National Elective Care Programme

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

Webinar: 21 January 2026

Summary and Guidance for GP Provider Collaboratives

Background

The NHS Medium Term Planning Framework sets out the strategic direction for transforming elective and planned care, including changes to digital infrastructure, clinical pathways, and performance expectations.

The National Elective Care Programme focuses on transitioning to a new model of planned care between 2026/27 and 2028/29, with a strong emphasis on improving productivity, strengthening clinical pathways, and delivering more integrated, patient-centred services.

Key Priorities

- Expanding the use of **Advice and Guidance (A&G)** as a core clinical pathway
- Improving productivity and reducing unnecessary outpatient activity
- Rethinking follow-up care models
- Strengthening neighbourhood and community-based care
- Investing in digital infrastructure to support modern service delivery
- Enabling more personalised, patient-led care

> A national roadmap sets out the implementation timeline, including the **expansion of Advice and Guidance from April 2026 for the 10 highest impact specialities** and **the introduction of Single Point of Access (SPoA) models by October 2026.**

All specialties will be expected to use **e-Referral Service (e-RS)** for Advice and Guidance requests, with third-party systems either integrated into e-RS or decommissioned by **October 2026**.

The Future of Planned Care

Planned care is expected to become more personalised, flexible, and delivered closer to home through digital technology and integrated clinical teams.

New care models will include:

- A **Single Point of Access (SPoA)** for elective referrals

- Expanded use of digital diagnostics
- Remote monitoring and virtual care pathways
- Greater use of community and neighbourhood-based services

There will also be a significant shift in how follow-up care is delivered, including increased use of:

- Patient Initiated Follow-Up (PIFU) via the NHS App
- Remote monitoring and wearable technology
- Integrated Neighbourhood Teams (INTs) and multidisciplinary team (MDT) working

Overall goals are to:

- Reduce administrative burden
- Improve pathway efficiency
- Increase clinical productivity
- Empower patients to manage their care digitally
- Deliver more care in community settings where appropriate

Single Point of Access (SPoA)

The Single Point of Access will enable **consultant-led clinical assessment of all Advice and Guidance requests and elective referrals (excluding urgent suspected cancer referrals).**

Referrals will be clinically reviewed before an appointment is booked, directing patients to the most appropriate pathway at the earliest stage.

This approach is intended to:

- Improve patient flow
- Reduce unnecessary outpatient appointments
- Shorten diagnostic pathways
- Increase efficiency across elective services
- Improve patient experience

Implementation will begin with **10 locally determined priority specialties** and will expand over time.

Northumbria SPoA Implementation Experience

The NHSE webinar uses the Northumbria model to demonstrate a transition from traditional referral systems (characterised by long waits and siloed working) to a more responsive, relationship-based approach focused on clinical advice and rapid triage.

Reported Performance:

- Referral to Treatment (RTT) performance consistently above 95% within 4 weeks
- Established Advice and Guidance services
- Twenty Advice and Support Initiatives (ASI) in operation

Implementation challenges included:

- Existing workload pressures in primary care
- Transfer of workload and risk to primary care without additional resource
- Resistance to organisational change in primary and secondary care
- Capacity constraints
- Workforce and time pressures in secondary care
- Lack of appropriate forums for discussion

Factors supporting successful implementation:

- Engaging enthusiastic clinical champions
- Leading with high-performing secondary care services
- Building strong relationships across the interface
- Framing decisions as advancing care, not rejecting referrals
- Maintaining professional, timely, pragmatic, respectful communication
- Creating positive early user experiences
- Engaging managerial expertise
- Ensuring robust referral validation processes

Advice and Guidance via e-RS

Significant national investment is being made to enhance the functionality of the **e-Referral Service (e-RS)** to support the shift towards consultant-led triage and SPoA models.

New features include:

- Two-way chat functionality
- Secure document and image attachments
- Structured communication workflows
- Digital dictation capability
- A&G dashboards showing request status
- Ability for requester or responder to close A&G requests

Enhancements are designed to support faster clinical decision-making and more efficient patient pathways.

Timely review of Advice and Guidance (A&G) requests and elective referrals is supported by the **national response standards**:

- **A&G requests:** A response to be provided within 5 working days of receipt.

- **Routine referrals:** Next steps actioned within 5 working days of receipt.
- **Urgent referrals:** Next step actioned within 2 working days of receipt.

Implementation Timeline

April 2026
Enhanced A&G functionality begins rollout across 10 priority specialties.

July 2026
All A&G requests expected to be submitted via e-RS.

October 2026
Full implementation of SPoA within e-RS.
Third-party referral systems to be integrated or decommissioned.

Areas of Focus for GP Provider Collaboratives

1. Early Engagement with System Design

NHS England states that Integrated Care Boards (ICBs) are responsible for engaging primary care representatives. GP Provider Collaboratives and Local Medical Committees (LMCs) can proactively participate in shaping local implementation and decision-making from the outset.

Early engagement is essential to ensure systems are:

- Clinically safe
- Operationally workable
- Sustainable for general practice

Practical Actions

- Engage early with ICBs and secondary care colleagues on SPoA and A&G implementation
- Ensure primary care representation in system design discussions.
- Identify relevant forums where SPoA planning and pathway redesign are being discussed
- Seek clarity on whether protected time, resource, or local funding is available to support GP attendance and participation
- Nominate enthusiastic clinical leads to represent the collaborative in relevant meetings.
- Build strong professional relationships across the primary and secondary care interface (develop an understanding and appreciation of each other's perspectives where possible).

- Explore opportunities to strengthen collaboration through existing initiatives, such as:

    - Shared clinical teaching sessions
    - Joint pathway design workshops
    - Interface meetings
    - Multidisciplinary education forums

- Work closely with Local Medical Committees (LMCs), which are well placed to support and coordinate engagement.

2. Communication Standards

Effective communication between primary and secondary care will be essential to maintain trust, support safe patient care, and avoid complaints.

Poor communication has the potential to damage professional relationships and generate patient dissatisfaction, particularly as patients may have visibility of A&G responses.

Expectations

Secondary care has been advised to:

- Provide timely, professional and courteous responses to A&G requests
- Avoid language that undermines GP clinical decision-making
- Offer constructive and helpful clinical advice
- Include patient self-management advice where appropriate
- Support collaborative decision-making

GP Provider Collaboratives could therefore:

- Promote shared expectations for professional communication in line with the **Good Medical Practice** framework under the domain of *Colleagues, culture and safety* which includes treating colleagues with kindness, courtesy, and respect, listening to colleagues, communicating clearly, politely, and considerately, and working collaboratively.
- Escalate concerns where communication standards are not met
- Encourage a culture of mutual respect and collaboration

3. Establishing a Feedback Process

A formal feedback mechanism will be essential to monitor performance, identify risks, and support continuous improvement. The approach should be designed collaboratively and include feedback from both primary and secondary care.

Measures to Monitor

- Quality and appropriateness of responses provided to GPs
- Timeliness of responses
- Number of referrals downgraded to Advice and Guidance (including whether the referring GP was contacted in advance and agreed to the downgrade)
- Impact on secondary care waiting list times and patient flow (this may come later)
- Free-text feedback on system usability and clinical safety

Governance and Accountability

The feedback process should clarify:

- Where feedback results will be reviewed
- Who is responsible for reviewing the data
- Who is responsible for implementing improvement actions
- How learning will be shared across organisations

4. Consultant-Led Clinical Triage

Consultant-led clinical triage is a central component of the SPoA model for A&G and referral requests.

GP Provider Collaboratives should be involved in defining how clinical advice is delivered and by whom.

Work with secondary care to:

- Define who is authorised to provide Advice and Guidance to primary care
- Agree which pathways require consultant assessment only
- Identify any pathways where appropriately trained non-consultant clinicians could provide advice e.g. Specialist cardiology nurses, diabetes nurses

These arrangements should be:

- Clearly defined
- Clinically governed
- Agreed in advance

NHSE supports allied health professionals working within the neighbourhood health model to be able to request Advice and Guidance where appropriate, but requests must be discussed with a named GP before submission.

5. Rejection and Downgrading of Referrals

The SPoA model allows elective referrals to be downgraded to Advice and Guidance.

NHS England emphasises that the intention is to provide specialist advice that supports appropriate care, rather than simply rejecting referrals.

The model prioritises "**Advice and Guidance before referral"**

The phrase **"Discuss with, not refer to"** has been promoted by NHSE as a preferred approach from GPs.

Recommended Principles

No GP referral should be downgraded to Advice and Guidance without:

- Direct discussion with the referring GP
- A clear explanation of the clinical rationale
- Agreement from the GP

If the GP considers specialist assessment necessary, the referral should proceed in line with GMC guidance requiring clinicians to refer when a condition falls outside their competence.

Referrals should not be rejected solely due to:

- Missing information
- Incomplete proformas
- Administrative errors

Instead:

Additional information should be requested directly from the practice.

Responsibilities for Practices

Practices should:

- Use **agreed** referral templates
- Aim to provide complete clinical information at the point of referral
- Follow locally agreed referral standards

6. Patient Choice

Referral management processes must comply with national patient choice requirements.

GP Provider Collaboratives are well placed to ensure that:

- Patient choice is preserved within SPoA pathways
- Local processes align with national policy requirements

- Referral decisions (including downgrading to A&G) do not inadvertently restrict patient choice

Particular attention should be paid to Jess's Rule and other NHS patient choice initiatives.

7. Workforce and Capacity Considerations

Increasing the use of advice and guidance in primary care will have significant workforce and workload implications.

Collaboratives can:

- Monitor workload impact on primary care
- Escalate capacity concerns early on
- Advocate for appropriate resourcing or "left shift"
- Ensure clinical safety is maintained during implementation

Checklist for GP provider Collaboratives

Engage early in system design and governance
Ensure strong primary care representation across SPoA and pathway redesign meetings
Confirm the 10 specialities included in rollout of SPoA and agree these with Acute Trust / ICBs
Maintain and promote professional communication standards and collaborative decision making
Establish robust feedback and monitoring processes
Define governance and accountability
Agree clear rules for clinical triage and referral management
Maintain escalation routes for clinical concerns
Protect patient choice
Monitor workload and workforce impact on general practice
Advocate for appropriate resourcing where appropriate
Build strong relationships across the primary–secondary care interface
Protect safe referral processes: - No referral should be downgraded with GP discussion and agreement - Referrals not to be rejected for administrative reasons alone - Use agreed referral templates and standards

In a recent *NHS England letter* to ICBS and Trust Chief Executives dated 1 April 2026, Sir James Mackey sets out the **next steps on planning and priorities for 2026/27.**

Integrated Care Boards (ICBs) are asked to further develop their strategic commissioning narratives by Friday 15 May, with particular emphasis on:

- What strategic commissioning means within the local system and how it will be developed over the next three years
- How neighbourhood care will be developed, including the system's strategic ambition and how this addresses key local challenges
- Whether changes to financial flows or payment systems are required to support delivery, and specifically what those changes should be
- Whether further national action is needed to accelerate local progress, including removing barriers where necessary

The letter identifies the "key priorities" described as the next set of "big leaps" for the NHS. These include a significant reset of outpatient care and reforms to urgent care access and scheduling in line with the webinar summarised earlier in this document.

Annex A — The Eight Key Priorities

1. **Outpatient transformation**
   Shifting away from traditional outpatient models through a major expansion of Advice and Guidance and a reduction in unnecessary follow-up appointments.
2. **A step-change in reducing hospital bed-days for highest-risk cohorts**
   Neighbourhoods to play a central role in implementing proactive care models for high-risk groups.
3. **Scheduling and access reform for urgent care**
   Making it easier for patients to book urgent care appointments in GP practices, urgent treatment centres, or other appropriate settings, reducing avoidable ED attendances.
4. **Technology-enabled productivity improvements**
   Expanding the use of digital tools including Ambient Voice Technology to improve theatre utilisation, discharge flow, waiting list management, Advice and Guidance, electronic prescribing in all Trusts, and crisis response.

National action will support these priorities through:

5. **The NHS App**
   Accelerating the development of the app as the digital front door to the NHS, enabling more effective triage, navigation, and patient access to services.
6. **Payment reform**
   Realigning payment systems to new service models, and the introduction of new payment models for urgent and emergency care.
7. **Quality**
   Re-establishing quality as a central focus through a new national quality

strategy, updated service frameworks (including mental health, sepsis, cardiovascular disease, and frailty), and new approaches to secondary prevention.

8. **Capability building and a focus on our people**
   Launching a new Leadership College to strengthen leadership capability and talent management across the NHS.

On **22 April 2026**, **NHSE** published a letter entitled **"Specialist advice and elective single point of access – what this means for you and your patients."**

The letter seeks to provide greater clarity to colleagues within the wider NHS and includes the following statements:

- *"This is not about doing more of the same or using specialist advice as a way to reject or refuse referrals from general practice."*
- *"The clinical threshold for referral remains unchanged."*
- *"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."*
- *"Systems should work with established local GP leadership structures to address issues if they arise."*

The letter states that the elective Single Point of Access (SPoA) model should be viewed as a tool to help reset current practice. In doing so, it:

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

It also notes that:

- *"The NHS's New Model for Planned Care is due to be published shortly. That wider programme looks at the whole outpatient pathway."*
- *"There is no national target for specialists, trusts or general practice to divert a fixed proportion of referrals away from hospital care."*
- *"The model is intended to support decision-making, not override it. A GP's 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."*
- *"Requests for referral or specialist advice will receive a response from a named consultant."*
- *"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."*

LMCs and GP provider Collaboratives will have a key role in "policing" the roll out of specialist advice and SPoA models by ensuring that GP practices and primary care providers have a clear and influential voice within their local systems with involvement in system redesign from the outset. They will initially have an important role in working with Acute Trust colleagues and ICBs to agree the ten priority specialities for their local system. There are no plans currently to include mental health as part of the system redesign.