

**NORTH STAFFORDSHIRE
LOCAL MEDICAL COMMITTEE**

**GENERAL PRACTITIONER
VISITING GUIDELINES**

INTRODUCTION

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 to develop “Visiting 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 were published by the North 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 shared the guidelines with the North Staffordshire Health Authority and North Staffordshire Community Health Council who felt able to endorse and support the proposals.

The guidelines were reviewed in June 2008, taking into account the New GP Contract and the changes in the provision of Out of Hours Services.

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, absence of chaperones, 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. The change of pattern 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 and other clinicians see many patients in properly equipped and staffed centres.

2. RELATIONSHIP TO THE NEW OUT OF HOURS ARRANGEMENTS

Changes to GPs out of hours service and the passing of the responsibility for out of hours provision of care to Primary Care Trusts means that in many cases, the provision of care will be in out of hours **primary health care centres**. Such centres can only function properly if the majority of patients attend the centres, rather than being visited at home.

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 containing heroin 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, 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**

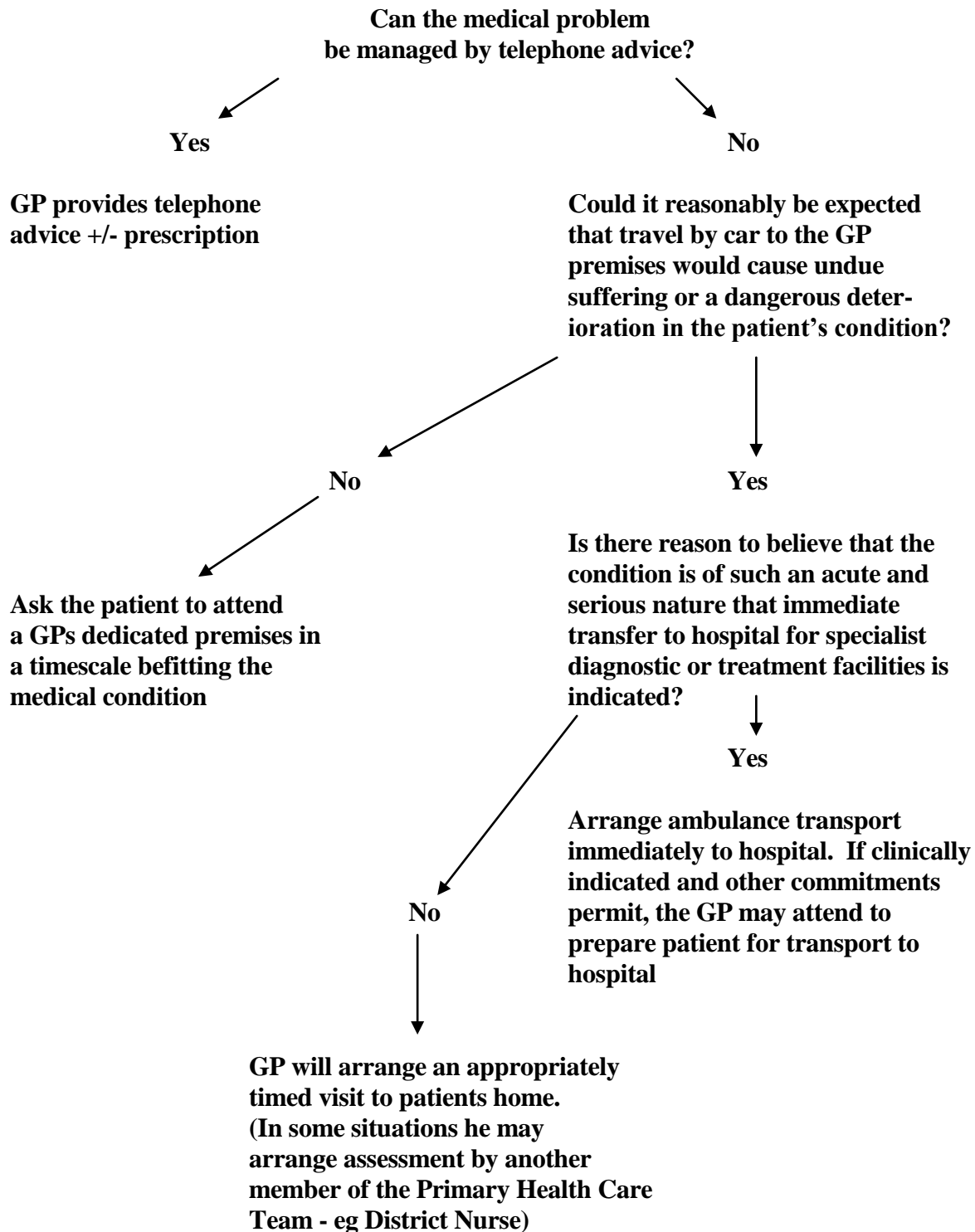
Cost. Paying highly trained and expensive GPs to spend much of their time driving themselves from house to house makes little sense.

PRINCIPLES AND FUNDAMENTALS UPON WHICH STAFFORDSHIRE VISITING GUIDELINES ARE BASED

1. **Terms of Service.** The introduction of the new GP Contract in 2004 re-affirmed that it is the doctor's decision whether or not the patient can reasonable be expected to attend surgery. The GP is only under obligation to attend the patient at any place other than the surgery if it is the doctor's reasonable opinion that it would be inappropriate for the patient to attend surgery. It is also very important to emphasise that it is specifically stated in paragraph 32, that there is nothing in the Contract that prevents 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".
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 to try and work this way and it would inevitably harm other aspects of our work. It is not 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.
3. In these guidelines, no distinctions between "in hours" and "out of hours" has been made. The "**rules**" governing where treatment takes place apply equally well in and out of hours.
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**



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:

- 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 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 doctors' 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.