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NHS England

Practical guide to implementing elective Single Point of Access in gastroenterology

November 2026



- Context and rationale
- Implementing the model
- Assurance
- Learning from early adopters

Supporting improvements in outpatient services

About this practical guide

This practical guide helps systems, trusts and clinical teams to implement an elective Single Point of Access (SPoA) model to:

- Support effective and timely care through the most appropriate route.
- Improve the quality of clinical discussions across the primary and secondary care interface using a shared learning approach.
- Improve clinician experience and job satisfaction through more effective, timely, and meaningful clinical decision-making.

While the focus of this guide is on gastroenterology, the principles can be used in other specialties implementing elective SPoA. For the purposes of this guide, the term gastroenterology includes hepatology.

The guide includes case studies from services that have implemented a SPoA model and checklists to support practical implementation.

The term SPoA is used to denote a unified approach to specialist Advice and Guidance (A&G) and clinical triage of referrals.

Co-produced with colleagues from the national SPoA programme, this guide should be used alongside NHS England's Elective SPoA resources and the materials in the Resources section.

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Audience

For regions, systems and trusts, with content of interest to:

- clinical leads – gastroenterology and other specialties;
- operational leads and service managers;
- Primary Care Networks;
- Integrated Care System elective leads;
- e-RS system administrators.



This list is not exhaustive.

Key resources

- **NHS England Elective SPoA Futures Workspace**
- **GIRFT Advice & Guidance Toolkits and Templates**



Section 1: Context and rationale

The case for change to Single Point of Access

What are the current challenges?

Traditional outpatient referral models are often characterised by prolonged delays before specialist review, diagnostic tests being requested only after clinic attendance, inefficient use of clinic capacity, and frustration for both patients and clinicians. The SPoA model provides an opportunity to re-design access into the specialty.

How SPoA improves access to specialist care

Early senior specialist review facilitates intelligent triage to diagnostics and clinics, reducing unnecessary appointments and investigations. This improves prioritisation and speeds up access to patient centred, personalised care.

SPoA can also enable a 'waiting well' approach by facilitating timely access to specialist advice, alongside prompt communication on the status of referrals.

SPoA supports the 'hospital to community' shift, enabling more care closer to home in line with the NHS 10 Year Health Plan for England.

A&G should not be mandated as a prerequisite to referral, and implementation of SPoA does not change the clinical threshold for referral.

Why this matters now

This approach is a key national priority for elective care. From 1 April 2026, all NHS providers of consultant-led services were expected to prioritise A&G as a mechanism for specialist input across at least ten locally selected specialties. It is recognised that, in many cases, this will involve the introduction of a SPoA model if not already in place. By October 2026, providers were expected to have implemented consultant-led clinical review of all A&G requests and elective referrals (other than those for urgent suspected cancer) for these ten specialities.

NHS England Elective SPoA: technical guidance

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Section 1: Context and rationale

Why implement SPoA for gastroenterology?

Gastroenterology is one of the largest outpatient specialties nationally, with high demand, long waiting times, and associated pressure on primary and urgent care services.

Gastroenterology is well suited to a SPoA model, where early specialist opinion directs patients to the most appropriate next step, including A&G, diagnostics, remote review, face-to-face outpatient review, or onward referral to another specialty.

This approach facilitates pre-clinic investigations where required, which helps to inform decision making and optimise use of clinic capacity. As a multi-organ specialty with various subspecialty clinics, early triage supports patients to reach the right clinic with the right diagnostics first time.

SPoA can improve the patient and referrer experience by providing timely reassurance and ensuring that investigations and appointments are undertaken when clinically indicated.

The model enables early specialist opinion and/or intervention which may help patients avoid seeking treatment through other, less appropriate, routes such as Urgent and Emergency Care (UEC) services. It can support disease prevention and reduce disease progression via provision of lifestyle advice and self-management guidance.



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Section 1: Context and rationale

The gastroenterology SPoA implementation programme

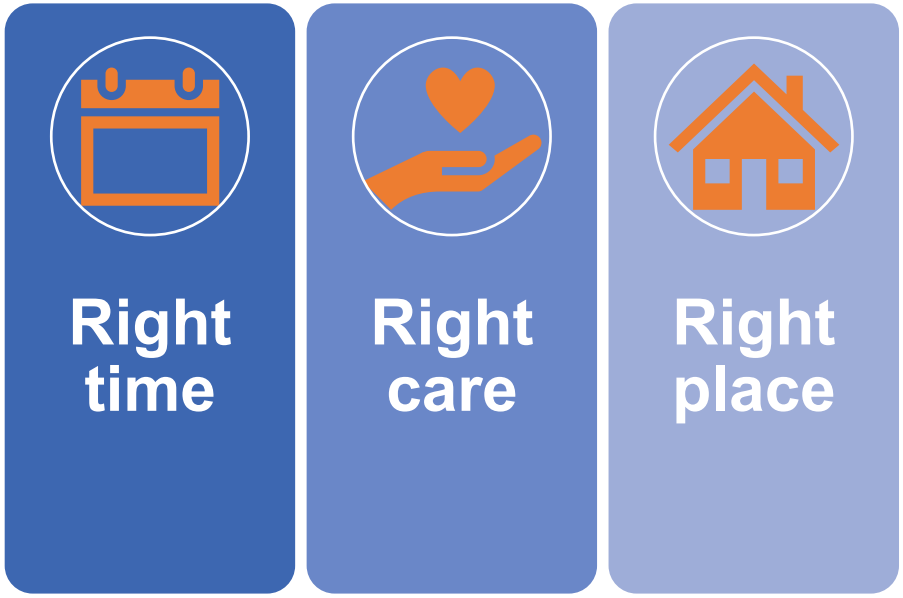
In 2025/26, NHS England commissioned Northumbria Healthcare NHS Foundation Trust to support trusts to implement a SPoA model within local gastroenterology services.

Northumbria was an early adopter of the SPoA model, having established the approach in 2023. The trust has consistently been among the top three trusts nationally for gastroenterology 18-week referral-to-treatment (RTT) performance over the past two years, regularly achieving best performance.

By establishing a SPoA model, the programme aimed to:

- **strengthen collaboration between primary and secondary care;**
- **support development of more responsive local patient pathways;**
- **reduce waiting times for specialist care.**

This guide has been developed as an output of the programme of work and has been produced by an expert working group. The case studies included highlight the work undertaken by Northumbria and the experience of the providers that participated in the programme.



- Directly supported ten provider trusts, with additional organisations engaged through a community of practice.
- Locally delivered support model.

Section 2: Implementing the model

Model overview and what success looks like

- All A&G requests and elective referrals are routed through a single digital entry point at specialty or sub-specialty level within secondary care.
- Specialist clinical review of primary care enquiries and referrals are undertaken within e-RS, or a digital solution integrated with e-RS, to determine the most clinically appropriate next step(s) or outcome.
- Patients and referrers receive communication in line with NHS Minimum standards for planned patient care and locally approved guidelines.
- Possible outcomes include:
  - **advice to support primary care management;**
  - **straight to test (STT) e.g., endoscopy after triage;**
  - **clinic appointment (sub-specialty specific);**
  - **request for further information prior to decision-making.**
- SPoA models may be implemented at provider level or as a 'group' (multi-provider, system or regional level).



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Section 2: Implementing the model

Core implementation principles

Successful implementation is underpinned by:

1. Establishing a robust understanding of the current service before designing and delivering enhancements.
2. A clear local vision, aligned to national expectations.
3. Shared understanding of the e-RS/SPoA offer.
4. Strong engagement with primary care before and after implementation.
5. A focus on improving patient experience.
6. Clinical and operational teams working together to achieve shared objectives.
7. Use of A&G to support earlier clinical decision-making.
8. Ongoing engagement at the primary and secondary interface to support oversight and continual refinement.

SPoA should be implemented alongside other improvement initiatives including those outlined in the GIRFT Operational Outpatient Guidance.

To ensure SPoA is successful, responses must be timely. Providers should work towards **achieving the Processing Standards for A&G Requests and Referrals** as follows:

- A&G responses: within five working days.
- Routine referrals: next step actioned within five working days.
- Urgent referrals: next step actioned within two working days.

These standards are outlined in NHS England's Elective Single Point of Access: technical guidance.

Key stakeholders

- Clinical team
- Operational managers
- Primary care clinicians
- Interface leads
- Local IT teams
- Performance teams
- e-RS system administrator
- Trust and primary care executive links

Section 2: Implementing the model

Understanding the current service

Developing a detailed understanding of the current service is essential before implementing a SPoA model. It ensures the model is based on a comprehensive assessment of existing service pathways rather than assumptions and provides a robust baseline for understanding demand, capacity and outcomes.

Use the checklist on this page to build a complete picture of the current service. Alongside external referral and advice routes, explicitly capture internal referrals – such as consultant-to-consultant advice, hot clinic requests, etc, – so that baseline demand, capacity and reporting reflect the full clinical workflow.

See **Appendix 1** for a list of questions to answer to support understanding your service in detail.

Refer to diagram 1 in the Elective SPoA: technical guidance for a clinical model to support service mapping.

Define the current service model and establish the baseline

- ☐ Confirm whether provision is whole-specialty or split by sub-specialty based on local agreement.
- ☐ Map all external referral and advice routes e.g., via e-RS or third-party providers.
- ☐ Confirm current referral volumes, activity, demand and capacity and understand unmet need including the size and profile of the backlog.
- ☐ Review current diversion rates and how they are defined and reported locally.
- ☐ Identify any gaps in baseline activity or diversion data.
- ☐ Confirm how e-RS is configured, including services, routes and sub-specialty options.
- ☐ Check whether reporting supports monitoring of activity, demand, capacity and diversion.
- ☐ Agree any changes needed to make dashboards and reporting meaningful.

Model Health System: Gastroenterology Specialist Advice Metrics

NHS England Specialist Advice Activity Dashboard

NHS England e-RS DoS review resources – Futures login required

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Section 2: Implementing the model

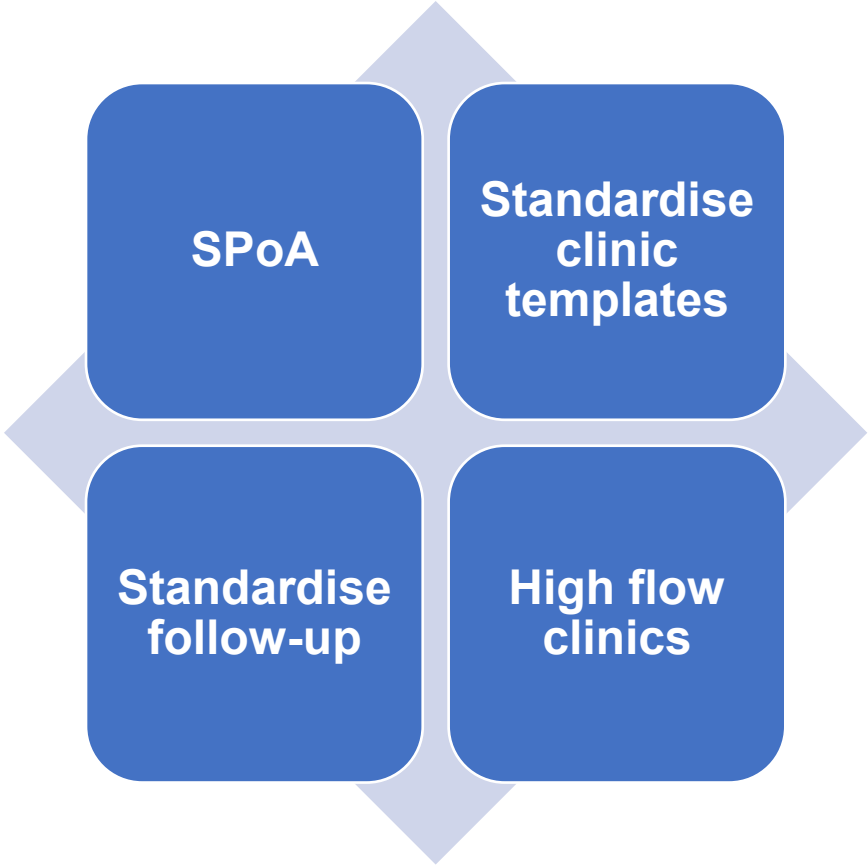
Enhancing the current service

Implement SPoA alongside other improvement initiatives

SPoA will have the greatest impact when implemented as part of a wider outpatient improvement plan, rather than as a standalone change.

Standardising clinic templates, reducing unnecessary follow-ups (by using standardised follow-up protocols, remote monitoring and improving the use of PIFU) and high-flow clinic models help release capacity and reduce variation. This ensures patients triaged through SPoA can access the right diagnostics, advice or appointment without creating new delays.

These improvement initiatives should be reviewed and adapted as part of a dynamic process as the SPoA model matures.



GIRFT Outpatient operational guide: Module 1 Standardising clinic templates

GIRFT Outpatient operational guide: Module 2 Standardising follow-up

GIRFT Outpatient operational guide: Module 3 High flow outpatient clinics

RCP Prescription for outpatients: reimagining planned specialist care

NHS England Medium Term Planning Framework

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Section 2: Implementing the model

SPoA design and delivery

Project implementation lead checklist

- ☐ Decide whether the full specialty is ready to implement SPoA. If not, begin with a single, engaged sub-specialty.
- ☐ Ensure the SPoA model is fully designed and tested prior to go-live, recognising that early user experience is critical to engagement and success.
- ☐ Implement SPoA in conjunction with maximising capacity within existing structures.
- ☐ Provide training for both clinicians and administrative teams.
- ☐ Establish regular feedback loops with primary care.
- ☐ Aspire to collect and review patient feedback.

Tip: Treat SPoA implementation and operation as a continuous improvement process.

Clinical team checklist

- ☐ Define which referrals are not suitable for SPoA e.g., urgent suspected cancer.
- ☐ Agree standardised triage outcome categories aligned to local pathways e.g., triaged straight to test.
- ☐ Select clinicians who are appropriately skilled and suited to undertake triage.
- ☐ Use clear, respectful language in responses to advice and referral requests.
- ☐ Set clear expectations for response times.
- ☐ Ensure consultants have:
  1. Access to GP records.
  2. Job-planned SPoA time.
  3. Agreed sessional expectations.

Tip: Ensure Residents (ST6 and above) are involved in clinical triage under appropriate supervision.

Operational team checklist

- ☐ Ensure there are clear roles for:
  1. Clinicians.
  2. Administrative and waiting list teams.
  3. Operational managers.
  4. e-RS system administrators.
- ☐ Use service level job planning to ensure SPoA model runs 52 weeks per year.
- ☐ Align with existing RTT validation, booking rules and clinic templates.
- ☐ Explore temporarily increasing new patient capacity after SPoA implementation. For example, by converting clinics to new slots only, and having clinics led by nurses, resident doctors and/or Allied Health Professionals.

Tip: Early clarity on responsibilities reduces risk at the go-live stage.

See NHS England's guidance on Job planning for single point of access

Section 3: Assurance

Monitoring impact and performance

SPoA supports delivery of better patient care through an improved clinical model. Demonstrating clear progress and outcomes is essential.

Services should review activity, demand and capacity before implementation. SPoA activity and demand should be monitored at specialty, clinic and clinician level, with findings shared across organisations to support joint learning. Where possible, services should work towards understanding the impact of SPoA on UEC attendances and on patients experiencing longer waits within sub-specialty pathways.

Robust data is essential to understanding baseline challenges and assessing ongoing impact – this is a continuous process that should be embedded. Performance improvement may take two or three months to start appearing in NHS England data submissions because of reporting cycles.

As SPoA is one of several approaches that can support performance improvement, data is highly likely to be influenced by other initiatives implemented to maximise and utilise capacity efficiently. Performance data should be reviewed in context of the whole specialty.

Key monitoring and performance checks

- ☐ Consider establishing a local SPoA dashboard to review activity, diversion rates and demand profiles.
- ☐ Monitor the composition and trend of the RTT Patient Tracking List (PTL) – this should include reviewing clock starts.
- ☐ Undertake co-ordinated, 12 weekly administrative and clinical validation of all patients on the waiting list.
- ☐ Work towards all clinically required diagnostic tests being completed and reported upon (if applicable) before the first outpatient clinic appointment.
- ☐ Assess the impact on diagnostic tests (DM01) performance specifically number of weeks waiting.
- ☐ Use existing governance and performance frameworks rather than creating parallel structures.



Tip: Get the clinical service right and the performance will follow.

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See the Resources section for GIRFT guidance on improving delivery of outpatient care.

Section 3: Assurance

Governance

Robust governance is critical to the safe and effective operation of a SPoA model, ensuring that clinical decision-making, operational processes and patient pathways are delivered to a high standard.

Governance structures should be established with defined clinical accountability, and trusts should have a clear position on medicolegal responsibility. There should also be agreed mechanisms to resolve areas of disagreement, uncertainty or safety concerns.

By aligning SPoA activity with existing organisational governance frameworks, providers can monitor activity, identify variation in outcomes and drive continuous improvement.

Effective governance also supports transparency, standardisation and collaboration across primary and secondary care, ensuring that processes are clinically appropriate and equitable.

Resources:

- Specialist advice and clinical responsibility FAQs
- Medicolegal coverage and liability FAQs

Key governance checks

- ☐ Establish a SPoA leadership structure and ensure understanding of clinical responsibility and medicolegal requirements.
- ☐ Put quality assurance and peer review processes in place.
- ☐ Reflect SPoA responsibilities in clinicians' scope of practice and review via annual appraisal.
- ☐ Ensure governance is connected to existing processes and structures e.g., Patient Safety Incident Response Framework (PSIRF), specialty meetings.
- ☐ Define clear escalation routes for uncertainty or disagreement.
- ☐ Make SPoA a standing agenda item at specialty or gastroenterology service meetings, with nominated management and clinical leads.
- ☐ Review data at departmental meetings.
- ☐ Discuss SPoA governance and performance at local interface forums.

Tip: Join local interface forums to create a collaborative learning space with primary care.

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Section 4: Learning from providers

Northumbria Healthcare – early adoption of SPoA in gastroenterology and sequencing across multiple specialties

Summary

Northumbria Healthcare is an early adopter of SPoA. The trust began its roll-out in 2023, starting with gastroenterology in response to long waits for outpatient care and delayed high-risk reviews. Implementation of SPoA supported improvements in prioritisation, clinic utilisation and patient flow. This in turn led to an improved RTT position and reduction in overdue follow-ups.

Approach

Northumbria considered local access and follow-up pressures, diagnostics, team engagement, confirmed job-planned time, resources and risk appetite before implementing SPoA. It should be noted that drivers differed e.g., diabetes focused on waiting well and rheumatology on new-patient access. Not every service is suitable, so it is important to locally agree any exclusions.

The Northumbria journey

PHASE 1 | 2023

June — Gastroenterology

August — Respiratory and sleep medicine

PHASE 2 | Specialty expansion

Rheumatology, cardiology, diabetes & endocrinology

Colorectal surgery & care of the elderly (early 2025)

PHASE 3 | Spring 2026

Lipids service

Haematology

PHASE 4 | July 2026

All remaining eligible services

Section 4: Learning from providers

Northumbria Healthcare continued

Barriers and challenges

- Limitations in e-Referral Service (e-RS) functionality.
- Differing views on the suitability of SPoA.
- Income does not match the clinical time required.
- Undertaking routine waiting list validation alongside SPoA is essential to releasing capacity.
- Securing support for SPoA across the wider clinical team.



Strategies to help overcome challenges

- Using A&G as its SPoA model due to its enhanced functionality, including two-way dialogue capability in e-RS and in many cases improved patient visibility of the referral conversation.
- Focusing on quality over activity.
- Choosing a consultant team with an interest in SPoA.
- Primary care engagement.
- Strong clinician and manager relationships.
- Consistency in approach to triage and providing advice.



Sources of assurance



Monthly KPI reporting



Governance



Peer review



Primary & secondary care interface



Patient/staff feedback



Risk appetite



NHS England Transforming Primary Care Podcast - How does A&G support general practice?

Section 4: Learning from providers

Case study: Barts Health NHS Trust – learning from the pilot sites

NHS England

Summary

Barts Health NHS Trust was one of the ten providers supported by the gastroenterology SPoA programme. This case study focuses on the rollout of SPoA at Whipps Cross Hospital, where rising referral demand and limited capacity had led to long RTT waits and 52-week delays for first outpatient appointments.

Approach and achievements

The team implemented a clinically-led SPoA model, creating a single clinical front door for all GP gastroenterology referrals. Early findings have been positive, with the team observing better identification of higher-risk patients through the triage process. There were also early indications that the model was supporting patients to 'wait well' and improving clinic preparation.

Key features of the model

- Consultant-led triage supported by job planned time.
- Strengthened, job-planned A&G service as an alternative to outpatient attendance where appropriate.
- Prioritisation of outpatient capacity for patients at greatest clinical risk.

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Section 4: Learning from providers

Case study: Barts Health NHS Trust continued

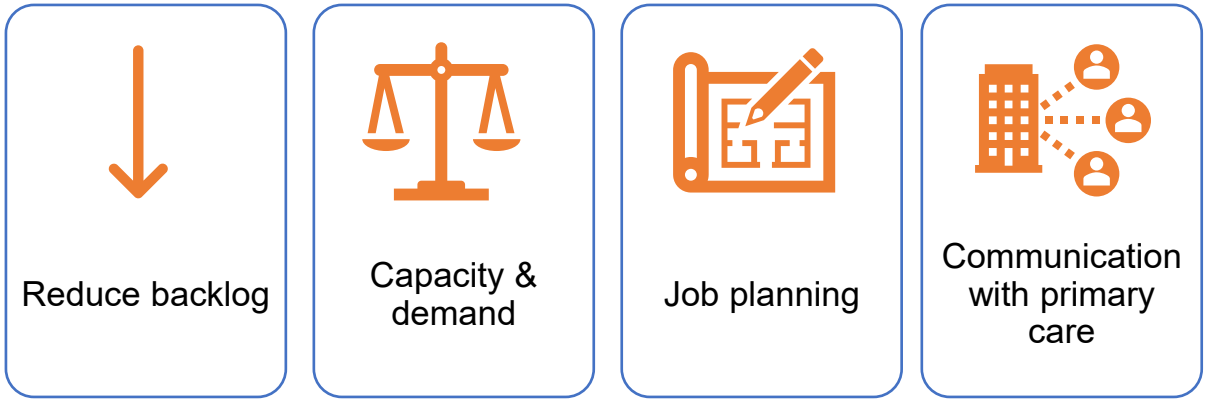
NHS England

Preparing for implementation

Preparation included:

- **Understanding unmet need, including the waiting list backlog** with plans to reduce the backlog to a reasonable level.
- Undertaking **demand & capacity modelling**.
- **Incorporating triage activity** into consultant job plans (i.e., ten minutes of job planned time per referral, ongoing review).
- Reconfiguring e-Referral Service (e-RS) pathways - close the previous Directly Bookable Service (DBS) route(s), use the agreed naming 'identifier' to **differentiate** from other A&G services *e.g., 'Advice & Refer/SPoA – [specialty/service name] service*'.
- Engagement and communication with primary care colleagues.

Key preparation



Learning and enablers

- SPoA is effective when clinically-led and operationally supported.
- Limitations within existing digital systems created some usability issues.
- The quality of referrals is variable, and this can make triage challenging. Consider education sessions to support primary care and FAQs.
- Recognise that SPoA models will continue to evolve as services learn and mature.

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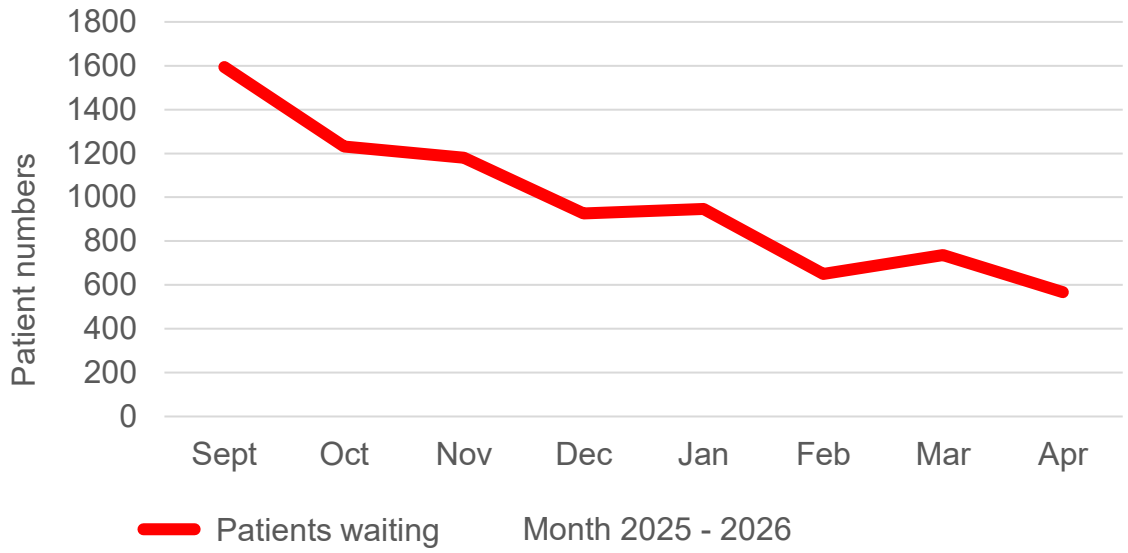
Section 4: Learning from providers

Case study: Manchester University NHS Foundation Trust – learning from the pilot sites

Summary

Manchester University NHS Foundation Trust took part in the gastroenterology SPoA implementation programme. The trust's SPoA pilot at Wythenshawe Hospital (September 2025-April 2026) significantly reduced the waiting list. Before the pilot, new outpatient appointments were booked up to 36 weeks ahead, with a follow-up backlog of approximately 18,000.

Performance improvement – New patient waiting list



4 engaged clinicians undertaking triage during the pilot

1 weekly triage session per triaging consultant

Approximately 25 referrals reviewed per session

Audit of triage outcomes by clinician

Locum employed to backfill lost clinic activity

Key learning: Review demand, activity and job-planned triage capacity regularly, and plan annual leave cover to maintain a 52-week service and help prevent referral backlogs.

Resources

- GIRFT (2026) Practical guide to Implementing elective SPoA in gastroenterology: editable checklists
- NHS England (2026) Elective SPoA Technical Guidance
- NHS England (2026) Elective SPoA: implementation considerations
- NHS England (2026) Job planning for single point of access (login required)
- British Society of Gastroenterology (2026) Consultant gastroenterologist job planning guidance
- Department of Health and Social Care (DHSC) and NHS England (2026) Neighbourhood health framework
- GIRFT (2025) Outpatient operational guide: Module 1: Standardising outpatient clinic templates
- GIRFT (2026) Outpatient operational guide: Module 2: Standardising follow-up protocols
- GIRFT (2026) Outpatient operational guide: Module 3: High flow clinics
- NHS England (2025) Medium term planning framework
- NHS England (2025) NHS 10 Year Health Plan for England: fit for the future
- Royal College of Physicians (2025) Prescription for outpatients: reimagining planned specialist care
- GIRFT Further Faster Gastroenterology Futures Workspace
- NHS England (2023) Specialist Advice and Clinical Responsibility: Frequently Asked Questions (FAQs)
- NHS England (2023) Specialist Advice Medico-Legal FAQs
- NHS England NHS e-Referral Service Collaboration Futures Workspace - DoS review resources

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Glossary

Term	Definition
Advice and Guidance (A&G)	A&G is an application within the NHS national e-RS system which supports asynchronous, bidirectional dialogue between primary and secondary care clinicians about individual patients.
Directory of Services (DoS)	The e-RS directory describing available services and their access criteria and routes.
Diversion rate	The proportion of specialist advice requests that are resolved through advice alone, without proceeding to an onward referral.
e-Referral Service (e-RS)	e-RS is a digital platform used to refer patients to service providers.
Interface services	All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care.
Referral Assessment Services (RAS)	An e-RS service that enables a provider to assess a referral before deciding the most appropriate next step, such as accepting, redirecting or returning it with advice.
Single Point of Access (SPoA)	Elective SPoA is a model where all suitable A&G requests and elective referrals are directed into a single digital entry point at specialty or sub-specialty level within secondary care.
Specialist advice	This is an umbrella term for a range of specialist-led models which allow the sharing of relevant clinical information between a specialist and referrer prior to, instead of, or about a referral to support the management of patient care.
Specialist review	Specialist review means that a specialist clinician reviews the referral or A&G request, provides advice and determines what should happen next. This may also be called specialist assessment or specialist opinion.
Straight to test (STT)	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway. This is different from Direct to Test (DTT) where GPs can directly access diagnostic tests without referral to secondary care.
Standard Operating Procedure (SOP)	A written document describing how a process or procedure should be carried out and who is responsible for each part.

Acknowledgements

The GIRFT programme wishes to formally acknowledge the contributions of the following individuals to the development of this guide:

Ayesha Akbar
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Appendices

Appendix 1: Service portfolio review

Use these prompts to assess your understanding of your service before implementing SPoA.

They are not pass/fail criteria but should be used to identify gaps and required actions.

Review prompt	Review status
1. Is there a complete list of all clinics, services and pathways that exist within the service across all sites?	
2. Is there a single up-to-date document that describes how the service operates?	
3. Is patient eligibility and exclusion criteria clearly defined for each clinic and pathway?	
4. Are all clinic booking rules documented, accessible and consistently applied?	
5. Are referral routes and triage outcomes clearly defined and understood by primary care and secondary care teams?	
6. Are all speciality level diagnostic pathways mapped, including any direct access investigations?	
7. Have clinician and administrative specific practices and local workarounds been identified and documented?	
8. Does the published e-RS Directory of Services accurately reflect the service offer and access routes?	
9. Are accessible, up-to-date standard operating procedures (SOPs) in place for key service functions, including triage, booking and scheduling?	

Appendices

Appendix 2: Pilot evaluation metrics

The following NHS England published metrics were included in the pilot evaluation:

- total number of incomplete pathways;
- total within 18 weeks;
- percentage within 18 weeks;
- average (median) waiting time (weeks);
- 92nd percentile waiting time (weeks);
- total 52 plus weeks and percentage 52 plus weeks;
- total 65 plus weeks and percentage 65 plus weeks;
- number of new RTT clock starts during the month.

Services should monitor emerging national metrics and guidance relating to SPoA.

Appendices

Appendix 3: Comparing the three SPoA models

Providers will be able to choose the model that best supports their processes, potentially offering a mixture across their specialties.

A&G only and triage only models require local agreement with GPs and commissioners.

Key difference	A&G + triage (RAS) combined	A&G only	Triage only (RAS)
Approach	Supports both advice requests and referrals through the same SPoA.	Supports a two-way clinical conversation before deciding the next action.	Supports specialist review of referral requests and appropriate next steps.
Entry route	Advice or referral requested via the same SPoA.	Advice request, found in advice searches.	Referral request, found in referral searches.
Clinical dialogue	Available for A&G requests but not initially available for triage.	Two-way e-RS conversations between the referrer and specialist clinician are enabled.	Not initially available in e-RS. Need to agree a secure alternative until this functionality is available.
Onward referral	Referrals can move between SPoAs. A&G requests must be converted to a referral first.	Cannot redirect to another SPoA that only offers A&G, but referrals can be returned to the referrer to be sent elsewhere.	Can redirect referrals to authorised services.
Issues to consider	Both worklists must be monitored to ensure that patients are managed chronologically.	Limits onward routing, patient visibility and out-of-area access.	If seeking advice, referrers from outside the local area will not be able to find these SPoAs.

Check current e-RS guidance before implementation.
See the following Futures workspaces for further information: NHS England Elective SPoA and NHS e-RS.

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