

National Elective Care Programme

Elective Single Point of Access (SPoA): Putting the Model into Practice



Welcome, please note the webinar will start at 12.00pm

19 March 2026

Housekeeping



Questions / Queries should be raised via the chat function within MS Teams
Use 👍 ('thumbs up') icon to indicate your interest in questions posted



We will be **monitoring questions** in the chat throughout and will respond during the webinar and in question time



The session is **being recorded** and the slides and recording will be available after the event on FutureNHS Collaborative Platform / Outpatient Recovery programme platform/Referral Optimisation

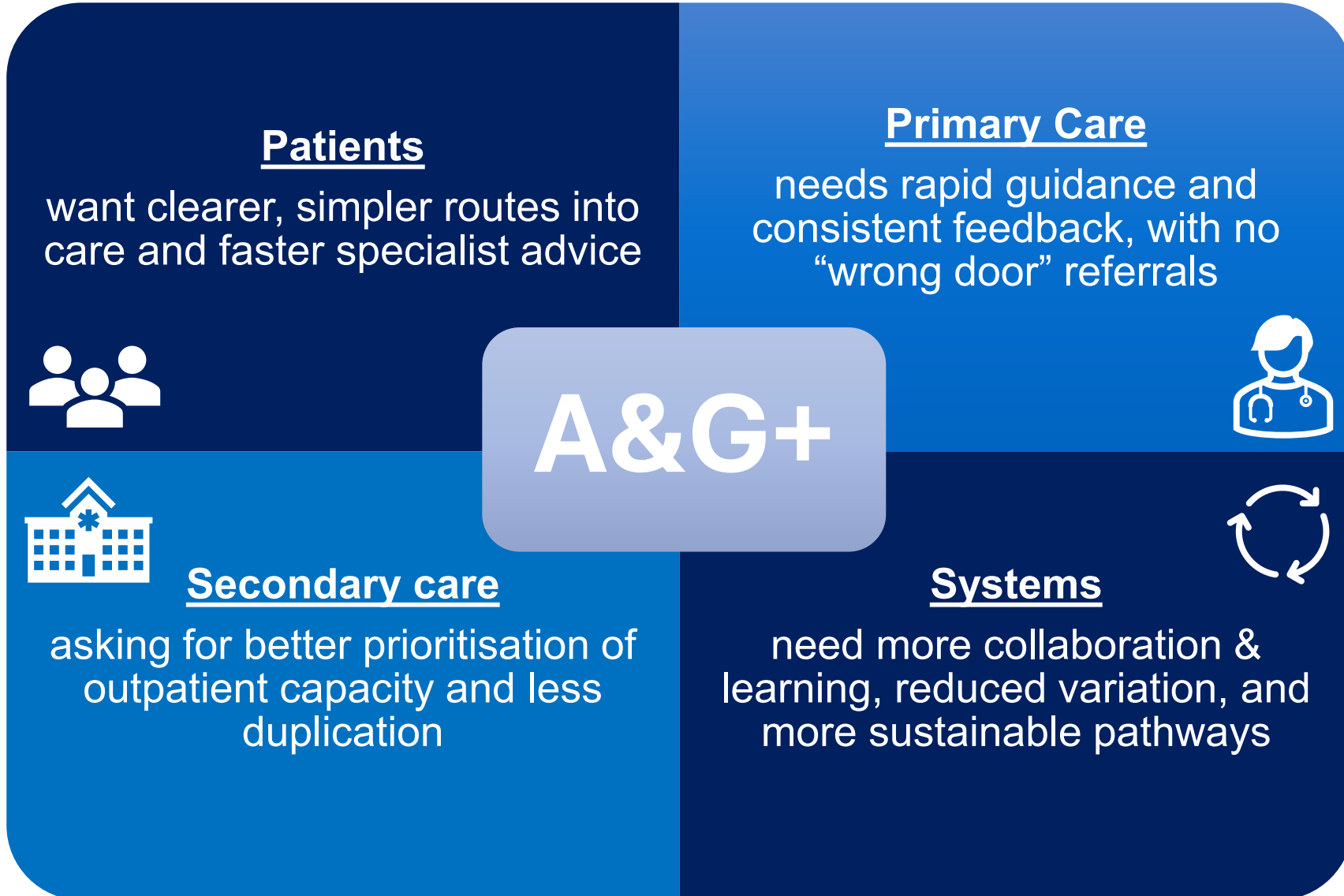
Elective Single Point of Access (SPoA): Putting the Model into Practice

Agenda

19 March 2026 12:00 – 13:30

Timing	Agenda Item	Lead
12:00	Welcome and introduction	Falguni Raja, Deputy Director Targeted Delivery, Referral Optimisation Lead, Programmes & Transformation Delivery, NHS England
12:05	Improving access and creating a more seamless patient experience	Stella Vig, National Clinical Director for Elective Care and Deputy National Medical Director for Secondary Care and Quality, NHS England Adeela Bashir, Clinical Advisor Elective Programme (Primary Care), NHS England Ian Eardley, National Clinical Director for Elective Care, NHS England
12:20	How elective SPoA's will benefit patients and our healthcare community	Vijay Rawal, National Primary Care Medical Directorate Lead for Planned Care (Including Cancer and Diagnostics)
12:25	Enhancing primary & secondary care experience and capacity through a single, consistent elective access point	Alistair Blair, GP Partner, Northumbria Healthcare NHS Foundation Trust Richard Sterry, Head of Performance and Improvement, Northumbria Healthcare NHS Foundation Trust Matthew Warren, Consultant Gastroenterologist, Northumbria Healthcare NHS Foundation Trust
12:45	Applying proven SPoA delivery approaches to improve consistency and quality across pathways	Dr Will Ricketts, Consultant Chest Physician and Outpatient Transformation Clinical Lead, Barts Health NHS Trust Dr Rebeca Goriz, Dermatology Consultant and Clinical lead, Barts Health NHS Trust
13:05	Q&A session & poll	Falguni Raja Plus speaker panel
13:25	Closing remarks	Ian Eardley Adeela Bashir

Improving access and creating a more seamless patient experience: You said...we heard...that led to the design of the elective SPoA and A&G approach



Improving access and creating a more seamless patient experience

The NHS Medium Term Planning Framework sets out that from October 2026 all NHS providers delivering RTT consultant-led care:

- Implement a consultant-led, multi-professionally delivered elective SPoA
- Ensure appropriate and consistent clinical triage

April 2026: Prioritise Advice and Guidance across **at least 10 locally selected specialties** for greatest overall benefit and to shape delivery of elective pathways.

By October 2026: Implement consultant-led clinical review of all A&G requests and elective referrals (excluding Urgent Suspected Cancer), starting with and then scaling beyond the initial 10 A&G specialties.

From October 2026: Utilise the enhanced e-RS functionality to support delivery of elective SPoA across e-RS and integrated third party systems.

By March 2027: Extend Advice and Guidance coverage across additional specialties and sub-specialties to achieve the broadest feasible coverage.

Note: Systems are expected to repurpose existing resources to meet the above requirements, rather than relying on new funding.

Improving access and creating a more seamless patient experience

The foundation to a successful SPoA

SPoA

**Strong
governance &
collaboration**


**Consistent
triage**

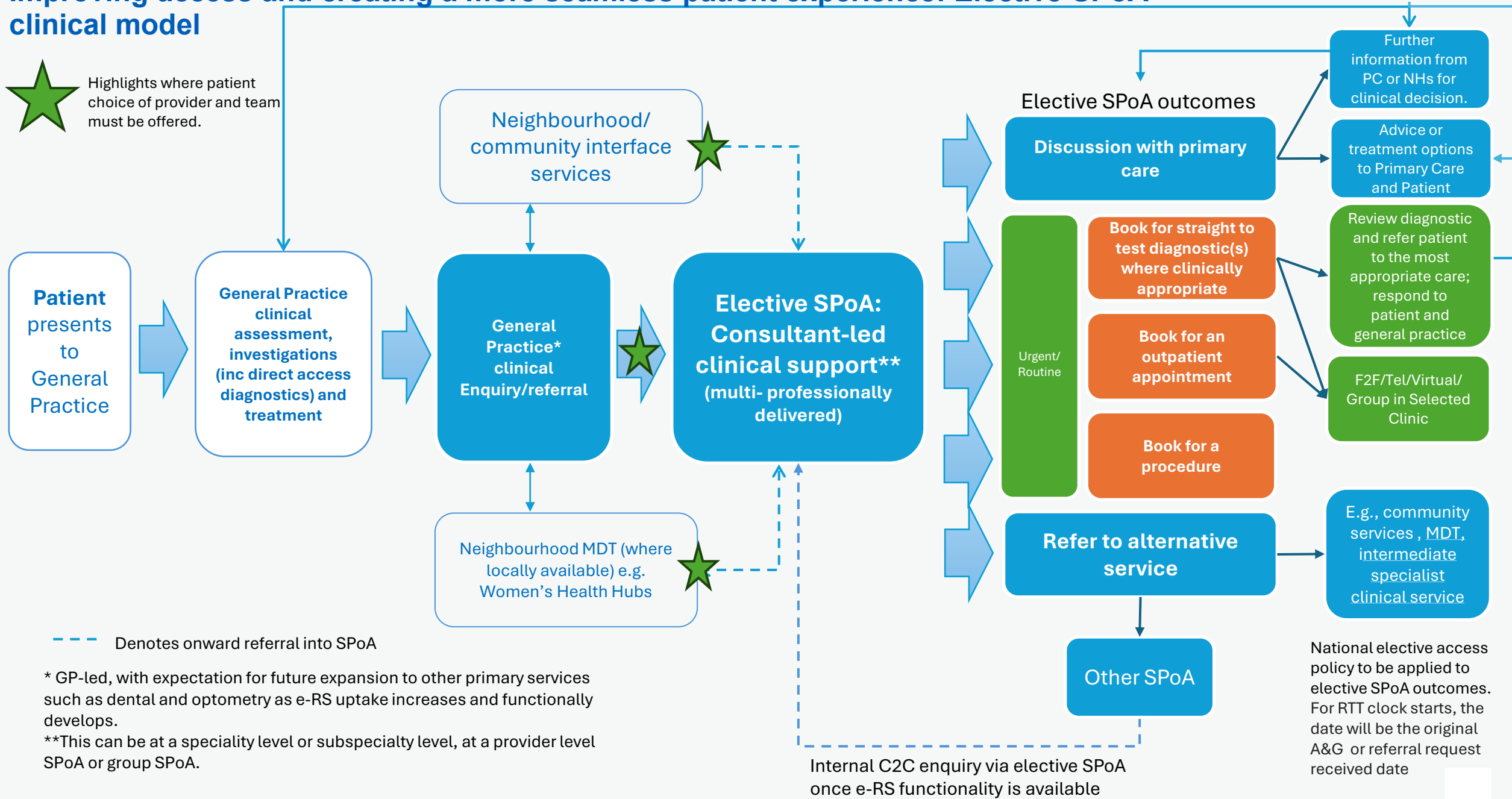
**Standardised
pathways**

**One digital
entry point**

Admin support

Improving access and creating a more seamless patient experience: Elective SPoA clinical model

 Highlights where patient choice of provider and team must be offered.



- - - Denotes onward referral into SPoA

* GP-led, with expectation for future expansion to other primary services such as dental and optometry as e-RS uptake increases and functionally develops.

**This can be at a speciality level or subspecialty level, at a provider level SPoA or group SPoA.

Internal C2C enquiry via elective SPoA once e-RS functionality is available

National elective access policy to be applied to elective SPoA outcomes. For RTT clock starts, the date will be the original A&G or referral request received date

Improving access and creating a more seamless patient experience: National standards for A&G and elective referrals

Referral Type	Process point	Maximum number of working days to process
ADVICE & GUIDANCE	Number of days from receipt of an A&G request to a response	5 working days
ROUTINE REFERRALS	Number of days from receipt of referral to actioning next step	5 working days
URGENT REFERRALS	Number of working days from receipt of referral to actioning next step	2 working days

The standards support timely review of A&G requests and referrals to improve patient experience and reduce clinical risk.

How elective SPoA's will benefit patients and our healthcare community

❤️ Benefits for Patients

- Simpler journey
- One consistent route into planned care
- Faster decisions: earlier specialist input and clear next steps
- Fewer delays: removes “wrong door” referrals and rework
- Closer to home: better access to community options
- Maintains choice: patients choose provider at the right point

🩺 Benefits for Primary Care

- Reduced admin: no need to choose between multiple service types
- Consistent triage: no change to existing thresholds across GP, community & hospital
- Better communication: supports shared clinical reasoning
- No bounce-backs: onward referrals handled within SPoA
- No additional workload for primary care
- Improved visibility: clearer view of pathways and waiting times

Health Care Community



Northumbria Healthcare
NHS Foundation Trust

THE NORTHUMBRIA WAY

PEOPLE CARING FOR PEOPLE

**Enhancing primary & secondary care experience and capacity
through a single, consistent elective access point
SPOA from Primary Care Perspective**

Dr Alistair Blair

Executive Medical Director NHFT and GP

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Enhancing primary & secondary care experience and capacity through a single, consistent elective access point

Principles

Avoiding the unnecessary

Speeding up the necessary

Supporting non-specialists

Reassuring and informing patients

Deflection is an unhelpful term

Hidden benefits – in every clinical area – eg orthopaedic waiters >18weeks had-
of 2 more contacts with primary care, 4 more primary care prescriptions, and
4 additional contacts with secondary care per year (NIHR 2024)

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Positive Perspectives

Benefits of A&G Services

- Improved navigation to the most appropriate service
- Faster access to specialist advice
- Support for GP decision-making
- Reduced unnecessary procedures and investigations
- More efficient use of healthcare resources

Collaborative Care

- Promotes collaboration across healthcare professionals
- Strengthens multidisciplinary working

Patient-Centred Care

- Respects patient preferences and values
- Encourages patient involvement in decision-making

Effective Communication

- Clear and concise communication improves understanding
- Builds trust between clinicians and patients

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Perspectives – Negative

Perception of A&G as an additional barrier to care

Loss of professional autonomy

- Improved navigation to the most appropriate service
- Concerns around clinical responsibility when patients are not seen directly
- Digital and interoperability limitations
- Referred vs might be seen

Workload transfer to primary care

- Capacity is stretched,
- Small Primary Care payment vs full OPD tariff
- First or subsequent OPD activities delegated
- Delegation beyond clinical experience
- Asks that are not possible

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Maximising SPOA

The Right Team

- Not all consultants may feel comfortable delivering A&G advice
- Appropriate training and engagement are important

Communication

- Advice should be clear, concise, and professional
- Always identify who is providing the advice
- Responses should be timely

Clinical Value

- Each interaction should help move patient care forward
- Educational elements should be included where appropriate

Quality and Governance

- Discuss and review quality
 - within teams
 - across Primary and Secondary Care

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Maximising SPOA cont

Structured Communication (Possible Frameworks)

- **QBIL:** Question, Background, Investigations, Lifestyle
- **SAS:** Summary, Actions, Safety Net

Best Practice

- Remember responses may be visible to patients
- Keep advice simple and actionable
- Complex or multi-step advice should prompt reconsideration or referral
- Responses should reflect clinical judgement rather than template replies
- Ensure suggested investigations can be initiated in primary care (e.g., MRI or specific blood tests may have restrictions)
- Embed Guidelines and FAQ

Enhancing primary & secondary care experience and capacity through a single, consistent elective access point:

Primary care teams

- pre referral
- Education Case discussion
 - Sharing internally
 - Guidelines
- Honesty regarding the issue
- Overt naming of GP discussed with
- Volume and quality data

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MAKING THE BEST USE OF ADVICE AND GUIDANCE

For Primary Care Teams

Keep the A&G referral polite and succinct with:

- A clear question that the advice will address
- Avoid simply screen shotting consultations -see point above
- Brief History and Examination findings
- Details of specific related investigations rather than 'see ICE'
- Attach any previous relevant A & G conversations between GP and consultant in that speciality- these are not easily accessed on the hospital system
- Ensure it is clear which GP the referral is from

Continue peer discussions for all the practice's referrals including A&G referrals.

If multiple issues need addressing then consider sending a regular e-referral instead.

Rather than using A&G write directly to the relevant consultant team if the patient is already under consultant care in that clinical speciality- sent via internal mail or contact details in the OPD letter.

If clinically urgent ring the speciality team, expect a turnaround of normally less than 5 working days maximally under 2 weeks.

Look at FAQ's /Guidelines where relevant

For Secondary Care Teams

Keep the A&G reply polite and succinct with:

- Clear advice
- Detail of why the patient does not need to be seen if that is the evaluation
- Check suggested investigation can be initiated eg GP can't request MRIs
- Ensure investigations are proportionate to a pre-referral workup
- Ensure it is clear which consultant the reply is from

Teams of clinicians coordinating and peer referencing the replies considered a model of best practice

Ensure that relevant local guidelines have been shared with the respective CCG's and consider Frequently Asked Questions documents to avoid repeated similar A & G queries.

List of specialities at Northumbria undertaking Advice and Guidance

Cardiology	Colorectal surgery	Diabetic medicine
Endocrinology	Gastro	Gynae
Haematology	Healthy Hearts/Lipids	Hernia
Paediatrics	Pain management	Plastics
Respiratory	Rheumatology	Sleep studies
Stroke/TIA	Upper GI	Urology
Musculoskeletal Medicine/Orthopaedics		



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THE NORTHUMBRIA WAY

PEOPLE CARING FOR PEOPLE

Single Point of Access (SPOA) Operational Implementation and Considerations

Richard Sterry
Head of Performance & Improvement
March 2026

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SPOA Implementation Principles

A national vision for the SPOA model, delivered locally and aligned with each service's goals.

Understanding the eRS SPOA offer and what this means in practice.

Local engagement and regular feedback is essential – continuous process.

Clinical and operational teams working in partnership, using existing senior clinical expertise and sharing responsibility for delivery.

Enables earlier clinical decision-making and challenges the traditional outpatient referral pathway – for example, by front-loading diagnostics where needed.

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Implementation

What are the key components of robust implementation?

- Administrative – Waiting List / Appointment Booking / Secretaries
- Clinical Team
- Operational Managers
- eRS System Administrator
- Trust Primary Care Executive/Link
- Other Stakeholders:
 - Internal Teams/Specialties
 - External with Primary Care
 - Enabling Services/Specialities e.g. Pathology, Radiology
 - Finance, Performance and Planning colleagues

SPOA is successful when implemented well and in conjunction with maximising capacity within existing structures e.g. clinic templates, validation and booking.

Use the SPOA Implementation Checklist from NHSE to shape delivery.

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Northumbria's SPOA Journey

- Started with Gastroenterology in June 2023
- Respiratory (including Sleep Medicine) live in August 2023
- Phase 2: Rheumatology, Cardiology, Diabetes & Endocrine, Upper GI and Colorectal Surgery and then Care of the Elderly followed in early 2025.
- Phase 3: Microbiology, Lipids Service and Haematology in Spring 2026
- Phase 4: Planning for all remaining specialties by Summer 2026.

Not one size fits all and each specialty has specific challenges – understanding the barriers.

Redistribution of activity for specialty level implementation.

The Challenge

- Population of 500,000 patient population largest geographical Trust in UK
- Multiple hospital sites for elective activity – waiting list management was a challenge to regular and timely access.
- Outpatient referral quality was variable – meaning that first appointment was often not as meaningful as it could be.
- Post-COVID 19 Pandemic – Team Burnout and low morale due to ‘learned helplessness’, not a sustainable position.
- Long Waiting Times of around 13 weeks for First Outpatient Appointment – led to further delays and clinical risk.
- Sickest outpatient referrals not seen in timely manner – further consequence of unplanned admission and ambulatory care attendances, and attendances back to primary care.

The Barriers

- National E-Referral system functionality limitations
- Mixed opinions on whether model is ‘right’ or ‘wrong’
- Clinical income doesn’t always stack up clinical time allocated
- Waiting List Validation must be done in tandem and undertaken regularly – this is critical to release capacity
- Selling the vision to wider clinical team to ensure buy-in

Robust Advise and Refer Service with NHS England Single Point of Access

Assurances

- Risk Appetite
- Monthly KPI Reporting
- Governance
- Peer Review
- Patient/Staff Feedback
- Primary Care Interface

The Lessons Learnt

- Not Target/Activity driven – quality is the overriding focus
- Choosing the ‘right’ Consultant Team – genuine interest is key
- GP and Primary Care engagement is critical to success
- Clinician/Management relationship is fundamental – ability to respect views and think flexibly.
- Consistency in approach is important to provide robust advice

Outputs of Sustainable Elective Outpatient Delivery

Activity and Performance

- Improved Clinic Utilisation
- Reallocation of OP Capacity to Endoscopy
- Increase RTT Position
- Reduced Overdue Follow-Ups

Primary and Secondary Care Link

- Improved Quality Advice
- Meaningful Dialogue
- Responsive Senior Medical Advice

Culture and Satisfaction

- Flexible Workforce
- Avoid Workforce Burnout
- Sub-Specialty Development
- Improved Recruitment/Retention

Training and Education

- Referral Trend Analysis
- Trainee Risk Decision
- Case Study Generation
- Case Triage to Education Clinic

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Performance

SPOA is there to really drive how we deliver better care for patients using an improved clinical model – demonstrating progress and outcomes is critical.

SPOA activity and demand volumes are key by specialty / clinic / clinician level.

Understand the demand both historically and also note the go live date.

Understanding variation across both capacity and demand is critical.

Data is key to understand challenge and assess ongoing impact for Trusts.

Performance improvement will take 2-3 months to appear on NHSE data submissions around submission cycles – consider alongside other methods of improving capacity.

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Performance continued

Acts as one of several tools to support performance improvement and helps build a sustainable local clinical model - it's not the only solution.

Less patients on the RTT PTL and ensuring right patients are on waiting list.

Ensuring diagnostic provision that is clinically required is actioned pre-outpatient clinic appointment e.g. Bloods, Scan Result.

Consider impact on demand for DM01 for diagnostic modalities.

Local SPOA Dashboard – still evolving to look at activity, conversion rates, demand profiles.

Some additional considerations:

- Impact on UEC and those patients on longer specialty waiting lists
- Increasing capacity for new patients for a defined period post go-live

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Northumbria SPOA Dashboard

NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST

Pre advice activity

*Based on A&G route only

Common Cause Special Cause Improvement Special Cause Concern

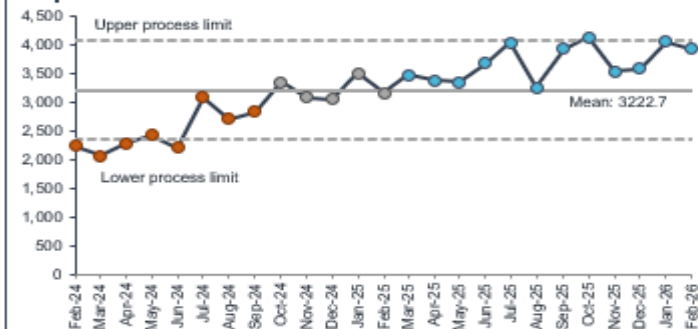
Filters:

- Business Unit**
- 2iW
 - Child Health
 - Clinical Support
 - Medicine
 - Not known
 - Surgey

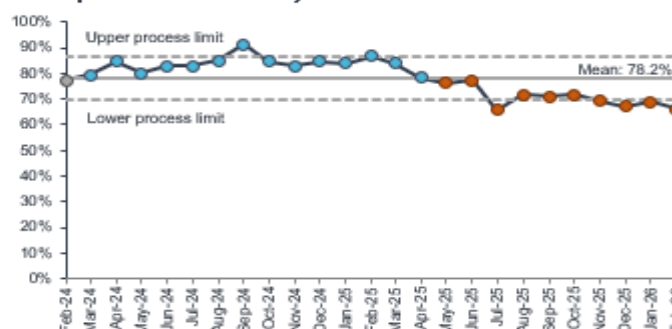
- Referral specialty**
- 2iW
 - Cardiology
 - Children & Adolescent Services
 - Dermatology
 - Diabetic Medicine
 - Ear, Nose & Throat
 - Endocrinology and Metabolic Medicine
 - General Medicine
 - Genetics
 - Geriatric Medicine
 - GI and Liver (Medicine and Surgery)
 - Gynaecology
 - Haematology
 - Infectious Diseases

- Referral service**
- 2iW Gynaecology RAC - Nurze RETRO...
 - 2iW Haematology - Arrazment - Hart...
 - 2iW Haematology - F2F - Northumbria...
 - 2iW Haematology - F2F - Northumbria...
 - 2iW Haematology - F2F - Northumbria...
 - 2iW Haematology - F2F - Northumbria...
 - 2iW Lauer GI - Arrazment - Northumb...
 - 2iW Lauer GI - Cana F2F - Northumbria...
 - 2iW Lauer GI - Cana F2F - Northumbria...
 - 2iW Lauer GI - Endoscopy Pre-Arrazm...
 - 2iW Lauer GI - Nurze RETROSPECTIV...
 - 2iW Lauer GI - Nurze Telephano - Hart...
 - 2iW Lauer GI - Nurze Telephano - Hart...

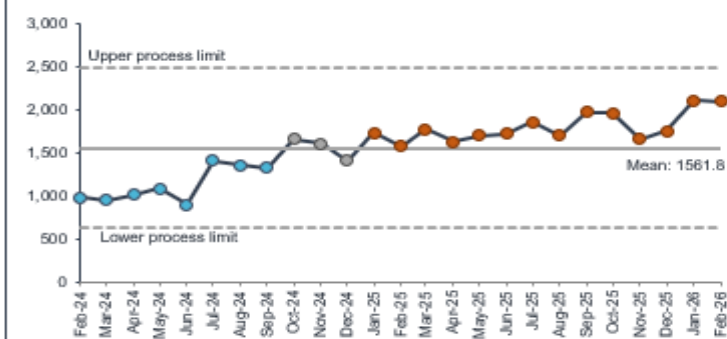
Requests received



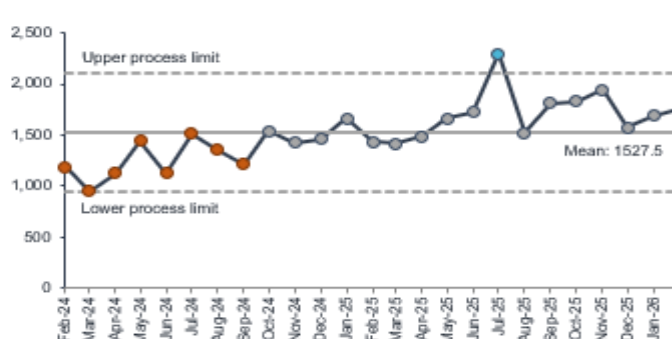
Response within 3 days



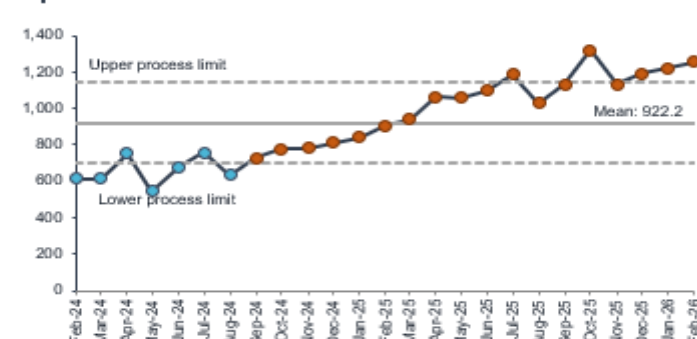
Outcome: convert to referral



Outcome: return to referrer with advice



Open referrals



Pre advice:	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Requests received	2252	2071	2300	2439	2222	3087	2719	2837	3358	3093	3062	3517	3172	3486	3396	3363	3680	4045	3268	3937	4138	3541	3587	4063	3934
Response within 3 days	77.5%	79.3%	84.7%	80.0%	82.3%	82.8%	84.3%	91.2%	84.5%	83.0%	84.8%	84.0%	86.7%	83.8%	78.4%	76.4%	77.4%	65.7%	71.8%	70.3%	71.8%	69.1%	67.0%	63.1%	66.0%
Outcome: convert to referral	381	351	1014	1090	306	1417	1360	1333	1660	1607	1414	1737	1581	1779	1629	1705	1726	1862	1702	1980	1967	1668	1756	2116	2103
Outcome: return to referrer with advice	1193	948	1123	1448	1131	1518	1352	1212	1541	1427	1458	1667	1436	1416	1489	1661	1726	2236	1522	1817	1832	1949	1579	1632	1754
% convert to referral (of all Outcomes)	45.1%	50.1%	47.4%	42.3%	44.5%	48.3%	50.1%	52.4%	51.9%	53.0%	49.2%	51.0%	52.4%	55.7%	52.2%	50.7%	50.0%	44.8%	52.8%	52.1%	51.8%	46.1%	52.7%	55.6%	54.5%
Open referrals	614	613	751	543	680	756	634	726	778	780	814	842	304	938	1061	1059	1100	1185	1030	1130	1320	1132	1131	1220	1255

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Northumbria SPOA Dashboard

NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST

Pre advice activity

○ Common Cause ● Special Cause Improvement ● Special Cause Concern

Filters:

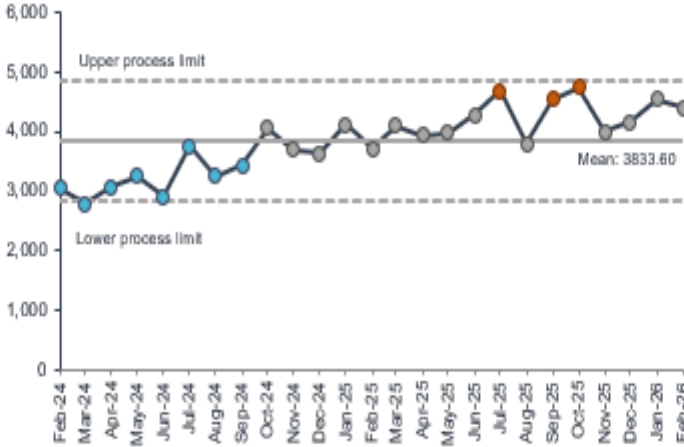
Business Unit

- 2WW
- Child Health
- Clinical Support
- Medicine
- Not known
- Superv

Referral specialty

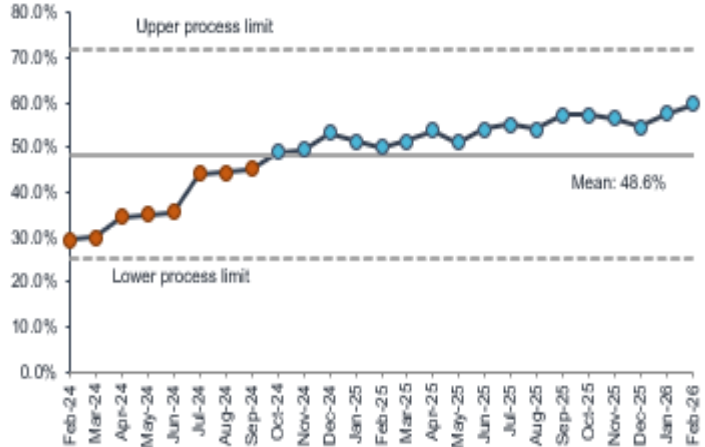
- 2WW
- Cardiology
- Children & Adolescent Services
- Dermatology
- Diabetic Medicine
- Ear, Nose & Throat
- Endocrinology and Metabolic Medicine
- General Medicine
- Genetics
- Geriatric Medicine
- Gland Liver (Medicine and Surgery)
- Gynaecology
- Haematology
- Infectious Diseases
- Neurology
- Not known
- Respiratory

A&G requests including triages returned to referrer



* Includes requests via A&G and triages completed via non A&G route

A&G requests as a proportion of total eReferrals



* Based on A&G route only

** Appt request created/ booked used as a proxy no. of eReferrals

Advice & Guidance:	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Requests inc. triages returned	3047	2785	3079	3250	2914	3747	3255	3425	4056	3695	3638	4118	3720	4090	3932	3971	4279	4680	3799	4530	4746	3990	4158	4532	4404
Requests as proportion of eReferrals	29.4%	30.1%	34.6%	35.2%	35.8%	44.2%	44.4%	45.2%	49.0%	49.5%	53.3%	51.6%	50.1%	51.4%	53.8%	51.3%	54.2%	55.2%	54.0%	57.3%	57.5%	56.4%	54.8%	57.7%	59.6%

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Learning

- Not one size fits all – both at trust and specialty/team level
- Starting with **one engaged specialty** and building rapidly thereafter
- Each specialty has a **different motivation locally** for implementation
- Get the clinical service right and the performance metrics will follow
- Clinicians and Managers **working together** towards implementation
- Consider redistribution of clinical activity as the demand profile changes
- Maximise the existing available eRS functionality
- Existing Governance arrangements within Specialty/Business Unit/Trust level



Single Point of Access (SPoA): Transforming Referral Pathways at Barts Health

Case Study

Will Ricketts,
Consultant Chest Physician & Outpatient Transformation
Clinical Lead

Rebeca Goiriz
Dermatology Consultant



Applying proven SPoA delivery approaches to improve consistency and quality across pathways

Barts Health's journey

Why

- Growing demand and insufficient capacity - long waits and backlog
- Most services relied on Directly Bookable Services (DBS) with minimal triage

Improvement Journey

- **Early A&G pilots** highlighted the value of clinical triage and dialogue with the potential to reduce unnecessary outpatient visits.
- **eRS tech advances** (conversion) and COVID-19 accelerated service redesign, locally badged as 'Advice & Refer (A&R), or Single Point of Access (SPoA).
- **Transformation funding** secured to support A&R implementation and elective recovery.
- **Oct 21: A&R launched in 13 specialities** to streamline referrals and improve access to specialists advice.



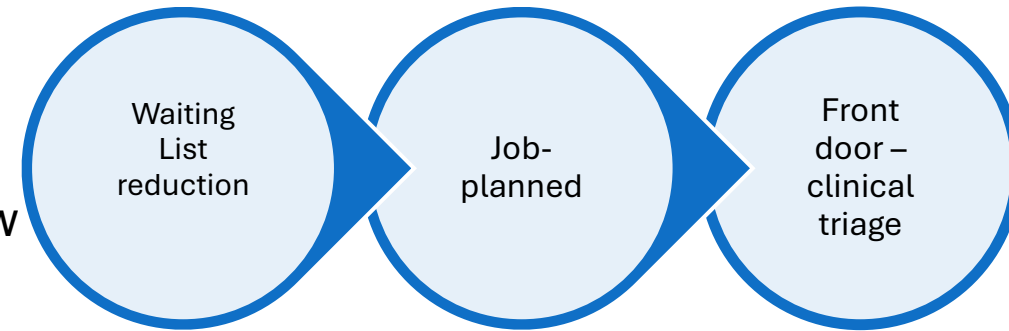
Applying proven SPoA delivery approaches to improve consistency and quality across pathways

SPoA model development

- Built on learning from A&G and RAS pilots; co-developed with primary care
- Single Point of Access (SPoA) created using A&G on eRS, with previous DBS routes closed.

Key components :

- Single clinical '**Front Door**' for all referrals.
- **Every request triaged** to advice, management or specialist review
- **Recognised clinical time** for triage job-planning
- Waiting list reduction



How it was implemented:

- '**Implementation Checklist**' with clinical, operational leads and eRS lead
- Governance across Trust and primary care channels
- **Shared forums** for pathway development and case learning
- Agreed eRS naming conventions to identify SPoA pathways



Adoption

- Growing recognition in clinical-led triage, with supporting data emerging and wider cultural change
- By 2025, over 90 services and sub-specialities had adopted the A&R model.

Applying proven SPoA delivery approaches to improve consistency and quality across pathways

Case study: The Royal London Hospital Dermatology SPoA

Problem

- High demand and long waits
- Limited triage (DBS-pathway)
- A&G service with slow response times

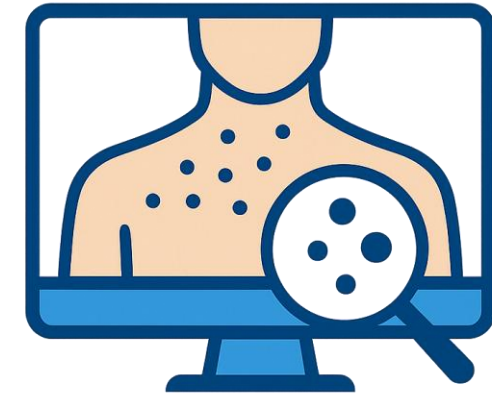
What was done before go-live

- Backlog reduction
- Team job planning and recruitment
- Improving A&G performance
- Extensive engagement ICB/Primary care

Go-live: A&R/SPoA with photo-triage for rapid review and decision making - July 2025

Early impact

- Referral demand reduction by 18% (*to be validated externally*)
- Conversion rates broadly unchanged despite increased volume going through triage route
- Indicative referral demand reduction by ~18% (*pending ICB validation of system impact*)
- Response times <5 days significantly improved from 45% → 95%

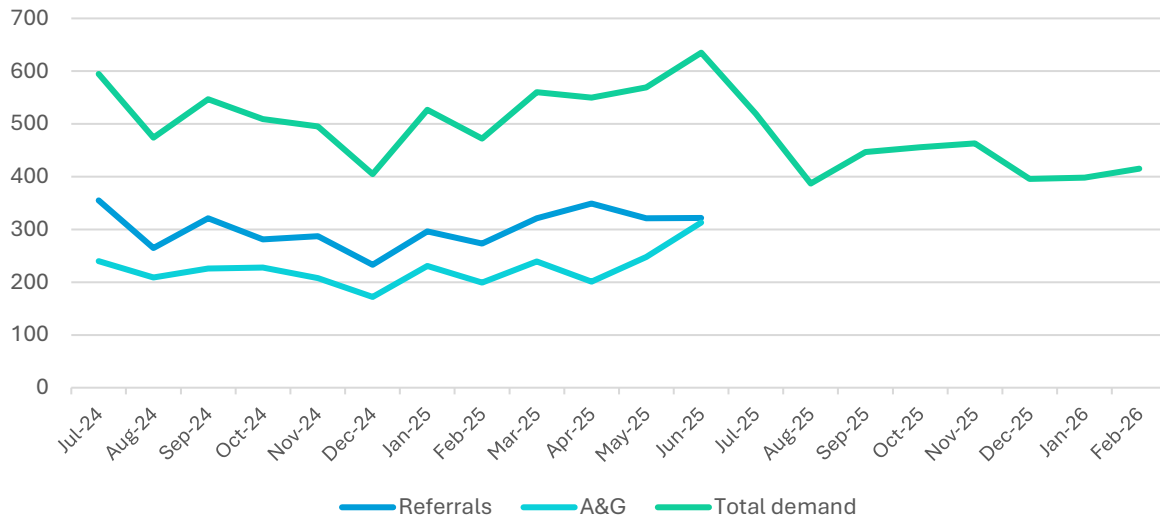


DERMATOLOGY



Applying proven SPoA delivery approaches to improve consistency and quality across pathways: Early impacts of the Dermatology SPoA model

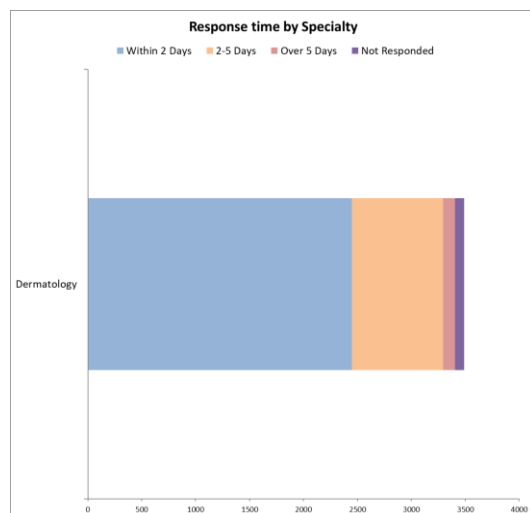
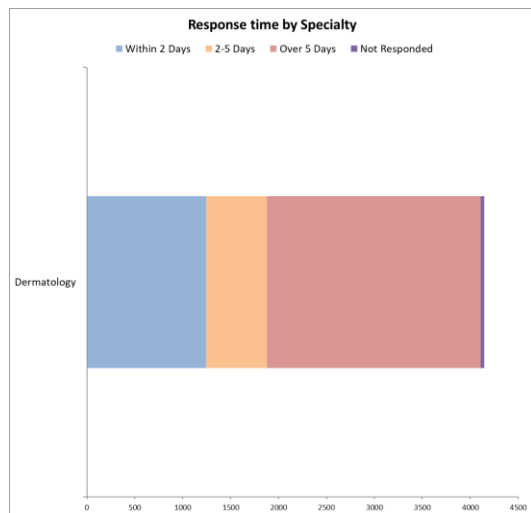
RLH Derm Referral Demand



Pre and post move to SPoA :

- Early data shows overall referral demand has reduced by ~18%*

**(subj to ICB assessment of system impact and unintended consequences)*



- A significant improvement in responses times.
- Left chart shows A&G response times < 5 days ~5%
- Right chart shows SPoA response time < 5 days ~95%

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Benefits, Challenges & Next Steps

★ Wider benefits


- Accurate **triage** right patient, right clinic first time
- **Better management while waiting** “*waiting well*”
- **Photo-based diagnosis**
- Reduced entry points GPs using A&R instead of hotlines freeing up Residents on-call
- Stronger collaboration with primary care
- Better cohort & disease insight

⚠ Challenges


- **System limitations** with photo view/interoperability
- Geographic restrictions
- Variable referral **quality** - (photos/info)
- **Clinic-only requests** or with minimal information
- **Thresholds and workforce shifts** – more staff groups requesting advice that would not have been previously discussed with consultants.

→ Next Steps

- Strengthen **feedback loops** with GPs and patients.
- **Improve referral** and photo standards
- Expand to Paeds Derm
- Maintain local access where demand is high.



“...triage patients on the waiting list – helpful when they flare...”

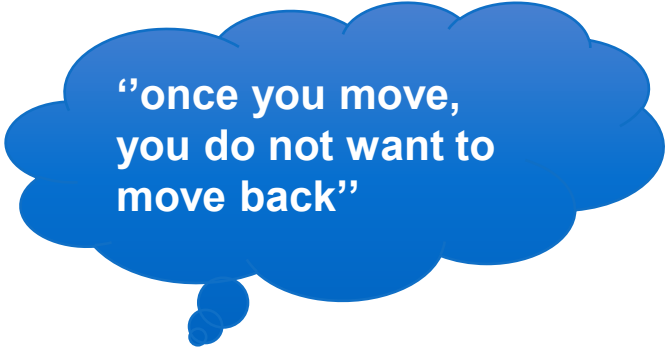


“...significant change to how we work...clinician engagement is increasing...”

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Wider Trust impact

Services who have moved rarely return to their old model “*the new normal*”



“once you move, you do not want to move back”

Impacts

- Reduced average **waiting times** in several services (rheumatology, renal, respiratory, paed).
Reduced overall demand in some services
- *Diversions* c. 27% and *Conversions* ~45% relatively stable despite increasing demand
- **Improved response times** <5 days for many services. Overall trust position ~75%. 90%+ for high volume specialities notably gynae, gastro STT and paed.

Qualitative impacts

- **High quality dialogues** and reassurance/management role in the interim
- **Efficient pathways:** ‘clinical focus’ and pre-work-up completed when attending clinic
- **Educational benefits:** consortias, case reviews, co-developing guidance.



TRIAGE

PRE-WORKUP

CLINIC

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Top 6 stakeholder quotes

Transformative “Once you move, you don’t want to go back.. Can’t imagine without it”

“Managing waiting lists so patients don’t deteriorate.”

“Everything in place before clinic — triage does this.”

“We support primary care and know our GPs.”

“Collaborative dialogues... high-quality advice.”

“Before A&R: 3 months triage, 12 months wait...”


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Stakeholder Themes

- Better **clinical dialogue** and relationship with Primary Care. Changing from binary 'reject/accept'.
- **Improved patient management** on waiting lists
- **Efficient pre-work up** at clinic.
- **Speed of response** in comparison to waiting for outpatient appt to be told something similar
- **Tailored** to patient




Challenges:

- **System limitations** – time, functionality & interoperability.
- **Multiple applications** opened
- **Thresholds** lowered, easier access
 -  Maintaining local population access
- Access to patient information if out of area.



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Lessons learned

 **Leadership & Engagement** – joint operational and clinical leadership working together, with eRS expertise.

 **Access** to local population

 **Referral Quality** - continuous feedback loop with primary care

 **Share the benefits/ impacts** through **clinical** champions and medical/clinical leaders and data “hearts and minds”

 **Recognise it is a change in practice** for both GPs and Secondary roles and the **initial outlay** in time and resources. It will take *time to embed* and mature.


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Next steps

 **Expand** SPoA model – e.g. site variation

 **Quality improvement** - feedback loops with primary care and performance.

 **Trust strategy:** Trust SPoA vs multi-site SPoA vs sub-speciality

 **Managing local demand and need** - where other Trusts do not yet have an A&G or SPoA model.

 **Accessible data** – support clinical leadership and service monitoring

Poll



Resources

- Recent recordings and slides, and future webinar details:
 1. NHS-Planning webinar held 19 January 2026:
[Preparing for Elective Care Delivery: Insights from the Medium Term Planning Framework](#)
(on FutureNHS – login required)
 2. National Elective Care Programme webinar held 5 February 2026:
[Operationalising single point of access](#)
(on FutureNHS – login required)
 3. An eRS webinar is planned for 15 April 2026: [Webinar: Powering the Future of e-RS – Upgrades to Transform A&G and Single Point of Access \(SPoA\) | NHS England Events](#)
- Elective SPoA Technical Guidance, Elective SPoA Technical Guidance Summary, Speciality Prioritisation Workbook have been circulated and is also available on FutureNHS in the new elective SPoA workspace - [Elective Single Point of Access \(SPoA\) - Outpatient Recovery and Transformation Platform - Futures](#)
- Demo of the initial eRS A&G upgrade [Advice & Guidance Demo_190226 - NHS e-Referral Service \(e-RS\) - Futures](#)
- The SPoA clinical toolkit and Frequently Asked Questions will be coming soon and will also be available on FutureNHS in the [new elective SPoA workspace](#).

Contacts

1. The national Referral Optimisation team: england.electivepmo@nhs.net

Please ensure the subject reads “Elective SPoA”

2. Referral and Appointments digital team (e-RS, BaRS and Wayfinder): england.randaoffice@nhs.net

3. The national Choice team: england.choice@nhs.net

4. The national GP Contracting team: england.gpcontracts@nhs.net

5. The national Independent Sector team: england.iscoordination@nhs.net

Thank you for attending today

Useful links



[Outpatient Recovery and Transformation Platform – Futures](#)
[NHS e-Referral Service \(e-RS\) - Futures](#)



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