Clinically Ready for Discharge (CRFD) Definition

Frequently Asked Questions

February 2023, version 1

Contents

General/Policy-related Questions

1. **Is the definition applicable to CAMHS and other specialised commissioned services, as well as ICB commissioned inpatient rehabilitation services e.g. HDU's (High Dependency Units)?**
   It applies to all age mental health, learning disability and autism inpatient beds.

2. **When is the new definition required to be implemented? Will the reporting of DToCs via the MHSDS dataset be paused whilst the new definition is set up?**
   There will be a supported transition period from 1st January-31st March 2023 where we can provide additional support to providers where needed, to enable them to put the necessary steps in place to capture the data in line with the definition. During this time providers should submit clinically ready for discharge (CRFD) data where possible. However, where the data doesn't currently quite meet the new CRFD definition providers should continue to submit their data and we will work with them to improve data quality in line with the new definition. From 1st April 2023 we will expect all providers to be using this definition for reporting to the MHLDA COVID-19 SitRep.

   In addition, when version 6 of the MHSDS goes live in April 2024, changes will be made to the delayed discharge reason codes to support the new definition. In the event that providers are able to start submitting CRFD data to the MHSDS before April 2024 then please do so, however where the data doesn't currently quite meet the new CRFD definition they should continue to submit their data and we will work with providers to improve data quality in line with the definition ahead of the version 6 update.

3. **What are the key differences between the old and new definition?**
   - It now **includes all delays** not just those that are external to the trust (see question below for the difference between internal and external delays).
   - **It doesn't include transfers of care to other inpatient settings** e.g. PICU to adult acute etc.
   - **It is more person-centred** by asking the multidisciplinary team to consider the person and their chosen carer/s' views and needs about discharge and involve them in co-developing the discharge plan, before concluding that someone is clinically ready for discharge.

4. **What is the difference between internal and external delays?**
   - *Internal delays* are those that are within the control of the service/organisation, for example, delays to NHS-led assessments, staffing etc.
   - *External delays* are ones that are outside the control of the service/organisation, for examples delays to local authority-led assessments, availability of suitable housing etc. We are expecting providers to record all delayed discharges (unlike the previous DToC definition, which focused on delayed discharges caused by external factors).
   - We are not however expecting providers to distinguish between whether a delay is internally or externally caused in reporting of this measure.

5. **Who was involved in developing this definition?**
   We worked with national policy teams, clinical advisors, experts by experience, clinicians in providers, system and regional colleagues, as well as ADASS and DHSC representatives.

6. **Will local authorities adopt this new definition as well?**
   Yes, all system partners will need to support this new definition for mental health discharges.

7. **Previously there was an expectation that delayed discharges were agreed across social care, commissioners and trusts before being reported. Will this still be the case?**
   Before someone can be classed as clinically ready for discharge (CRFD), the multi-disciplinary team (MDT) must have involved any services who will be involved in the person's care following discharge, as well as the person and their chosen carer/s. This will help to make sure supporting services are aware of what ongoing support is needed and enable better decision making about when someone is CRFD. Following this, the decision about whether someone is CRFD will need to be made by the inpatient MDT.

8. **Will this new definition come with any additional funding?**
   There is no additional funding to support the definition specifically, however by having more accurate data that better reflects what's happening in services, it means we can better make the case for funding when opportunities arise.

   The Department of Health and Social Care (DHSC) has however recently made £500 million available to support adult social care and discharges from inpatient settings along with a further £200 million, and mental health discharges are within scope of this funding. This funding provides a significant opportunity to help unblock some of the barriers to discharge from adult mental health, learning disability and autism inpatient settings and ensure people can access the right social care input and housing support in a timely way. The following supporting guidance helps to explain how the funding can be used for mental health discharges.

9. **Why does mental health need a different definition/process from acute hospitals?**
   When engaging with stakeholders, the feedback was that the definition developed for acute trusts didn't fit with the way of working in mental health. This is due to the fact that the acute definition has been developed based on a medicalised model and doesn't reflect the multi-disciplinary model that is used in mental health. Therefore, it presents an opportunity to develop a definition that is a better fit for the mental health sector.

10. **Are there any potential unintended consequences of implementing the new definition and can we ensure that it doesn't lead to attributing blame?**
    An unintended consequence could be that people feel that there is increased scrutiny of delayed discharges. However, it isn't about attributing blame instead it supports our understanding of where there are pressures in the system and helps to identify how these could be addressed. Delays are virtually never due to individual staff but are due to system flow and decision-making issues.

11. **What impact will this new definition have on flow, eliminating out of area placements and improving patient outcomes?**
    The new definition provides greater transparency on the number of delayed discharges to a community setting. It can help providers and ICS's to identify what is leading to these delays and to put in place actions to address them.

    It can also help services to plan discharge early on in an admission, identifying what needs to be achieved to enable discharge to the community. Ensuring people receive the right support in a timely manner to aid their recovery may contribute to a reduction in long lengths of stay in inpatient settings. In turn, this can improve flow through the acute inpatient mental health pathway, helping to improve bed availability and to reduce the reliance on out of area placements.

    The new definition is one part of a range of work that NHSE are doing to improve flow through the acute mental health pathway. Draft Guidance has been developed and is available on the NHS Future Collaboration Platform, which includes key principles for providers and systems to

support the delivery of high-quality adult acute mental health inpatient care. Plus, a new discharge challenge for mental health was launched in December which outlines 10 key initiatives that systems can take to improve flow, reduce avoidable length of stay and delayed discharges.

12. **How can the information be used to support commissioning of viable alternatives to inpatient admission and improve capacity to support discharges?**
    By having more robust data in place which accurately reflects what is happening in inpatient services, providers/ICS's can better understand what the common barriers are to discharge and where the pressures are in systems.

    This can help to inform local conversations and development of strategic plans/business cases, to identify where targeted investment is needed in local services or where there are gaps in provision and new services need commissioning. It can also help to highlight where service improvements are needed to support existing care pathways and prevent bottlenecks/improve capacity.

    How can we support the wider system and local authorities to prioritise mental health discharges on a par with acute trust discharges?
    The discharge challenge for mental health was launched on 6th December 2022. This asked integrated care boards (ICBs) and providers of mental health and community inpatient services to focus on ensuring that they have robust discharge processes in place and to focus their resources on areas that will drive the biggest improvements locally.

    It highlighted the need for engagement across systems with key leaders from the NHS, local government and other relevant local partners, with support from regional executive discharge leads and their teams. Therefore, it is hoped that this will provide the catalyst to ensure mental health discharges are given the same high profile and attention as acute discharges, at both national and local level.

13. **How does this definition fit in with the wider system, could we capture whole system focused metrics?**
    Clinically ready for discharge data should not be viewed in isolation, as often delays are a symptom of a wider system-issue. Therefore, we encourage providers, systems and regions to use a range of urgent and emergency care (UEC) and acute metrics to understand how the whole acute mental health pathway is operating. To support this we have recently developed the UEC pathway pressures dashboard for mental health which can be filtered to system level.

14. **Should trusts report CRFD data moving forwards or should ICBs?**
    The expectation is that providers should submit the data and monitor it to understand the number of people who are clinically ready for discharge and occupying beds, however, monitoring and analysis should also be carried out at a system level to identify cross-system challenges and actions to reduce the number of people who are CRFD and occupying beds.

15. **How do we account for people that are clinically ready for discharge for mental health reasons but not for physical health reasons?**
    In the event that someone no longer requires mental health inpatient treatment but requires inpatient care for their physical health needs, the mental health provider still has a duty to make sure that the person is in contact with their allocated key worker and the right discharge support is put in place to support their mental health needs for when they are ready to be discharged from an inpatient setting. If there are any delays to someone being admitted to an acute hospital bed, then this would be recorded as clinically ready for discharge, as the person no longer requires mental health inpatient assessment, interventions or treatment.

16. **Do we still need to attribute who is responsible for the delay?**
    With the establishment of ICBs, which cover health and social care partners, and the Better Care Fund being extended to include mental health discharges, the responsibility for the delay should be system-wide rather than focused on attributing responsibility for the delay to any particular partner, as often the solution is better collaboration and system planning.

17. **Does the definition include people in independent sector beds?**
    Yes, people in independent sector beds that have been commissioned by any NHS-led organisation are included in the definition and reporting of CRFD data.

18. **Why doesn't mental health have discharge to assess beds like acute hospitals?**
    Some mental health providers have set up discharge to assess processes, such as implementing trusted assessors or carrying out assessments in the person's discharge location where appropriate, rather than in the inpatient setting. The following guidance previously developed for the additional discharge funding during 20/21 and 21/22 provides examples of this, and can support other areas to consider a similar approach.

19. **Will NHSE offer any training to help support understanding of the new definition?**
    Yes, we are happy to attend existing forums to talk through the definition or respond to queries by email.

Questions relating to Recording and Reporting

20. **What national oversight/monitoring does NHSE have for CRFD data?**
    There are currently two datasets that are used to capture clinically ready for discharge data across all mental health, learning disability and autism inpatient services. These are the MHLDA COVID-19 daily SitRep and the MHSDS (Mental Health Services Dataset). Secure services are also required to submit to the national case management system (NCMS), which also helps to capture delayed discharges.

    Data is then shared and discussed regularly at national and regional level meetings to help identify what the current challenges are and what possible solutions could be put in place e.g. targeted support or investment, or any other ways that NHSE can work with systems to support with any local challenges.

21. **How will this affect data submission to the MHSDS or the COVID-19 SitRep?**
    Data should still continue to be submitted via the MHSDS and daily SitRep. The main changes will be:
    - Only reporting delays relating to discharges to a community setting (excluding any delays relating to transfers to other inpatient wards)
    - Reporting all delayed discharges (rather than only reporting ones which met the previous DToC definition i.e. external delays only)

22. **Will the delayed discharge reasons from MHSDS fit into four broad definitions in the COVID-19 MHLDA Sit Rep and are these the same that acute providers currently use?**
    We have mapped the existing MHSDS delayed discharge reason codes to four high level categories, which have been added to the COVID-19 Sit Rep. These high-level categories are slightly different to the ones used by acute providers, they are as follows:
    - Hospital processes
    - Community/other external interfaces
    - Housing/accommodation

- Social care/Local Authority

We are reviewing the MHSDS delayed discharge reason codes alongside the new definition to ensure they align. These will be implemented when MHSDS Version 6 goes live in April 2024.

23. **Will CRFD replace both DToC and Medically Ready for Discharge (MRFD) as some mental health trusts currently report two separate figures for DToC and MRFD?**
    Yes, the new CRFD term and definition will replace both of these. Providers will still be required to submit to two datasets, one is the daily COVID-19 MHSDS SitRep and the other is the monthly MHSDS, however both of these data collections follow the new CRFD definition.

24. **Will there be a target for reducing the number of people who are CRFD?**
    We are not currently looking into introducing a threshold for CRFD as we want to first ensure people focus on implementing the new definition and getting the data and clinical practice in line with this. However, it is something that we may look at introducing in the future.

25. **Will you capture total bed days delayed?**
    We currently can't capture bed days delayed in the MHLDA COVID-19 SitRep at patient level; however, we can start to capture this using MHSDS data once the new definition has been implemented.

26. **We understand the difference between Clinically Ready for Discharge and Delayed Transfer of Care but our clinical system cannot differentiate. How can we resolve this issue?**
    Please contact your clinical system provider to discuss what changes are needed to be able to accurately capture data in line with the new definition.

27. **Given the partnership nature of effective discharge planning, will the data be routinely available for all system partners to monitor?**
    Ideally all system partners should be able to access local CRFD data. To support this, ICBs are encouraged to establish integrated governance structures across acute, community and mental health service providers so that discharges can be monitored across the system. This can give systems a better understanding of the whole pathway and whether there is sufficient community resources in place to support discharges. To support this we have recently developed the UEC pathway pressures dashboard for mental health which can be filtered to system level.

28. **How will delays be reported if someone is not clinically ready for discharge (CRFD)?**
    If someone's care on the ward is delayed (for example there is a delay in treatment), and they are not CRFD, then they would not be reportable nationally. However, at local level, flow tools such as red2green can help to capture people who are not clinically ready for discharge but are experiencing delays to their assessment or treatment, to ensure these are picked up and resolved.

29. **Are providers required to proactively check the CRFD status of their patients and report it weekly/monthly?**
    Yes, providers are required to submit data on the number of people who are clinically ready for discharge on a daily basis to the MHLDA COVID-19 SitRep, and on a monthly basis to the MHSDS.

30. **Once the person is classed as CRFD, at what point following this would you reasonably expect us to begin counting the delay?**

Providers should start reporting people who are CRFD but still occupying a bed the same day that they have been classed as CRFD.

Questions relating to Clinical Practice

31. Does the definition mean people have to leave inpatient services as soon as classed CRFD?

No, absolutely not, it is about understanding when there are blockers that are preventing someone from being discharged when they are clinically ready and where solutions may be needed to remove these blockers. We wouldn't expect someone to be discharged until it is possible to deliver the support needed as outlined in the person's discharge plan.

32. If someone is classed CRFD but not delayed, does it mean they will be discharged today?

Providing the person, their carer/family and any ongoing support services have been given sufficient notice (wherever possible, this should be at least 48 hours) and the right discharge support is available to support the person after discharge, then people who are clinically ready for discharge should be discharged as soon as possible.

33. Why don't we reference safe in the definition, or assessing risk?

The key question is whether the person will gain therapeutic benefit from further assessments, interventions and/or treatments, which can only be provided in an inpatient setting. If the same or better therapeutic benefit can be provided in the community then the person should be discharged to the community, to help maximise the benefits and minimise avoidable, unnecessary harms to the person.

34. Are there any criteria for who should be involved in the MDT, i.e. which professions?

The multi-disciplinary inpatient team can include all staff that are involved in the planning or delivery of care in mental health inpatient settings as well as the person's ongoing care, therefore where staff in-reach into inpatient services such as housing leads, social workers, discharge support workers, then they should be considered as part of the multi-disciplinary team.

Services that do not provide any in-reach/support to inpatient services should still be engaged as part of discharge planning and decision making however, as they will play a key role in the person's ongoing care.

35. How should I explain this definition to service users and their carers?

Service users and carers should be supported during the whole discharge process. Be clear with your communication, explaining that you will be involving the individual and their carer in planning their discharge as far as possible, including identifying what support they would find helpful in the community. Explain that you are also working with external providers where necessary, to ensure the right support is available upon discharge. The person, their mental health recovery and their wellbeing, should remain the primary focus throughout the discharge planning process.

36. What if the inpatient MDT doesn't agree that someone is clinically ready?

If someone believes that discharge is not appropriate by the expected date they should specify why so that mitigating actions can be taken promptly. As part of purposeful admission and use of flow tools there should be few, if any, occasions when this happens at the point of expected discharge. If disagreements persist then the trust's escalation protocols should be followed.

37. How will disputes be resolved when the person or carer doesn't agree with any of the discharge options being offered?

The inpatient MDT should ensure early engagement with the person and their family/carers to help prevent any issues further down the line, and ensure they are involved in co-developing the discharge plan.

If the person has been assessed as clinically ready for discharge and there are disagreements about the discharge support offered, then the team should seek to understand what the person or their carer's perspective is and look for alternative solutions or ways to resolve the issue, for example this could include setting up a visit to the discharge location/meeting with the staff there, or facilitating a trial period with the discharge support with a set review date built in to see what has worked well and whether any changes are needed. If this is still not resolved, the rapid escalation process should be followed and this process should be clearly explained to the person and their chosen carer/s. It is important to log any disagreement as soon as it arises to give the longest opportunity to resolve it.

38. Does the person's or their family's views have equal weight to the professionals involved in planning discharge and determining when someone is ready for discharge?

As mentioned in the answer above, the inpatient MDT should ensure early engagement with the person and their family/carer, as part of discharge planning to help prevent any issues. However, where the inpatient MDT have made every effort to include and consider the person and their family/carer view as part of the decision-making about whether someone is CRFD, but it is not possible to reach an agreement, the decision about whether someone is clinically ready for discharge rests with the inpatient MDT team. As a result, this would be reportable as the person being CRFD but delayed due to patient or family choice.

39. What happens if the community MH team don't agree that someone is CRFD?

The inpatient MDT should seek to understand why the community mental health team don't agree and work with them to identify any mitigating actions that can be taken to get their agreement. If disagreements persist then the trust's escalation protocols should be followed.

40. Could you describe how this may affect those patients who are subject to the Mental Health Act (MHA)?

All delays are reportable where someone is CRFD but has not been discharged, regardless of their detention status. The MHA should not be a reason for someone remaining in hospital when they are CRFD. The MHA should only be used where essential for someone's care and treatment, therefore if it is being cited as a reason for a person who is CRFD not being discharged, then this should be escalated.

41. Many of the delays for people with a learning disability and autistic people can last a long time, and are usually due to external factors, how will this definition account for this?

We would expect that planning for discharge starts as soon as anyone with a learning disability or who is autistic is admitted, as with all people admitted to an inpatient mental health setting. This involves identifying a care and support provider, if needed, and ensuring that provider can work with the person whilst they are in hospital to ensure a smooth transition out of hospital. It also includes ensuring plans are in place for any accommodation needed to enable the person to leave hospital.

The intention is that these things would be in place once someone is assessed as being CRFD. It is anticipated that this definition will support efforts to start discharge planning as soon as possible, to minimise delays once someone is clinically ready to be discharged.

42. If someone goes on section 17 leave, should I class them as CRFD?

Section 17 leave can be an essential part of assessing whether or not a person is clinically ready for discharge. If used as part of this assessment then by definition the person is not CRFD as it is still assessing this. It is for the team to decide whether the section 17 leave is part of an essential ongoing assessment or therapy plan to get the person clinically ready for discharge in which case it should not be labelled CRFD.

In some cases, people get sent out on long term section 17 leave, therefore the question is why would they need to be compulsorily detained in hospital but not actually be in hospital – that would be a flow and effectiveness issue rather than a CRFD one.

43. A team may not consider someone to be ready for discharge until they can test the setting to which they will be discharged to for a period of time. If such a setting is not available, then the team may not feel they are able to discharge.

If the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting, and the MDT have met the three criteria in the definition, then the person can be classed as clinically ready for discharge.

If the discharge location is not available for the person to be discharged to or if a period of leave is needed to 'test' whether the discharge location is suitable (rather than whether someone is clinically ready for discharge), then on both of these occasions the person would be reportable as clinically ready for discharge.

44. What about the role of the Ministry of Justice (MoJ) regarding Conditionally Discharging restricted patients? If the MDT believe someone is CRFD but awaiting MoJ agreement - does that mean they are CRFD?

The role of MoJ remains unchanged with the new definition. If the MDT have assessed someone as being clinically ready for discharge, however the person is unable to be discharged without MoJ agreement, then they would be reportable as clinically ready for discharge.

45. What if a clinical team considers that a restricted patient is CRFD but cannot persuade the Mental Health Casework Section or the Mental Health Tribunal to order a (deferred) discharge?

The person would be reportable as clinically ready for discharge.

46. Should inpatient staff be determining what social care support is needed prior to an assessment?

The inpatient MDT should engage social care early on in a person's admission to help identify what social care support may be needed following discharge.

47. Is there a risk of not including transfers to other inpatient settings in reporting?

The change from DTOC (delayed transfer of care) to clinically ready for discharge (CRFD) is, in part, an opportunity to reduce risks. This is because it removes the blurring between discharge back into the community and transfer to another inpatient bed (no matter who provides it or where) as for the person and their family a transfer is not a discharge, it is a move between inpatient settings.

The focus should always be on purpose of admission and what needs to be done to achieve the earliest feasible discharge date. If a person requires ongoing inpatient care and treatment then by definition they are not CRFD. The clinical team have determined that they need essential ongoing inpatient care and treatment but in a different type of unit. That is a valid clinical decision if the next unit fits with better delivering the next stage in achieving the purpose

of admission and hence the earliest feasible discharge, but it is a different process and outcome to discharge from inpatient to community care and treatment.

Whatever the type of unit or the likelihood that a person will be directly discharged to the community, it is essential that the clinical team are clear on what needs to be done to achieve successful discharge from the beginning of the admission. This can include a transfer e.g. to a less restrictive setting, and this is an essential step or one of a number of steps in achieving the earliest feasible discharge. Delays along these pathways are not CRFD, until the person is clinically ready for discharge to the community.

The evidence of delays and issues in the effectiveness of the treatment pathway and flow, should be picked up and addressed/escalated through use of tools such as red2green as soon as they arise at any step in the pathway. Reducing CRFD delays and the use of flow tools to address any delays prior to the person becoming clinically ready for discharge are complementary but different workstreams.

48. What is the clinical responsibility when CRFD is ongoing but community support is not ready?

In situations where someone is deemed CRFD, but it is not possible to discharge them, the person must continue receiving interventions, activities and other support in hospital, so that they remain CRFD and can be discharged as soon as the appropriate support has been put in place for them.

49. What is being done to alleviate risk-averse approaches from clinicians when making decision about someone's discharge?

The NHS Long Term Plan and NHS Mental Health Implementation Plan set out an ambition to develop new and integrated models of primary and community mental health care. This ambition is supported by an additional £1 billion funding per year by 2023/24 to ultimately transform the provision of community mental health care for adults and older adults with severe mental illnesses.

Bolstering community capacity and improving the community mental health provision available, will mean people are better supported in the community, preventing unnecessary admission to inpatient care and enable more timely and effective discharges.

The Long-Term Plan expects close working and input from community mental health services into the discharge processes for inpatients from the point of admission. This should maximise the opportunities to agree the essential community aftercare plan and to resolve any disagreements well before the person reaches clinically ready for discharge.

In a scenario where the community services who will be responsible for delivering the aftercare believe they have what is essential in place, but the inpatient team are not in agreement, then in general it is the community team who can decide if the aftercare is adequate as they are responsible for that. The aim is always to achieve the earliest feasible discharge date. Therefore, if the discharge doesn't proceed then it should be escalated for a decision to be made.

50. Court of Protection decisions can cause significant delays which impacts patients hugely. How are these delays going to be highlighted within the current guidance?

Currently these delays can be reported against the delayed discharge reason code 'awaiting outcome of legal requirements' in the MHSDS. Also, for secure inpatient services, these are reported via the NCMS and can be reported against the reason code "awaiting court of protection proceedings". We are currently reviewing the delayed discharge reason codes in the

MHSDS so that we can capture a more accurate reflection of all the delayed discharges in mental health, learning disability and autism inpatient services.

51. **Should providers complete a full assessment process for people even where there is no indication for a certain assessment, if this will help to speed up someone's discharge?**
In general people should not have to undergo assessments or reassessments unless there is good reason as to why these are essential to improve their health and recovery. Unnecessary assessments are not just a waste of scarce funding and resourcing but put the person through unnecessary stress and can cause additional harms. If people are being expected to undertake unnecessary assessments for purely "tick box" purposes then such a process indicates a poor-quality step in the care pathway and as such should be escalated.

    On the other hand, if an assessment/reassessment of certain matters is essential to providing key information not otherwise available that will determine what is essential for delivering a feasible aftercare plan, then it should be done promptly. If the inpatient and community teams disagree about what assessments are essential to support discharge, the team requiring the additional assessment in hospital will need to explain the rationale for this. If there is still disagreement or if such issues crop up repeatedly it requires escalation.

52. **How do we address determining the need for admission in the first place, ensuring the emphasis is on therapeutic value of inpatient care?**
This can be addressed by identifying the purpose of the admission, setting an expected date of discharge (EDD) for when this purpose will be achieved, and communicating this with the person, family/carers and any teams involved in the person's care post-discharge, e.g. community mental health team (CMHT) or crisis resolution home treatment team (CRHTT). This should be done within 72 hours of the person's admission and will help to clarify what therapeutic benefit they should expect to gain during their hospital stay, and how long they are expected to stay for.

53. **How will this new definition affect the setting of an estimated discharge date (EDD)?**
The EDD should be determined by the inpatient team, based upon what is known about the person and what is required to help them quickly reach the point where hospital inpatient care and treatment is no longer essential. This should be a realistic date for the inpatient setting that the person has been admitted to and the type of intervention required.

    For adult acute mental health inpatient settings, there is a national expectation that all services work towards an average length of stay of 40 days or fewer. Therefore, if the EDD is 60 or more days after admission date then this should be flagged up immediately so that the reasons for that length of admission can be explored and tested to see if there are any reasonable ways of shortening it, so that people aren't staying in a service longer than necessary.

54. **Many people are CRFD (i.e. no further treatment required) but are still waiting for adult social care to assess for Section 117 aftercare. Would this be a delayed discharge under the new definition?**
Yes, the person is CRFD as they no longer require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting. Therefore, they would be reportable as clinically ready for discharge.

55. **Does the definition include where someone is delayed stepping down within a provider, e.g., from a PICU to an acute ward, or from acute to a rehab ward?**
This depends on whether the service they are being stepped down to is defined as an inpatient service, or if it is a community service. If a person requires ongoing inpatient care and treatment then by definition they are not CRFD. However, if the person is being discharged to a

step-down service in the community then they would be classed as CRFD, as they no longer require inpatient care and treatment.

56. Previously, anyone who required ongoing non-acute care (rehabilitation etc.) was classed as DToC, with the new CRFD definition, will they be classed as CRFD?
Rehabilitation covers a broad spectrum of services and interventions, from working with people in their own homes, through supported living settings, to inpatient rehabilitation, to locked rehabilitation, and other such long stay units. Therefore, it depends on how the beds are recorded. As above, if they are classed as inpatient beds then they are a transfer not a community discharge; if they are not classed as inpatient beds they would be classed as a discharge and CRFD would apply.

57. Where the lead commissioner of community-based placements is the responsible local authority, and they have not identified a plan or a placement, can the person be defined by the MDT as a CRFD?
The inpatient team needs to engage with the local authority early on in the person's discharge planning, particularly if they will likely require local authority-led support. If the person is assessed as CRFD but there is no community-based placement available, then they are reportable as CRFD.

58. What if a person is CRFD but the team have not actioned a request for the discharge support needed, does this mean they are not CRFD, as the ward team/local authority has not actioned a request for the ongoing support needed?
This scenario would be reported as CRFD because if the support was available then there would be no reason not to discharge the person. The inpatient team should engage with ongoing support services/partners early on in the person's discharge planning, to help prevent any possible delays from occurring.