Appendix 1 Potential solutions, and getting it into practice[3,4,6,27,28,29]

What follows is a summary of recommendations based upon a program of research focusing on the primary-secondary care interface. Some of the suggestions may be achievable at a personal level, others are more related to wider systems and processes. At the end of each section, practice points are asked to help consider what changes could be made within your own local context.

Communication Clear pathways exist for urgent and outpatient referral, but no clear system exists for important 'middle ground' queries, which require 'quick answers' for GPs and patients. Email may play an important role in such situations. Those patients for whom their clinicians are 'email active' may have easier access to specialist information, and less likelihood of having to travel unnecessarily compared with those for whom their clinicians prefer not to use email. How we communicate with one another may influence the quality of working relationships.

Getting it into practice: Do you have ready access to a list of 'email friendly' clinicians/practices/departments? What tone of communication do you use in your clinical correspondence when something could have gone better? How well do you deeply listen to your interface colleagues? What is stopping you 'picking up the phone?'

Education Clinicians saw education as a tool for developing relationships, with specialists keen to emphasise a model of shared learning. Aligning primary and secondary care protected learning times may be advantageous, given 'out-of-hours' educational meetings may be limited in their ability to engage with clinicians who have worked an intense clinical day.

Getting it into practice: What opportunities for shared learning exist in your area? How could you promote this? When did you last invite a colleague from primary or secondary care to your regular 'in-house' educational sessions? When was the last time you ran a joint SEA meeting with interface colleagues?

Governance Given the diverse expressions of clinical email storage identified, there is a need to define governance issues around email usage, to help inform more specific national clinical email policy (which at present does not exist). There is also a need to provide medico legal clarity over lines of responsibility regarding unanswered emails, and the role of 'out-of-office.'

Getting it into practice: How do you translate electronic clinical communication into your patient record? Do you have a practice or unit policy for clinical email? How do you use your 'out-of-office?'

'Shadowing' to improve understanding Clinicians acknowledged that understanding one another more, and the context in which each other worked, may help reduce unrealistic expectations of each other. One recommendation that may be considered is the formal promotion of 'shadowing days' where GPs and specialists spend time in each other's 'kingdoms,' to help them to better understand each other's roles.

Getting it in to practice: Have you organized a 'shadow day' with an interface colleague? If not, who may you usefully 'shadow' in this coming year? Would they also like to 'shadow' you?

Relationships To maintain continuity of patient care, both primary and secondary care teams need to be helped to see they are working as one larger team. The importance of developing relationships at the interface based on trust should not be underestimated, and investing in the social capital of interface relationships may be helpful here. New methods of sharing information across the interface where a new clinician arrives in an area may be usefully established.

BMJ Careers has reported on a productive and simple method of achieving some of the above:
http://careers.bmj.com/careers/advice/Consultants_and_GPs_walk_and_work_together

Getting it in to practice: Whom do you need to intentionally invest and form a relationship with across the interface? Thought of a walk, a coffee, or a cycle with an interface colleague? How do you share the news with interface colleagues when a new member joins your clinical team?

Working together Initiatives promoting co- mentoring between interface clinicians may also be a novel approach to consider. Joint working groups (involving clinicians from both sides of the interface) may usefully develop interface-focused guidelines.

Getting it in to practice: Start small; is there a guideline that would benefit from your input? Who will you work with to move the work forward? Is co-mentoring an option (e.g. meeting a colleague once a month, 30 minutes each, then stop)?

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