighbourhood-based pathways.

While many clinical and non-clinical skills mirror those used in hospitals, neighbourhood working places greater emphasis on:

- collaborating across diverse MDTs
- using digital tools to provide remote advice and participate in virtual MDTs
- managing patients with limited access to immediate hospital-based investigations
- taking balanced clinical risks in settings where escalation is available but not always immediate.

> 'It's helpful to get into the nitty gritty of the neighbourhood physician's role to identify those areas that aren't currently addressed in the training programme. Things like taking part in neighbourhood MDTs and having dedicated time to manage patients remotely who are contacting us through the NHS App. These types of in-reach activities aren't really incorporated at the moment.'
>
> **– Resident doctor, focus group participant (February 2026)**

© Royal College of Physicians 2026

Although postgraduate medical curricula include competencies for community-based work, our engagement with RCP members and fellows indicates that opportunities to apply these skills can be limited in practice. Resident doctors frequently report limited exposure to community-based or virtual MDTs and a lack of opportunities to undertake supervised clinics, largely due to the demands of the acute take.

This does not necessarily require traditional community-based placements. Many of the capabilities needed for neighbourhood working can be obtained through structured learning opportunities – whether in a neighbourhood setting, hospital or virtually – provided adequate time and support are available. This means protecting time for training (for both residents and educators), supported by reliable access to the digital tools needed for neighbourhood working. Investment in the quality and experience of medical training, including protected time for teaching, supervision and non-clinical skill development, is essential to ensure that doctors are prepared for new service models.

Workforce capacity

The expertise of physicians must be available consistently across the country to avoid unintended variation in care – but we know that current workforce shortages will be a significant barrier. That relies on having enough doctors to support these services and care pathways. **Nearly 300 physicians told us in our 2026 survey that insufficient workforce capacity is one of the main barriers to successfully delivering neighbourhood health.**

The 10 Year Workforce Plan is a critical opportunity to ensure that neighbourhood health models have the physician expertise they need, while sustaining acute services that will continue to experience significant pressure. To do so, government must invest in the medical specialty workforce, recognising that effective neighbourhood care relies on enhancing medical specialist input rather than substituting it with non-specialist roles that are not trained to manage complex medical decision making. Government must maintain its commitment to expand medical school places to 15,000, using the 10 Year Workforce Plan to set out a feasible delivery plan and timetable for achieving this.

We must also expand the number of postgraduate medical specialty training places based on population need. We need a significant expansion in training posts, with every additional medical school place being matched with an increase in foundation and medical specialty training posts, especially in areas that are most deprived. Delivering this expansion will also require investment in clinical academics, educators and supervisors, alongside plans to increase capacity so that senior doctors have the time to give meaningful support to a larger number of students.

Strategic commissioning to allocate resources effectively

Neighbourhood health offers a more agile and integrated approach to population health, where GPs and traditionally secondary care-based professionals use local population data to target preventative work. Stronger, evidence-driven commissioning will enable INTs to act proactively on patterns of disease and address inequalities within their local communities. To realise that, local systems need a clear view of what services are required and how resources should be allocated based on population health insights, and strategic commissioning offers a way to do this.

NHS England's strategic commissioning framework sets a clear expectation that integrated neighbourhood models must maximise value and improve outcomes, with ICBs positioned as central to improving population health and tackling inequalities as strategic commissioners. This is echoed in the Neighbourhood health framework, which provides ICBs with guidance on reflecting this new model within their commissioning approach.

Current strategic commissioning arrangements have significant limitations. Most areas in England lack a reliable way of deciding where resources should go based on population need or value for money. As a result, decisions are often shaped by historical investment patterns rather than evidence of what works. A significant barrier is the inconsistent involvement of directors of public health (DPHs), public health consultants, and primary care and provider organisations in local planning. These groups hold vital intelligence about need, demand, inequalities and outcomes – but they are not always part of discussions about service design or prioritisation. This makes it harder for systems to decide which interventions will deliver the greatest benefit for patients and plan specialist input.

ICBs must be supported to undertake value-driven planning (prioritising services that deliver the greatest benefit, based on evidence and value for money), and structures that enable consistent engagement of the right expertise to inform this planning. For instance, local systems could establish a formalised decision-making forum where physicians, public health experts in

healthcare public health, primary care and providers work together to plan health and social care in a value-driven way. Such forums could provide a structured mechanism for identifying which neighbourhood services to prioritise, where specialist expertise is most needed and ensuring that prevention and population health considerations inform each stage of pathway design.

It is clear in NHS England's strategic commissioning framework that this aim goes beyond preventative services to cover all aspects of current healthcare provision, so it should be central to how physicians are empowered to play their part in neighbourhood service design.

Preparing estates for neighbourhood planned care

Delivering planned specialist care safely in neighbourhood settings depends not only on workforce and digital capability but also on having the right clinical estate infrastructure. Many community estates may not have sufficient consultation rooms, diagnostics capacity and space for MDT working, which limits the scope of care that can realistically be shifted out of hospitals. This challenge is particularly key for specialties with high diagnostic or imaging requirements. In rheumatology for example, many of their complex patients require timely access to laboratory testing, ultrasound, PET-CT and MRI – equipment that is typically located in a hospital. It is unclear to what extent NHCs will be able to accommodate the diagnostic and clinical facilities required for more complex specialist activity, meaning that some elements of planned care will still need to remain in hospital settings.

However, with appropriately equipped estates, other aspects of specialist care – such as follow-up reviews and joint case discussions – could be delivered safely and effectively in community environments. In addition, the acceleration of climate change means that NHCs must be built to withstand the severe weather events that will become more frequent and intense.

In the UK and globally, health systems are increasingly exposed to changing climatic conditions such as extreme heat, air pollution, flooding and severe storms. Around 90% of hospitals in England are at risk of overheating – and in a June 2025 RCP member snapshot survey, 58% of 484 UK physicians said that they felt their workplace was either somewhat unprepared or not at all prepared for extreme weather events. The creation of NHCs provides a crucial opportunity to ensure that new and renovated facilities are designed with climate resilience at their core. This will not only help safeguard services against increasingly extreme weather, but will also likely reduce long-term costs.

© Royal College of Physicians 2026

Summary

There is huge potential in a model for planned care that brings together neighbourhoods and hospitals in an integrated way. It could shorten long waits for care, reduce the confusion patients often face when navigating a complex system, strengthen population health approaches and ultimately improve patient outcomes and experience. But turning this vision into reality requires careful consideration of the conditions needed for neighbourhood working to succeed.

First, the new model for planned care must genuinely integrate medical specialist care with neighbourhood services – without this, these services risk reinforcing the fragmentation and lack of clarity between professionals that currently characterise the NHS. Second, delivering this new way of working depends on having a workforce with the right training, capacity and time. And finally, this all needs to be supported by investment in digital tools, physical infrastructure and strategic commissioning so that local systems and their clinicians have the right foundations to deliver this model effectively.

Published April 2026

Development of the *RCP view on neighbourhood health: planned specialist care* was led by the RCP's clinical vice president, Dr Hilary Williams. The report draws on findings from a 2026 snapshot survey of clinically active physicians in England, insights from a roundtable with medical professionals working in areas where neighbourhood health is being rolled out, and input from focus groups with members of the RCP's career-grade committees and Medical Specialties Board. The report was approved by RCP Council prior to publication.

Contact: policy@rcp.ac.uk

© Royal College of Physicians 2026