INTRODUCTION
Health care has seen a seismic shift to the utilisation of telehealth, remote consulting, and virtual meetings. Through the use of this technology many practices have seen a significant reduction in home visits, an acceleration of existing trends. However, at the boundaries of such acceleration we find older patients, people at the ‘Far End’.

This newly named Far End cohort may experience further marginalisation if the existing decline in home visits continues. Therefore, this Far End concept, the nature of home visits, a blended model of delivery, and virtual visits should now be considered to ensure the equitable, efficient, and safe provision of home visits to those at the Far End.

FAR END
Our older patients represent this Far End and are analogous to Deep End patients. They experience the same levels of multimorbidity and associated drivers of the inverse care law, such as permeability of service access, candidacy, and health-seeking behaviour. Moreover, Far End older patients often have the associated burdens of sensory losses, declining capacity, reduced social capital, sarcopenia, and frailty. Undoubtedly, COVID-19 has exacerbated some of these Far End factors and reduced home visits. Therefore, it seems timely to review our provision of home visits in terms of their benefit, who should provide them, and the impact of virtual visits, particularly in the Far End population.

HOME VISITS OR HOUSE CALLS?
Being allowed into the home of people from every section of society is a rare privilege. It is surely more than the brief impersonal interaction suggested by a ‘house call’. A ‘home visit’ conveys concepts of relationship and welcome. Doubtless they are time expensive, but this investment speaks of dignity and value that transcend time. Home visits remind us that our histories with patients are novels not unconnected short stories.

Through intuitive observations and healthy curiosity, we gain insights into medication compliance [those cupboards overflowing with untaken drugs], functional status and family support [the foot-long front lawn], and executive function [that pile of unopened bills]. The furniture and decoration, especially the pictures and photographs, are like a projection of a person’s mind. Patients become more readily seen, as people, with an illness. This fuller picture allows us to discern ‘what matters most’ to our patients.

Perhaps these insights matter most for our Far End patients where this deeper knowledge of our patients enhances our empathy and advocacy? Perhaps those moments of transitional care planning are made easier as shared decision making is more fully informed?

A BLENDED MODEL
Home visit provision is, however, a contentious issue, and who should provide these home visits also remains a moot point with a limited evidence base. Paramedics and advanced nurse practitioners are increasingly used for home visits in primary care in the UK, but there is wide variation.

INTRODUCTION
Through intuitive observations [of the patient’s home] and healthy curiosity, we gain insights into medication compliance … The furniture and decoration, especially the pictures and photographs, are like a projection of a person’s mind.”

VIRTUAL WARDS OR VIRTUAL HOME VISITS
A logical extension of our COVID-19 induced acceleration to video consultations may be towards virtual home visits. Virtual wards and integrated home-based care have existed for several years. It is difficult to draw firm conclusions that they achieve
their aim of reducing hospital admission rates.13 Studies in the UK, Canada, and the US do show a reduction but require ‘meso’ levels of integration, are more secondary care led, and require resources not typically available to primary care.14–16

As primary care recovers from COVID-19, virtual home visits are likely to develop more organically, requiring only micro-integration and minimal additional resource. Expressions of this are being trialled, with GPs visiting patients (sometimes during the district nurse visit) by video links, often augmented by basic medical equipment. Further strategies (for example, family involvement and a practice tablet) need trialling to mitigate the inverse care law in Far End patients with less ability to utilise such technology.

There will always be a need for home visits (in person or remotely). Their optimal provision requires further research, most critically in our Far End patients. What seems clear is that the additional knowledge we gain about our patients combines with an expression of compassion as the GP “is out on home visits” — Cum Scientia Caritas.

REFERENCES
5. Frey J. General practitioners at the deep end: the experience and views of general practitioners working in the most severely deprived areas of Scotland. Br J Gen Pract 2012; DOI: https://doi.org/10.3399/bjgp12X652427.