Report of the Health Service Commissioner

Failure to provide long term NHS care for a brain-damaged patient

London : HMSO

Health Service Commissioner

Second Report for Session 1993–94

Failure to provide long term NHS care for a brain-damaged patient

Presented to Parliament pursuant to Section 119(4) of the National Health Service Act 1977, as amended by the Health Services Act 1980.

Ordered by The House of Commons *to be printed 2 February 1994*

LONDON: HMSO

National Health Service Act 1977

In June 1993 I agreed to investigate a complaint which had been referred to me by the chief officer of Leeds Community Health Council on behalf of a woman whose husband was discharged to a private nursing home when he no longer needed acute hospital care. Her complaint was that she had been placed under an obligation to pay for continuing care which should have been provided free of charge by Leeds Health Authority.

I consider that my investigation has raised issues of general public interest. I have therefore decided to make a report on the case, to the Secretary of State for Health, to be laid before both Houses of Parliament in accordance with Section 119 (4)(b) of the National Health Service Act 1977.

An epitome of the case is provided on page 1. The ensuing pages contain the full text of my investigation report but with the identity of the complainant anonymised in order to preserve confidentiality.

January 1994

W K REID

Health Service Commissioner for England

FAILURE TO PROVIDE LONG TERM NHS CARE FOR A BRAIN-DAMAGED PATIENT—CASE NO: E.62/93–94

Matters considered

Statutory framework and policy context—provision for long term care.

Summary of case

A man suffered a brain haemorrhage and was admitted to a neuro-surgical ward in the General Infirmary at Leeds. He received surgery but did not fully recover. After 20 months in hospital he was in a stable condition but still required full time nursing care. Since nothing more could be done, the consultant decided that he should no longer stay in the ward. The man's wife was told that he would be discharged and that she should find a suitable nursing home for his future needs. Despite her misgivings she agreed to the discharge and he moved to a local nursing home in September 1991. The next year the man's wife — with assistance from her local community health council — complained to Leeds Health Authority (the body responsible for purchasing health care for Leeds residents) that they had not met their responsibilities towards her husband. Despite further correspondence and a meeting no resolution was found, and the woman complained to me in 1993. The complaint which I investigated was that the woman had been obliged to pay for her husband's continuing nursing care, which should have been provided through Leeds Health Authority free of charge under the NHS.

Findings

No one disputed that the man was in a seriously incapacitated condition or that he needed full-time nursing care. The National Health Service Act 1977 places a general duty upon the Secretary of State to meet 'all reasonable requirements'. However, in connection with an earlier investigation of mine, the chief executive of the NHS Management Executive had explained that, while a duty existed where a doctor judged such care to be necessary on clinical grounds, authorities had an overriding duty to determine their priorities within the financial resources available — which meant that an individual patient might never receive treatment. Leeds Health Authority's policy was to make no provision for the continuing care of patients with neurological conditions; also, the man's age (he was 55 years at the time of his discharge) meant that he was not able to gain access either to the services for elderly people or to a unit for the younger disabled. Not only were there no suitable hospital beds for the man's continuing care but no provision had been made for such care in a nursing home under a contractual arrangement. In my opinion that situation amounted to a failure in service and I upheld the complaint. (I liken this case to one—W.478/89–90—involving a woman who suffered a severe head injury, which was published in the Selected Case volume for October 1990—March 1991.) While they were not formally the subject of my investigation, I found that aspects of the discharge arrangements had been unsatisfactory. None of the Infirmary's staff was aware of the Department of Health guidance which required them to set out in writing, before discharge, whether the Health Authority would pay the nursing home fees. Although the man's wife agreed to pay those fees herself, I considered in the circumstances that that had been inequitable.

Remedy

Leeds Health Authority, and the Trust which manage the Infirmary, apologised for the shortcomings which my report identified. Leeds Health Authority accepted all my recommendations, which were that they should make an *ex gratia* payment to the complainant for the nursing home costs which she had already incurred; that the man's future nursing care should be provided at the expense of the NHS; that they review provision of services for patients such as the complainant's husband; and that they remind their service providers of the need to follow Department of Health guidance on discharge procedures.

Failure to provide long term NHS care for a brain-damaged patient—Case No: E.62/93–94

Background and complaint

1. In December 1989 the complainant's husband suffered a brain haemorrhage and was admitted to ward 5 at the General Infirmary at Leeds (which is administered by the United Leeds Teaching Hospitals NHS Trust). On 6 August 1991 the senior ward sister told the complainant that nothing more could be done for her husband, that his bed was needed for other patients and that she should find a nursing home placement for him. She objected, believing that a nursing home could not provide the range of care which her husband required and that her own financial position would be damaged. In September the patient was discharged to a local nursing home, where he remains.

2. On 16 September 1992 the local Community Health Council (the CHC) complained on the complainant's behalf to Leeds Health Authority, which is the relevant health authority responsible for purchasing provision in the area, that they had not met their responsibility to provide for her husband's care needs. Leeds Health Authority replied on 20 January 1993 and wrote again on 8 March after a meeting on 11 February. The complainant remained dissatisfied with their refusal to meet the cost of her husband's nursing home fees.

3. The complaint which I investigated was that the patient was obliged to pay for continuing nursing care which should have been provided through Leeds Health Authority free of charge under the National Health Service.

Investigation

4. The summary of complaint for my investigation was issued on 2 June 1993. I explained to the complainant that some of the decisions of the staff concerned might relate, in my opinion, to the exercise of their clinical judgment taking them statutorily outside my jurisdiction. I obtained the comments of Leeds Health Authority and examined relevant papers including the patient's clinical and nursing records. My officer took evidence from the complainant, Health Authority staff and staff at the Infirmary. Although they are not within my jurisdiction, my officer also took evidence from the chief officer of the CHC, two social workers employed by the local Social Services Department and the matron of the nursing home. I have not put into this report every detail investigated but I am satisfied that no matter of significance has been overlooked. My investigation was not concerned directly with the circumstances of the patient's discharge from the Infirmary to the nursing home or whether the Trust had carried out their responsibilities in accordance with Department of Health guidance. Some references to the patient's discharge are included, however, to provide background information and the context in which the complainant and the CHC have pursued the complaint.

Statutory framework and policy context

5. The provision of health services in England and Wales is governed by the National Health Service Act 1977, which states in section 3(1) that:

> 'It is the Secretary of State's duty to provide .... , to such extent as he considers necessary to meet all reasonable requirements—
>
> (a) hospital accommodation;
>
> (b) other accommodation for the purpose of any service provided under this Act;
>
> (c) medical, dental, nursing and ambulance services;
>
> ....
>
> (e) such facilities for .... the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;
>
> ....'

6. In connection with another investigation I was undertaking at the time the chief executive of the NHS Management Executive wrote to me in 1991, about the provision of care by health authorities:

> '....If in a doctor's professional judgment a patient needs NHS care, then there is a duty upon the Health Service to provide it without charge .... this can be done by providing community nursing care to the patient's own home, by providing in-patient care or by a contractual arrangement with an independent sector home (ie paid for in full by the health authority). The level of service provided overall is a matter for individual health authorities in the light of local circumstances and priorities.'

and:

> '....
>
> a. there is no general duty on a health authority to provide in-patient medical or nursing care to every person who needs it. Legal precedents have established that the Secretary of State's duty under section 3 of the Act is qualified by an understanding that he should do so "within the resources available".... Thus
>
> b. in any particular case the provision of such care may be deferred so that cases may be dealt with, in order of clinical priority, within the resources available; and
>
> c. consideration of clinical priority may mean that a particular patient may never be provided with in-patient nursing care.
>
> Further
>
> d. where a person is receiving private care, in a nursing or residential home, the Health Authority has no power to make "top up payments" to cover any shortfall between the charges of the home and any income support .... health authorities have, financially, an "all or nothing" responsibility for patients
>
> ....'

7. The Department of Health issued guidance (circular (HC(89)5)) in February 1989 about the discharge of patients from hospital. It states:

> 'The [discharge] procedures should provide for:
>
> '....
>
> 'ii. liaison with social services .... about alternative arrangements, if it appears likely the patient will not be able to return to his/her current place of residence .... Such arrangements must be made in good time and be acceptable to the patient and, where appropriate, the patient's relative or carers .... Where a person moves from hospital to a private nursing home, it should be made quite clear to him/her in writing before the transfer whether or not the health authority will pay the fees, under a contractual arrangement. No NHS patient should be placed in a private nursing or residential care home against his/her wishes if it means that he/she or a relative will be personally responsible for the home's charges.'

Failure to provide long-term care

8. The complainant told my officer that her husband had been admitted to the hospital on 8 December 1989 and had had surgery for a brain haemorrhage. In 1990 the consultant in charge of her husband's care indicated that eventually he would have to move from the ward. On 6 August 1991 the senior ward sister asked her to find an alternative placement because her husband's bed was needed for other patients. She asked if her husband could stay in the hospital, even if not in ward 5, but was told that there was no point in that. Another nurse took her to visit three nursing homes but the nurse thought that they might not be able to meet all her husband's needs at that time. On, she thought, 22 August 1991 the continuing care facilitator (a senior nurse who assessed elderly patients and facilitated their transfer to private nursing homes) and a social worker spoke separately to her about the discharge arrangements. She told them that she

feared that a nursing home would not be able to provide sufficient care. She also expressed disquiet that she might not be able to afford the fees and that she might have to sell the family home. There was little discussion about the financial issues but the continuing care facilitator said that only nursing homes with medical beds, of which there were only a few in the area, would be suitable. Later, the complainant visited two of those homes and chose the one where he now resides; her husband was discharged from the Infirmary and moved there on 20 September. Before his discharge the senior ward sister presented her with a 'discharge form' which she refused to sign because she did not agree with the discharge.

9. The complainant said that the care provided at the nursing home was generally acceptable. Her husband remained totally dependent on the nurses for his every need. He was doubly incontinent, had no mobility, had to be fed and could not communicate. (The home's matron confirmed that in separate evidence to my officer.) He also had a kidney tumour and cataracts in both eyes and had occasional epileptic fits for which he received medication. The nursing home fees had been £1,224 every four weeks but had risen to £1,344. Her husband had received relevant benefits from the Department of Social Security which offset the cost of the fees, but an annual shortfall of over £6,000 remained. An occupational health scheme to which he belonged did not provide financial assistance for those with chronic conditions.

10. After reading a newspaper article in March 1992 about the loss of hospital beds in Leeds for patients requiring long term care, the complainant contacted the CHC chief officer who said that she had good reason to complain about having to pay for nursing care. The CHC chief officer wrote to the Health Authority in a letter dated 16 September about her concerns. (The CHC chief officer told my officer that the letter might not have been sent until October.) The Authority's chief executive replied in January 1993 (see paragraph 12). The complainant remained dissatisfied and a meeting took place on 11 February with the CHC chief officer, the Authority's chief executive and the headquarters services manager. Four main issues were raised: the pressure applied on her to agree to her husband's discharge from the Infirmary; the failure to be informed of her right to refuse the discharge and the payment of the nursing home fees; the failure to be provided with written information about who would pay the nursing home fees; and the duty of Leeds Health Authority to provide her husband's nursing care free of charge. She had not been satisfied with the headquarters services manager's letter dated 8 March to the CHC (see paragraph 12). She could not reconcile her husband's condition with being told that he did not meet the criteria for NHS care. If his care could not be provided in a hospital the cost of his care in the nursing home should in her opinion have been met by Leeds Health Authority.

11. The CHC chief officer told my officer that the meeting on 11 February had been amicable and had lasted about an hour and a half. The chief executive and the headquarters services manager had appeared sympathetic to the complainant's view that her husband should have continued to receive NHS care. They had said that 'their hands were tied' by national policy in respect of providing long term nursing care and they had been more willing to discuss the discharge arrangements than issues concerning their responsibility to provide care. Their letter dated 8 March had set out fairly the questions raised at the meeting, although the central question of whether the NHS had a responsibility for providing continuing care had not really been addressed. Over recent years there had been a reduction in the provision of long term care beds in Leeds; *the public had become conditioned to that and now rarely complained.* Although Leeds Health Authority intended to provide community services for people with learning difficulties or mental illness, there was no provision for the continuing care of brain-damaged patients. She believed that the Act (paragraph 5) placed on authorities an obligation to provide such care. Discussions were taking place in Leeds about the future of neurosurgical services but the results had not been

disclosed. (I have seen that the Leeds CHC's Annual Report for 1991–92 highlighted issues about the discharge of patients into private nursing homes and the extent to which continuing care was, or should be, available under the NHS.)

12. Relevant extracts from the letters to which I have referred in paragraph 10 are as follows:

(i) The chief executive's letter of 20 January 1993 to the CHC:

'You will know that within the NHS in general over recent years there has been a tendency to reduce the number of continuing care beds in hospitals, concentrating on offering acute and rehabilitative medical services. This has reflected the national policy of providing continuing nursing care services within a community setting, with social security benefits being tailored towards meeting the cost of such services provided within private nursing homes ....

'It has not been the Authority's policy to "top up" Social Security payments for individual people being cared for in private nursing homes. In a different context, advice from the NHS Chief Executive is that such an arrangement is not possible. Against this background I am afraid that the Authority is not able to consider meeting the cost of [this patient's] nursing home fees.

'From 1 April 1993 I understand that it will be possible for [the complainant] to approach the Local Authority .... to ask for financial support in this respect. [They] will have discretion to offer such financial support, having regard to the means of the applicant.'

(ii) The headquarters services manager's letter of 8 March 1993 to the CHC:

'[With regard to the patient's discharge from the Infirmary] I am told that it is documented that [the complainant] stated she did not wish her husband to be discharged ...., but it was a clinical decision by the medical team that [her husband] would not benefit further from acute clinical care. Staff at the Infirmary believe that [his] discharge was handled appropriately and with sensitivity ....'

'[Regarding continuing care] .... it has not been the Authority's policy to [enter into contractual arrangements with nursing homes] in relation to the requirement for individual patients needing continuing nursing care .... [The letter then restated the position described by the chief executive and quoted in (i) above].

'There have been occasions where the Authority has agreed to meet the cost of continuing care for a limited period when specialist services were required .... This has been done because this was felt to be clinically necessary .... In [the patient's] case, there were four nursing homes locally which were able to meet his care requirements ....'

(iii) The chief executive's formal response to me about this complaint:

'.... There is very little which can be added to the letters which have been written on this matter, and .... they form the basis of my official response ....'

13. The consultant responsible for the patient's care while he was at the Infirmary told my officer that even when he was discharged his condition had still been very poor. He had severe neurological damage and a renal tumour and had had a heart attack. He needed full nursing care and could not have returned home. However, his condition was stable and no further active treatment could have been given. Ward 5 was intended to provide only acute treatment. It had been difficult to find an alternative placement for him because the complainant was worried that a nursing home would not be able to provide the quality of care required. (I have seen an entry in the patient's clinical records dated 6 August 1991, which stated: '[seen by the senior registrar] start investigating placement? [another nursing home]'.) If she had not agreed to her husband's discharge he

would have had to stay longer in the ward. The consultant sympathised with the complainant's complaint that the cost of her husband's continuing care should be met by Leeds Health Authority; in his view, that was their duty but it might lead to the rationing of other services. There had been five or six other long stay patients in the ward at that time and they also had been discharged to nursing homes. There appeared to him to be a service gap for patients requiring continuing care. (I have seen the contract documentation for neurosurgical services, for 1991–92, between Leeds Health Authority and the United Leeds Teaching Hospitals NHS Trust. It relates to the 'surgical management of disease and injuries of the nervous system and its covering', including subarachnoid haemorrhage. It states that 'inpatient .... facilities are provided at [the Infirmary]' and that there is 'a full [multi-disciplinary] team .... who work together .... to ensure rapid inpatient rehabilitation and a rapid and smooth progress to discharge and continued outpatient care'. There is no reference to continuing residential care.) The consultant said that he was not aware of the requirements of the guidance (paragraph 7) and considered that it was not the responsibility of medical staff to ensure that patients were notified about who would pay nursing home fees (a matter which I as Health Service Commissioner find remarkable in the light of other investigations I have undertaken).

14. The senior registrar in the consultant's team told my officer that the consultant's decision to discharge the patient had been supported by all members of the multidisciplinary team. Ward 5 was not a suitable place for providing long term care (patients now stayed there no longer than about six months). Before his discharge he had asked a consultant geriatrician whether the patient could be offered a geriatric bed but he had been told that he was too young to be eligible for that (the patient was then aged 55 years). There was no provision for patients who were too young for geriatric care and yet not suitable for admission to a disability unit for younger people. Discharge to a nursing home had been the only realistic option. There had been no discussion with the complainant about who would pay for the nursing home fees and he had assumed that the cost would be met by Leeds Health Authority. In his view the care of someone as disabled as the complainant's husband should be met by the NHS and he was sympathetic to her complaint.

15. My officer interviewed separately the senior ward sister and a junior ward sister from ward 5 and the continuing care facilitator. Their evidence about the patient's clinical condition, his total dependence on nursing care and the decision to discharge him did not differ materially from that given by the consultant and senior registrar. The senior sister said that the discussions and preparations for the patient's discharge had begun in May and had continued until his discharge in September. She could not recall presenting a discharge form to the complainant; if she had refused to accept her husband's discharge, that would have been recorded. The continuing care facilitator said that it was not the Infirmary's policy to put in writing who would pay the nursing home fees; the complainant had agreed, however, to pay them.

16. The Trust's chief executive told my officer that, on the basis of the information available to him, it seemed that, while some points of detail might have been overlooked, it had not been an option for the patient to stay in ward 5 and, if his wife had not agreed to his discharge, he would probably have been sent to a [unspecified] long stay institution because there was no other suitable ward at the Infirmary. Leeds Health Authority had not been aware of, or involved in, the patient's discharge plan. The staff at the Infirmary had been better placed to know about alternative placement options than the staff at Leeds Health Authority.

17. For his part the chief executive of Leeds Health Authority told my officer that he first knew about the complaint when the CHC wrote to him in October 1992 (paragraph 10). When a clinician decided that active treatment in hospital could no longer be justified, the patient's discharge had to be arranged. He had

wondered how much information had been given to the complainant at the time of her husband's discharge to the nursing home. At the meeting on 11 February she had said that she had agreed to her husband's discharge although she had been unhappy about it. If, however, the discharge procedures had not been followed correctly, that was a matter for both Leeds Health Authority and the Trust. (The contract documentation provides that 'where the complainant holds the Purchaser [that is, Leeds Health Authority] responsible in respect of its procurement of services, the Purchasers shall respond ....'. The Provider (that is, the Trust), 'shall ensure that its staff are properly .... instructed with regard to all its policies and procedures'. The Trust's revised discharge policy, dated April 1993, states that where a patient requires placement in a nursing home the social worker and continuing care facilitator will 'ensure resources are available and can be committed': there is no reference to making clear in writing whether the NHS will pay the fees involved.) The Trust's duty was to ensure that the discharge was planned and implemented in an acceptable way, and Leeds Health Authority monitored the services provided. The purchaser/provider relationship was a positive one and it was in the interests of both that nationally-agreed procedures and guidelines were followed.

18. The chief executive said that Leeds Health Authority could not meet every health need. Present policy was for shorter inpatient stays with continuing care being provided in the community. The Authority did not provide for any long stay medical beds in hospital or have any contractual arrangements for such beds in private nursing homes. They were no different in that respect from most other health authorities. There were many residents receiving care in private nursing homes; if Leeds Health Authority were expected to pay nursing home fees they would soon become financially overstretched. He sympathised with the complainant's position and felt that the issues her complaint raised needed to be addressed nationally. He believed that the Authority had acted reasonably in this case. He stood by what he had said in his reply to the complaint.

19. The headquarters services manager told my officer that, while the 1977 Act appeared to place a general requirement on Leeds Health Authority to provide for all healthcare needs, that could not be held to be absolute since there had to be discretion so that account could be taken of financial limits and clinical priorities. The Authority were expected to provide continuing care in community settings. The Yorkshire Regional Health Authority had issued in May 1990 a guidance document on services for elderly people. (I have seen an extract which states that 'Requirements for long term care to be local, homely, small in scale and delivered according to a social rather than a medical model mean that long-stay wards in hospitals are inappropriate'.) He did not believe that any member of staff at Leeds Health Authority had been approached at the time of the patient's discharge.

20. The Authority's director of public health told my officer that she had not been involved in the handling of the complaint. She said that it was a health authority's duty to identify the health needs of the local population and to ensure that services were in place to meet those needs. That duty was limited by the resources available, and authorities had to identify priority areas. In Leeds, priority had been given to moving patients from long stay institutions into community settings. For acute medicine the regional policy was to move patients needing only nursing care into nursing homes. There had been a gradual reduction of long stay beds and the former Leeds Western Health Authority had had a declared policy of not providing medical beds for long term care. Some patients with severe brain damage were sent to placements outside the district, but that was for assessment rather than for the provision of continuing care. Leeds Health Authority monitored the performance of their providers, which were expected to conform to national policies and guidelines. In that way the Authority monitored the actions of the Trust. Hospital staff had a duty to provide relevant information to relatives before patients were discharged.

Findings

21. The complaint is that the patient's care in the nursing home should have been provided through, and paid for by, Leeds Health Authority. In order to place matters in context I have set out evidence about the discharge process which was followed in 1991. It is abundantly clear from the evidence of the consultant at the Infirmary, and the matron of the nursing home, that at the time of his discharge the patient was seriously incapacitated and required full time nursing care. At the heart of the complaint lies the question what provision should be made by health authorities for patients, like him, who need such care on a continuing basis. I have set out in paragraph 6 the position of the chief executive of the NHS Management Executive. The officers of Leeds Health Authority recognise the difficulties which the complainant faces in having to pay a substantial part of the nursing home fees, but they believe that the extent of the provision they have made is in line with national policy and that their services are broadly similar to those of other health authorities. I have been referred to regional policy (paragraph 19), but I take the view that it is irrelevant to the present case. It relates to elderly patients—usually interpreted as being those aged over 65 years—who are not by a long way as incapacitated as this patient. He was only 55 when discharged from the Infirmary.

22. The chief executive of the NHS Management Executive has stated that the NHS has a duty to provide care without charge where a doctor judges such care to be necessary on clinical grounds. He qualifies that by saying that there is an overriding duty to determine priorities within the financial resources available, and that consideration of clinical priority may mean that a particular patient needing inpatient nursing care may never have it provided. How should I regard Leeds Health Authority's position in the light of that guidance and the circumstances of this particular case? The patient had been in the care of the Infirmary for over eighteen months under a contract made by Leeds Health Authority. No one disputes that by August 1991 his condition had reached the stage where active treatment was no longer required but that he was still in need of substantial nursing care, which could not be provided at home and which would continue to be needed for the rest of his life. Where was he to go? Leeds Health Authority's policy, as explained by their chief executive, was (and still is) to make no provision for continuing care at NHS expense either in hospital or in private nursing homes. In particular I note that the contract for neurosurgical services makes no reference to continuing institutional care. This patient was a highly dependent patient in hospital under a contract made with the Infirmary by Leeds Health Authority; and yet, when he no longer needed care in an acute ward but manifestly still needed what the National Health Service is there to provide, they regarded themselves as having no scope for continuing to discharge their responsibilities to him because their policy was to make no provision for continuing care. The policy also had the effect of excluding an option whereby he might have the cost of his continuing care met by the NHS. In my opinion the failure to make available long-term care within the NHS for this patient was unreasonable and constitutes a failure in the service provided by the Health Authority. I uphold the complaint. I recommend that Leeds Health Authority make an *ex gratia* payment to the complainant to cover those costs which she has already had to incur and to provide for her husband's appropriate nursing care at the expense of the NHS in the future. I recommend also that the Authority review their provision of services for the likes of this man in view of the apparent gap in service available for this particular group of patients. (I record the similarities between this case and one—W.478/89–90—which was published in the Selected Case volume for October 1990–March 1991 and involved a failure to provide NHS after-care to a woman who had suffered severe head injuries.)

23. Although not formally subject to investigation by me, I am concerned about some faults in the arrangements made for the patient's discharge. The consultant decided in the exercise of his clinical judgment that the patient no longer required active treatment in ward 5. Since it was made clear that continuing occupation of an acute bed was not clinically appropriate, the complainant was left in the difficult position of choosing between refusing to accept his discharge or meeting the home's charges. None of the hospital staff

was aware of—nor did Infirmary policy apparently provide for—the requirement in the guidance (paragraph 7) to set out in writing, before discharge to a nursing home, who would pay the fees. I criticise that significant omission. The complainant was not given that information. I therefore regard her as having been placed under duress through that failure to inform her of all the relevant considerations she should have had placed before her. (I liken it to a case which I examined as Parliamentary Commissioner for Administration and published as a special report—Fourth Report for Session 1992–93, HC 519.) Although she acquiesced in the need for her to pay the nursing home fees, in my opinion that was inequitable in the circumstances. I recommend that Leeds Health Authority remind their providers of the need to follow the Department of Health's guidance on discharge procedures.

Conclusion

24. I have set out my findings in paragraphs 21—23. Leeds Health Authority have asked me to convey—as I do—their apologies to the complainant for the shortcomings which I have found and have agreed to implement my recommendations in paragraphs 22 and 23.

January 1994

W K REID

Health Service Commissioner for England

Printed in the United Kingdom for HMSO
Dd 5061928, 2/94 C9, 65536, 3398, Ord 275067 03/29062

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