BMA England

GPCE updated guidance on Advice and Guidance (A&G) and Single Point of Access (SPoA)

April 2026

Contents

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Key Messages for Practices

- **GPs retain the ability to refer patients for specialist assessment** where this is clinically appropriate. Advice and Guidance (A&G) systems must not prevent or inappropriately delay referrals.
- **Single Point of Access (SPoA)** systems are intended to streamline referral pathways but **do not override the GP's clinical decision to refer**.
- **Advice and Guidance should support clinical care**, not be used to deflect referrals, or transfer unfunded work into general practice.
- **GPs must work within their competence.** Where specialist input is required to provide safe care, it must remain accessible.
- **Jess's Rule** highlights the importance of reconsidering diagnoses when patients present repeatedly with unresolved symptoms.
- **Local Medical Committees (LMCs)** should be involved in the development and implementation of SPoA pathways and any arrangements that may transfer workload into primary care.
- Where referrals are **inappropriately returned as Advice and Guidance**, practices may wish to respond formally and retain correspondence in the patient record.

Purpose of this guidance

This document provides guidance for **Local Medical Committees (LMCs)** and **general practices** regarding the use of **Advice and Guidance (A&G)** and the introduction of **Single Points of Access (SPoA)** within the NHS as part of the **2026/27 GP Contract changes**.

It is intended to support LMCs and practices where A&G systems are not functioning as intended or are creating inappropriate workload or barriers to referral.

NHS England continues to promote the use of A&G to reduce pressure on secondary care and reduce referrals into hospital services. Under the **2026/27 GP Contract**, the £80 million A&G funding (uplifted to **£82 million**) has been incorporated into the **core GP contract funding**.

This change **does not remove the ability of GPs to refer patients for specialist care**.

However, NHS England expects **Integrated Care Boards (ICBs)** to identify their **top ten specialties** and ensure that by **1 October 2026** these specialties operate via a **Single Point of Access (SPoA)** model.

LMCs should be involved in the development and implementation of local systems relating to A&G and SPoA.

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The GP's Role and the Ability to Refer

GPs are **independent clinical decision-makers** and retain the professional responsibility to refer patients for specialist assessment where this is clinically appropriate.

Preventing or obstructing referral may place doctors in conflict with their **professional obligations under Good Medical Practice**, which states that doctors must:

"Refer a patient to another suitably qualified practitioner when this serves the patient's needs."

Further GMC guidance on delegation and referral is available here:

https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/delegation-and-referral

This principle is also supported by the **NHS Constitution**, which protects patient choice in accessing specialist care.

Advice and Guidance systems should therefore **support clinical decision-making rather than act as a barrier to referral**.

Single Point of Access (SPoA)

SPoA systems are intended to provide a **single digital entry point** for referrals and clinical enquiries.

NHS England describes SPoA as a mechanism to:

- Route all clinical enquiries and referrals through a single access point
- Enable shared clinical decision-making between primary and secondary care.
- Provide timely access to senior specialist advice.
- Reduce unnecessary administrative complexity.

NHS England states that SPoA **does not override the GP's decision to refer** but aims to ensure that once a referral decision has been made the patient is directed to the most appropriate service.

For primary care, SPoA should:

- Provide a **transparent route to specialist input.**
- Offer **clear response times.**
- Enable early access to specialist advice where community management may be appropriate.
- Reduce avoidable administrative burden once referrals are submitted.

Following SPoA triage, the outcome may include:

- Allocation of an **outpatient appointment**
- A request for **additional clinical information**
- **Advice and Guidance** regarding investigation or treatment
- Redirection to a **more appropriate specialist service**

Development of SPoA Pathways

Pathways developed to operate through SPoA must include **appropriate stakeholder engagement**.

LMCs, as the **statutory representatives of general practice**, should be involved in pathway design and implementation.

Pathways should also be supported by **appropriate commissioning arrangements** where workload shifts into primary care.

Appropriate Use of Advice and Guidance

The **General Practitioners Committee England (GPCE)** is clear that A&G may be used as a **supportive clinical tool**, but **must not be used to:**

- Delay appropriate referrals.
- Deflect referrals inappropriately.
- Prevent patients accessing specialist assessment where clinically required.

A&G systems should not undermine the GP's role as the **patient's clinical advocate**.

Clinical Responsibility and Jess's Rule

Jess's Rule highlights the importance of reconsidering diagnoses where patients present repeatedly with unresolved symptoms.

Clinicians are encouraged to reconsider the diagnosis if a patient presents **three times with the same symptoms or concerns**, particularly where symptoms:

- Persist unexpectedly.
- Escalate
- Remain unexplained.

In such circumstances clinicians should **review and reflect on the diagnosis and management plan**, and where clinically appropriate **consider further investigation or referral for specialist input**.

Jess's Rule was developed following the death of **Jessica Brady**, who died from bowel cancer after repeated presentations in primary care.

Further information can be found here:

https://www.gmc-uk.org/news/news-archive/jesss-rule-cancer-diagnosis

Clinical Safety and Professional Limits

Clinical safety and professional limits must be respected in the use of A&G.

The **General Medical Council (GMC)** states that doctors must work **within the limits of their competence**.

Further GMC guidance can be found here:

https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-medical-practice

GPs should not be expected to manage conditions that:

- Require specialist expertise.
- Fall outside their clinical competence.
- Cannot be safely managed with available primary care resources.

Where specialist input is required to provide safe care, this must be **accessible without unreasonable barriers**.

Patients also have the right to request referral for specialist care:

https://www.nhs.uk/nhs-services/hospitals/referrals-for-specialist-care/

Avoiding Unfunded Workload Transfer

Advice and Guidance must not be used to transfer **unfunded workload into primary care**.

Requests for:

- Investigations
- Monitoring
- Initiation of specialist treatments

should align with **locally agreed commissioning arrangements**.

Primary care should not be asked to undertake work requiring specialist expertise unless this has been **formally agreed, commissioned, and appropriately resourced**.

LMCs should be involved where workload shifts into general practice are proposed.

Documentation and Accountability

All Advice and Guidance interactions should be **clearly documented within eRS**.

Where pathways involve shared care or A&G processes, the **clinical responsibility at each stage must be clearly defined**.

Clear documentation supports **clinical safety and medico-legal accountability**.

Referrals via eRS and SPoA

SPoA via **eRS** is expected to become the primary route for referrals in the identified specialties from **October 2026**.

Where a GP requires **specialist assessment rather than advice**, the referral should clearly state that the request is for **a specialist consultation**.

If a referral requesting a consultation is returned with Advice and Guidance instead, practices may respond to clarify that the request was for **a referral rather than advice**.

Acceptance and Rejection of Referrals

The **NHS Standard Contract** states:

"The Provider must accept any referral of a service user made in accordance with the referral processes and clinical thresholds set out in this Contract or otherwise agreed between the parties, and where necessary to enable a service user to exercise their legal right to choice as set out in the NHS Choice Framework."

Further information can be found here:

https://www.england.nhs.uk/nhs-standard-contract/

Managing Rejected Referrals

Where a referral is rejected and replaced with Advice and Guidance that:

- does not resolve the clinical issue, or
- requests additional unfunded work in primary care,

GPCE recommends that practices **formally respond to the provider**.

A copy of this correspondence should be **saved within the patient's medical record**, ensuring transparency and allowing the patient to view it via the **NHS App**.

This may also support patients who choose to raise concerns with their **ICB, NHS England, or their Member of Parliament**.

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Template Letter: Referral Returned as Advice and Guidance

Practice letterhead

Date

Trust Name and Address

Cc: Trust Medical Director

Patient Name
Date of Birth
NHS Number
Patient Address

Re: Referral Returned with Advice and Guidance

We have been advised that our recent referral for the above patient has been returned with Advice and Guidance which we did not request. This appears to fall outside locally agreed commissioned pathways and may be inconsistent with **Jess's Rule**, which encourages clinicians to reconsider diagnoses and, where clinically appropriate, seek specialist input when symptoms persist or remain unexplained: https://www.gmc-uk.org/news/news-archive/jesss-rule-cancer-diagnosis

Having reviewed the referral and reflected on our contractual and professional obligations, we remain satisfied that this referral is **clinically appropriate**. The referral letter provides the necessary information to ensure safe transfer of care and is consistent with the NHS Standard Contract – Service Conditions: Acceptance and Rejection of Referrals; our Primary Medical Services Contract; and GMC guidance, which requires doctors to refer when clinically necessary

We remain committed to putting the needs of our patients first, using NHS resources responsibly, and working collaboratively across our local Integrated Care System. We would encourage your Trust Medical Directorate to discuss the use of Advice and Guidance and SPoA pathways with our Local Medical Committee. In the meantime, we would request that our patient is provided with an outpatient appointment without delay. Failure to do so may lead to delays in care and potential harm which we wish to avoid.

Yours sincerely,

GP Name

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Template Letter for LMCs:

A&G and SPoA — Patient Safety, Clinical Accountability and System Risk

LMC Letterhead

Date

Dear [ICB Chief Executive / Acute Trust Medical Director],

Re: Advice & Guidance (A&G) and Single Point of Access (SPoA) — Patient Safety, Clinical Accountability and System Risk

We are writing on behalf of GP colleagues to raise significant concerns regarding the implementation and proposed mandating of Advice and Guidance (A&G) and Single Point of Access (SPoA) within referral pathways.

We recognise that A&G, when used appropriately, voluntarily, and with adequate resource, can support patient care. However, current implementation — particularly where A&G is mandated or used as a gatekeeping mechanism — introduces systemic risks to patient safety, clinical accountability, and access to care. These risks are not incidental or implementation-dependent; they arise from the design of a mandatory model itself.

GPs are independent clinical decision-makers and retain a professional duty to refer patients for specialist assessment where this is clinically appropriate. This is supported by GMC Good Medical Practice and the NHS Constitution. Advice and Guidance systems, including SPoA models, must therefore support clinical decision-making rather than obstruct or delay referral. While SPoA may provide a single access route into services, it does not override the GP's decision to refer.

Mandatory A&G introduces additional steps into referral pathways, creating a foreseeable risk of delayed diagnosis and treatment. Patients with serious or evolving pathology may be redirected back to general practice based on remote advice, without specialist assessment or access to the full clinical picture. This creates fragmented, multi-step pathways in which patients may be lost to follow-up. General practice does not have the administrative capacity to safely manage this increased complexity at scale, increasing the risk that serious conditions are identified later than they should be.

At the same time, mandatory A&G transfers significant clinical and administrative responsibility into general practice without equivalent resourcing or accountability. Where a GP acts on remote specialist advice and harm occurs, liability appears to rest with the GP rather than the specialist who has provided advice without direct patient assessment. This creates a clear imbalance in risk. More fundamentally, this model risks placing GPs in conflict with GMC Good Medical Practice, which requires clinicians to work within the limits of their competence. Where advice requires actions beyond a GP's scope or available resources, and where no alternative referral route is available, safe and compliant practice cannot be assured. In a voluntary system, GPs retain discretion to accept, challenge, or bypass advice where necessary. Mandatory A&G removes that discretion.

There is also a significant impact on patient access to general practice. Each A&G interaction generates further clinical review, administrative processing, patient communication, and follow-up. This work directly competes with core GP activity and is not resourced. In practice, this leads to reduced availability of GP appointments, including for patients with urgent needs. Waiting times are not eliminated but displaced from secondary care into general practice, where there is insufficient capacity to absorb them.

We are already aware of cases where A&G has been used as the only route for referral, with concerning outcomes. In one anonymised case, a patient referred urgently under a suspected cancer pathway had their referral repeatedly downgraded to Advice and Guidance. Despite persistent symptoms and repeated GP concern, specialist assessment was delayed until a third referral. Cancer was subsequently diagnosed more than nine months after the initial referral. Throughout this period, the patient was not examined by a specialist. This case illustrates that the risks described above are not theoretical.

This is particularly concerning in the context of Jess's Rule, which emphasises the need to reconsider diagnoses and escalate care where patients present repeatedly with unresolved or unexplained symptoms. Systems that delay or obstruct referral in these circumstances run counter to this principle and introduce a clear and avoidable patient safety risk.

Advice and Guidance can be a valuable clinical tool when used appropriately. However, it must not be used to delay appropriate referrals, deflect referrals inappropriately, or prevent patients from accessing specialist assessment where clinically required. It must also not be used to transfer unfunded workload into general practice. Requests for investigations, monitoring, or initiation of specialist treatments must align with agreed commissioning arrangements and appropriate resourcing.

There are also clear contractual and governance concerns. While secondary care providers are required to offer A&G, there are no mandated standards regarding response times, quality, or accountability for advice provided without patient assessment. By contrast, GP practices are expected to use A&G, creating a clear asymmetry. The burden of clinical responsibility, administrative workload, and medicolegal risk falls disproportionately on general practice. We would welcome written clarification as to whether GPs retain the right to refer directly where clinically indicated, and under what circumstances this may be overridden.

Our position is clear.

We support A&G where it is voluntary, clinically appropriate, and delivered within a well-governed and properly resourced system. We cannot support mandatory A&G pathways that override clinical judgement, delay access to specialist care, or transfer risk and workload without appropriate accountability and commissioning.

We therefore ask the ICB to:

- Confirm in writing that GPs retain the right to refer directly where clinically indicated
- Define clinical accountability for advice provided through A&G locally
- Work with us to establish minimum standards for A&G services, including response times and quality
- Assess and appropriately resource the workload impact on general practice
- Ensure LMC involvement in any prospective pathway redesign and implementation
- Escalate any concerns to NHS England patient safety structures

Safe patient care depends on timely access to specialist assessment, clear lines of responsibility, and systems that support — rather than obstruct — clinical judgement.

We remain committed to working collaboratively to ensure referral pathways are safe, sustainable, and clinically accountable, and we would welcome early engagement on how these risks will be addressed.

Yours sincerely,

On behalf of <insert LMC>