SOUTH STAFFORDSHIRE
LOCAL MEDICAL COMMITTEE

GENERAL PRACTITIONER
VISITING
GUIDELINES

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Reviewed in 2012 by Dr D Dickson and Prof R Chambers

INTRODUCTION

There have been significant changes in British general practice over recent years, and similarly great changes in the structure of British society, particularly in terms of housing, wealth, attitude, welfare provision and mobility.

With this change in mind it is rather surprising that the visiting practices of general practitioners in many cases remain much as they were at the inception of the National Health Service and before.

There is no doubt that this failure to adapt is due in part simply to habit. From the patient point of view visiting is convenient, they may be blissfully unaware that domiciliary care in many cases impedes the provision of modern medicine. As far as the doctor is concerned he/she may well remain unsure as to where he/she stands in relation to his contractual obligation and might fear that to modify established patterns of visiting behaviour may render him/her at risk of criticism.

In the summer of 1995, Staffordshire Local Medical Committee decided that patients, doctors and all those involved in health care provision would benefit from a review and rationalisation of the role of home visiting in modern general practice. To do this, a group of general practitioners from across the County met and developed these guidelines. In undertaking this they took into full account the need to provide to patients medical care of the highest standard, the need to provide services in a fashion that complies with their contractual obligations, and also recognising that there is a need to be efficient in provision of care in order to cope with an ever increasing workload as technology moves on and care shifts from the secondary to primary sector.

The resulting guidelines in their current form have been produced by the South Staffordshire Local Medical Committee for the assistance of general practitioners but must be regarded as general advice subject to the decision/judgement of individual general practitioners as to their applicability with regard to each set of circumstances.

The LMC have shared the guidelines with South Staffordshire Health Authority and Mid and South East Staffordshire Community Health Councils who have felt able to endorse and support our proposals.

Subsequent to advancements in patient care and management these guidelines were reviewed in 2012.

Dr D Dickson
South Staffordshire LMC Secretary

REASONS BEHIND THE NEED TO RATIONALISE GP HOME VISITING

1. **QUALITY OF MEDICAL CARE**

   a. A doctor's ability to properly assess and to treat a patient seen in their own home is often impaired by the **non ideal clinical situation** of poor lighting, unhygienic conditions and such simple difficulties as soft beds, making it impossible to palpate abdomens correctly.

   b. As technology moves on, sophisticated tests, treatments and equipment are being increasingly employed to improve care, much of this is not portable and thus not available on home visits.

   c. Speed of treatment is facilitated by restricting home visiting to those patients who really need it. Others are to be encouraged to attend properly equipped medical facilities where triage can take place, ensuring patients are seen quickly and those that need it immediately.

   d. A change of patterns of care during evenings and nights from the traditional model where many GPs each see a few patients through the night at patients' homes, to a situation where fewer doctors see many patients in properly equipped and staffed centres is more efficient.

   e. Local services/initiatives for referral of patients to avoid hospital admissions are now in use. These may not always require a GP home visit and can be accessed by others such as Community Matrons. Patients have greater availability to consult a GP or nurse at walk in centres outside GPs' normal working hours when carers or family can take them to such centres thereby avoiding the need for a GP home visit.

   f. Care homes (residential/nursing homes/EMI) are staffed in a minimal way by their mainly private providers with limited capacity/transport to bring patients to GP surgeries in daytime or centres during OOHs. These providers need to address their capacity/transport issues and make greater efforts to bring their patients to GP surgery/OOH centres.

2. **OUT OF HOURS ARRANGEMENTS AND 111**

   GP Out Of Hours services only function properly if the majority of patients attend the centres, rather than being visited at home. Triage by professionals who are not GPs occurs in many centres and they will base decisions on guidelines similar to these. It is not the role of 111 to decide whether a GP visit is required but to recommend the patient contacts their GP.

3. **INTERNATIONAL COMPARISON**

No other country has adopted the visiting habits of British general practice.

4. **ISSUES FOR THE PROFESSION**

a. **Workload.** The workload of British general practitioners has increased greatly over recent years. It seems that it is set to rise further and unless GPs are allowed to deliver care in the most efficient way possible the system seems likely to break down. If patients are seen at designated centres, rather than their own homes, then quite simply more patients can be attended to by a given number of clinicians.

b. **Safety**. Doctors are particularly vulnerable to physical attack when home visiting, walking alone through inner city streets with a black bag is far from safe for GPs of either sex.

c. **Stress/Low Morale/Poor Recruitment.** Inappropriate demands for home visits are often quoted by GPs as a major source of dissatisfaction.

d. The current **medico-legal** climate is such that it is reasonable for a GP, with some justification, to have reservations about the prudence of making decisions based on an assessment made in the far from ideal clinical setting of a patient's home.

5. **FINANCIAL**

Cost. Paying highly trained and expensive GPs to spend much of their time driving themselves from house to house makes little sense.

PRINCIPLES AND FUNDAMENTALS UPON WHICH STAFFORDSHIRE VISITING GUIDELINES ARE BASED

1. **Regulations.** Schedule 6, Regulation 26, Part I of General Medical Services Contracts (GMS) Regulations in 2004 clearly state that in the case of a patient whose "condition is such" it is for the doctor to decide, based on "the doctors reasonable opinion" as to whether the patient should attend a doctors premises or be visited at home.

It is also very important to emphasise that it is specifically stated that there is nothing in the Regulations that prevent a doctor referring a patient directly to hospital without first seeing them, providing "the medical condition of the patient makes that course of action appropriate".

These paragraphs in the Regulations equally apply to Personal Medical Services (PMS) contracts.

2. **General practice has never been, and can never be an emergency service along the lines of the police or ambulance.** There is neither the manpower for this, nor the infrastructure – e.g. communications to work in this way. To try and work this way would inevitably harm other aspects of our work. We cannot provide an emergency response service when we are scrubbed up providing minor surgery to our patients. Neither is it appropriate for a doctor to feel compelled to leave a busy pre-booked surgery to attend a patient at home, who it would seem may be suffering from a serious medical emergency. It is highly likely that the doctor will contribute little to the patient's care above and beyond that offered by the paramedics. Waiting for him/her to attend may well cause ultimate delay in hospital treatment and in addition to all of this, the major disruptions to many patients timetable caused by the doctor leaving his/her surgery patients.

It is now accepted medical practice that suspected myocardial infarctions and cerebrovascular accidents are immediately admitted to hospital via 999. Extreme shortness of breath and haemorrhage are managed in a similar way.

3. In these guidelines, no distinctions between "in hours" and "out of hours" have been made. The **"rules" governing where treatment takes place apply equally well in and out of hours.** It is for a doctor to decide, based on "reasonable opinion" as to whether a consultation needs to take place before the next time the patient could be seen within normal hours.

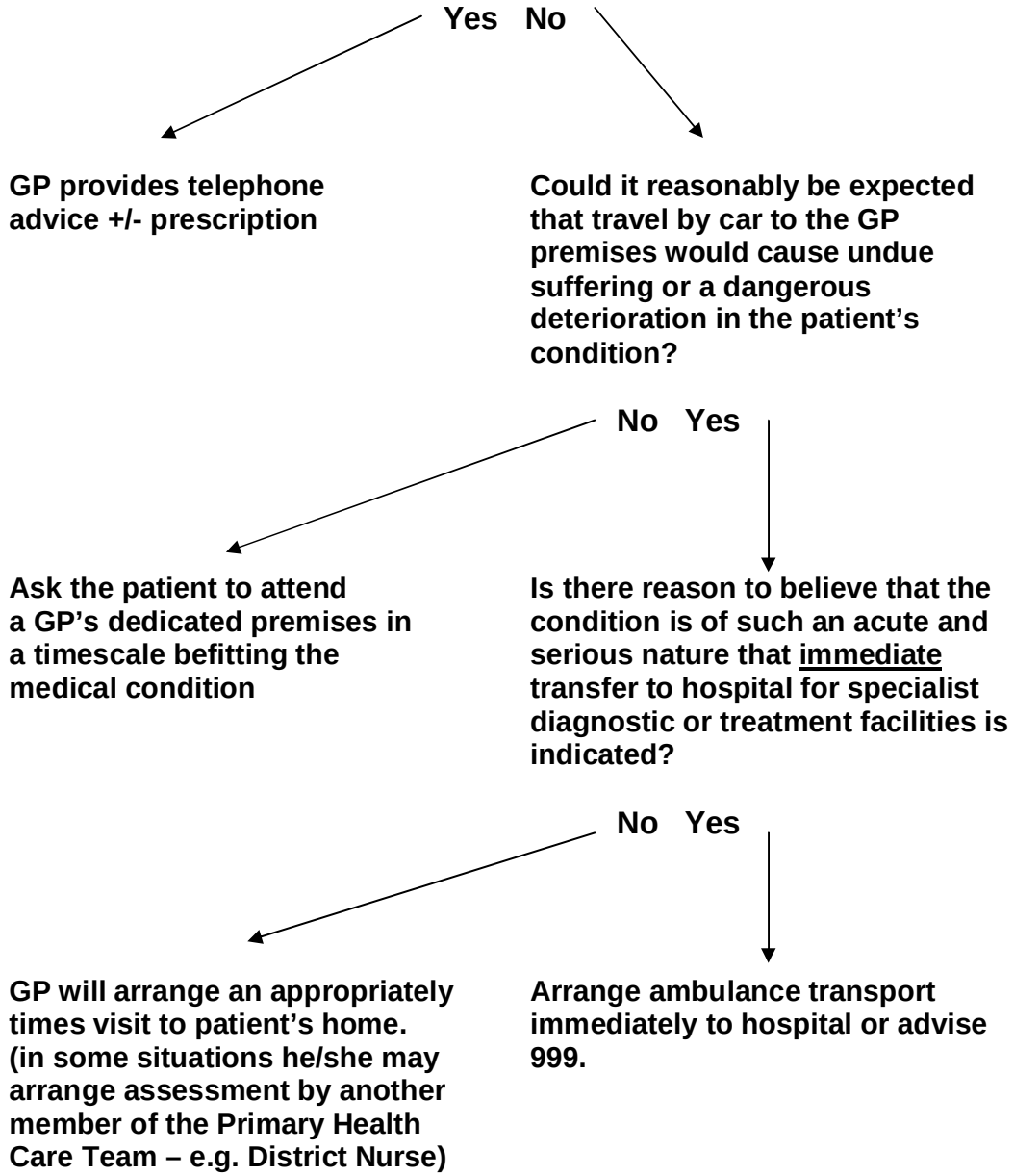
GPs working in out of hours services from 6.30 pm to 8 am will use these same guidelines when deciding whether a home visit is merited.

4. Throughout the development of these guidelines, the **quality of medical care** offered by general practitioners to their patients has been of paramount importance. The emphasis is that clinical effectiveness must, in some circumstances, take precedence over patient convenience.

VISITING GUIDELINES AT A GLANCE

Request for medical care made by patient (usually by telephone) to general practitioner or other person trained in triage and backed by appropriate protocols

Can the medical problem be managed by telephone advice?



CLARIFICATION AND EXAMPLES OF VISITING GUIDELINES IN ACTION

1. **Situation where GP home visiting makes clinical sense and provides the best way to give a medical opinion and initiate treatment:**

   a. The **terminally ill**
   b. The truly **bedbound** patient in whom travel to premises by car would cause a deterioration in medical condition or unacceptable discomfort

2. **Situations where on occasions visiting may be useful:**

   a. Where, after initial assessment over the telephone, a seriously ill patient may be helped by a GPs attendance to **prepare them for travel to hospital**. That is where a GPs other commitments do not prevent him/her from arriving prior to the ambulance.

   It must be understood that if a GP is about to embark on a booked surgery of 25 patients and is informed that one of his/her patients is suffering from symptoms suggestive of a serious condition the sensible approach may well be an emergency paramedical ambulance rather than attending personally.

   b. Dependent travellers. Patients who when well are able to be transported by relatives but are less able when ill.

   c. Annual reviews of patients in nursing homes.

3. **Situations where visiting is not usually required:**

   a. Common symptoms of childhood, fevers, cold, cough, earache, headache, diarrhoea/vomiting and most cases of abdominal pain. These patients are almost always well enough to travel by car. The old wives tale that it is unwise to take a child out with a fever is blatantly untrue. It may well be that these children are not indeed fit to travel by bus, or walk, but car transport is sensible and always available from friends, relatives or taxi firms.

   It is not a doctor's job to arrange such transport.

   b. Adults with common problems of cough, sore throat, "flu", back pain, abdominal pain are also readily transportable by car to a doctors premises.

   c. Common problems in the elderly, such as poor mobility, joint pain, general malaise would also be best treated by consultation at a doctors premises. The exception to this would be in the truly bed bound patient.

4. **Visits to Children** in situations where the parent refuses to attend the GP surgery or Out of Hours centre. The safety of the child is paramount in these situations where the parent is not fulfilling their responsibility in making arrangements for travel. Many GPs will visit the ill child first and discuss with the parent later.