

Date published: 22 April, 2026  
Date last updated: 23 April, 2026

# Specialist advice and elective single point of access – what this means for you and your patients

[Publication \(/publication\)](#)

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Classification: Official  
Publication reference: PRN02476

To:

- GP practices
- Primary care networks:
  - clinical directors

cc:

- NHS England regions:

- regional directors of primary care
- regional primary care medical directors
- regional chief operating officers
- Integrated care boards (ICBs):
  - primary care leads
  - chief operating officers
- Trusts:
  - chief executives
  - chief operating officers
  - medical directors

Dear colleagues,

## **Specialist advice and elective single point of access – what this means for you and your patients**

Thank you for your ongoing work in providing timely and high-quality patient care and supporting with activity to manage safe and appropriate referrals into secondary care.

I know some GPs have concerns about specialist advice and the introduction of elective single points of access (SPoA). This letter explains what we mean by the model and what you should expect from secondary care.

### **What we are trying to achieve**

The purpose of elective SPoA is to ensure patients and practices receive rapid specialist assessment and a clear next step, using modern referral and triage approaches. This is not about doing more of the same or using specialist advice as a way to reject or refuse referrals from general practice. **It is important to emphasise that the clinical threshold for a referral remains unchanged.**

### **Co-design with general practice**

Trusts and ICBs must ensure that local GPs and GP leaders, for example, local medical committees and interface groups are involved in the design and ongoing refinement of elective SPoA pathways. To be effective this should include involving specialties that are in scope and local GPs, ensuring pathways are clinically appropriate and workable for all. Systems should be working with established local GP leadership structures to address issues if they arise. This relies on ongoing and honest conversations between trusts, ICBs and local general practice.

We have worked with primary and secondary care clinicians, operational teams and patients, and have taken their feedback seriously. There are some fantastic examples of where advice and guidance is working really well: this is often where teams are working closely together to design ways of working that optimise the opportunities that advice and guidance brings, both for clinicians and for patients. However, we have also heard clearly that this is not universal: with concerns about variation, inconsistency and poor communication between services and we are determined to tackle this.

Our collective challenge is working through how we mainstream the experience where patients receive timely specialist assessment and management advice without needing a hospital outpatient appointment, which is quicker and more efficient for patients, and for both primary and secondary care. We will ensure that creating positive conditions around advice and guidance is a priority for trust leadership teams in the months ahead.

The elective SPoA model should be viewed as a tool to help reset the current practice. In doing so it:

- brings specialist advice requests and referrals together through a single route
- introduces clear clinical standards,
- encourages more consistent 2-way communication between GPs and secondary care consultant teams.

It is one element of a broader programme of outpatient transformation, which will be set out in the NHS's New Model for Planned Care, which are due to be published shortly. That wider programme looks across the whole outpatient pathway to improve patient experience and make better use of clinical capacity across primary and secondary care.

## **No national diversion targets**

I know there have been concerns about the terminology used in the recently published neighbourhood health framework, in particular that SPoA can contribute to a diversion rate of at least 25%. **But is important to be clear that there is no national target** for specialists, trusts or general practice to divert a fixed proportion of referrals away from hospital care. The objective is simply to identify the most appropriate next step for each patient, based on specialist assessment and triage at speciality or sub-specialty level. The figure quoted relates to an estimate of the potential proportion of patients, including those who are the subject of an A&G enquiry, who could be appropriately assessed and supported by a specialist consultant without a hospital outpatient appointment. It is not the proportion of referrals to be sent back to general practice.

Where there is clear clinical evidence, the intention is to avoid adding patients to outpatient waiting lists when they can receive timely diagnosis, advice or management in a more appropriate setting.

## **Your clinical judgement remains central**

You should continue to make a clinical decision to refer for specialist care where that is in the patient's best interests, and to request specialist advice where that is what you need. The model is intended to support decision-making, not override it. **A GPs clinical decision to refer remains unchanged.**

Where specialist advice is provided but the GP remains concerned that referral is clinically appropriate, there should be a clear route for referral, supported by additional clinical context from the GP where needed, to ensure the most appropriate pathway for the patient is agreed.

## **Operational standards you should expect**

### **Timely responses**

- routine referrals: 5 working days from receipt of referral to actioning next step
- urgent referrals: 2 working days from receipt of referral to actioning next step
- specialist advice request: a response within 5 working days from receipt of request

### **Senior, accountable specialist input**

- **requests for referral or specialist advice will receive a response from a named consultant.** Where a local model is already in place, or is established by local agreement between primary and secondary care, that provides timely specialist clinical assessment with clear accountability and oversight from a named consultant, this may continue.

### **Clear next steps**

- outpatient appointment where needed
- straight-to-test or diagnostic pathways organised by the trust
- advice on primary care diagnostics, where this has been requested by the GP
- clear and patient specific specialist advice as requested by the GP, or where primary care management is clinically appropriate

## **Diagnostics and follow-up**

Where specialist assessment identifies the need for diagnostic tests as part of the specialist pathway, **those tests should be organised by secondary care, with results reviewed and acted on by the trust.** These tests should not be returned to general practice to arrange. General practice should continue to arrange diagnostic tests that are routinely undertaken as part of assessment or prior to referral.

Where a patient is awaiting tests or treatment in secondary care, as is the case currently, GP teams should continue to escalate concerns to secondary care where clinically indicated.

## **Raising concerns and next steps**

Where concerns arise about how specialist advice or elective SPoA is operating locally, we expect trusts, clinicians and ICBs to work together to resolve these issues through established local governance and clinical leadership arrangements.

Where systems are unable to resolve issues locally, NHS England will support further discussion and review, focusing on learning, consistency and improvement.

We will continue to provide national communications and will hold a webinar for general practice, clinically led across primary and secondary care, to address practical questions about the model.

Additionally, there is an NHS CEO leadership event being held on 28 April 2026 to talk through specialist advice and SPoA, at which clinical representation, including GPs, will be present.

Thank you for your continued hard work, patience as we work through these changes and your commitment to provide the best care possible to your patients.

**Dr Amanda Doyle OBE, MRCP**, National Director for Primary Care and Community Services  
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