National Elective Care Programme

Preparing for Elective Care Delivery: Insights from the NHS Medium Term Planning Framework

Welcome, please note the webinar will start at 1pm

21 January 2026

NHS Planning Community of Practice

Supporting the introduction of medium-term planning

Today's session

- Invitations were sent to members of the Planning COP, with forwarding enabled to invite relevant colleagues.
- The session will be recorded.
- Materials from the session will be shared in the NHS Planning Futures workspace: Webinars - NHS Planning - Futures
- The Q&A is open. Please 'upvote' questions rather than repeating them.

About the Planning COP

The aim of the CoP is to support NHS organisations to plan effectively by:

- Supporting colleagues in understanding how planning will evolve following the release of the 10 Year Health Plan and as part of the medium term planning process.
- Sharing information on planning processes and national expectations at the earliest opportunity with key stakeholders, at ICB and system/provider level.
- Facilitating discussion about best practice in planning and sharing tools and techniques that will help develop plans.
- Identifying barriers to effective planning and supporting ways to overcome these.

Preparing for Elective Care Delivery: Insights from the NHS Medium Term Planning Framework

Agenda

21 January 2026, 13:00 – 14:00

Timing	Agenda Item	Lead
13:00	Welcome and introduction	Barny Leavers, Acting Director, National Outpatient Transformation Team, NHS England Ian Eardley, National Clinical Director for Elective Care, NHS England
13:10	Northumbria GI - Single Point of Access (SPoA)	Matt Warren, Consultant Gastroenterologist, Northumbria Healthcare NHS Foundation Trust
13:30	Advice & Guidance in eRS	Andy Todd, Assistant Director Operations and Delivery Planned Care, NHS England
13:35	Q&A session	Ian Eardley, National Clinical Director for Elective Care, NHS England
13:55	Closing remarks	Ian Eardley, National Clinical Director for Elective Care, NHS England

Medium Term Planning Framework 2026/7 to 2028/9
Key principles for how we start to transition to the new model

Year 1 transition to the new model of planned care will focus on:

Single Point of Access/ A&G

- **Prioritise Advice & Guidance (A&G) over referrals**
- **A&G for available for the 10 highest-impact specialties from April 2026**
- **e-RS to be used for all A&G** requests from July 2026 (Oct 2026 if third party)
- All requests and referrals within these ten specialties to receive **appropriate clinical triage** and flow through a **Single Point of Access by October 2026**

Improving productivity

- Standardising practice in-line with GIRFT guidance
- Including, conducting comprehensive review of clinic templates and standardising them in line with job planning guides.
- Appropriately managing waiting lists, including through validation

Re-thinking follow up care

- Reducing routine, clinically low-value follow-up appointments, supported by GIRFT speciality-level guides
- Empowering patients with greater choice and control over their follow-up care e.g. through PIFU, digital monitoring and remote consultations

Neighbourhood health

- ICBs, trusts and general practice to work together to plan for delivery of the new neighbourhood health approach, with further details to be set out in the Model Neighbourhood Framework

Adopting and embedding a **modern digital infrastructure**, to progress a digitally enabled, patient-led planned care model

This builds on work already underway delivering Elective Reform Plan commitments, including priority pathway transformation work in ENT, gastro, respiratory, cardiology and urology

National Elective Care Programme - 2026/ 27 Roadmap

Apr – Sept 2026 Expanding the use of Advice & Guidance (A&G)

Oct 2026 – Mar 2027 Implementing elective Single Point of Access (SPoA)

From Apr 2026

NHS providers of RTT consultant-led care must make available and **prioritise A&G across at least 10 specialties**, selected locally for greatest benefit.

From Oct 2026

Providers must **implement consultant led clinical assessment of all A&G requests and elective referrals** (excluding referrals for urgent suspected cancer) **through (implementing) an elective SPoA at specialty or sub-speciality level.**

APR 2026

OCT 2026

MAR 2027

From Apr 2026

Providers must open existing digital channels (e-RS and third-party systems) for all specialties where A&G is clinically appropriate.

From Jul 2026

e-RS must be used for all A&G requests managed within e-RS.

From Oct 2026

e-RS must be used for all A&G requests where a third-party service is used and integrated with e-RS.

Oct 2026 – Mar 2027

SPoA within e-RS and third-party systems must start with the 10 specialties prioritised for A&G (as a minimum) and expand to remaining relevant specialties and sub-specialties as early as possible.

Any third-party solutions not integrated with e-RS by October 2026 are to be decommissioned, with exceptions only by agreement where third-party software prevents delivery.

Different service types e.g., DBS, RAS, CAS must be decommissioned unless exceptions are agreed.

Digital enablement of Advice & Guidance (A&G)

What will planned care look like in the future?

An overview of the New Model of Planned Care

Over the next 10 years care will become more personalised and flexible to each patient's individual needs. Services will be better connected, and patients will be able to access the care that they need quicker and closer to home. Technology will improve efficiency, increase productivity and empower patients to have more control over their own care.

A new Single Point of Access system

From 2026/27 facilitate clinical prioritisation, enable easier diagnostic access and support care closer to home

- Use e-RS to submit **all** A&G requests, requests for diagnostics (straight to test) and referrals
- Improve communication between primary & secondary care
- Improve triage at beginning of a patient pathway

Highly productive digitally-enabled care

Improved productivity, patient access and communication

- Reduced admin burden, increase efficiency and improve communication
- Patients will have more control over their care via NHS App
- Clinicians will be able to use digital clinical tools and have improved access to patients' records

Four main areas of change

Radical rethinking of follow-up care

Using digital tools, neighbourhood MDT working with emphasis on empowering patients

- Remote monitoring and wearable technology
- Digitally supported PIFU via App
- Integrated Neighbourhood Teams will support proactive self-management and F/UP care in community

A new Neighbourhood Health Service

Multidisciplinary neighbourhood working with more care closer to home

- Enable more patients to receive treatment, monitoring, or follow-up care closer to their home
- Integrated Neighbourhood Teams provide support for those with long-term or multiple conditions

Northumbria SPoA

Experience
Challenges
Tips

Matt Warren

Traditional Model
(Where we started!)

Long waits

Silo-ed working

Service-wide impact

Unhelpful activity / inefficiency

Zero-sum game

Patients getting a bad deal

Need for change

Northumbria Work

Speed:
Routine NP 4/52
Rapid dialogue to support Primary Care

1. **Build Relationships with Primary Care**

2. **A&G / SPoA**
   - **“Discuss with, not Refer to”**
   - **Think outside the clinic room**

3. **Get the Basics Right**
   - Clinical / managerial team
   - Validation and housekeeping

Timeline

I. **Informal email advice service**

I. **Early adopters of eRS RAS and A&G**

II. **Summer 2023 – SPoA**

III. **700 referrals per month**

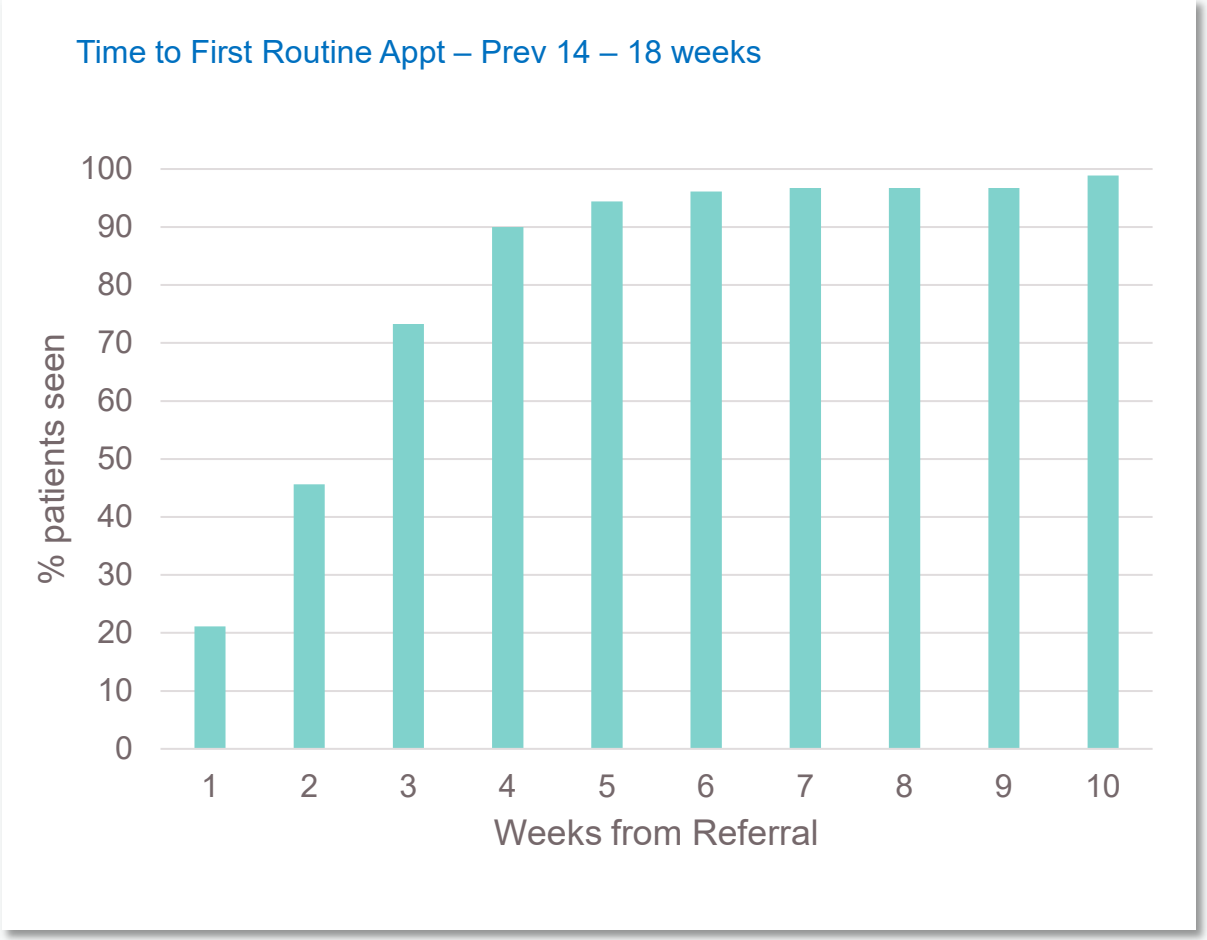
Current Performance

4/52 wait

RTT > 95%
(no long waits)

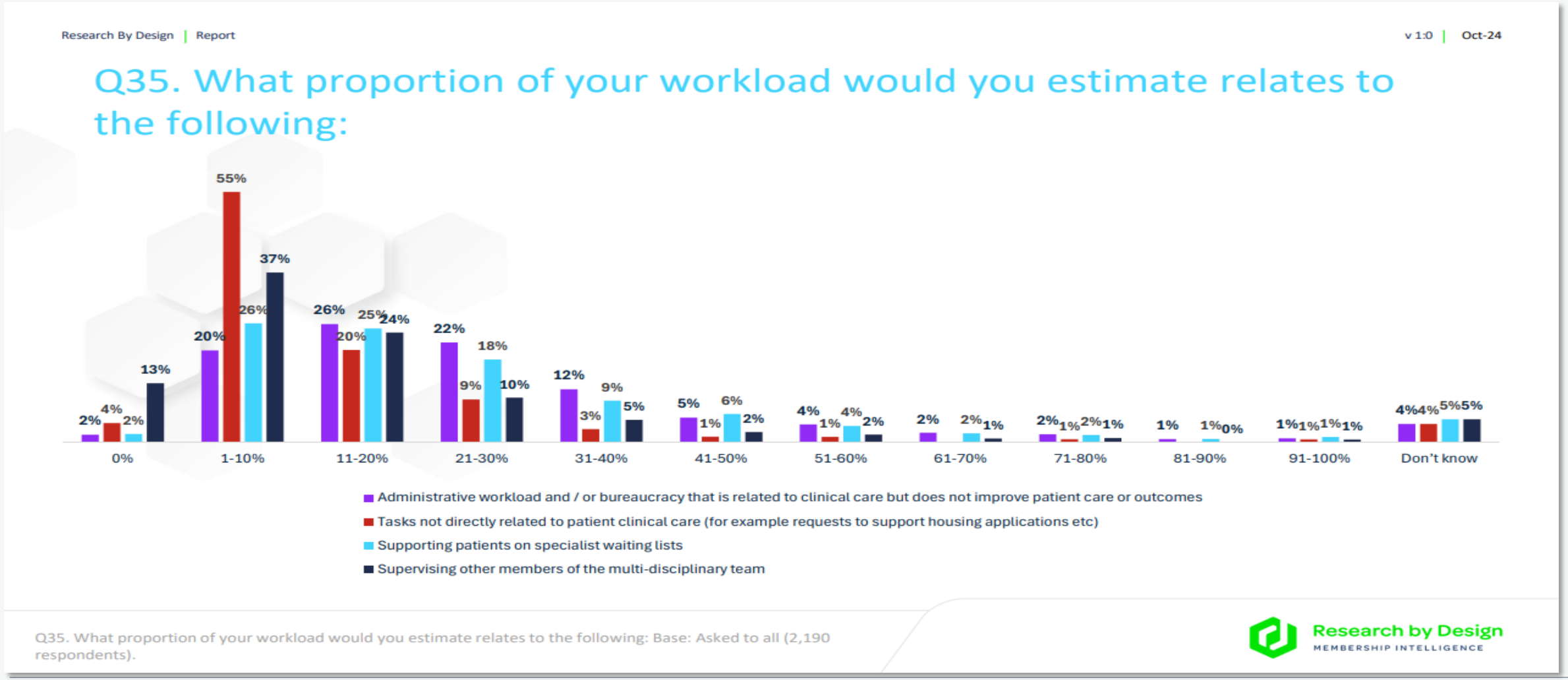
< 20 ASI

No WLI



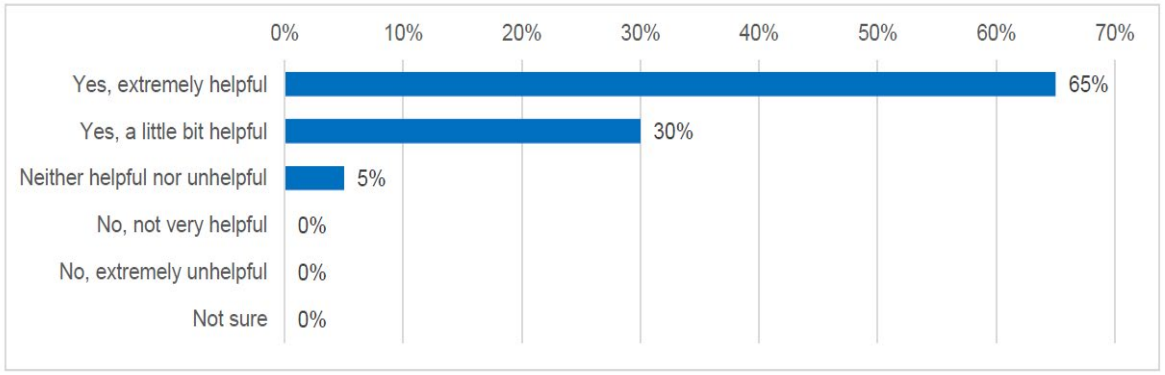
Primary Care

Building relationships is key – the WL has impact on Primary Care

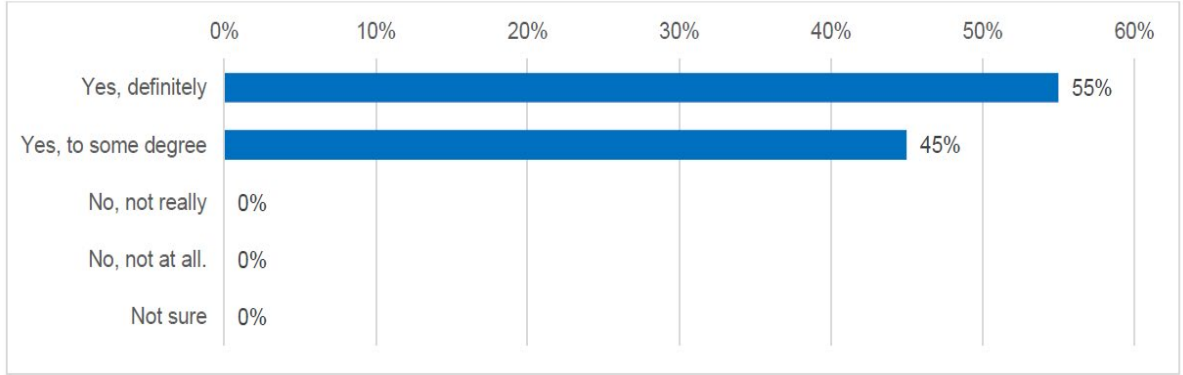


Primary Care feedback

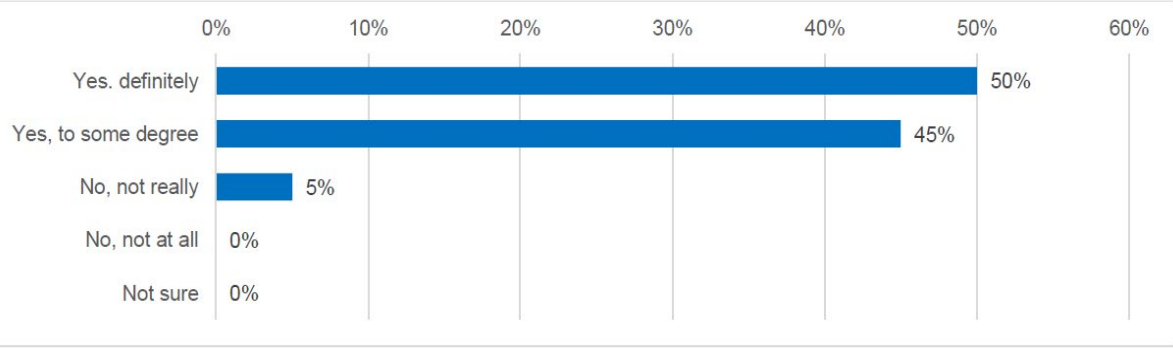
2. Was the advice you received from GI helpful for you to manage your patient's condition?



5. Do you think this service model is beneficial to patients?



6. Do you feel that the current approach has led to an increased workload for primary care colleagues where referrals are "returned with advice"?



Done well - they like it, despite workload

Done less well…

What is “Good” SPoA?

Good SPoA – A holistic, professional conversation

Advances care
Not: “Reject”

Timely

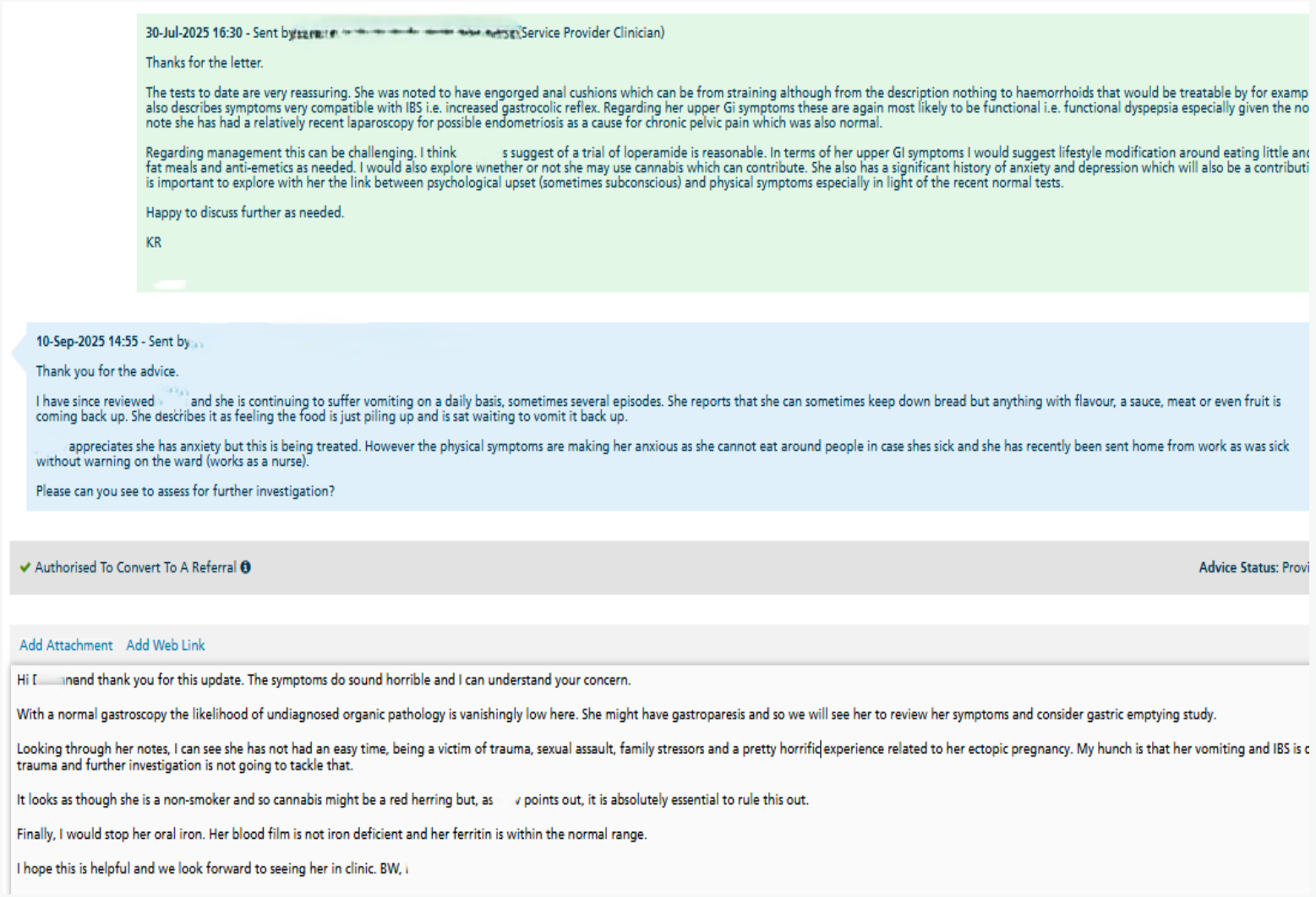
Generalist and pragmatic

Polite and Respectful

Reasonable – no shopping lists

Open ended

Read by the patient!



30-Jul-2025 16:30 - Sent by (Service Provider Clinician)

Thanks for the letter.

The tests to date are very reassuring. She was noted to have engorged anal cushions which can be from straining although from the description nothing to haemorrhoids that would be treatable by for examp also describes symptoms very compatible with IBS i.e. increased gastrocolic reflex. Regarding her upper Gi symptoms these are again most likely to be functional i.e. functional dyspepsia especially given the no note she has had a relatively recent laparoscopy for possible endometriosis as a cause for chronic pelvic pain which was also normal.

Regarding management this can be challenging. I think s suggest of a trial of loperamide is reasonable. In terms of her upper GI symptoms I would suggest lifestyle modification around eating little an fat meals and anti-emetics as needed. I would also explore wnether or not she may use cannabis which can contribute. She also has a significant history of anxiety and depression which will also be a contributi is important to explore with her the link between psychological upset (sometimes subconscious) and physical symptoms especially in light of the recent normal tests.

Happy to discuss further as needed.

KR

10-Sep-2025 14:55 - Sent by

Thank you for the advice.

I have since reviewed and she is continuing to suffer vomiting on a daily basis, sometimes several episodes. She reports that she can sometimes keep down bread but anything with flavour, a sauce, meat or even fruit is coming back up. She describes it as feeling the food is just piling up and is sat waiting to vomit it back up.

appreciates she has anxiety but this is being treated. However the physical symptoms are making her anxious as she cannot eat around people in case shes sick and she has recently been sent home from work as was sick without warning on the ward (works as a nurse).

Please can you see to assess for further investigation?

✔ Authorised To Convert To A Referral ⓘ Advice Status: Provi

Add Attachment Add Web Link

Hi nand thank you for this update. The symptoms do sound horrible and I can understand your concern.

With a normal gastroscopy the likelihood of undiagnosed organic pathology is vanishingly low here. She might have gastroparesis and so we will see her to review her symptoms and consider gastric emptying study.

Looking through her notes, I can see she has not had an easy time, being a victim of trauma, sexual assault, family stressors and a pretty horrific experience related to her ectopic pregnancy. My hunch is that her vomiting and IBS is c trauma and further investigation is not going to tackle that.

It looks as though she is a non-smoker and so cannabis might be a red herring but, as v points out, it is absolutely essential to rule this out.

Finally, I would stop her oral iron. Her blood film is not iron deficient and her ferritin is within the normal range.

I hope this is helpful and we look forward to seeing her in clinic. BW,

Getting the basics sorted

“There is no magic in magic, it’s all in the details” Walt Disney

Validation

18-week RTT tracking meetings

Templates and SLA job plans

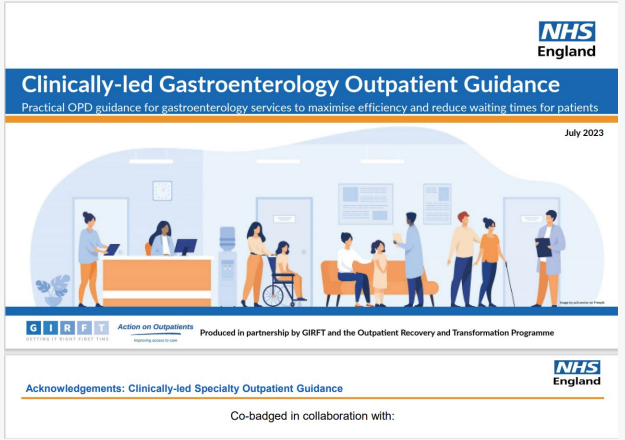
Deployment of trainees

FOWL

A lot of (ongoing) work:

But it is essential

Clinical / managerial teamwork



Challenges

There are many. But “Do Nothing” option isn’t viable.

Primary Care

Existing workload
Transfer of work
Risk
Resistance to change
Resource not following workload

Secondary Care clinicians

Resistance to change
Selecting a team
Resource
Risk
Time pressures

Providers

Forums for discussion / ICB
Capacity versus Capability
Finance – “lost income”
Finance – consultant Pas
Winter / other pressures

Quick Wins…

…or “where to get started”

Find and support your champions

Lead with your “best” services

Make the first encounters positive

Managerial expertise

SLA / clinic templates

GIRFT checklists

Validation

Advice & Guidance in eRS

Andy Todd

Advice & Guidance requests in eRS

Supporting the increased use in A&G

- Significant investment being made in eRS
- Developments being made in eRS which will deliver a significantly upgraded version of the A&G functionality to support delivery of the planning framework.
- Improved functionality will include:
  - **2-way chat functionality**
  - **Remove character restrictions** from A&G request and response
  - **View attachments** without having to download
  - A&G **dashboard** available to users which illustrates status of all A&G requests
  - Use of **digital dictation** in system for clinicians to dictate requests and responses
  - Requester or responder able to **close A&G request**

Advice & Guidance requests in eRS

Improved A&G and move towards SPoA

- Ability to use the new A&G service in eRS is to be rolled out in April 2026.
- eRS to be used for all A&G requests made by primary care with effect from:
  - July 2026 – where requests are managed within the eRS user interface;
  - October 2026 – where 3rd party systems are used.
- New A&G functionality underpins the strategic direction towards Single Point of Access (SPoA) – critical to future planned care models.
- From October 2026, SPoA to be implemented within eRS with consultant led clinical triage of all A&G requests and elective referrals, commencing with priority specialties.

Q&A Session

Thank you for attending today

Please take some time to complete our Teams poll
Your feedback will help us improve future webinars

Useful links

Futures [Outpatient Recovery and Transformation Platform - Futures]

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england.nhs.uk