North Staffordshire
LOCAL
MEDICAL
COMMITTEE

General Practitioner

Home Visiting Guidelines

Revision 5, 01.11.19

North Staffordshire Local Medical Committee
Home Visiting Guidelines 2019

North Staffordshire LMC are proud of their robust home visiting guidance but we felt it was time for an update, particularly given the last update was in 2012 and following this there have been significant changes to the health landscape both locally and nationally.

Practices may use this guidance and the home visit request pathway in Appendix 1 to formulate their own practice home visiting policies.

1 Regulations

The National Health Service (General Medical Services Contracts) Regulations 2015, 7.6.1 stipulate it is the reasonable opinion of the contractor as to whether a visit is required and that the clinician should determine where it is most appropriate to see a patient.

This should consider patient safety, clinician safety, access to equipment and facilities to best assess a patient, which is usually at the practice.

The regulations do not prevent a Doctor from referring a patient directly to the hospital without first seeing them providing this is the most appropriate course of action for the management of the patient in the opinion of the Doctor.

2 Safety

A *patient safety alert* was issued in 2016 by NHS England regarding the prioritisation of general practice home visits to assess whether a visit is clinically necessary and the urgency of the response for medical attention.

GP practices should have systems in place to triage and prioritise home visits. It is not clinically acceptable for a visit request in the morning to be triaged or dealt with after the morning surgery.

GP practices should consider how they respond to visit requests in a timely manner, this could involve telephone triage in advance to get further information to make an informed decision about whether a visit is appropriate and whether any emergency care is required. E.g. Patient with chest pain should be redirected to 999 emergency response, and would not be appropriate to wait for a home visit at the end of a routine surgery.

3 Governance

There are some services commissioned by the Clinical Commissioning Group (CCG) to support review of acutely unwell patients who might otherwise present to the emergency portals. These include services such as the Acute Visiting Service locally or other initiatives.

Some practices manage in house visiting by use of allied healthcare professionals employed by the practice such as ANPs or Paramedic practitioners.

These services may require GP Practice referral and agreement at the outset. If they have capacity and are available, then these offer an option for rapid assessment of a clinically unwell patient but bear in mind these services can be transient in funding and capacity can fluctuate.

The overall governance structure will mean that the GP holds clinical governance for the patient while under review of such intermediary services.

4 111 Disposition

NHS 111 is run by non-clinical advisors who match a patient's symptoms to algorithms within clinical pathways software to arrive at an appropriate disposition for care. There are several Primary Care dispositions. It is not the remit of 111 to dictate a GP visits a patient at home nor for the GP to be expected to see patients who need emergency care which is not part of the GMS contract.

5 Residential and Care Homes

With ever increasing life expectancy, we can expect a larger number of patients will be over the age of 65 years old. This has given rise to several independent living homes, mixed residential and care settings sadly with little thought about the implications for health care provision. Ever more complex patients with multiple comorbidities who traditionally would have been resident in nursing homes are living in these independent living settings with limited staff capacity and skills mix to manage them.

Visit requests from independent living, residential and care home settings should be treated no differently to a request for a GP visit to a resident's own home or private residence.

Booking transport for a patient to and from the surgery is not the responsibility of the Practice and does not constitute a requirement to request a GP visit.

Care staff are responsible for the care of their residents and have a duty to arrange transport, either through the resident's family or friends or to be arranged by the care home themselves.

As a general principle, if a patient is fit enough to attend a hospital outpatient review with or without transport, then they are fit enough to be attend the surgery.

6 Transport

One of the most common reasons for a home visit request is due to lack of transport rather than due to a patient's medical condition. It is not the GP practices responsibility to arrange transport or to visit a patient at home because the patient has difficulty arranging transport. Patients should be encouraged to seek help with transport from relatives, neighbours, friends or taxi firms.

Practices may want to consider contacting taxi firms or community/voluntary patient transport services that can accommodate transport for wheelchair users and people with disabilities to enable patients to attend the practice for review.

7 Children

Children should usually be brought to the surgery by a parent or responsible adult. If a home visit is requested then more information should be sought as to the nature of the problem and where the parent refuses to bring the child in to the surgery or arrange suitable transport, it may be more appropriate for the GP to visit and assess the child first and discuss with the parent later.

Difficulty sorting out childcare is sometimes sited as a reason to request a home visit. This is not clinically appropriate; the patient may bring their children to the practice rather than miss their appointment or request a visit for this reason.

8 Lone Working

Where a visit is deemed appropriate and clinically necessary, practices should review their own lone working policy and identify any risks with visiting alone.

9 Intimate Examinations

Intimate examinations should not be undertaken in the home without a chaperone, if not urgent then it may be more appropriate to rearrange the examination with a chaperone present and if an intimate examination is required and clinically urgent then consider whether it would be more appropriate for this to take place in hospital. Refer to the GMC guidance *Intimate Examinations and Chaperones* for further information.

10 Technology

Telephone triage, video calling and electronic consulting are all available and their increased uptake is encouraged. Whether these are appropriate routes to triage requests for acute home visit requests remains to be seen. GP Practices should consider seeking the view of their indemnity providers when developing their own home visiting policy.

11 New Ways of Working

New models of care, Clusters, Federations, Alliances and PCNs exist to provide services on behalf of Primary Care at larger scales of economy. Some of the services and allied health professionals recruited to projects or services within these models could be deployed to see acutely unwell patients and along with Access Hubs and Walk in Centres could offer a potential alternative location and pathway for patients requesting home visits to be seen.

12 Out of area registrations

Practices are not obliged to accept *registration for out of area patients*. Where a practice has an agreement with NHS England to register such patients, then they can agree to registration without the obligation of providing home visits; NHSE have a responsibility to procure home visiting services and out of hours services for this cohort of patients

Appendix 1 – Home Visit Request Pathway