

Elective single point of access (SPoA) Clinical Toolkit

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Elective SPoA Clinical Toolkit

Introducing the Elective SPoA Clinical Toolkit

This toolkit has **been developed for clinicians and by clinicians in primary and secondary care**, building on the Elective Single Point of Access (SPoA) Technical Guidance for 2026/7. It should be read in conjunction with the Medium-Term Planning Framework and any relevant local standards or guidance.

Using the SPoA Clinical Toolkit

This toolkit sets out what good looks like in delivering elective SPoA. It should be used to support high-quality, patient-centred communication and safe, effective, collaborative asynchronous working.

It can be used by all clinicians across the healthcare community to support Elective SPoA activity and should be applied alongside clinical judgement, local pathways, and national guidance. The [annex](#) provides an example of a Clinical Service Assessment Tool for secondary care clinicians to support development and reflection - this can be edited and adjusted to support local need.

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Elective SPoA is a national approach, implemented locally to improve coordination within our healthcare community and enable more specialist care closer to home

Elective Single Point of Access

As outlined in the [Medium-Term Planning Framework](#), the elective SPoA is a key priority for 2026/27 to enable more specialist care to be delivered closer to home. To improve coordination, the healthcare community will be:

- **standardising the use of Specialist advice** in delivery of elective pathways
- **moving to e-Referral Service (e-RS) being used** for all Advice requests and referrals from general practice (excluding urgent suspected cancer)
- ensuring all referrals receive appropriate **specialist review**, flowing through a single point of access

Elective SPoA creates a single digital entry point within secondary care.

It brings together advice requests, referrals and clinical triage, replacing fragmented routes with a more consistent process.

It does not change the clinical threshold for referral or remove patient choice. Its purpose is to support timely specialist assessment, agree the most appropriate next step, share clear information with patients and referrers, and ensure care is delivered in the **right place first time**, whether through advice, diagnostics, outpatient review, or onward referral.

Why are we moving to elective Single Point of Access?

- **Getting patients to the right care, first time.**
- **Simplification:** Creates one clear route for advice requests and elective referrals, excluding urgent suspected cancer.
- **Care closer to home:** Helps patients receive timely specialist input, reducing avoidable hospital visits.
- **Collaboration and learning:** Strengthens communication between general practice and secondary care, builds capacity and capability in asynchronous clinical communication and supports shared learning through feedback and use of specialist advice.



[Elective Single Point of Access](#)
[FutureNHS Collaborative Platform \(login required\)](#)

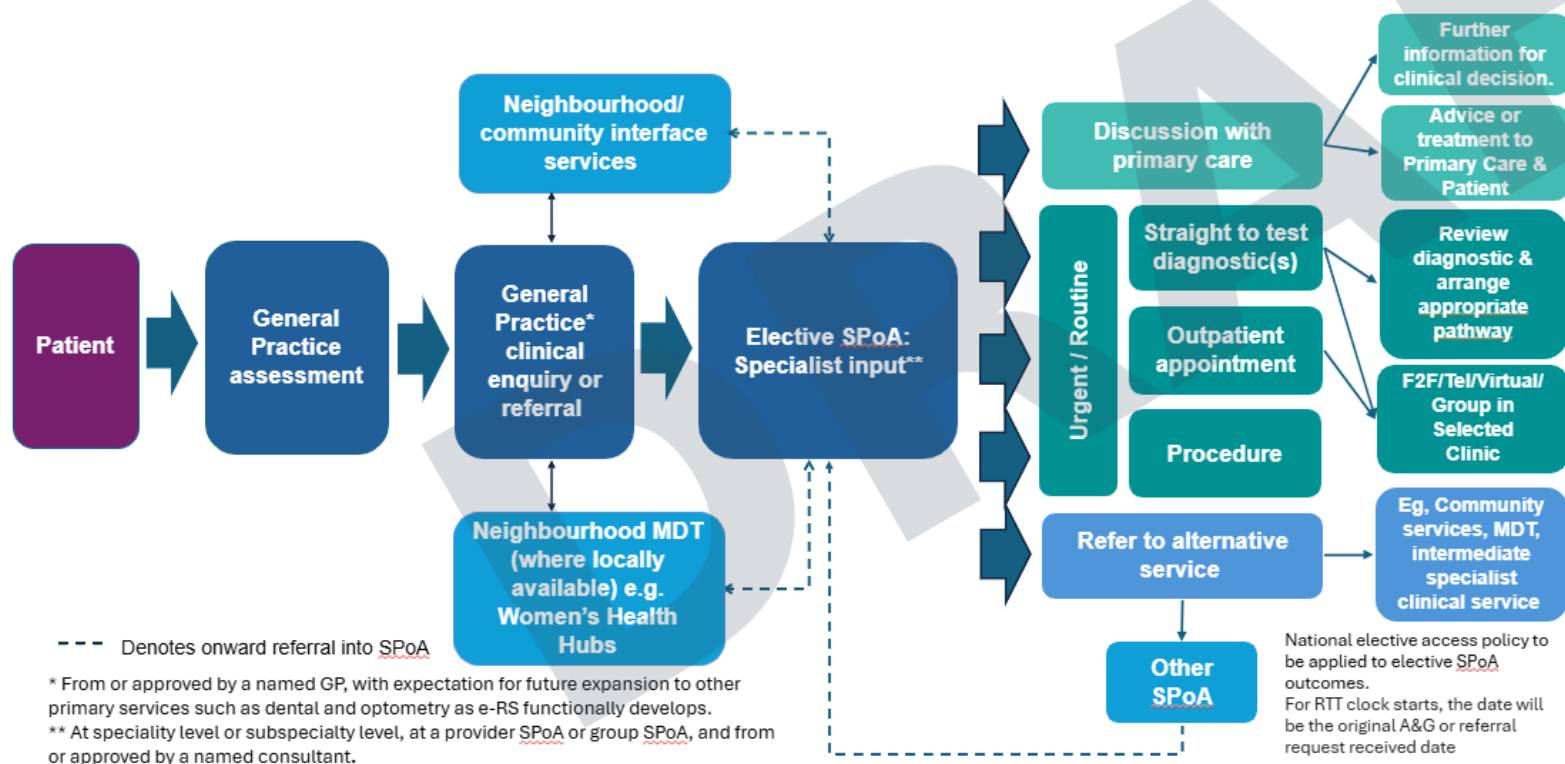


[Elective Single Point of Access](#)
[Technical Guidance for 2026/27](#)

What is elective single point of access?

Definition: Elective Single Point of Access (SPoA) is a model where all Advice and Guidance requests and elective referrals (other than those for urgent suspected cancer), are directed into a single digital entry point at specialty or sub-specialty level within secondary care. Specialist review of general practice advice and referrals is undertaken within e-RS or a digital solution integrated with e-RS. This specialist review determines the most clinically appropriate next step(s) or outcome for the patient, enabling straight to test and other diagnostic and management pathways. Communication to both the patient and the referrer in line with local guidelines follows, which could include a video or asynchronous consultation with the patient.

Elective Single Point of Access



This diagram illustrates the elective SPoA clinical model, showing how patients move from general practice through clinical review to the most appropriate elective care process.

The clinical review may result in:

- a discussion with primary care, including advice or treatment options
- Movement onto an elective pathway, booking for straight-to-test diagnostic or other diagnostic tests, an outpatient appointment or procedure
- a referral to an alternative service, which may include another SPoA

Elective SPoA within e-RS or an integrated third-party system will facilitate two-way consultation, enabling the patient to be guided to the correct outcome, first time.

Elective SPoA Clinical Toolkit: **What good looks like?**

Elective SPoA - What good looks like?

Core principles of high quality SPoA

The core principles of high quality SPoA clinical support are:

Best patient care: Every SPoA decision exists to improve patient outcomes, experience, and safety by ensuring care is delivered in the right place, at the right time.

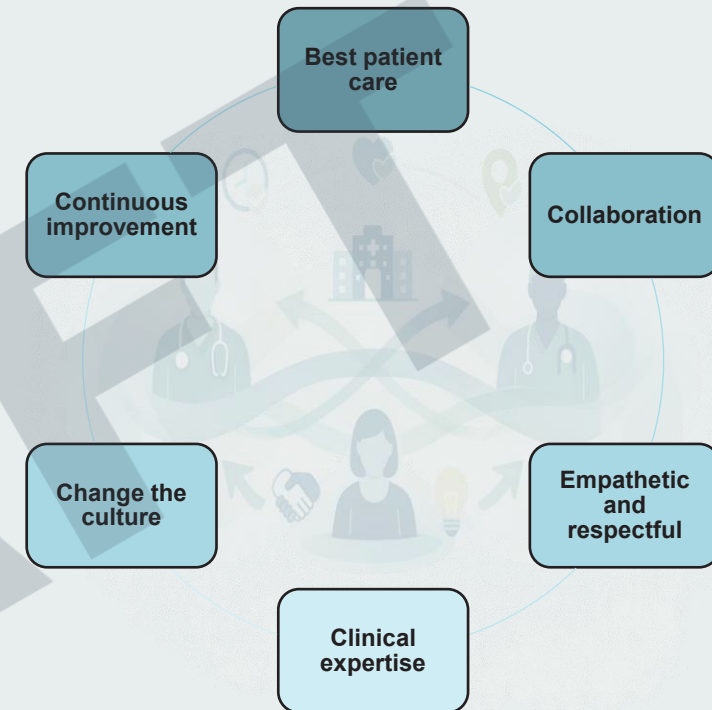
Collaboration as peers: SPoA enables clinicians to work together across specialties and across the primary–secondary care interface.

Empathetic and respectful communication: SPoA allows for professional, compassionate, and patient-centred communication, recognising its permanence, transparency, and impact on trust.

Clinical expertise: SPoA brings together the right clinical expertise at the earliest point, ensuring decisions are informed, proportionate, and supported by the right skills and governance.

Changing the culture of elective care: SPoA reflects a shift from transactional referral pathways to collaborative care, supporting modern, flexible, and learning-oriented models of elective delivery.

Continuous improvement: SPoA encourages the use of feedback, data, reflection, and peer review to improve quality, consistency, relationships, and outcomes over time.



Elective SPoA - What good looks like?

Requesting and providing advice

Requesting advice from a colleague

Opportunity to discuss

Use the opportunity to bring in advice early, supporting decision-making and access to the right care, including referral where appropriate. Check relevant national and local guidance and consider the patient's preferences and choice.

Make the question easy to answer

Ask a focused question, state the urgency, and specify the outcome you are seeking. Name the concern explicitly and provide enough clinical and psychosocial context to support safe, tailored advice, avoiding unnecessary long attachments. Use each response to inform future practice and share learning.



Providing advice to a colleague

Answer the question. Address the concern

Answer questions directly and address the underlying concern, whether diagnostic, risk-related, or about reassurance or next steps. Make the next steps clear to ensure the patient is seen in the right place at the right time. Support shared decision-making, reflect patient preferences, and reduce uncertainty for both referrer and patient.

Explain the thinking. Guide the next step

Approach each exchange with an educational mindset. Explain the rationale for recommendations, keep the door open for re-engagement. Where investigations are suggested, has this pathway been pre-agreed locally or should the responsibility remain with you. These should be pragmatic and proportionate (avoid long lists) and within the scope and capability of the setting in which the advice will be acted upon.

Requesting and providing advice from a colleague is an exacting professional task that requires dedicated time. When done well, it improves patient experience, strengthens clinical decision-making, fosters trust between primary and secondary care clinicians and supports more timely, appropriate care by ensuring patients are managed in the right setting, at the right time.

The development of this document builds on extensive national work to develop and improve the primary–secondary care interface, including the [Red Tape Challenge](#), [Escape the Tape](#) programme, and GIRFT's [Bridging the Interface](#) review.

Elective SPoA - What good looks like?

Building the interface through high-quality SPoA - the quality of conversation matters

The following four case examples are anonymised and drawn from clinical practice to demonstrate how the quality of conversation – clarity, context and collaborative planning – directly influences outcomes and reduces uncertainty for clinicians and patients.

Case 1

Dear Dr Fry,

I'd like to discuss with you the possibility of a cholecystectomy in a 42-year-old, Joan Collins, with recurrent right upper quadrant pain after fatty meals and uncomplicated gallstones on ultrasound. Mobilises independently, works full-time: teacher, symptoms occasionally disruptive. BMI 31, non-smoker, drinks minimal alcohol. PMHx: mild asthma. Medications: salbutamol inhaler PRN. LFTs, FBC and CRP are normal. We have reviewed the guidance and agreed to conservative management but would ask for advice on thresholds for referral and whether early surgery might be preferable?

Best wishes, Dr Cooper

Dr Cooper, thank you for your summary. I can see how these symptoms are troubling for Ms Collins. I think this is uncomplicated biliary colic. Conservative management is appropriate: low-fat diet, simple analgesia, and safety-net if pain becomes prolonged, recurrent, or associated with fever or jaundice. No further imaging needed at this stage. If her symptoms escalate or affect daily function despite lifestyle measures, please do re-contact us (not anticipating this) but we will arrange a routine appt for her. She would benefit from these links:

[“Waiting well link”](#)

[“Prehabilitation link”](#)

[“Patient information leaflet on Laparoscopic Cholecystectomy”](#)

KR, Dr Fry

Requesting
clinician

Signs of
high
quality

- Personal. Respectful. Safe, and person-centred.
- The GP provides context, checks existing guidance, and poses a clear question.
- Reply empathetic, acknowledges the patient's experience, and maintains openness for re-contact. Proactive “waiting well” to minimise delays. Ownerships of next steps.

Responding
clinician

Elective SPoA - What good looks like?

Building the interface through high-quality SPoA - the quality of conversation matters

Case 2

Dr White,

I have seen a 75-year-old Mr Iqbal with ongoing LUTS despite medical management. Symptoms: Poor urinary flow, hesitancy, and intermittency. PMHx: Anxiety + depression. Background: PSA 1.9, DRE: normal

Abdomen soft, no palpable bladder, Renal function normal.

Community ultrasound: normal kidneys, post-void residual 175 ml

Treatment to date:

Tamsulosin — tolerated and ongoing, Finasteride — discontinued due to side effects. Lifestyle advice given. IPSS 14 QOL 4.

He remains independent (CFS 2), systemically well, and keen to improve symptoms and consider further management options.

Question: Clinical referral to discuss further management options?

Best wishes, Dr McCafferty

Dear Dr McCafferty

Thank you for the enquiry.

Thank you for providing an IPSS and PSA test. We will request a Bladder diary prior to seeing him. I wonder if an MSU can be done in the community to exclude infection – I have not seen one on the system.

Thank you for the u/s renal tract with post micturition residual volume.

I have booked Mr Iqbal to be reviewed by LUTS clinic following a flow test. He will need an up-to-date IPSS to this appointment with a bladder diary. Continue tamsulosin. If he cannot pass urine, he should seek urgent care. If he has recurrent UTIs, rapid worsening of LUTS or bleeding please contact us urgently.

He can read the following information below: <https://www.england.nhs.uk/publication/decision-support-tool-making-a-decision-about-enlarged-prostate-bpe/>

https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/IPSS.pdf

https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Male%20LUTS.pdf

Pelvic floor exercises:

https://www.baus.org.uk/patients/information_leaflets/32/pelvic_floor_exercises_in_men Thanks, Dr White

Requesting
clinician

Signs of
high
quality

- Personal. Use of validated scores. Clear question
- Use of pre appointment investigations ordered by secondary, interpreted by secondary care.
- Patient decision aids provided. Clear “red flags” provided.
- Use editable GIRFT A&G template when appropriate

Responding
clinician

Elective SPoA - What good looks like?

Building the interface through high-quality SPoA - the quality of conversation matters

Case 3

Dear Drs,

This woman was found to have a cyst of the liver.
It was known to be present 11yrs ago and was 6mm.
She had a CT scan last year where it was measured at 20×19mm and the advice was to repeat in a year.
She has had a USS and they measured the cyst at 25×20mm and describe it as a simple cyst.
We have arranged to check her LFTs but these have previously been normal.
The earlier advice from an upper GI consultant was that this was not concerning so f/u was unnecessary
The patient is increasingly concerned about the cyst and wants to know the cause of it and why it is growing so rapidly and whether this should be monitored.
She has asked for advice from a liver specialist.

Thank you, Dr Perry

Requesting
clinician

Signs of
high
quality

- The request states the patients concern with enough context. Patient centred. Professional. Investigations mentioned.
- This response is: Empathetic. Maximally helpful. Respectful and educational.

Hello. Simple liver cysts are extremely common. The attached paper quotes a prevalence of 21.9% in the general population. Furthermore, it is not unusual for them to enlarge (from secretion of fluid by the cells lining the cyst) and this tends to happen more in younger females. Very rarely (<2%), the cyst will become large enough to cause symptoms, whereupon there is the option of percutaneous drainage or marsupialisation.

In Janes case, this is still a relatively small cyst and I am reassured by her normal LFTs and further reassurance could be enabled by an AFP test.

I do not think any action is needed here and we will arrange a telephone appointment as she is clearly worried. I hope this is helpful and reassuring to Jane. BW.

Dr Shah

<https://www.nature.com/articles/s41598-022-16875-z>

Responding
clinician

Elective SPoA - What good looks like?

Building the interface through high-quality SPoA - the quality of conversation matters

Case 4

Dear Drs,

This 84-year-old lady has recently had a chest CT and this has picked up a 70% stenosis of the left subclavian artery.

She is asymptomatic from this and is right-handed.

She is known to have cardiac disease, having had an MI in 2018.

BMI 32. She is otherwise well and lives alone.

Non-smoker.

Does she need any follow up or intervention?

Thank you

Dr Patel

Requesting
clinician

Signs of
high
quality

- Request: concise and sufficient: it states the concerning radiological finding, patient context, relevant risk factors, and the decision needed.
- Response: proportionate and actionable: it avoids unnecessary intervention and gives clear safety-netting and follow-up triggers.

Hello

Thank you for this. If she is asymptomatic, and right-handed, I would not intervene at all radiologically.

I would suspect that she is already medically optimised as she has cardiac disease, but you might wish to check this. This certainly will reduce the risk of progression of the stenosis.

I am happy to see her if she becomes symptomatic.

Worth letting her know that her blood pressure on the left will be artificially low and should be checked with her right arm.

Dr Emmanuel

Responding
clinician

Elective SPoA Clinical Toolkit:

Clinical responsibility and medicolegal summary

Elective SPoA - Clinical responsibility and medicolegal summary

This summary outlines the core principles of clinical responsibility and medico-legal expectations when using the elective SPoA and signposts relevant documents. It draws on national guidance. It does not replace legal advice or local governance policies.

Legal and Professional Framework

Clinical responsibility for elective SPoA clinical communication sits within existing NHS and professional standards:

NHS Constitution for England – patients' rights to safe, effective care, clear communication, involvement in decisions, and timely access.

GMC – Good medical practice and Delegation and referral – clinicians remain responsible for their decision to delegate or refer, and for the overall management of the patient while they remain the responsible clinician.

NHS e-RS joint guidance and delegation guidance – clarifies responsibility when using **e-RS and when delegating tasks** to administrative or external staff.

Specialist Advice Clinical Responsibility FAQs and Specialist Advice Medicolegal Liability and Coverage FAQs (NHS England) - these documents provide clarification on clinical responsibility and accountability when using Specialist Advice (including A&G in the context of the SPoA). This guidance sets out **who holds responsibility at each stage of an advice interaction** and clarifies the respective responsibilities of requesting and providing clinicians. It addresses common questions on returned referrals, recommended investigations, competence, escalation, and shared decision-making, and should be used alongside the Specialist Advice Medicolegal Liability and Coverage FAQs to support use of SPoA.

Delegation, e-RS Roles and administrative support

Delegation does **not** transfer accountability for overall patient care. Clinicians must ensure that those to whom they delegate are:

- competent
- appropriately trained
- supervised
- provided with sufficient information

Administrative staff are never clinically responsible; the delegating clinician retains responsibility for the decision to delegate.



Elective SPoA - Clinical responsibility and medicolegal summary

Understanding asynchronous communication – Primary Care

SPoA enquiries and referrals are clinical interactions. Through understanding risk in asynchronous interactions particularly around information, communication, and clinical responsibility we can begin mitigating against them. These tables outline key risks and mitigations to support safe, consistent decision-making.

Prompt	How It appears in practice	How to prevent or reduce it
Patient assumes requesting advice equates to a referral?	Patient assumes advice equals referral, leading to confusion or dissatisfaction.	• Explain the SPoA process clearly at the outset. • Reinforce that it is a clinical dialogue, not a booking. • Document the discussion. • Offer choice at the point of enquiry. Inform patient about SPoA and what it means for them.
Not enough information for provider to make decision.	Missing key data (e.g., results, medication list, pertinent negative symptoms, patient's function/biopsychosocial context) leads to incomplete advice or repeat queries. Does the speciality have access to your records?	• Before sending, double-check that your summary contains the essentials: current diagnosis, comorbidities, latest investigations, allergies, and what's already been tried. Familiarise yourself with What Good Looks Like. • Use local templates to prompt key fields.
Unclear knowledge around pathways, or guidelines	Unfamiliarity with specialty thresholds or pathways leads to premature referral or delay.	• Check local referral criteria, decision-support tools, and NICE guidance. Seek peer input when uncertain and document your reasoning. • Be mindful of 'grey areas', conditions that are technically manageable in Primary Care but where the patient's specific complexity/frailty necessitates specialist navigation.
Poor communication	Requests written in shorthand or medical jargon are unclear to the specialist and confusing for patients when viewing them.	• Write as if the patient will read it. Use plain English, explain abbreviations, and maintain a collegial tone. End with a clear focused question.

Elective SPoA - Clinical responsibility and medicolegal summary

Understanding asynchronous communication – Primary Care continued.

Prompt	How It appears in practice	How to prevent or reduce It
Not sure about the next steps and the SPoA outcome?	Uncertainty about whether the SPoA request has been converted into a referral or outcome.	• Include option to conversion in the request if appropriate. • If unclear in the response, follow up with the provider. • Be aware of timeframes available to reopen advice windows, if advice is retired and fails in this window, reopening preserves audit trail. • Administrative teams can support reviewing and tracking SPoA outcomes. • Data will be available for outcomes and notifications of outcomes to patients and practices.
Disagree with the clinical advice?	The advice does not answer the questions asked by the referrer, or is unsafe, unclear, or not deliverable in primary care, for example it requests investigations unavailable locally, treatments outside GP scope, or overlooks key patient factors such as frailty or comorbidity. The GP is left responsible for care without a workable plan.	• If the advice does not answer the question(s) asked, respond via the e-RS thread. • If the advice cannot be implemented or appears unsafe, respond via the e-RS thread. • State clearly why the action is outside local primary care pathways and request either specialist investigation or an alternative plan. • Escalate to local/ regional forums and groups when necessary.

Elective SPoA - Clinical responsibility and medicolegal summary

Understanding asynchronous communication – Secondary Care

Prompt	How It appears in practice	How to prevent or reduce it
Not enough information to make a decision	Missing context from the request, for example, unclear comorbidities or incomplete investigations, leading to over-cautious triage or unnecessary clinic bookings. Offering a reply when there is no clear question. Digital system in place do not support access to patient records.	• Look for what is missing, seek information within EPRs – if not available, request further information before booking a patient directly. • If key details are absent, send a polite clarification. Seek clarity on the question asked.
Over- testing or under-testing	Recommending unnecessary investigations or missing the key one that would change management.	• Rationalise investigations. • Explain why you are recommending a test and what the result would mean for management. • Secondary care are responsible for tests that they order.
Poor communication	Written advice is technically correct but overly clinical, difficult to follow, or phrased in a way that feels abrupt or dismissive. The referrer may understand, but the patient — who can view the message — may not, leading to confusion or anxiety.	• Write in clear, plain English and assume the patient will read it. • Acknowledge the referrer's efforts, keep the tone collegial and supportive, and separate clinician actions from patient-facing explanations. • Finish with safety-netting and next steps in patient-friendly language.
Cognitive bias	Anchoring on the GP's suspected diagnosis or your first impression; confirmation bias (only looking for data that supports your assumption); or over-confidence after a run of similar cases.	• Deliberately ask: "What else could this be?" before committing to advice. • Use the "diagnostic time-out" technique: step back, re-read the case after a short pause.

Elective SPoA - Clinical responsibility and medicolegal summary

Understanding asynchronous communication – Shared Risks

Prompt	How It appears in practice	How to prevent or reduce It
Understanding medicolegal roles and responsibility	Uncertainty about who holds responsibility for next steps.	• Read conversation carefully, document actions, update the patient when appropriate, and keep notes clear. • Familiarise yourself with local and national guidance on delegation. • Know your scope of practice and declare responsibility clearly. • State explicitly who should act, by when, and how, in secondary, to re-contact if needed. • Attribute every reply with your name and role. Document discussions and escalation decisions. • Understand the medico-legal guidance on Specialist Advice.
System navigation	Lack of awareness of local systems or community options causes unnecessary referrals.	• Keep an updated pathway directory; attend interface and service-update briefings. • You may want to double check with colleagues as to what is available.
Continuity	There will be times when another GP/Consultant follows up on your behalf.	• Record clearly that Elective SPoA enquiry/referral has been requested or responded to, and what actions are pending. Clear next steps and why. Handover for selected cases. • Consider alternative workflow, and workforce solutions that suit local practice to help mitigate.

Appendix 1: Elective SPoA – Clinical Service Assessment Tool for secondary care clinicians

For those secondary care clinicians wishing to partake in SPoA activity you may consider using this tool to reflect on readiness in delivering SPoA. You may wish to use this at intervals to reflect on your practice and as an educational tool.

Date:			
Domain	Readiness Indicators	Self-Rating (1–5)	Actions / Notes
Clinical confidence and reasoning	• Demonstrates confidence managing common conditions remotely; articulates uncertainty clearly; • Recognises when in-person review is required and when enquiry or referral can be returned to		
Risk tolerance and decision-making	• Understands patient safety in the context of asynchronous communication. • Investigates proportionally; understands risks of asynchronous communication, can mitigate and manage risk within competence; knows when to escalate.		
Communication and clarity	• Writes structured, concise responses that are actionable, courteous, and comprehensible if read by the patient.		
Governance and supervision	• Has defined escalation routes (understands interface forums), peer review opportunities, and protected time for SPoA activity.		
Digital and documentation skills	• Proficient with e-RS or local systems; ensures records are complete, traceable, and auditable.		
Patient-centred approach	• Frames responses around what is best for the patient, incorporating shared decision-making and equality of access.		
Learning, reflection and quality improvement	• Uses advice cases to identify learning points, seek feedback, and demonstrate progression in clinical reasoning.		

Contact for the
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Thank You



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