NHS England

Draft Enhanced Service Specification – General Practice Requests for Advice and Guidance 2025/26

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Contents

The text in yellow highlight indicates text that has changed since version 1.0 of the 2025/26 General Practice Requests for Advice and Guidance Enhanced Service specification was published on 27 March 2025.

1. Introduction

1.1. This enhanced service (ES) is subject to amendments from time to time. It is a national specification that cannot be varied locally.

1.2. This ES is offered by the Commissioner to all General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contract holders.

1.3. An ES is designed to cover and/or support enhanced aspects of clinical care, all of which are beyond the scope of essential and additional services. No part of this ES specification by commission, omission or implication defines or redefines essential or additional services.

1.4. All GP practices are offered the opportunity to sign up to this ES provided they meet the requirements of this specification. By signing up to deliver this ES, a GP practice agrees to a variation of its primary medical services contract to incorporate the provisions of this ES. The provisions of this ES are therefore deemed a part of the GP practice's GMS contract, PMS agreement or APMS contract.

2. Commonly Used Terms

2.1. This specification is referred to as this "**ES**".

2.2. In this ES:

2.2.1. the "**Commissioner**" refers to the organisation with responsibility for setting the terms of these ES arrangements, which is NHS England and the Integrated Care Board (ICB) for the role of contract management.

2.2.2. "Secondary Care" refers to hospital trusts that provide pre-referral advice and guidance.

2.2.3. a "**GP practice**" refers to a provider of essential primary medical services to a registered list of Patients under a General Medical Services contract, Personal Medical Services agreement or

Alternative Provider Medical Services contract who has agreed with the Commissioner to deliver this ES.

2.2.4. **Pre referral Advice & Guidance** (sometimes referred to as 'Specialist Advice'). The definitions used for local implementation should be in line with those used in the collection of data via the system EROC (the national data collection covering specialist advice activity) as outlined below.

2.2.5. Pre referral advice and guidance refers to specialist advice which supports a clinical dialogue, enabling a referring clinician to seek advice from a consultant led specialist service prior to, or instead of referral about a named patient.

2.2.6. Advice and Guidance in this enhanced service is defined as GP led, non-face to face activity which could be real-time/synchronous advice, such as a telephone call, or asynchronous advice when carried out electronically through the NHS e-Referral Service (e-RS) or dedicated email addresses.

2.2.7. It supports GPs in managing non-urgent (elective) patients that they may be considering referring to secondary care. The types of advice that may be requested include, but are not limited to, treatment plans, interpretation of results and/or advice on appropriateness of referrals/tests.

2.2.8. Advice and guidance may be provided by appropriately trained and commissioned specialist consultants in secondary care, community, primary care providers, interface or intermediate services, and referral management systems. We will expect ICBs to use their primary-secondary care interface group to monitor the quality of GP requests and advice provided.

2.2.9. This will typically be accessed via a digital communication channel and facilitate a two-way dialogue and sharing of relevant clinical information in relation to the management of a named patient where, at the outset of the interaction, there is uncertainty about the need for a referral to secondary care. This is non face to face activity, with no referral or booking having yet been made, and as such there has been no recording and reporting referral to treatment (RTT) Clock Start. There will not be a requirement that pre-

referral A&G is sought prior to referrals being made. This ES does not require that pre-referral A&G is sought prior to all referrals being made, however, some ICBs may have local referral management processes in place, which must be followed.

2.3. In this ES words importing the singular include the plural and vice versa.

3. Background

3.1. Partnership working between Consultant Specialists and GPs is front and centre to the Government's commitment to move patient care closer to home. Pre-referral advice and guidance supports integrated care and peer to peer learning as well as service improvement. General Practices across the country already support advice and guidance pathways, which are intended to help to ensure patients receive care in the right place at the right time. However, advice and guidance pathways have workload implications for both general practice and secondary care.

3.2. Reforming elective care for patients[1] sets out that both primary care and secondary care will be funded to deliver advice and guidance for new patients. It is expected that uptake will increase to deliver up to four million pre-referral advice requests from GPs in 2025/26 (up from 2.4 million in 2023/24).

4. Process

4.1. This ES begins on 1 April 2025 and shall continue until 31 March 2026 unless it is terminated in accordance with paragraph 4.2.

4.2. This ES may be terminated on any of the following events:

4.2.1. the Commissioner is entitled to require that the GP practice withdraws from this ES, having provided the practice with 3 months notice, as set out in this ES;

4.2.2. the Commissioner is entitled to terminate this ES where the GP practice has failed to comply with any reasonable request for information from the

[1] NHS England » Reforming elective care for patients

Commissioner, relating to the provision of the services pursuant to this ES; or

4.2.3. the GP practice terminates this ES, having provided their ICB with 3 months' notice.

4.3. This ES will be available on CQRS from 30 April 2025. Unless section 10 of this ES applies, the Commissioner must invite all GP practices to participate in this ES on CQRS no later than 13 May 2025. GP practices must sign up to participate in this ES on CQRS on or before 27 May 2025, (but see 4.4), unless the Commissioner agrees otherwise. GP practices must record their agreement to participate in this ES in writing to the Commissioner.

4.4. Only where a practice signs up to this ES in accordance with 4.3, will practices be able to claim the IoS fee for each pre-referral A&G request made since 1 April 2025.

4.5. Payment under this ES is conditional on GP practices:

4.5.1. entering into this ES, including any variations and updates; and

4.5.2. complying with the requirements of this ES.

4.6. A GP practice's participation in this ES shall only continue for so long as it is in compliance with its terms and if it does not do so the Commissioner will be entitled to require that the GP practice withdraws from the ES.

5. General Requirements

5.1. Each GP practice participating in this ES will:

5.1.1. comply with any reasonable request for information from the Commissioner relating to the provision of the services pursuant to this ES;

5.1.2. have regard to all relevant guidance published by the Commissioner or referenced within this ES;

5.1.3. take reasonable steps to provide information to patients about the services pursuant to this ES, including information on what to expect from the practice when advice and guidance is requested;

5.1.4. ensure that it has in place suitable arrangements to enable the lawful sharing of data, including patient records, to support the delivery of the services, business administration and analysis activities under this ES in line with data protection legislation; and

5.1.5. ensure that any sub-contracting arrangements related to the provision of services under the ES, comply with the requirements set out in the statutory regulations or directions that underpin its primary medical services contracts in relation to sub-contracting, which will also apply to any arrangements to sub-contract services under the ES.

6. Service Delivery Specification[2]

6.1. The aims of this ES are:

6.1.1. to recognise the workload created for general practice through the process of seeking pre-referral advice and guidance from secondary care through the provision of an Item of Service (IoS) fee (subject to the conditions set out in this ES).

6.1.2. to ensure that patients and General Practice teams are, where feasible and appropriate, supported through the provision of advice and guidance from secondary care, thus avoiding delays in treatment or intervention that can be delivered in primary care, or referral decisions;

6.1.3. to ensure referrals when relevant to secondary care are appropriately targeted when needed and of good quality.

6.2. **Eligibility Criteria and the identification of appropriate cases**

6.2.1. GP practices must develop and implement a protocol for the identification and appropriate use of pre-referral advice and guidance. This should include:

- ensuring that the patient is informed that their case is being referred for pre-referral advice and guidance and ensuring that they understand what it means (including that it is not the same as an appointment being requested in secondary care for the patient, but that this may follow

[2] GP practices must ensure they have read and understood all sections of this document as part of the implementation of this programme and to ensure understanding of the payment regime.

depending on the advice provided). Shared decision-making principles should apply.

- ensuring that requests for pre-referral advice and guidance are GP led; where they are not initiated by a GP, they must be reviewed by a GP ahead of being submitted to ensure appropriateness, quality control and relevant content.

- that the practice has considered relevant guidance on making pre-referral requests.

- that the practice will ensure requests for pre-referral advice and guidance are appropriately recorded.

- the request must be for pre-referral advice and guidance.
- the requests are not limited to specific specialities or clinical conditions.
- each request for advice and guidance, including all subsequent interactions between the GP practice and the specialist regarding the relevant episode of care, are counted once for the purposes of a claim under this ES.

7. Payment and Validation

7.1. Practices will be entitled to claim a £20 Item of Service (IoS) fee per request for pre-referral advice and guidance. Only one claim can be made per episode of care (i.e. multiple contacts between the practice and specialist for the same clinical issue are counted as one A&G referral). The request must be GP led and the person providing the advice and guidance must be in accordance with paragraph 2.2.5. For the avoidance of doubt, ongoing communication between the referrer and the respondent regarding the same episode of care will not attract a further IoS fee.

7.2. To maximise requests for advice and guidance, while ensuring expenditure stays within the £80m national funding envelope for 2025/26, at a local level, Integrated Care Boards (ICBs) may introduce a mechanism to cap the number of (monthly, quarterly or annual) advice and guidance requests which can be claimed per practice. At any point during the year, the ICB may set a cap or change a cap. If a cap is changed in year, it will not be set below the level of delivered activity at that point. Each practice that signs up to this ES will be notified by its ICB of any cap (where applicable) and any in year changes to the cap. ICBs may want to discuss any capping approach with the Local Medical Committee (LMC). Practices may continue to make pre-referral requests

above any cap set by the ICB but will not be able to claim payment for those requests under this Enhanced Service.

7.3. Activity should be counted as the total number of requests made, be this through synchronous or asynchronous, as per the eligibility criteria in 6.2.

7.4 In 2025/26 practice level claims for payment of pre-referral A&G requests will be made via the Calculating Quality Reporting Service (CQRS). Practices will make manual monthly claims which will then be approved by commissioners.

7.5 This should be within 12 days of the end of the month when the pre-referral advice and guidance was requested. Payments will be made monthly by commissioners.

7.6 Commissioners are responsible for post payment verification. This may include auditing practice claims to ensure that they meet the requirements of this ES. Local quality audits may be required where unexplained significant increases in A&G activity levels are detected.

7.7 Table 1 sets out the relevant subject and finance system codes that commissioners will be required to use to support all payments under the 2025/26 A&G ES:

Table 1: National subjective and finance system codes for the A&G enhanced service

Payments	Paycode	APMS/GMS/PMS	Paycode description	Subjective code
Item of Service fee	ADVGUA	APMS	APMS A&G Enhanced Service	52161471
	ADVGUP	PMS	PMS A&G Enhanced Service	52161472
	ADVGUG	GMS	GMS A&G Enhanced Service	52161473

8. General payment provisions relating to practices wishing to withdraw from the ES

8.1 Where a GP practice has entered into this ES but its primary medical services contract subsequently terminates or the GP practice withdraws from this ES prior to the end of this ES, the GP practice is entitled to a payment in respect of its participation if such a payment has not already been made, in accordance with the provisions set out below. Any payment will fall due on the last day of month following the month during which the GP practice provides the information required, subject to paragraph 8.2.

8.2 In order to qualify for payment in respect of participation under this ES, the GP practice must comply with and provide the Commissioner with the information in this ES specification or as agreed with the Commissioner before payment will be made. This information should be provided in writing within 28 days following the termination of the contract or the GP practice's withdrawal from this ES.

8.3 The payment due to a GP practice whose primary medical services contract subsequently terminates or that withdraws from this ES prior to the end of this ES will be based on the number of requests for pre-referral advice and guidance (as set out in section 7), prior to the termination of the primary medical services contract or withdrawal from this ES.

9. Provisions relating to GP practices who merge or are formed

9.1 Where two or more GP practices merge or a new primary medical services contract is awarded and as a result two or more lists of registered patients are combined, transferred (for example from a terminated practice) or a new list of registered patients is developed, the new GP practice(s) may enter into a new or varied arrangement with the Commissioner to provide this ES.

9.2 In the event of a practice merger, the ES arrangements of the merged GP practices will be treated as having terminated (unless otherwise agreed with the Commissioner) and the entitlement of those GP practice(s) to any payment will be assessed on the basis of the provisions of section 7 of this ES.

9.3 The entitlement to any payment(s) of the GP practice(s), formed following a practice merger, entering into the new or varied arrangement for this ES will be assessed and any new or varied arrangements that may be agreed in writing with the Commissioner will begin at the time the GP practice(s) starts to provide this ES under such arrangements.

9.4 Where that new or varied arrangement is entered into and begins within 28 days of the new GP practice(s) being formed, the new or varied arrangements are deemed to have begun on the date of the new GP practice(s) being formed and payment will be assessed in line with this ES specification as of that date.

9.5 Where the GP practice participating in the ES is subject to a practice merger and:

9.5.1 the application of the provisions set out above in respect of practice mergers would, in the reasonable opinion of the Commissioner, lead to an inequitable result; or,

9.5.2. the circumstances of the split or merger are such that the provisions set out above in respect of practice mergers cannot be applied,

the Commissioner may, in consultation with the GP practice or GP practices concerned, agree to such payments as in the Commissioner's opinion are reasonable in all of the circumstances.

10. New contract awards

10.1 Where a new primary medical services contract is awarded by the Commissioner after the commencement of this ES, the GP practice will be offered the ability to opt-in to the delivery of this ES.