NHS Providers

Briefing

21 July 2021

ADDRESSING THE CARE BACKLOG

An essential partnership between primary and secondary care

Foreword

As providers come together across organisational boundaries to work collaboratively in neighbourhoods, places and integrated care systems (ICSs), partnerships between primary and secondary care colleagues are pivotal in delivering high quality, sustainable patient care. These partnerships will take many forms, often blurring traditional boundaries and incorporating a complex patchwork of general practice, primary care networks (PCNs), large scale primary care providers, trusts and other partners.

We hope that this briefing, produced in partnership between NHS Providers and the At Scale Primary Care Networking Group is a timely contribution to the debate about how such development might be achieved, with relevant case studies for colleagues in providers of all types and sizes. Given the national, NHS-wide drive to tackle waiting times and recover the backlog of care caused by the disruption of the pandemic, we have deliberately focused our first joint briefing on sharing how primary and secondary care providers are working together to manage waiting lists and support patients.

Behind the headline figures of the national waiting list, which has reached 5.3 million, lie difficult experiences and sometimes poorer outcomes for the individuals affected. Effective partnership working between primary and secondary care providers will be essential both to address the care backlog effectively, and to support patients and their families while they wait. Quick and practical steps will need to be taken by local health and care partners to improve communication between organisations and with patients. In some instances, service developments that were being considered prior to COVID-19 will need to be expanded, refined or accelerated. Elsewhere, entirely new approaches may be required – for example through more extensive and sophisticated use of digital technology and data analytics.

We hope this briefing offers a helpful contribution to this important and urgent debate. We would like to thank all the contributors to this report.

Chris Hopson

Chief Executive,
NHS Providers

Vincent Sai

On behalf of
At Scale Primary Care Networking Group

1

Introduction

The experience of the pandemic, and the adjustments as we learn to 'live with' COVID-19 have accelerated a trend across the health and care sector for providers to work more collaboratively together, to streamline support and communications for patients, and to improve pathways. The new Health and Care Bill will shortly solidify the most significant structural reforms in a decade, placing ICSs on a statutory footing and formally removing the competition encouraged by the 2012 Health and Social Care Act.

NHS Providers is keen to mirror the partnerships our members are forming at the frontline within neighbourhoods, at place and at a system and multi-ICS levels, recognising that these partnerships take many different forms across the country. We are delighted to benefitting from the expertise of the At Scale Primary Care Networking Group in a new partnership, with the support of NHS England and NHS Improvement. We hope that this first joint briefing focused on how primary care and secondary care can work together to reduce the backlog of care generated by the pandemic, and support patients during this time, is a beneficial contribution. We look forward to developing further outputs together.

2 Key messages

Our conversations with leaders from large scale primary care organisations and trusts on their work to reduce waiting times and support those patients who are waiting, highlighted the following enablers.

Local enablers

- **Building strong relationships and mutual understanding is key**. The health and care system has faced unprecedented demands over the course of the pandemic. New focus is needed to develop a shared understanding of issues and to co-create new pathways which remove barriers for patients, trusts and GPs alike.
- **There will not be a 'one size fits all' model across the country on where conversations between primary and secondary care should take place**. Colleagues from primary care and secondary care will need to work with the most appropriate 'unit' for their local footprint. In some instances, this will be clinical commissioning groups or PCNs, in others, a GP federation or a large-scale practice.
- **Primary and secondary care providers will need to collaborate in assessing and managing the care backlog**. This is likely to include introducing local processes to check data and details on waiting lists, ensuring shared input into clinical prioritisation, and establishing protocols for patient communication which ensures individuals are kept up to date about their planned care pathway and any delay to any step of it.
- **Diagnostic pathway changes are central to improving patients' experience of care**. Given the likelihood of longer waiting times for treatment, better communication between trusts and GPs can reduce the uncertainty at the outset of care as patients wait for tests or receive a diagnosis. These case studies display diverse approaches but have in common ensuring patients, GPs and consultant staff have shared visibility of results and treatment options.
- **Data on new pathways must include ethnicity and deprivation so that the impact on exclusion can be fully understood**. Colleagues across primary care and secondary care should work together to baseline data at both ends of any new pathway.
- **NHS leaders now wish to assess which innovations should be retained as 'business as usual'** and highlighted the following considerations:
  - **Digitally enabled services should be considered as a priority** where connectivity can reduce the need for travel or allow information to be collated before clinical advice is requested. New funding models for these services are also vital to sustain innovation beyond the pandemic.
  - **A greater volume of outpatient practice can be undertaken within primary care led services**, including using digital approaches. The examples in this briefing help to meet demand through co-located multi-disciplinary working in accessible locations, and often have higher discharge rates and lower waiting times.

2

National enablers

- **National investment and support to help reduce waiting times should be offered to primary care, including general practice and trusts**. The elective recovery fund (ERF) provided by NHS England and NHS Improvement with additional government funding, has been an important catalyst to reduce waiting times for patients. The ERF understandably prioritises particular procedures but could form the basis of wider support for all providers, benefitting more patients.
- **There remains a need for government to commit to an appropriate reward offer for staff across the sector**. The NHS as a whole recently received the accolade of the George Cross. However, staff burnout, staff retention and the cumulative impact of exhausted teams across primary and secondary care, is a concern. There remains a pressing need for government to commit to an appropriate pay award which recognises the personal and collective contribution of NHS staff.
- **National policy frameworks will need to keep pace with new pathways and more flexible working patterns**. For example, consultant job planning, and associated contracting, will need to be refined to recognise new ways of working. This is especially crucial where discretionary additional work can create pension and taxation liabilities.

Context: the impact of the pandemic

3

A complex pattern of new partnerships

The policy direction within the health and care sector has strongly encouraged health and care organisations to work together for the benefit of patients, and their own staff, for several years. This spirit of collaboration has been accelerated by the experience of the pandemic as organisations sought mutual aid, and rapidly developed new pathways and innovations.

The sector is not homogeneous, and these partnerships will take many forms, often blurring traditional boundaries, and incorporating a complex patchwork of general practice, PCNs, large scale primary care providers, trusts and other partners. NHS leaders in large-scale primary care organisations and within trusts all tell us, however, that new partnerships will be key in delivering the aims of the NHS long term plan, in improving shared understanding of data to reduce health inequalities and support population health management approaches, in driving digital transformation and improving care pathways, and in supporting patients and staff alike as we recover the care backlog.

Pressures across the system

We know that providers' achievements during the pandemic were significant: primary care pivoted successfully to digital and online delivery alongside maintaining critical face-to-face appointments and trusts continued to deliver urgent and emergency services and urgent cancer care, with renewed focus on elective treatment since the second peak of the pandemic. However, despite the best efforts of the NHS' committed staff, there is now a need to sustain and accelerate the drive to recover waiting times and address a significant backlog of patients whose care has been delayed – an initiative helpfully supported by the ERF provided by NHS England and NHS Improvement and supported by the learning from a number of accelerator sites.

By May 2021, there were 5.3 million people waiting to begin hospital treatment – the highest figure since records began in August 2007 – and a core priority for colleagues across the NHS, as for government. Too many patients are also still waiting for 52 weeks or more for their care, although the number waiting this length of time decreased for the second consecutive month at the time of writing in July 2021.

Trusts have thus far outstripped national targets to recover planned care and reduce waiting times for elective services. This achievement reflects the commitment of NHS staff within trusts and primary care to deliver for their patient populations. However, the NHS faces a challenge ahead to sustain this momentum as restrictions on social interaction are eased and community infection rates inevitably rise leaving greater numbers of NHS staff in self isolation. The ERF is also only available to acute trusts for certain procedures and cannot be accessed by community or mental health providers.

While political attention often focuses on elective care, demand is rising for services across the system, creating a cumulative pressure on staff, and new challenges for primary and secondary care partners as they seek to support more patients in different ways, within

a constrained funding envelope. As demand for urgent and emergency care rises, the risk of elective procedures being delayed and cancelled inevitably rises.

The following summary provides an overview of key demand pressures which will place pressure on providers' joint work to reduce the wait times for certain procedures:

- Activity continues to rise across the urgent and emergency care pathway placing pressure on GP out of hours services, NHS 111 and ambulance services which are facing unprecedented levels of demand for this time of year. For example, category one incidents (those requiring immediate intervention and resuscitation) are up by 8.1% on last month and by 27% from the same point of the year, two years ago. Trusts and their partners in primary care will need to balance the need to respond to urgent demand, with their efforts to reduce waiting times for planned care.
- Diagnostic activity increased in May 2021 but remains below pre-pandemic levels. The diagnostic waiting list has increased by 3.4% to 1.31 million since the previous month, with 22.3% of people waiting six weeks or more for a test in May – missing the national target that no more than 1% of patients should wait more than six weeks. Reassurance and support from general practice, underpinned by good communications between specialists and primary care colleagues, will be key for patients awaiting a diagnosis or seeking clarity on next steps in their treatment plan.
- Cancer activity is now slightly above pre-pandemic levels, however, there is still a need to meet existing national targets including for urgent GP referrals seen within two weeks and waiting 62 days for treatment from an urgent GP referral.
- Pressures on mental health services continue to rise, with the highest number of people (1.41 million) in contact with mental health services since records began, 8.8% more people in contact compared to a year ago. Demand for child and adolescent mental health services (CAMHS) has increased sharply, exacerbated by isolation and other factors related to the experience of the pandemic. While NHS England and NHS Improvement is seeking to increase funding for mental health services, and for children's services, there is no doubt that the increase in complexity and overall demand is generating new challenges for primary care and for trusts.

Impact on patient experience and outcomes

Behind these figures are difficult experiences for individuals and their families. As patients seek clarity on their treatment plan, there is an increased risk of individuals being 'bounced' back and forth between primary and secondary care, with no clear pathway for treatment and having to live with pain and worry. We also know that not all patients with long term conditions waiting for care or clarity on next steps, will be captured within the definition of the national waiting time standards yet they are very likely to make regular contact with general practice to seek advice. There is a time dividend in primary care to be gained from much better access to queueing information for patients directly from their secondary care provider.

This does not just mean poor patient experience. In those who are managing long term conditions – estimated to be more than 15 million people in England – delays can lead to exacerbations and harms that may otherwise have been avoided. In cancer care, much has rightly already been written about the impact of delayed diagnoses and treatment during the pandemic, despite the NHS sustaining urgent cancer care.

The impact of the pandemic on mental health and wellbeing is becoming clearer, with sharp rises in demand for CAMHS services, and a need to support the wellbeing of carers rising to the fore.

Impact on staff providing care

The NHS has just celebrated its 73rd birthday. At no moment have the challenges faced by staff in all disciplines been greater. Recognising the sacrifice, exhaustion, frustration and success felt by leaders and their teams is vital. In a recent NHS Providers survey, 48% of trust leaders said they had seen evidence of staff already leaving their organisation due to early retirement, COVID-19 burnout, or other effects from working in the pandemic. Three quarters of trust leaders told us that they are concerned that recovery will be disrupted by further COVID waves in winter, with 78% extremely worried about winter itself. These anxieties are of course also reflected across primary care providers.

Although improved partnership working cannot alleviate all these pressures, leaders from large scale primary care, and secondary care providers told us that new partnerships helped make best use of limited staff capacity, and that it helped staff to develop common aims and to develop their networks of mutual support.

4 Case studies

The following case studies are drawn from different types of partnerships between primary and secondary care, and from different parts of the country with different challenges. However, they all have in common a commitment to:

- embrace new approaches led by primary care colleagues in community settings, where possible
- improve communications and shared information between staff in cross-organisational teams and in direct support of patients
- champion clinically led and data driven approaches
- embrace digital transformation and new technologies.

Northumbria Healthcare NHS Foundation Trust, Northumberland Clinical Commissioning Group (CCG) and North Tyneside CCG

Using advice and guidance to improve communication between primary and secondary care

Advice and guidance services, by which GPs can request advice from consultants on patients before making a formal referral, have become an increasingly common tool in the management of outpatient care.

The national elective care transformation programme, introduced in March 2017, includes such provision as a central plank. As with so many areas of new practice, however, the pandemic has seen the applications of this sort of model greatly expand.

In Northumbria Healthcare NHS Foundation Trust, covering Northumberland and North Tyneside, an enhanced advice and guidance setup has been an important part of managing waiting lists. It has also helped bolster communication between primary and secondary care.

Under advice and guidance, any GP within Northumberland CCG and North Tyneside CCG is able to request advice from consultants at Northumbria Healthcare NHS Foundation Trust.

Notably, however, there is also the capacity to send images relating to the request. If, for instance, a patient presents with a skin lesion then the GP can take a photo on any smartphone and attach it to an advice and guidance request. To meet information governance requirements, all photos are held in the cloud rather than on the device.

If a plastic surgeon concludes from the photo that the lesion needs removing, they can then directly book the patient into an operative slot. This entirely avoids the need for an initial outpatient consultation, or for GPs to have to perform the difficult task of accurately describing a lesion without visual aids.

Plans for the advice and guidance facility pre-date the pandemic, but it was launched formally in February 2020 just as the first wave of the virus began to hit. Trust leaders say they worked closely with local PCNs and local CCGs on the service, which has now been built into primary care commissioning.

In the first six months alone, there were about 5,000 requests for advice. Consultants' job plans have now been revised to allow dedicated time to review such requests and feedback. Where urgent same day advice is needed, there is a telephone 'hotline' available.

Local leaders emphasise, however, that the purpose of advice and guidance is not to turn consultants into gatekeepers of outpatient referrals. Instead it is considered a way of enabling structured conversation and discussion between GP and specialist.

Consultants are not expected to make a binary decision focused on whether or not the patient simply requires an outpatient appointment. Rather the idea is to progress the patient journey through advice. That might involve giving clarification on which pathway is appropriate, details of which tests need to be performed prior to a referral, specific treatments or reassurance on a 'watch and wait' approach. GPs also have the option to ask that the guidance request be immediately transferred to an outpatient department appointment should that be required.

Since the advice generally comes back within three working days, patients do not have long periods of time 'stuck' in the system due to lack of clarity over the best care pathway or what to do next. That in turn enables the trust to manage its outpatient capacity in the most effective way possible.

For more information
Alistair Blair, medical director, Northumbria Healthcare NHS Foundation Trust
alistair.blair@northumbria-healthcare.nhs.uk

Modality Partnership and Sandwell and West Birmingham Hospitals NHS Trust

Delivering outpatient services in the community

Modality Partnership have been working with Sandwell and West Birmingham Hospitals NHS Trust to expand outpatient provision in the community in response to the pandemic.

Under the model GPs can choose to refer a patient to a community-based outpatient service for a number of specialties. The system was first established five years ago, but has been extended to help reduce waiting times as hospitals managed the large influx of COVID-19 patients.

GP 'super practice', Modality, is sub-contracted to provide these services, which are generally run in a GP practice or community facility. Consultants travel to these local sites to deliver appointments, leading a team of GPs with extended roles, nurse specialists and allied health professionals.

This allows for much more multi-disciplinary input into a patient's care than might be given via the traditional hospital-based outpatient model. It also means that all healthcare professionals, including consultants, are able to focus on tasks that make the most appropriate use of their expertise.

During the pandemic, the model has given the trust an alternative to relying on acute settings for the delivery of outpatient services. Capacity in many hospital settings has been reduced and subject to redeployment to enable acute providers to manage COVID-19 patients. By having facilities in the community, it has been possible to avoid significantly the lengthened waiting lists that have resulted from pressures on acute facilities.

The specialties covered have been jointly decided between primary and secondary care doctors, and generally are areas in which there had been pressing challenges with their provision in hospital: workforce issues, for instance, or very lengthy waiting times.

Since April 2020, more services have been moved into primary care. For instance, echocardiography can now be performed in community settings. The use of virtual appointments has also expanded, including for community-based outpatient services. This has been particularly valuable for dermatology, where patients can share a photograph of a mole or rash that is concerning them ready for discussion during an appointment. It has also allowed members of staff who needed to shield or self-isolate to continue working.

It is anticipated that this mixed model of online and in-person community outpatient appointments will continue in the future: patients could initially be seen virtually and then face-to-face if needed.

As well as reducing pressure on hospitals, the community setup is more convenient for patients. Weekend and evening slots are available, which may not have been possible for hospital-based outpatient care. If a face-to-face appointment is required then, in most cases, the community site is also much closer to a patient's home than the hospital.

In January 2021, Sandwell and West Birmingham Hospitals NHS Trust had the shortest local waiting times across 10 specialties for which Modality provides community outpatient services (cardiology, dermatology, ear, nose and throat (ENT), gynaecology, neurology, ophthalmology, respiratory, rheumatology, urology, orthopaedics).

In many cases, the difference is a large one. Patients referred to a cardiology outpatient appointment, for example, had a seven week wait at Sandwell and West Birmingham Hospitals. At another local trust, the wait was 42 weeks. In ENT, the wait was 10 weeks. The next shortest local wait was four times that.

In a survey of almost 5,000 patients, 91% said they preferred to be seen at a community site rather than the hospital.

For more information
Vincent Sai, chief executive, and Naresh Rati, executive partner, Modality Partnership
vincent.sai@england.nhs.uk, naresh.rati@nhs.net

Gateshead Health NHS Foundation Trust

Using remote testing to triage patients with symptoms of bowel disease

Waits for tests that diagnose bowel disease have lengthened significantly during the course of the pandemic. Across the country anyone referred for a colonoscopy or flexi sigmoidoscopy should be seen within six weeks, or within two in suspected cancer cases. Yet in May 2020, during the first wave of the pandemic, 67% of all patients referred for these procedures nationally were waiting longer than that.

At Gateshead Health NHS Foundation Trust, the use of faecal immunochemical testing (FIT) – all delivered entirely remotely – has been central to managing waits and appropriately triaging patients who may need a colonoscopy or flexi sigmoidoscopy.

FIT identifies the level of blood in faeces, which can be a sign of lower gastrointestinal disease that requires further investigation. The test is used for the national bowel cancer screening programme, but separately to that GPs in CCGs served by Gateshead Health NHS Foundation Trust can also make referrals for symptomatic testing – where a patient has presented with symptoms which may be indicative of bowel disease. GPs make referrals where they believe the patient may require further investigation through a colonoscopy or flexi sigmoidoscopy.

Since these tests are used to check for a wide range of bowel conditions, including cancer, it is important that local healthcare systems find ways to reliably identify patients who need to be seen most urgently.

Prior to the pandemic, a patient in north east England referred for symptomatic testing would have to attend their GP practice to collect a testing kit, and to drop it off once complete. The test would then be sent to Gateshead Health NHS Foundation Trust for analysis.

But to support the move to virtual consultations, and the need to reduce patients visiting health settings unnecessarily, a postal setup has been introduced during the pandemic. The GP's referral for a FIT test goes to the trust, which posts out a kit to the patient. Once complete, the patient posts it back for analysis.

The results of FIT tests allow clinicians to appropriately triage patients who require a colonoscopy or flexi sigmoidoscopy, ensuring those whose results are most indicative of possible serious disease are seen first. Where the test does not show a problem, it also allows GPs to give the patient speedy reassurance.

FIT has therefore been important in managing waiting lists and ensuring patients progress along care pathways where they need to. Around 5,000 to 7,000 symptomatic tests are now performed every month, and all entirely managed by post. Prior to the introduction of the postal system, that figure was around 1,000 to 1,200. The growth is such that a new business case is now being constructed for the service, to demonstrate its value over the longer term.

Leaders at the trust say they worked closely with the local cancer alliance to embed FIT testing across the region. That included offering GPs guidance on the introduction of symptomatic testing. The triaging approach used for symptomatic testing in primary care has also informed the approach to the triage of high-risk patients in secondary care.

For more information
Caroline Addison, senior biochemist, Gateshead Health NHS Foundation Trust
caroline.addison@nhs.net

Salford Royal NHS Foundation Trust and Salford CCGs and PCNs

Rapidly creating a community diagnostic hub

Cardiorespiratory investigations such as heart rate monitoring are relatively simple and swift to perform. But in over the course of 2020/21, pandemic-related pressure had made it difficult for patients in the Salford area to have these tests rapidly. On average, they were having to wait more than 100 days for tests including heart rate monitoring, spirometry, FeNO testing (used to diagnose asthma) and sleep studies.

To help address all of this, primary and secondary care in the area have worked together to establish a small community diagnostic hub. The steering group, established in late January 2021, included commissioners from the CCGs, clinical directors from PCNs, and secondary care clinicians.

Local leaders say this integrated approach to working has been long been established in the local area, and that it supported the very swift development of the diagnostics hub – it was up and running by early April, within three months of the steering group being convened.

The hub is intended to reduce the number of outpatient appointments and hospital visits needed for diagnostic investigations, so helping reduce pressure on hospitals and offering greater convenience to patients. The hub is based in central Salford, near to the shopping centre and the council offices, and in the same building as the library. For most people, the

venue is far easier to travel to that the local hospital as there is parking readily available and the building is located on several bus routes.

There are up to 200 appointment slots available each week at the hub, with the proportion dedicated to each test determined by consultants and GPs.

A significant portion of the workforce are band three employees who had previously been hired on fixed term contracts for the local vaccine hub. In some instances, it had become clear that they were not being fully utilised, with many keen to continue working in the NHS and to do more to help. The diagnostics team therefore offered some rapid training, enabling these members of staff to move across to the new diagnostics hub. Extra shifts were also advertised to primary care staff.

More than a third of Salford GP practices have made referrals to the hub in the first two months of its existence. And by the middle of May 2021, patients were waiting between five and 15 days between their referral to the community diagnostics hub and the test taking place – compared with the NHS constitution standard of six weeks.

The hub is seen as part of a broader evolution of approaches to primary and secondary care in Salford. It is designed to support the use of advice and guidance services, triaging of referrals and of virtual consultations. This has all been aided by the use locally of a shared electronic care record, which allows GPs and consultants to see the same information about a patient, and enables test results to always be available to every relevant clinician.

Plans are now in place to create a second community diagnostics hub, to provide further additional capacity for tests which are currently being booked to close to full capacity.

For more information
Sarah Cannon, senior programme manager, integrated care,
Salford Royal NHS Foundation Trust
sarah.cannon@srft.nhs.uk

Croydon Health Services NHS Trust and Croydon CCG

Supporting improved ultrasound referrals

In common with the rest of London, waiting times for a non-obstetric ultrasound at Croydon Health Services NHS Trust had been steadily lengthening in the years leading up to the pandemic. An annual 2.5% growth in demand from 2016 onwards led to opening extra capacity out of hours and, by the start of 2020, an ability to just about manage demand such that most patients were seen within the six-week target for diagnostic tests.

Then COVID-19 hit. The impact in Croydon was particularly hard. In the first wave more than half of the trust's hospital beds were needed for patients with the virus. Elective

operations came to a halt, and it became very difficult to continue diagnostic procedures and outpatient care. Conversations between primary and secondary care led to an assessment being undertaken of what capacity remained and how best to use it. This looked at what services would continue face to face, what would become virtual, and what had to temporarily stop due to lack of capacity or staff.

For diagnostics, there was a huge list of patients for whom tests had been requested and a need to decide what should happen given the enormous pressures of the pandemic. The trust's clinical lead for diagnostics and support services and the vice-chair at the CCG – who is the south west London GP lead for diagnostics – worked together to help determine the best approach for individual patients on lists and for diagnostics more generally.

Conversations about non-obstetric ultrasound were informed by an audit of 200 routine referrals from GPs. It suggested that 25% of such referrals were made for cases in which it was unlikely an ultrasound would be helpful. The result was that these patients had a long wait for a procedure that would not advance their care, and as a result, patients who did need a scan urgently were less likely to be seen swiftly.

A big part of the problem is that guidance to GPs on when an ultrasound is needed is complicated. Several bodies have published advice, so information available to GPs is disparate and recommendations are sometimes conflicting.

Secondary and primary care in Croydon have therefore worked together to develop a non-obstetric ultrasound decision support algorithm for GPs, which combines all current guidance and local expertise. It guides GPs on when an ultrasound is likely to make a difference, when a direct referral to a secondary care outpatient appointment is more appropriate, and when it is best to simply adopt a 'wait and watch' approach.

The intention is to integrate the decision support algorithm into the electronic patient record systems used locally in primary care. This will mean that, when a GP goes to make a referral for ultrasound, they will be shown a few short questions to help identify whether the test is likely to help the patient in question.

Since a key aim of this work has been to further increase communication between radiology departments and GPs, there will also be the ability for GPs to contact hospital specialists if they have any questions regarding a particular patient's management.

The hope is that the algorithm will help reduce the number of patients who have to wait for a non-obstetric ultrasound that may not be helpful for them, and thereby increase the speed with which patients who do need a scan can be seen. Work is continuing on its introduction in Croydon, with plans now in place to roll it out across the whole of London.

For more information

Ketul Patel, consultant radiologist, Croydon Health Services NHS Trust
ketulpatel@nhs.net

5 Conclusion

As providers across primary and secondary care increasingly work together in a range of new collaborative arrangements, there is common agreement that new partnerships will be required to sustain and accelerate the drive to reduce the care backlog generated during the most disruptive days of the pandemic. Effective communication between primary care and secondary care colleagues will be central in supporting patients through what may be a difficult time. There are also significant opportunities to reshape the primary/secondary care interface with better use of digital technology, and to make more extensive use of data analytics to better understand of population health need and transform how it is met. We propose exploring these solutions in more detail following this initial review. We hope that this briefing shares some practical insights into how this can be achieved, building on the learning, disruption and transformation unleashed by the pandemic.

The **At Scale Primary Care Networking Group** brings together the leaders of an influential group of large scale primary care providers to share information, resources and ideas to help advance the development of primary care. The At Scale Primary Care Networking Group includes thought leaders from a number of well-known large-scale practices covering significant patient populations across the country, all with an interest and commitment to innovation which improves patient care. The group's leading members include:

GP Care Group
Greenwich Health
Intrahealth
Malling Health
Modality Partnership
Operose Health/AT Medics
Symphony Healthcare Services
The Hurley Group

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

For more information:
www.nhsproviders.org/addressing-the-care-backlog

Suggested citation:
NHS Providers and At Scale Primary Networking Group (July 2021), *Addressing the care backlog: an essential partnership between primary and secondary care.*