Grove House Surgery in Shepton Mallet
Innovation and an amazing sense of team

About the practice

Grove House is a small, well run practice in the heart of Shepton Mallet serving just over 6,400 patients. The team has a very supportive family feel and the majority of the staff team have worked there for many years.

The practice prides itself on knowing their patients really well, ensuring lots of GP input and oversight and providing great continuity of care. The practice enjoys a very good reputation amongst local patients and considerable loyalty from its staff, who in total have worked there for 104 years! The practice is traditional in many ways and has introduced many changes and empowered the team to maximise their skills and implement new ideas. https://www.grovehousesurgery.nhs.uk/ Here are some examples:

Clinical Admin – Releasing Time For Our GPs

Within the practice this is referred to as 'scanning' but it's a lot more involved than the name might suggest. Four of the admin team have been trained to manage **all** the correspondence from hospitals, nursing homes, community services and other agencies.

The team scan these into the EMIS system, prioritise which need to be seen by the GPs, add appropriate coding, directly action straight forward referrals or requests for treatment or tests at hospital or by community teams such as ophthalmology, podiatry or audiology order blood tests and x-rays.

The key steps and processes followed by the team are set out in a practice protocol which has developed over time. Initially the team dealt directly with a small range of letters and correspondence and this has grown with GP support into a very long list. Over time the team have grown in knowledge and confidence and can now manage a wide range of documentation expertly and safely. The protocol includes a clear set of items that need to be seen by the GP, those that do not need to be seen by the GP and can be actioned directly.

In introducing this change the practice adopted a supportive, learning approach. For example the team meet with one of the GPs, Dr Pippa Girling to share learning on a regular basis. They have established a shared folder of learning where the GPs add examples of correspondence which the GP didn't need to see or suggested coding changes.

Over time the team have become quicker and more efficient and each day manage between 100 and 200 pages of correspondence which arrive via email, fax or hard copy in the post. Some providers send multiple copies (a fax, an email and followed up by letter) and managing this duplication is a significant burden. Some correspondence can be managed within a few minutes, others (e.g. 8 pages long) can take 20 to 30 minutes.

The outcome of this change has been a considerable reduction in the correspondence that needs to be managed by the GPs and was often managed by GPs at the end of a busy day. All the GPs now have a dedicated admin session each week, one GP focuses specifically on Quality Improvement.

Advice for other practices considering this include: dedicated scanning time built into the day, ideally am and pm, provide staff with a quiet place to do this work due to the concentration required, have a supportive approach with access to GPs at any time, start small and build up, have opportunities for sharing learning, provide the staff with 2 computer screens, agree where to record certain issues where no standard fields are available on EMIS.

Following up patients discharged from hospital: The practice has also introduced a new system whereby all patients discharged from hospital (after having a non-elective admission) are followed up in person over the telephone by a lead receptionist. During the conversation the practice checks that the person is clear about their medication and ongoing treatment plan and their next appointments etc . Any concerns or gaps are flagged with GPs or other relevant local services. Patients have fed back to the practice on many occasions that this has been very helpful and reassuring. This has also been important from a clinical perspective given that a number of potential serious problems have been avoided. For example patients with insufficient medication, medications not corresponding with those on the GP record but changes not specified on the hospital discharge summary, no package of social care support in place, patients feeling very isolated or not coping, wounds and dressing needing attention, blood or other tests being needed.
This new process was introduced by the team member keeping a log and discussing this and any queries on a regular basis with Dr Ken Macleay. Commonly the team member deals with 15 calls per week which take ½ hr to 1 hr per day.

Huddles: The practice holds multi-agency huddles rotating on either Tuesdays or Wednesdays to allow different staff to attend. These involve GPs, administrators, nurses, community nurses, Health Connectors, Aster Housing and social care coming together to discuss their collective support for patients with more complex needs. Once a month Dr Kerr, a Geriatrician from the Royal United Hospitals also attends.

Nurse practitioners and nursing roles: The practice employs 2 nurse practitioners who are both non-medical prescribers and undertake home visits. One of the Nurse Practitioners provides a proactive ward round in local care homes which is followed by dedicated liaison time with one of the GPs. All the nurses and GPs use EMIS mobile to access patient notes when undertaking these and other visits.
The whole nurse team focus on supporting patients with long term conditions e.g. diabetes, COPD, Asthma as well as providing childhood immunisations, smears, Inter Uterine Devices (IUDs) and wound care.

Skilling up Health Care Assistants: The practice has provided training and support for one of their Health Care Assistants to provide a much wider range of support and procedures to patients. This includes: phlebotomy, Vitamin B12 injections, flu vaccinations, shingles vaccinations, Coronary Heart Disease reviews, follow up dressings, spirometry, diabetes checks, blood pressure checks, care planning.

Rotating, varied roles: The practice administrators all provide secretarial cover, scanning and front desk work. Two of the administrators are also trained as phlebotomists. Reception staff ask patients a broader set of questions in order to direct them to the most appropriate member of the team.

Working with other organisations: The practice has a number of other organisations working in the practice at various times across the week. This includes: Turning Point drug and alcohol service, Citizens Advice, Talking Therapies, Private Counsellors, Stop Smoking Group. All staff have visited the local Boots Pharmacy Team and the Boots Manager visits the practice one a month. The introduction of the two private counsellors came about by allowing them access to patients (who gave their consent) whilst they were in final stages of training and needing to gain experience. This developed into a symbiotic situation where the counsellors use the practice rooms for free and the practice can offer an alternative to NHS funded CBT (Talking Therapies), such as psychodynamic and other longer term therapy, which although is a private service is less costly than average.

Quote from member of the team: 'I love my job, its like a family. It's small enough so everyone knows each other but we are not in each others pockets. The patients know us by name, they know we care. The GPs appreciate us and the Practice Manager is always there'.

Who to contact to find out more

If you would like to know more about any of the above, please get in touch with Rachel Witcombe, Practice Manager rachel.witcombe@nhs.net or Dr Ken Macleay, GP Partner, k.macleay@nhs.net