Electronic patient record systems – electronic referrals for ongoing care: advice and guidance

Health Services Safety Investigations Body (HSSIB) interim report, published 18 August 2026

A Summary and Guidance for LMCs

Context and Key Findings

The HSSIB interim report raises important patient-safety considerations for GPs and Local Medical Committees involved in designing and implementing local Single Point of Access (SPoA) arrangements.

The report focuses on patient-safety risks arising from Advice & Guidance (A&G), including where A&G is built into SPoA models, and examines how these systems currently operate. It does not argue that A&G or SPoA should be abandoned. Rather, HSSIB is explicit that its purpose is to support their safe implementation and expansion.

How the SPoA model works: A&G requests and elective referrals (other than urgent suspected cancer referrals) enter a single digital route at specialty/sub-specialty level in secondary care. Secondary care then clinically reviews the request or referral and decides the next step, which may be:

- specialist advice back to general practice;
- requesting further investigations;
- redirecting the patient to another service; or
- accepting the patient onto a specialist waiting list.

HSSIB recognises that A&G can work very well when properly designed, resourced and governed but there is substantial variation in how it currently operates.

Where A&G has worked well

- Improved communication between GPs and specialists
- Enabled quicker specialist input
- Reduced unnecessary outpatient appointments
- Supported GPs' clinical decision-making
- Improved relationships between primary and secondary care

Where A&G has contributed to harm

HSSIB identified incidents and near misses where A&G contributed to:

- delayed or missed diagnoses
- delayed treatment, including delayed cancer diagnoses
- avoidable surgery
- prolonged symptoms
- psychological harm
- patients becoming effectively "lost" within referral processes

HSSIB could not quantify overall risk, because safety data are inadequate and incidents in general practice are under-reported. A low number of reported incidents should not be taken as evidence that the process is safe.

Recommendation: HSSIB calls for a rapid national evaluation of A&G (including its use within SPoA) before further expansion, given concerns about variation in implementation, capacity, clinical safety, training, digital risk management and incident reporting.

Considerations for LMCs

1. SPoA must not become a barrier to GP referrals

A&G was never intended to prevent GPs from referring patients. HSSIB records NHS England's clarification that:

- there is no national target for diverting referrals away from hospital care;
- the GP's decision to refer remains unchanged;
- if, after receiving specialist advice, the GP remains concerned that specialist assessment is clinically appropriate, there should be a route for referral;
- A&G should not replace an urgent suspected cancer referral.

Despite this, HSSIB found local pathways that had effectively required GPs to use A&G before making a referral, and cases where GPs repeatedly requested specialist assessment because of ongoing clinical concern but received advice instead which in some cases contributed to patient harm.

The contractual requirement to follow relevant local referral pathways where clinically appropriate does not remove the need for an effective route to specialist assessment when the GP remains clinically concerned.

Suggested LMC action: Ensure NHSE's clarification is enacted locally.

2. "Clinically appropriate" needs to be defined locally

National guidance uses the term "clinically appropriate" without consistent definition, and GPs and specialists can disagree about whether a patient needs specialist assessment.

HSSIB recommends that ICBs clarify what "clinically appropriate" means locally and establish a mechanism for resolving differences of clinical opinion.

Suggested questions for LMCs to ask:

- Who decides whether a referral is clinically appropriate?
- What happens when the GP and specialist disagree?

A safe SPoA should not allow a specialist to reject a GP's referral with no meaningful route of escalation. There should be a clearly defined process, such as:

GP referral → SPoA clinical review → advice/assessment decision → GP disagreement → named clinical escalation route → resolution/acceptance

The report specifically calls for mechanisms to resolve differences in clinical opinion and to support collaborative care planning.

3. Cancer pathways should be preserved at all costs

HSSIB found evidence of A&G being used in pathways where GPs had requested specialist assessment for suspected cancer, contributing to diagnostic delay in some cases.

Example: In a case of suspected melanoma, repeated referrals were routed through A&G and repeatedly answered with advice based on a photograph. The patient was eventually diagnosed with melanoma more than six months later, by which point it was more advanced.

HSSIB's local learning says implementation should:

- align with national expectations;
- ensure suspected cancer referrals are managed appropriately; and
- establish formal routes where general practice remains concerned that specialist assessment is clinically appropriate despite a referral being declined.

Suggested LMC action: Ensure there is an explicit exclusion/protection for urgent suspected cancer pathways, with no SPoA/A&G pathway creating an additional barrier to referral.

4. Clarify clinical responsibility and medicolegal accountability

The interim report identified uncertainty about roles and responsibilities once specialist advice has been given. HSSIB asks organisations to clarify who is responsible for:

- undertaking clinical investigations;
- interpreting results;
- prescribing;
- other clinical actions following specialist advice.

GPs raised concerns that A&G/SPoA could transfer risk and workload back to general practice. HSSIB found examples where specialists asked GPs to perform tasks that GPs considered:

- outside their commissioned role;
- beyond their expertise;
- impractical within general practice; or
- inappropriate without specialist involvement.

This included ordering/interpreting specialist investigations and prescribing unfamiliar medication. This was described by HSSIB as a distinct patient safety hazard with associated medicolegal concerns.

LMC action: Define roles and responsibilities within a SPoA.

5. A&G responses should be clinically useful

HSSIB found considerable variation in the quality of specialist responses. A useful response should make clear:

1. what the specialist thinks is happening;
2. what the GP should do;
3. what investigations are required;
4. who is responsible for arranging them;
5. who will review the results;
6. what follow-up is required;
7. what should trigger re-referral;
8. whether the patient requires specialist assessment;
9. what safety-netting is required.

Poor responses identified by HSSIB included:

- generic answers;
- answers that did not address the question asked;
- "treat and re-refer" without explaining when or under what circumstances;
- advice from clinicians whose seniority was unclear; and
- advice subsequently revised by a consultant.

Because SPoA increases the number of clinical decisions made without face-to-face assessment, the report identifies a need for training in asynchronous clinical consultation, and for standardised A&G request and response templates.

6. Agree timelines for A&G responses

National expectations:

- 5 working days for A&G responses
- 5 working days for routine referrals
- 2 working days for urgent referrals

HSSIB found substantial variation in actual performance. Although most A&G requests received a relatively quick response, approximately 15% took more than 10 days (based on May 2026 data), with individual examples of delays lasting weeks or months.

Suggested LMC action: Clarify local timelines and ensure there is:

- automatic escalation when needed;
- visibility of outstanding requests;
- a mechanism for GPs to chase/escalate;
- clinical prioritisation;
- clear ownership; and
- protection against patients disappearing into the system.

7. The ability to track patients is a fundamental safety issue

GPs and practice staff described uncertainty about:

- where the patient was in the process;
- whether the request had been received;
- whether it had been reviewed;
- whether it had been converted to a referral;
- whether the patient had been accepted;
- whether investigations had been arranged; and
- who was responsible for the next action.

Some practices resorted to maintaining spreadsheets and creating their own tasks simply to stop patients being lost in the system. HSSIB identified problems with tracking patients through referral processes, including limitations in data quality, accessibility and interoperability.

Suggested LMC action: Ensure that any proposed system does not require general practice to build parallel tracking systems to compensate for weaknesses in the SPoA/e-RS process.

8. Digital safety needs to be addressed before implementation

SPoA relies heavily on e-RS and other digital systems. HSSIB found significant concerns around:

- interoperability;
- manual transfer of information;
- copying and pasting between systems;

- information being lost or degraded;
- inability to track patients;
- system usability; and
- unclear digital clinical risk-management responsibilities.

Providers HSSIB engaged with could not provide evidence that DCB0160 requirements had been met for their use of e-RS. HSSIB's safety observation is that general practices and ICBs need to agree who is responsible for the digital clinical risk management of e-RS.

Suggested LMC action: Ensure any proposed local SPoA configuration and workflow has undergone appropriate DCB0160 clinical safety assessment, with a resulting risk assessment/hazard log and mitigation plan.

9. SPoA requires genuine primary–secondary care collaboration

HSSIB repeatedly emphasises the importance of co-design between general practice and secondary care.

Where co-design worked well, there were generally:

- established primary/secondary care relationships;
- effective interface roles;
- mutual understanding;
- meaningful engagement; and
- collaborative development of processes.

Conversely, unilateral decisions by secondary care and poor professional relationships contributed to problems.

Suggested LMC action: Ensure that LMC representatives are involved in co-designing SPoA through their interface groups, covering:

referral criteria · A&G criteria · what information is required · specialist response standards · escalation arrangements · clinical disagreement · cancer pathways · responsibility for investigations · responsibility for results · prescribing · follow-up · safety-netting · patient tracking · incident reporting

HSSIB specifically recommends that ICBs undertake this work through co-design with general practice, secondary care and people with lived experience.

10. Capacity and workload

HSSIB found tension between national implementation timescales and the actual capacity of providers and ICBs to implement SPoA safely. Providers described needs including:

- project management;

- process training;
- improved digital infrastructure;
- interoperability;
- clinical accountability guidance;
- information-sharing arrangements;
- workforce capacity; and
- protected time.

At the same time, the investigation was told that implementation was expected to occur within existing funding, with "no new resource".

Suggested LMC action: Monitor additional work being generated for general practice and the resource required to accompany it and advise practices accordingly. This includes not just submitting A&G/referrals, but:

- monitoring outstanding requests;
- reviewing specialist advice;
- arranging investigations;
- interpreting results;
- communicating with patients;
- re-referring;
- chasing delayed responses;
- escalating disagreements; and
- maintaining safety nets.

11. Incident reporting

HSSIB found a gap between patient-safety incidents described by clinicians and incidents formally reported through national systems. General practice faces barriers including difficulties with interoperability, access to reporting systems, and recognising incidents arising from complex digital processes.

Suggested LMC action: Ensure local SPoA governance makes it easy to report:

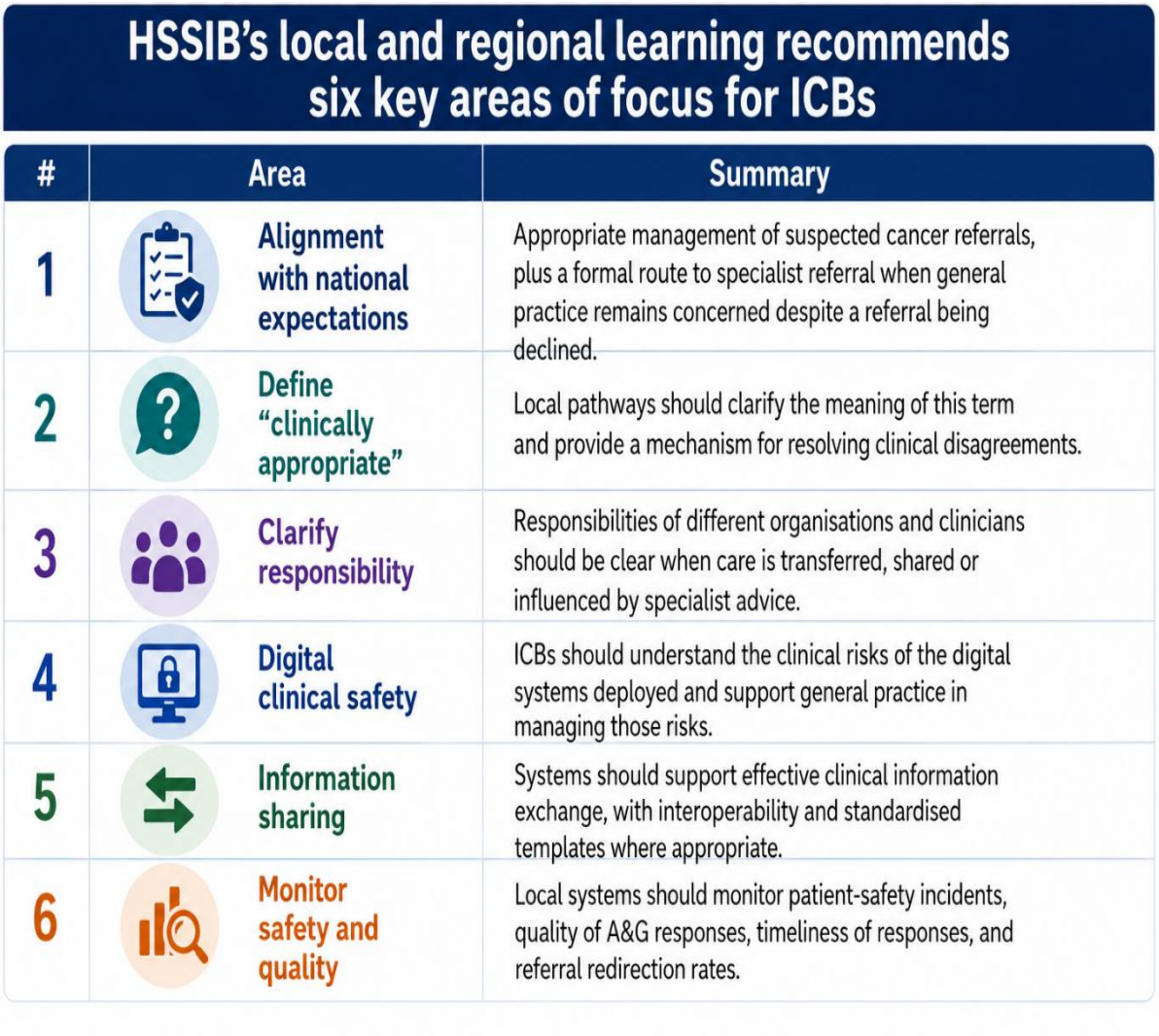
- delayed responses;
- lost or failed referrals;
- inappropriate advice;
- referral rejection despite persistent GP concern;
- delays in cancer pathways;
- failures to communicate results;
- unclear responsibility;
- system failures;
- patient harm or near misses.

12. Health inequalities should be considered

HSSIB raises concerns that A&G/SPoA processes could contribute to inequalities, particularly where systems are poorly designed for vulnerable patients. Local design should consider whether the pathway works safely for patients who may have:

- communication difficulties;
- disabilities;
- cognitive impairment;
- language barriers;
- difficulty accessing digital services;
- limited ability to navigate complex healthcare pathways;
- reduced ability to recognise deterioration or seek further help.

What HSSIB Asks ICBs to Demonstrate



HSSIB's local and regional learning recommends six key areas of focus for ICBs

#	Area	Summary
1	Alignment with national expectations	Appropriate management of suspected cancer referrals, plus a formal route to specialist referral when general practice remains concerned despite a referral being declined.
2	Define "clinically appropriate"	Local pathways should clarify the meaning of this term and provide a mechanism for resolving clinical disagreements.
3	Clarify responsibility	Responsibilities of different organisations and clinicians should be clear when care is transferred, shared or influenced by specialist advice.
4	Digital clinical safety	ICBs should understand the clinical risks of the digital systems deployed and support general practice in managing those risks.
5	Information sharing	Systems should support effective clinical information exchange, with interoperability and standardised templates where appropriate.
6	Monitor safety and quality	Local systems should monitor patient-safety incidents, quality of A&G responses, timeliness of responses, and referral redirection rates.

HSSIB's National Safety Recommendations

HSSIB recommends that NHS England and the Department of Health and Social Care carry out a **rapid evaluation of A&G processes, including their use within SPoA**, addressing the varying patient-safety risks created by:

1. limited resources and capacity within ICBs and providers;
2. variation in the effectiveness of interface groups;
3. training needs for the multidisciplinary workforce undertaking asynchronous consultations;
4. limitations in identifying and mitigating digital clinical risks associated with e-RS;
5. gaps in reporting patient-safety incidents from general practice.

HSSIB's position is that completing this evaluation and addressing its findings before further expansion would help ensure risks are properly identified, assessed and managed.

HSSIB also recommends greater standardisation of A&G request and response templates, working with relevant Royal Colleges.

Two safety observations

Workforce training

Healthcare education providers should address gaps in knowledge and skills required for safe asynchronous consultation.

Digital clinical safety

Organisations should ensure DCB0160 requirements are met when deploying e-RS, with clear agreement between general practice and ICBs about who is responsible for digital clinical risk management.

Mitigating risk in SpoA where A&G is incorporated: Key Considerations for GPs

A practical checklist to help ensure safe, effective and patient-centred pathways

A REFERRAL RIGHTS

ASK:

- Can a GP still refer when they believe specialist assessment is required?
- What happens if the specialist disagrees?
- Can a referral be rejected repeatedly without meaningful clinical dialogue?
- Is there any local performance target that could create pressure to reduce referrals?

GP PRINCIPLE:

A&G should support clinical decision-making, not create a barrier to referral.

B CLINICAL DISAGREEMENT

ASK:

- What does "clinically appropriate" mean locally?
- Who resolves disagreement?
- Is there a named senior clinician or escalation route?
- How quickly must disagreement be resolved?
- Can the GP speak to an appropriate specialist when necessary?

GP PRINCIPLE:

A difference of clinical opinion must result in clinical dialogue, not simply administrative rejection.

C CANCER

ASK:

- Is the urgent suspected cancer pathway completely protected?
- Can A&G ever delay a cancer referral?
- What happens when a GP remains concerned about cancer after specialist advice?
- Is there an explicit escalation route?

GP PRINCIPLE:

A GP with persistent cancer concern must have a safe and timely route to specialist assessment.

D ACCOUNTABILITY

ASK:

- Who owns the next action?
- Who orders the investigation?
- Who reviews the result?
- Who acts on an abnormal result?
- Who prescribes?
- Who follows up the patient?
- When does responsibility transfer between organisations?

GP PRINCIPLE:

Every clinical action generated by an SPoA response should have a clearly identifiable responsible clinician/service.

E QUALITY OF SPECIALIST ADVICE

ASK:

- Are there standard response templates?
- Is the clinical question answered?
- Is the recommended action explicit?
- Is responsibility explicit?
- Is safety-netting included?
- Does the response specify when the patient should be referred or reviewed?

GP PRINCIPLE:

A response should be sufficiently clear that another clinician can safely understand and act upon it.

F TIMELINESS

ASK:

- What is the local response standard?
- How are overdue requests identified?
- What happens when the standard is breached?
- Is there an escalation process?
- Can GPs see the status of an outstanding request?

GP PRINCIPLE:

A&G/SPoA must not create an invisible waiting list between primary and secondary care.

G PATIENT TRACKING

ASK:

- How are patients tracked through the pathway?
- How are rejected referrals monitored?
- How are outstanding actions identified?
- How are system failures detected?
- How does the GP know what has happened to the patient?

GP PRINCIPLE:

There must be no point at which responsibility for the patient becomes ambiguous.

H DIGITAL SAFETY

ASK:

- Has DCB0160 been completed?
- Who owns digital clinical risk?
- Have interoperability hazards been identified?
- Can specialists access the relevant clinical information?
- What is the contingency if the system fails?

GP PRINCIPLE:

Digital architecture is part of clinical safety.

I CAPACITY AND WORKLOAD

ASK:

- What additional workload will SPoA create for practices?
- Is there sufficient specialist capacity?
- Who funds implementation and ongoing management?
- What happens if demand exceeds capacity?

GP PRINCIPLE:

A referral reduction is not necessarily a workload reduction.

J MONITORING AND GOVERNANCE

ASK:

- What safety indicators will be monitored?
- How will incidents and near misses be reviewed?
- Will redirection rates be monitored?
- Will response quality be audited?
- Is there GP representation in governance arrangements?
- Can the pathway be changed if safety problems emerge?

GP PRINCIPLE:

SPoA should be treated as a continuously monitored clinical system, not a one-off IT implementation.

KEY MESSAGE: SPoA can improve access and use of specialist expertise, but only when designed with clear safeguards, accountability

GPs SHOULD BE INVOLVED IN:
Co-design, implementation, governance and continuous improvement.

SPoA Implementation Checklist for GP Representatives

Minimum safeguards to seek before supporting implementation of Single Point of Access (SPoA) and Advice & Guidance (A&G)

AREA	MINIMUM SAFEGUARD TO SEEK	CHECK
GP REFERRAL	GP retains ability to refer where they feel it is clinically appropriate	☐
CLINICAL DISAGREEMENT	Defined and timely escalation process	☐
CANCER	Urgent suspected cancer pathway protected	☐
ACCOUNTABILITY	Responsibility for each clinical action explicitly allocated	☐
RESULTS	Clear responsibility for reviewing and acting on results	☐
ADVICE QUALITY	Structured, clinically meaningful specialist responses	☐
TIMELINESS	Defined response standards and escalation for overdue cases	☐
PATIENT TRACKING	Mechanism to identify outstanding or failed referrals/actions	☐
DIGITAL SAFETY	DCB0160 responsibilities and risk controls established	☐
CAPACITY	Specialist and primary-care workload assessed realistically	☐
INCIDENT REPORTING	Simple route for reporting safety concerns and near misses	☐
GOVERNANCE	Meaningful GP participation in ongoing oversight	☐
CO-DESIGN	General practice involved in pathway design, not merely consultation	☐
INEQUALITIES	Impact on vulnerable and digitally disadvantaged patients assessed	☐

If any safeguard cannot be demonstrated, raise this with the ICB, secondary care partners and governance leads before supporting implementation.