Possession of Hospital Beds and Delayed Discharge

'*Bed blocking'*… '*delayed discharges'* – patients who are subject to a delayed transfer of care are increasingly seen as one of the main sources of the NHS's woes by silting up the smooth transfer of people through the system as they clog up available beds.

What do you do if you are a hospital trust and you have a patient, with capacity, who simply refuses to leave, despite offers of appropriate residence and care? The answer is that you seek a possession order of the hospital bed in the county court which will allow you to enforce an eviction.

But proceed with care – seeking possession of a hospital bed has the potential for reputational damage – as the James Paget Hospital in Norfolk discovered to their cost last week when they evicted 63 year old Adriano Guedes after two years in hospital and found themselves the subject of numerous articles in the media *(full disclosure: I advised the local housing authority involved with Mr Guedes*).

The actual possession claim is generally straightforward. The trust will have to establish it has a right to the hospital bed P occupies i.e. what its interest in the land/hospital is, that P has never been a tenant or sub tenant, that P entered as a bare licensee to facilitate medical treatment, that medical treatment (at least from this hospital) is no longer required and that the trust has revoked its consent or license for P to remain on the land and P is now a trespasser. *Barnet PCT v X* [2006] EWHC 787 (QB) and *Sussex Community NHS Foundation Trust* [2016] EWHC 3167 (QB) are two cases where trusts successfully sought possession orders.

As one will see from those cases, there is generally no real defence for P to put forward - on public law or Article 3/8 grounds – where the trust has done its preparatory work. This will likely include: a Mental Capacity Act 2005 assessment that concludes that P has capacity to make decisions on residence and care; a stepped procedure of meetings where the trust and its partner agencies (e.g. housing, social care) seek to work with P (with the assistance of a Care Act advocate where required) to gain his agreement to leave and meet any reasonable objections he may have to proposed care packages; a series of notifications that possession will be sought and signposting to sources of legal advice; final notification that consent has been withdraw/the license terminated; previous offers of accommodation and care that meet P's assessed eligible needs which have unreasonably been refused, and up-to-date evidence that P remains medically fit for discharge.

Although not vital for the possession action it may assist in gaining either an outright order for possession or quick date for the possession order if the trust can show that on eviction day the trust (or a partner agency) will: arrange for the appropriate transport (e.g. provide an ambulance/pay for a taxi); notify the police or security to attend if P is likely to exhibit challenging behavior; and work with partner agencies so P has somewhere to be transported to with care workers to provide any assistance required in the transfer.

Of course in many cases P may be ineligible for homelessness assistance and/or social care on transfer out of hospital. This need not be a bar to possession on human rights grounds – I've successfully obtained possession orders of hospital beds where the transfer plan was a taxi to the local social services offices in the hope and/or expectation that they would provide interim relief while undertaking a human rights assessment under schedule 3 of the Nationality Immigration and Asylum Act 2002.

Peggy Etiebet is giving a presentation at a workshop hosted by ADASS on '*Tackling the wicked issues underpinning Delayed Transfers of Care'* on 13 February 2017.

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