Witness Name: Kathryn Smith
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UK COVID-19 INQUIRY - MODULE 6

WITNESS STATEMENT OF KATHRYN SMITH, OBE
ON BEHALF OF THE SOCIAL CARE INSTITUTE FOR EXCELLENCE

I, Kathryn Smith, OBE, will say as follows:

1. I am Kathryn Smith, Chief Executive Officer of the Social Care Institute for Excellence (SCIE), a position I have held since May 2020.

2. Before joining SCIE, I served as Chief Operating Officer at the Alzheimer's Society and Director of Services at Scope. My career in social care began in 1989 as a care worker and has spanned roles in the private sector, a health trust, four local authorities, and the Commission for Social Care Inspection. I have also taught social work courses at Leeds University and the Open University.

3. As SCIE's Chief Executive, I am responsible for overseeing the delivery of our strategy, managing operations, and ensuring effective use of financial and human resources to achieve our charitable goals. I also work closely with SCIE's Board of Trustees to support the organization's governance. The Board is currently chaired by the Rt Hon Paul Burstow, who has held this role since July 2017.

4. This statement outlines SCIE's role in supporting the social care sector's understanding and implementation of government policies during the pandemic. By providing practical resources, we helped make pandemic-specific rules and requirements more accessible to commissioners, providers, and professionals. These resources, hosted on a dedicated digital hub on SCIE's website, were regularly updated as scientific knowledge and

government policies evolved. The statement also highlights other activities we undertook, including research and learning from the sector's pandemic experiences.

5. As an independent UK-registered charity, SCIE's mission is to enhance people's experiences and outcomes in social care, supporting them to lead better lives. With a focus on improvement rather than service delivery or advocacy, SCIE occupies a unique position in the sector. This allows us to provide an impartial perspective on the events and lessons of the Covid-19 pandemic.

About the Social Care Institute for Excellence

6. Since its establishment as a charity in 2001, SCIE has become a trusted authority on evidence-based best practices for social care. We produce evidence-based guidance and tools for care organisations that support adults, children and families. By engaging with policymakers and partners across the care sector, SCIE works to drive improvements in local social care systems and services. [KS/01 - INQ000560926]

7. SCIE achieves its goals by researching evidence on effective social care practices, translating this evidence into practical resources and shaping public policy reforms. These resources, including best practice guidance and tools, are disseminated through SCIE's website, training sessions, events and consultancy projects.

8. SCIE's remit encompasses social care policy and practice in England, Wales, and Northern Ireland, with resources accessible across the UK and internationally. Our work supports a wide range of organisations, including local authorities, private providers, and third-sector entities, across all care settings. SCIE is committed to promoting co-production principles across the sector and within our operations.

9. Our expertise covers diverse social care topics—ranging from care planning and commissioning to mental capacity and safeguarding—addressing the needs of children, young people, people with disabilities, learning disabilities, autism, older adults, and unpaid family carers.

10. Since our establishment, SCIE has maintained a long-standing relationship with the UK Department of Health and Social Care (DHSC). This has included an annual grant to create and share evidence-based resources, tools, and e-learning, as well as direct support to local authorities and care providers. The grant supported the implementation of key statutes, such as the Care Act 2014, and the hosting of Social Care Online, a digital library of best practices in social care.

11. Following the 2010 UK reforms to government arms-length bodies, SCIE's funding from DHSC was significantly reduced. This shift led SCIE to adopt a more commercial business model. Over half of our income is now derived from consultancy, training, and research contracts with government bodies, local authorities, and charities.

12. Unlike statutory bodies such as the Care Quality Commission (CQC), the sector's regulator, or the National Institute for Health and Care Excellence (NICE), SCIE does not hold regulatory or statutory powers. SCIE cannot enforce compliance with regulatory standards. That means we do not collect performance data from local authorities or care providers, rate their services, or systematically gather evidence from service users. Consequently, SCIE is unable to directly assess the pandemic's impact on the provision of social care and care recipients.

13. Prior to 2012, SCIE independently developed best practice guidance for the social care sector, funded by the annual government grant. However, the Health and Social Care Act 2012 gave statutory recognition to this function for the first time and assigned it to NICE. Although SCIE's government funding was further reduced, we continued to contribute to guidance development by leading the NICE Collaborating Centre for Social Care from 2013 to 2016 under a separate contract. During this period and extending through 2018, we produced guidance on selected social care topics, including a series of "quick guides" on different topics and other accessible resources, many of which are still available on the NICE website. Examples include:

    - Helping to Prevent Infection (for managers and staff in care homes) [KS/01a - INQ000560931]
    - Homecare [KS/01b - INQ000582895]
    - Older people with multiple long-term conditions [KS/01c - INQ000582896]
    - Transitions from hospital to home [KS/01d - INQ000582897]

- Intermediate care, including reablement [KS/01e - INQ000582898]
- Decision-making and mental capacity [KS/01f - INQ000582899]
- Child abuse and neglect [KS/01g - INQ000582900]

14. By early 2020, SCIE had become a central source of best practice evidence for social care. We developed best practice resources on additional topics, such as strengths-based social care practice, older people's mental health and adults with learning disabilities. We also published "how-to" guides and tools for local authorities to foster innovation, improve commissioning and deliver integrated care. Our engagement and reach across the sector were extensive. SCIE's website was engaging over 4.3 million users, and our monthly e-newsletter was reaching over 100,000 subscribers. Webinars and e-learning sessions were attracting hundreds of participants, particularly on topics like dementia awareness and safeguarding.

15. The specific challenges posed by the Covid-19 virus, particularly for the care sector, were not fully anticipated by public health experts responsible for pandemic planning. While SCIE's guidance before March 2020 did not address pandemic-specific issues, many of our best practice resources served as valuable benchmarks and starting points for managing social care needs during the crisis. Below, I outline how SCIE adapted its evidence and tools for this purpose, along with the pandemic-related activities and resources we delivered between 1 March 2020 and 30 June 2022.

16. Although SCIE operates across England, Wales and Northern Ireland, the geographic scope of our pandemic-related work was focused on England and the UK government. During the same period, SCIE also received public funding for activities unrelated to COVID-19.

17. In England, the grant from the Department of Health and Social Care (DHSC) supported the development of guidance, tools, e-learning, and resources to improve adult social care. To support pandemic-related activities, the DHSC agreed two short-term contracts with SCIE during the 2020-21 financial year; these were additional to the core grant. The first contract, covering mid-April to September 2020, describes in detail the pandemic-related initiatives SCIE was funded to deliver. A smaller second contract, spanning October 2020 to March 2021, extended this work and supported the regular updating of Covid-19 resources on SCIE's website hub. The details of these funded

activities and their impact are outlined below. [KS/02 - INQ000560927] [KS/03 - INQ000560928]

18. In Northern Ireland, SCIE worked under a service-level agreement with the Department of Health (DoH) to produce good practice guidance for local implementation. SCIE's contract did not include advisory services or guidance related to Covid-19. We are therefore unable to answer questions about the pandemic response specific to Northern Ireland.

19. SCIE's contract with Social Care Wales primarily supported research and best practice evidence based on priorities set by Social Care Wales and the Welsh Assembly Government. The scope of work in 2020-21 and 2021-22 was unrelated to Covid-19, with one exception. For that small project, Social Care Wales was seeking to provide information, signposting and resources for the social care sector in response to the Covid-19 pandemic in Wales. Their objective was to ensure Welsh Covid-19 policies and evidence-based guidance could reach the care workforce in a timely and accessible way, and they wanted to build on existing communications and stakeholder networks. SCIE's research helped to map professional networks and identify communication and stakeholder engagement channels. We do not have a record of how the research informed or influenced the Welsh government's Covid-19 activities. Beyond this small project, SCIE had no remit to produce or disseminate Covid-19 resources or support the Welsh Assembly Government's pandemic response. Consequently, SCIE cannot provide insights into Wales's pandemic response.

20. SCIE did not receive funding from the Scottish Government, offer advisory services or undertake activities specific to Scotland's response to the Covid-19 pandemic. We therefore cannot provide insights about the Scottish Government's pandemic response.

21. While SCIE's pandemic-related work was significant, our broader activities during the same time period continued. Our income during the period under review came from four main sources: contracts, grants, service-level agreements, and fees. For example, we supported local authorities with commissioning improvements, technology-enabled care adoption, and financial recovery. We also launched forward-looking initiatives, such as the SCIE Commission on the Future of Housing with Care and Support and contributed evidence and policy proposals to the government's White Paper on Social Care (2021).

Statutory frameworks and core principles underpinning social care

22. Key legal frameworks for adult social care include the Care Act 2014, Mental Capacity Act 2005, and Equality Act 2010. These laws outline the responsibilities of governments, particularly local authorities, and the duties of social workers, care providers, and other professionals. They address individual rights, safeguarding, anti-discrimination, wellbeing promotion, care assessments, planning, and providing information and advice.

23. SCIE has long published guidance, toolkits, and training to enhance understanding and implementation of these laws. Up-to-date resources, including fact sheets on the Care Act, are available on our website.

24. Personalisation is a foundational principle of social care. It focuses on recognising individuals' strengths and preferences and placing them at the centre of their own care and support. Historically, service-led approaches limited people's choices and control. The Care Act embeds personalisation in law, requiring needs assessments and care planning that prioritise individual choices.

25. Personalisation is especially critical for understanding care experiences during the pandemic. If followed, all systems, processes, staff and services would put the holistic needs of people who draw on care and support at the centre of decision-making affecting their lives. This would include having access to information, advocacy and advice so people could make informed decisions about their care. It would also include involving people in personal care-related decisions and offering them choices.

26. Another key principle is safeguarding, which ensures individuals' rights to live safely, free from abuse and neglect. The Care Act places a general duty on local authorities to promote wellbeing, including protection from abuse and neglect. The Mental Capacity Act makes ill-treatment and wilful neglect a criminal offense. SCIE has a strong history of supporting the sector in safeguarding practices and meeting these legal duties.

27. The Deprivation of Liberty Safeguards (DoLS), an amendment to the Mental Capacity Act, protect individuals unable to consent to care arrangements that deprive them of liberty in

care homes or hospitals. DoLS ensure such arrangements are necessary, in the person's best interests, and subject to representation and appeal rights.

28. Long-standing delays in processing DoLS cases have highlighted the need for reform. The government passed the Mental Capacity (Amendment) Act 2019 aiming to replace DoLS with Liberty Protection Safeguards (LPS). While LPS promised a streamlined authorisation process and simplified legal framework, the changes have yet to be fully implemented. SCIE continues to support the sector with training, knowledge-sharing, and person-centred approaches to meet obligations under the Mental Capacity Act and DoLS.

29. Public understanding of social care often reduces it to care for older people in care homes, often linked to medical crises and long-term care post-hospitalisation. However, this narrow perspective overlooks the broader scope of social care. Many individuals with long-term needs, including older people, people with learning disabilities, autistic people, those with mental health needs, vulnerable young people, and people experiencing homelessness, live at home or in supported living arrangements.

30. This limited view of social care's scope and beneficiaries may have influenced government decision-making during the pandemic, particularly in its early stages. There is no evidence that the suspension of laws, government directives, or social restrictions were assessed for their impact on the broader care sector or those reliant on it. Despite the sector's critical role during the public emergency, the UK Government's understanding of its readiness, capacity, and capability appears to have been incomplete, poorly understood or overlooked.

The state of the social care sector prior to the pandemic

31. SCIE's view, with hindsight, is that the adult social care sector was poorly prepared for the COVID-19 pandemic. For decades, the sector has faced inadequate funding, an undervalued workforce with low pay, rising care costs, and increasing demand due to demographic changes. Unlike the NHS, social care operates as a fragmented system with over 18,500 mainly private care providers across England, delivering a mix of residential, home, and day care services. These services cater to both short-term needs, such as recovery after hospital discharge, and long-term support for disabilities or age-related conditions.

32. Few would describe the social care system as fair, affordable, or sustainable. The pandemic exposed and amplified longstanding weaknesses, including growing demand for care, insufficient resources, workforce crises, quality and safety issues, and a lack of political consensus on sustainable funding. These systemic issues remain unresolved.

33. Local authorities in England, Scotland and Wales have statutory responsibility for adult social care. Social care funding comes in part from central government grants and also from local revenue-raising mechanisms, such as council and local business taxes. Northern Ireland's health and social care trusts have this responsibility because their health and care system is integrated.

34. Over many decades, local authority funding for social care has been vulnerable to squeezes from central government, leaving local authorities in search of savings at the same time demand for social care services was rising. The overall effect has been to severely limit public resources for adult social care.

35. For example, following the UK government's Gershon Efficiency Review (2003-04), all local authorities were required to make annual efficiency savings of 2.5% each year from 2005 to 2008. Government austerity measures, which were introduced in 2010 following the global financial crisis, slashed public spending further and deeper, including the grants for social care to local authorities.

36. Local authorities have sought to protect adult social care from the scale of the austerity-related cuts, but funds have been insufficient to meet the growing demand for care and support. One way of controlling local authority budgets has been to maintain existing financial eligibility thresholds for publicly funded care; these thresholds have not changed since 2011-12. The consequences for people who draw on care and their family carers include unmet needs, delayed care assessments, limited care options, reliance on personal finances, and inconsistent care quality—despite local authorities' statutory duties under the Care Act.

37. In its 2018-19 State of Care report, the CQC highlighted concerns about the sector's fragility and the need for better integration between health and social care to prevent

crises. These issues were reiterated in the CQC's 2019/20 State of Health Care and Adult Social Care in England, which analysed the pandemic's initial impact.

38. Successive governments have acknowledged pressures on the sector, such as the "postcode lottery" of care access and insufficient public funding, particularly for community-based care. Low eligibility thresholds have forced more people to depend on their own finances and unpaid family carers. The overall picture of the sector is of more people seeking publicly funded care but fewer people receiving the support. For example, by 2022-23, 2% fewer people were receiving support than in 2015/16, despite 11% more people requesting it (Source: NHS England 2022/23, as reported by the King's Fund, "Social Care 360", 2024).

39. The ongoing workforce crisis, marked by low wages, high vacancies, and high turnover, has further undermined care quality, as reported by Skills for Care in their annual report, "The State of the Adult Social Care Sector and Workforce in England."

40. Despite numerous government reports and policy proposals since the late 1990s, progress has stalled due to the unresolved question of funding reform: who should pay? High-profile reform attempts include the 2010 Dilnot Commission, which recommended capping individuals' lifetime care costs. The Dilnot Commission on Funding Care and Support was set up by the UK government in 2010, and its report with recommendations was published in July 2011. While the Care Act 2014 partially adopted the Dilnot proposals, key provisions—such as reforming care payments, expanding service choices, improving information and advice, and enhancing preventative care—remain unfulfilled due to resource constraints.

41. The absence of political consensus on sustainable social care funding has led to decades of inaction and reliance on short-term crisis funding, often in response to winter pressures. The Chartered Institute of Public Finance and Accountancy (CIPFA) has criticised this approach as "crisis-cash-repeat," creating a destructive cycle that stifles innovation and leaves the sector ill-equipped to meet growing needs.

42. Successive governments have expressed concern about the health and social care interface, particularly delays in hospital discharges. Delayed discharges occur when patients remain in hospital due to waits for care assessments or lack of suitable

post-discharge care arrangements, such as care home beds. This affects NHS productivity. The long-standing capacity and funding issues in social care have exacerbated this problem, as faster hospital discharges require more complex, costly post-discharge care packages combining health and social care services. According to the CQC's "State of Care, 2022-23" report, about a third of all hospital discharges are delayed for social care reasons.

43. Pre-pandemic efforts to improve social care delivery included the UK government's Better Care Fund (BCF), introduced in 2015 to promote the integration of health and social care in England. The BCF aimed to help people remain safe and independent at home for longer by pooling NHS and local authority funding for integrated local services. It encouraged a shift from residential care to community-based "home first" services, focusing on strengths-based and self-directed care approaches. Further details about the BCF are available from the Department of Health and Social Care or the Ministry of Housing, Communities and Local Government. Other key partners include NHS England and the Local Government Association.

44. The BCF programme continues to this day. However, the combination of longstanding pressures and urgent demands on local care systems results in BCF resources being redirected to tackling immediate issues, such as delayed hospital discharges, instead of supporting upstream prevention and integration efforts.

45. In July 2019, the Prime Minister pledged to "fix the crisis in social care once and for all." The 2019 Conservative Party manifesto echoed this promise, proposing reforms to ensure no one would need to sell their home to pay for care. By January 2020, the Prime Minister committed to delivering a plan within the year. However, the pandemic delayed this timeline, and substantial reforms remained unrealised.

46. The pandemic shone a light on the perilous state of the social care sector across the UK. Today, the sector's stability remains precarious. The impact of another pandemic would likely be devastating, potentially leaving many vulnerable people without essential care and support. Pressures from stakeholders continue to mount for government action to address the sector's unresolved structural, financial and quality of care problems.

SCIE's initial Covid-related activities, 1 March to 15 April 2020

47. Like other organisations in the sector, SCIE could not have fully anticipated the societal impact of Covid-19 or its specific implications for social care policy and practice. However, when the pandemic began, SCIE quickly responded to sector questions and considered how to best deploy its expertise.

48. The first two months of the Covid-19 pandemic, March and April 2020, occurred before my tenure at SCIE. The pandemic's onset coincided with a leadership transition and the need to address its impact on SCIE's operations. During this period, SCIE's Chair took a more active role in liaising with the government and the care sector about how we could best support them during the crisis.

49. Having carried out an extensive review of our internal records, it is my understanding that SCIE did not develop or contribute to the UK government's pandemic policy decisions or the issuance of official government guidance. This includes the government's official guidance on discharging patients from hospitals, Covid-19 testing, critical care and treatment decisions (DNACPR), the shielding of vulnerable people, visitors' restrictions for hospitals and care homes, and the use of personal protective equipment in primary and community settings, including care homes. For the avoidance of doubt, during the whole of the pandemic, SCIE was not responsible for setting official government policy and guidance. Whilst it would have been appropriate and beneficial for UK government policies to have consulted with or involved organisations like SCIE, the initial months of the pandemic required rapid decision-making based on the scientific understanding of the Covid-19 virus at that time. To the extent we are aware, the policies issued in March and early April 2020 focused on public health and the NHS response. We are not aware of the UK government's decision-making including an assessment of the impact of the policies on the social care sector and the people who draw on care and support.

50. Only after the publication of the UK government's *COVID-19 Action Plan for Adult Social Care* on 15 April 2020 did SCIE have an official role. From that point, SCIE was contracted by the DHSC to support the care sector's uptake of official government policies. We

achieved this by disseminating practical resources that enabled policy implementation via our website. Organisations and individuals who subscribe to our SCIEline newsletter were informed of the resources available. Based on subscriber records, recipients include people who worked at local authorities, private care providers, non-profit care providers, universities and NHS Trusts; in terms of roles, individual subscribers included care managers, care workers, social workers, students and healthcare professionals. Our intention was to make the government's detailed policy requirements and rules accessible and easy to understand for social care commissioners, providers and professionals. The Annex to this statement lists the practical guidance and quick guides SCIE produced.

51. In the initial weeks of the pandemic, before our official role, SCIE was actively engaging with sector stakeholders to understand their questions and concerns and to identify practical ways we might help. The stakeholders we engaged with are those organisations and individuals who subscribed to the SCIEline newsletter. Our voluntary support to the sector during this time included promoting pre-existing good practice and other relevant resources not specific to Covid-19. We disseminated these materials via SCIE's website, networks, newsletter (*SCIE Line*), and social media. With face-to-face training no longer feasible, we quickly shifted our e-learning and training offers online. [KS/04 - INQ000560929] [KS/05 - INQ000560930]

52. In mid-March 2020, SCIE independently established a COVID-19 information hub on its website to address the lack of a central source of social care-specific advice, guidance, and information. Recognising the sector's need for reliable resources, SCIE filled this gap. Unlike SCIE and sector partners, the UK government did not have a direct communication channel with the social care sector.

53. Our COVID-19 hub was featured on SCIE's website landing page. The hub's former web address was: https://www.scie.org.uk/care-providers/coronavirus-covid-19. Initial content included links to official government guidance and SCIE's own evidence-based resources. Although this early content was not specifically adapted to the risks of Covid-19, the resources offered prudent measures at the start of the pandemic. One example was the promotion of the SCIE/NICE *Quick Guide* on *Helping to Prevent Infection in Care Homes*. Originally published in 2018, the guide included practical steps for infection control based on best practice evidence. [KS/01a - INQ000560931] [KS/04 - INQ000560929]

54. The hub's launch was promoted through SCIE's social media and *SCIE Line* newsletter on 19 March, reaching over 270,000 contacts. In its first week, the SCIE Covid-19 hub had over 14,500 visits, and the SCIE/NICE quick guide was viewed nearly 6,000 times. After the initial launch, we expanded the hub with the addition of blogs, information webinars and e-learning. Over time, the hub signposted visitors to resources from across the sector. Further details about the hub's contents and sector engagement offers are described below.

55. The SCIE Covid-19 hub was not the same as the UK government's CARE App, which was launched later in May 2020. A review of internal documents indicates that SCIE was not involved in the CARE app's design, contents or deployment, although we signposted to it through our sector communications at the time it was launched.

56. Throughout March and prior to 15 April 2020, SCIE staff held early, informal discussions with UK government officials and civil servants about how we could support the sector during this period of fear and uncertainty. These exchanges focused on developing COVID-19 guidance around people with learning disabilities and autism, and there was interest in SCIE supporting a recruitment campaign for the care workforce.

57. Between 11 and 16 March, SCIE was approached by the DHSC to host a "Question and Answer" social media session, fielding questions about the UK government's Covid-19 advice for social care providers and then publishing responses in an online blog. The SCIE Line newsletter from 19 March included a link for submitting questions to SCIE about the UK government's coronavirus advice. Although directed to all SCIE Line recipients across the UK, the SCIE Line describes that answers would be published in a blog by the DHSC. [KS/04 - INQ000560929]

58. Our SCIE Line newsletter from 2 April reported on the outcome of a Q&A session with SCIE's Chair, the Minister for Care and the Director of Ageing Well and Community Service from NHS England. Links to the answer blog and SCIE's Covid-19 hub were included. This edition of SCIE Line included two new SCIE publications developed in direct response to sector questions: guides about safeguarding adults and the Mental Capacity Act. Other publications were announced through SCIE Line over the coming weeks and months. [KS/05 - INQ000560930]

59. SCIE's early response to the sector's concerns reinforced our role as a trusted source of social care information and highlighted the need to support the dissemination of government guidance. In March 2020, SCIE staff liaised with contacts at the Department of Health and Social Care (DHSC) and Public Health England (PHE), submitting a formal offer of support to DHSC on 2 April. [KS/06 - INQ000560932]

60. By early April 2020, Covid-19 was widespread across health and social care settings and in the community. As widely recognised and reported at the time, there were growing numbers of people receiving care infected with Covid-19 and deaths of older, vulnerable residents in care homes, mounting concerns about the effects of discharging hospital patients to care homes without routine testing for Covid-19 and acute shortages of personal protective equipment for social care workers across all settings.

61. As with our conversations behind the scenes at DHSC, we sensed government leaders were recognising the pandemic's impact on social care and starting to realise that the needs of the sector could no longer be an afterthought to protecting the NHS.

SCIE's Covid-19 Support to Government, from 15 April 2020 through 30 June 2022

62. SCIE's role with the UK Government during the COVID-19 pandemic concentrated on supporting the social care sector's uptake of official government policies. Our practical resources offered useful guidance, training, and best practice information for those working in a variety of social care settings and with different groups of people drawing on care and support. As noted above, SCIE was not responsible for setting official government policy and guidance.

63. Our initial Covid-19 contract with the DHSC included the rapid production of sector-specific guidance materials, the expansion of SCIE's Covid-19 website hub and learning offers to the sector. As the pandemic carried on, and as part of our second Covid-19 contract with the DHSC, we regularly updated our outputs to align with changes to UK government policies, emerging priorities and evolving scientific evidence. We continued our communications with the sector, aiming to meet the information needs of social care professionals and providers.

64. SCIE's work undertaken on behalf of the UK government was consistent with our role as an improvement agency, i.e., enabling the spread and uptake of best practices in social care through guidance development and dissemination; implementation support involving tools, resources and consultancy; and various learning and training offers.

65. The Annex to this witness statement sets out an itemised list of the guidance and quick guides offered through the SCIE Covid-19 Hub, by topic and over time. Through our second DHSC Covid-19 contract, starting from November 2020, we strived to keep the hub resources up to date, since official government policies and Covid-19 rules were often changing. The content list in the Annex was compiled based on a comprehensive review of our internal records, but given the frequency of official policy changes, there is a small possibility that not every update has been captured.

66. Our support to the UK Government did not begin formally until after the UK Government published its COVID-19 Action Plan for Adult Social Care (Action Plan) on 15 April 2020. Based on a review of SCIE's internal documents, my understanding is that we were not directly involved in developing the Action Plan or shaping its priorities.

67. Reiterating the Care Act's statutory framework and expressing the government's commitment to the sector during COVID-19, the Action Plan included new measures managing outbreaks and infection control, including testing symptomatic residents in care homes; all residents prior to care home admission, starting with those transferring from a hospital stay; and all care workers with symptoms. In addition, the Action Plan established the government's CARE-branded website and app for the social care workforce, which was to be launched by the end of April 2020, coupled with a recruitment campaign. The government's Action Plan described many actions directed at local authorities and care providers, including a national support offer.

68. SCIE's role within the UK government's plan was described as "developing good practice resources and support for social care professionals, including e-learning on safeguarding, infection control, and support to family carers, and guidance on supporting people with learning disabilities, support to Safeguarding Adults Boards, and good commissioning practice during the pandemic, among others." This description was consistent with the contract we subsequently agreed to deliver.

69. Following the publication of the UK Government's Action Plan, SCIE submitted a letter of support to the Minister for Care. This was followed shortly thereafter by a contract to develop the range of guides, improvement tools and support for the sector, including the COVID-19 hub on SCIE's website. Annex 1 includes a list of the guides SCIE published on the hub. [KS/07 - INQ000560933] [KS/02 - INQ000560927] [Annex 1]

70. SCIE's initial offer to government focused on three areas: (1) Disseminating information and trusted guidance aimed at helping care workers reduce the spread of the Covid-19, including expanding the content of the SCIE hub; (2) Developing the skills of the workforce so that they are better equipped to respond to Covid-19 outbreaks over the longer term, such as through webinars and e-learning; and (3) Producing new best practice guidance for social workers and care workers, starting with the support of vulnerable people drawing on social care, who at the time were self-isolating.

71. SCIE was well-placed to rapidly gather, collate and publish this material and raise the awareness more widely of emerging good practice. For example, we were observing the emergence of online social networks, good neighbour schemes (local volunteer schemes that were set up to support vulnerable people isolating at home) and video conferencing to connect people in care homes with loved ones.

72. SCIE's Covid-19 activities on behalf of the UK Government were initially funded through two addenda to our core funding grant in 2020-21. The first tranche of funding was for Covid-19 activities delivered from mid-April 2020 to 30 September 2020; a smaller second tranche of funding covered the six months from 1 October 2020 to 31 March 2021. Subsequent Covid-19 activities were funded through the core government grant to SCIE during 2021-22. [KS/02 - INQ000560927] [KS/03 - INQ000560928] [KS/08 - INQ000560934]

73. Our regular grant reporting to DHSC highlights the contractually agreed activities we delivered, what was achieved and their impact. SCIE's broad reach included millions of website visits, thousands of webinar participants, and extensive dissemination of newsletters and training materials. We also captured formal feedback from our learning events. [KS/09 - INQ000560935] [KS/10 - INQ000560936] [KS/11 - INQ000560937] [KS/11 - INQ000560938] [KS/13 - INQ000560939] [KS/14 - INQ000560940] [KS/15 -

INQ000560941] [KS/16 - INQ000560942] [KS/17 - INQ000560943] [KS/1 - INQ000560944]

74. With the initial pandemic activities agreed, SCIE's team of social care experts worked rapidly and efficiently to tackle the information gaps and improve the workforce's technical skills. For instance, we issued two more editions of SCIE Line during April, on the 17 April and 23 April. [KS/19 - INQ000560945] [KS/20 - INQ000560946]. These continued to promote the SCIE Covid hub and included links to advice and information blogs, the promotion of training webinars (Safeguarding adults, Covid-19 and care providers), an invitation to submit questions to expand the Q&A blog, and the announcement of additional publications, including updates:
    - Covid-19: Supporting autistic people and people with learning disabilities – guides for social workers and OTs; for care staff; and for carers and family. [KS/97 - INQ000582957] [KS/99 - INQ000582959] [KS/101 - INQ000582903]
    - Coronavirus infection control for care providers – briefing for providers. [KS/66 - INQ000582926]
    - Supporting people who are isolated or vulnerable during the Covid-19 crisis. [KS/70 - INQ000582930]
    - Safeguarding children and families during the Covid-19 crisis - guide. [KS/79 - INQ000582939]
    - Domestic violence and abuse: safeguarding during the Covid-19 crisis – guide [KS/81 - INQ000582941]
    - Updated: Coronavirus infection control for care providers – quick guide; KS/67 - INQ000582936] and
    - Updated: Covid-19 guide for social workers and OTs supporting autistic adults and adults with learning disabilities. [KS/98 - INQ000582958]

75. SCIE's role remained flexible as government priorities changed along with the evolving pandemic. The Hub content was regularly updated as scientific or clinical evidence about Covid-19 changed how the disease was managed, when lockdown restrictions were lifted, and as government policies relevant to social care were modified. We also sought to capture the sector's early learning and best practices to share more widely.

76. Initially our aim was to disseminate trusted information and guidance to reduce COVID-19 spread; later, the information and guidance shifted to a focus on safe management of the

disease in different social care settings. Initial plans were adjusted, with new workstreams such as a Care Home Good Practice Hub and resources for home care added to our contract deliverables. Updates to the Hub's guidance reflected emerging evidence, new government policies and feedback from the social care sector. Best practices were promoted to social care professionals through online webinars and e-learning modules; recordings were made available to extend their reach.

77. The Annex to this statement lists all the guidance published on the SCIE Covid-19 Hub. SCIE's regular newsletters (SCIE Line), especially during 2020-21, provide the best overview of the full spectrum of SCIE's Covid-19 offers to the sector, including information, guidance, webinars and e-learning resources. Exhibited here for reference are all the editions of SCIEline newsletter announcing new and updated guidance SCIE published on its hub by date. [KS/21- INQ000560947] [KS/22 - INQ000560948] [KS/23 - INQ000560949] [KS/24 - INQ000560950] [KS/25 - INQ000560951] [KS/26 - INQ000560952] [KS/27 - INQ000560953] [KS/28 - INQ000560954] [KS/29 - INQ000560955] [KS/30 - INQ000560956] [KS/31 - INQ000560957] [KS/32 - INQ000560958] [KS/33 - INQ000560959] [KS/34 - INQ000560960] [KS/35 - INQ000560961] [KS/36 - INQ000560962] [KS/38 - INQ000560963] [KS/38 - INQ000560964] [KS/39 - INQ000560965] [KS/40 - INQ000560966] [KS/41 - INQ000560967] [KS/42 - INQ000560968] [KS/43 - INQ000560969] [KS/44 - INQ000560970] [KS/45 - INQ000560971] [KS/46 - INQ000560972] [KS/47 - INQ000560973] [KS/48 - INQ000560974] [KS/49 - INQ000560975] [KS/50 - INQ000560976] [KS/51 - INQ000560977] [KS/52 - INQ000560978] [KS/53 - INQ000560979] [KS/54 - INQ000560980] [KS/55 - INQ000560981] [KS/56 - INQ000560982] [KS/57 - INQ000560983] [KS/58 - INQ000560984] [KS/59 - INQ000560985]

78. To produce our practical resources, we started with official UK Government Covid-19 policy, followed by the integration of evidence-based practice, peer expertise and practical examples. We collaborated and consulted with experts from within government, trusted sector organisations and where feasible, coproduced with people who draw on care and support. For example, the guide about mental capacity during Covid-19 (April 2020) focused on care assessments and Deprivation of Liberty Standards and was developed in collaboration with National Mental Capacity Forum and 39 Essex Chambers. For the guide about best interest decisions (July 2020), liaison and scoping were undertaken with the

DHSC legal team, the interim Chief Social Worker and the National Mental Capacity Forum.

79. The sector was keen for SCIE to publish "Quick Guides" that summarised detailed guidance into more accessible, easier to read content for frontline care staff. These drew on UK government guidance, existing good practice guidance and examples of emerging practice. Practical in nature and focus, these Quick Guides could be found on SCIE's hub. The quick guides applied SCIE's expertise, good practice evidence and statutory frameworks to the pandemic's unique challenges to social care practice. Some guides were developed in response to the questions and concerns from the sector; others aimed to maintain social work good practice and standards of care.

80. Examples of our Quick Guides include the use of remote (video) social work assessments, including a technology checklist, and risk assessment during virtual interactions; adapting best practices in infection control to accommodate COVID-19 requirements, e.g., isolating patients and the use of PPE; supporting vulnerable people who were isolating; protections for people with dementia and mental capacity issues; best interest decisions; and safeguarding adults, children and families during the pandemic's lockdowns.

81. Our Quick Guide about supporting people living with dementia in care homes was developed through joint working with the Alzheimer's Society (published in May 2020). For the social work guides we involved experts like the interim Chief Social Worker, the British Association of Social Work (BASW), the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA). Guides specific to people with learning disabilities also involved the interim Chief Social Worker; experts at BASW, NHS England, PHE and Mencap; as well as SCIE staff with extensive frontline experience, user and sector engagement.

82. SCIE developed practical Covid-19 guidance and offered webinars specifically for local authority commissioners. The initial priorities were informed by questions arising from commissioners and providers, which were gathered through an informal sector survey and interviews, and a focus group with people who used services. The guides addressed important considerations for commissioners during the pandemic and beyond, from understanding hospital discharge and preventing unplanned hospital admissions to legal and policy issues during the pandemic. Updated versions of these guides, reflecting some

of the post-pandemic learning, currently remain on our website. Webinars we offered at the time addressed co-production with communities and commissioning challenges during the pandemic. For example, on 28 September 2020, we hosted a webinar called "Social Care Personal Assistants: the Forgotten Home Care Service During Covid-19". A full list of webinars is included as an exhibit. [KS/60 - INQ000582921]

83. We produced guidance for commissioners about hospital discharge and preventing unnecessary hospital admissions during COVID-19, building on official UK government policy (August 2020). The content addresses commissioning tasks, includes good practice advice and reminders about roles and responsibilities, and describes the challenges associated with transfers of people from hospital to care homes as well as approaches to preventing unplanned hospital admissions. Last updated in January 2022, the guide remains on SCIE's website. In its latest form, the guide for commissioners discusses the lessons learned from hospital discharge and avoidance during the COVID-19 pandemic, and it highlights good practice to take forward. [KS/60a - INQ000582919] [KS/60b - INQ000582920]

84. As part of the initial set of commissioned activities, we also launched a Care Home Good Practice Hub at the request of the DHSC in June 2020. Recognising the particular challenges facing care homes, the Care Home Good Practice Hub was developed with engagement from the National Care Forum and the Registered Nursing Homes Association, and it promoted relevant SCIE guidance and signposted to resources and practice examples from across the sector. It was updated daily. SCIE resources for care homes generated 148,000 online visitors by early September 2020. The Annex to this statement lists the care home guidance published on the SCIE Covid-19 hub during the pandemic.

85. Online content dedicated to care homes was supported by training and informal virtual events. How to maintain standards of care during the pandemic emergency was a clear focus. For example, virtual meetups with care home managers took place to understand lessons learned and share good practice on 1 and 8 July 2020. These meetings were a useful source of intelligence about how the sector was coping with and adapting to COVID-19 requirements. Key messages from these events were shared with DHSC in June 2020, and they are described in full in the exhibited slide deck. Among these messages were: (1) the plea for information that supports the practical application of

guidance, which was viewed as high level; (2) the request for a trusted central repository of pandemic guidance and supporting materials, such as the SCIE hub; and (3) the need to more closely coordinate efforts of national sector partners in developing and disseminating guidance and tools. Concerns were also being raised that the Hospital Discharge process still felt rushed, and that the policy was often leading to people being discharged to the wrong care home environment. [KS/61 - INQ000560986]

86. Other activities on the Care Home Good Practice Hub were designed to answer questions and disseminate learning. A "dementia in care homes Q&A" with Professor Alistair Burns, NHS England's National Clinical Director for Dementia and Older People's Mental Health, was published on 15 June 2020, and a collation of quality-checked guidance and best/emerging practice examples, "Care Homes and Supported Living: Learning and Sharing Resource", was published in August 2020.

87. We also published learning resources for family and informal carers, "Caring safely at home." These were published in June 2020 as part of Carers Week. The resources included information and advice on particular conditions and caring for family members during the pandemic. Not all content was Covid-specific, but where it was, the resources are relevant to the impact of the pandemic on people's experience of the Care Sector and infection prevention and control measures for those providing care in the home, including by unpaid carers. By early September 2020, 2,800 sessions of the learning materials were completed. [KS/61a - INQ000582924]

88. SCIE identified a gap in guidance for safely reopening community adult day centres, which play a vital role in reducing social isolation for adults with care needs and providing respite for carers. These services were overlooked at the pandemic's onset, with initial government efforts focused on care homes and hospital discharges. Day centres closed during the first lockdown in March 2020 due to the vulnerability of their clients and the face-to-face nature of services. This impacted older adults, particularly those with dementia, people with learning disabilities and autism, and unpaid carers. The closures led to social isolation, disrupted routines, loss of personal care support, reduced independence, and increased stress, anxiety, or cognitive and physical decline.

89. To address the gap, we produced new guidance, *Delivering Safe, Face-to-Face Adult Day Care*, in collaboration with Public Health England, the Local Government Association, and

King's College London as part of the NIHR Applied Research Collaboration South London. Reviewed and approved by DHSC, the guidance was published on the SCIE Hub in July 2020, alongside a learning webinar. The guidance acknowledged challenges like contract changes, redeployment of staff, reduced service hours, and increased demand for home-based or technology-supported care. It also covered infection prevention, safeguarding, risk assessment, and best practices. These resources remain accessible on SCIE's website. Although day care is not within the scope of Module 6, we include a copy of the guidance in our evidence. [KS/73 - INQ000582933]

90. For our infection prevention and control e-learning offer, SCIE, in collaboration with NHS-backed digital health innovators HCI, had an existing Care Certificate course targeted at care workers in non-clinical, care home and home care environments. The video-based course was updated with content relevant to the pandemic, published in May 2020 and distributed via the CARE app, Health Education England, the Care Provider Alliance and Skills for Care. The e-learning course was studied by 6,778 people by September 2020 and was made freely available for 6 months.

91. During the pandemic, SCIE provided support and resources to Adult Safeguarding Boards (SABs) under the DHSC grant agreement, complementing the safeguarding quick guides. This included enabling Safeguarding Adults Reviews (SARs) in rapid time to identify and share lessons from COVID-19-related incidents of abuse or neglect. The approach, developed with input from key stakeholders such as the Local Government Association, CQC, SAB Chairs Network, NHS England, and SAB Business Managers Network, was piloted in Luton, Newham, Cornwall, and Dorset. Published resources included the *Safeguarding Adult Reviews In-Rapid-Time Briefing* (21 July 2020) and SAR tools and guidance for SABs. A supporting webinar on 25 August 2020, attended by 324 participants, introduced these tools.

92. The initial support DHSC commissioned from SCIE included a workstream focused on engagement with the sector, including two-way dialogue. We used SCIE's e-bulletin, email and social media to push out timely information that attracted visitors to the hub and participants to learning events. For example, we issued 16 editions of SCIE Line between March and September 2020, sending them to over 100,000 key contacts. The email list was over 1,700,000 people, and social media posts were seen by over 2 million.

93. We maintained the SCIE Hub's guidance and resources throughout the pandemic, updating and revising content in response to changes in official UK Government guidance, such as the introduction of vaccines and the removal of social restrictions. We formally reported to the DHSC about the maintenance of Covid-19 materials through our regular grant reports and progress meetings. For example, the pandemic's lingering effects on the sector meant SCIE's Covid-19 guides were reviewed and updated fourteen times between 1 April 2021 and 31 March 2022 in response to changes to official government guidance. Following the pandemic, the guides for commissioners and social workers were updated further, drawing on learning from the pandemic.

94. We agreed with the DHSC that the maintenance of these materials would support four objectives: (1) commissioners and providers would continue to adopt best practices in social care; (2) updating of resources would enable improvements in commissioning and local services; (3) senior leaders would feel supported to deliver evidence-based changes; and (4) updated resources would sustain sector learning. The guides needing revisions most often were those addressing infection control, safeguarding adults, safeguarding children and families, MCA and the guides for supporting people with learning disabilities and autistic people. [KS/13 - INQ000560939]

95. We did not track the specific impact of SCIE's guidance and hub materials, but we did gather website engagement data and reported these figures to the DHSC in our grant reports. For example, SCIE's Covid-19 Hub and related resources and learning offers achieved significant reach across the sector, including 11 million website visits, 115,000 newsletter subscribers, over 30,000 webinar registrants and 65,000 e-learning participants between March 2020 and June 2022. We kept the sector updated and informed through our SCIE Line newsletters, blogs, training webinars and enhanced sector engagement.

96. By the end of March 2021, the hub had received over 780,000 visitors. We continued to make available, update and promote the Covid directory of social care resources; and all comms associated with our Covid-specific activities. Based on website records (page visits and downloads), the resources were still being referred to and used. This included a directory signposting visitors to over 1,800 sector resources.

97. SCIE's comprehensive activities and sector engagement underscores our pivotal role in supporting the social care sector during a critical period. The nature of the pandemic

period meant that government policies were regularly changing, and guidance was frequently updated. From the perspective of the social care professionals accessing SCIE's resources, we aimed for reliability and timeliness of our content and learning offers. A key learning point for us is that the value of any future Hub could more easily be measured by clearly demonstrating how the content and activities directly responded to, or aligned with, the sector's specific information and service delivery needs.

98. Although the SCIE COVID-19 hub is no longer in existence, some of SCIE's pandemic guidance remains on our current website in updated form because it simply represents good practice. This includes social work good practice guides, Safeguarding Adults Reviews in rapid time, and commissioning guides. The guides for social workers and commissioners were considered to have ongoing relevance. Other resources were decommissioned during the 2021-22 financial year, such as all the quick guides, which were removed from our website at the end of March 2022. This included the Covid-19 specific quick guides focused on the Mental Capacity Act, Best Interests Decisions and drug and alcohol rehabilitation.

Early Learning: SCIE's "Beyond Covid" Report, July and August 2020

99. In summer 2020, SCIE launched a research and analysis programme titled *"Beyond COVID: New Thinking on the Future of Adult Social Care."* The programme aimed to assess the pandemic's impact on the sector—both negative and positive—while identifying lessons for system recovery and long-term reform. It sought to explore improvements needed for the future of social care, outline reform priorities, and envision the sector's post-pandemic evolution. [KS/62 - INQ000560988]

100. The programme included essays and podcasts from sector leaders, analysis of sector engagement during COVID-19, and a roundtable on 22 July 2020, attended by the Minister for Care. The resulting report, *"Beyond COVID-19: New Thinking on the Future of Adult Social Care,"* was published on 2 September 2020 and proposed policy ideas and recommendations to guide the sector's future. [KS/62 - INQ000560988]

101. SCIE's research highlighted the sector's structural challenges, resilience, and areas for innovation—findings that remain relevant and align with the Public Inquiry's focus. Key conclusions included:

- Decades of underfunding and undervaluation left the sector poorly equipped to respond.
- Pre-existing inequalities were exposed and worsened by the crisis.
- The sector's fragmented structure hindered rapid and coordinated responses.
- Residential care was disproportionately impacted, creating an opportunity to rethink its role.
- The sector urgently requires sustainable national and local funding reform.

102. Despite these challenges, the sector demonstrated resilience, innovation, and adaptability. Local leaders were working collaboratively, cutting through bureaucracy, sharing information, and adopting new technologies effectively. From this crisis a sector-wide consensus on the need for long-term reform in social care was emerging.

103. SCIE's *Beyond COVID* report called for a long-term plan for social care, akin to the NHS Long Term Plan. It recommended three critical shifts that remain relevant to this day:
    - Sustainable Funding: Move from short-term to long-term funding to secure the sector's future.
    - Prevention and Early Support: Invest in preventative models of care, housing, and technology, scaling innovations with proven effectiveness.
    - Workforce Reform: Address the workforce crisis by improving pay, working conditions, and career progression, with the goal of achieving parity of esteem with the NHS.

The Social Care Sector Covid-19 Support Taskforce, July and August 2020

104. SCIE participated in the UK Government's Social Care Sector Covid-19 Support Taskforce during July and August 2020. The Taskforce, established in June 2020, completed its work in August, delivering a final report to the Minister for Care. Full information about the Taskforce, its scope of work and membership can be found from the UK government. Our understanding is that the Taskforce's recommendations aimed to guide government policy and planning for the winter period (through spring 2021) as the sector continued to face significant challenges in capacity, capability, and resilience. Eight subject-specific advisory groups were set up to offer information, advice and recommendations to the Taskforce.

105. I co-chaired the Guidance, Good Practice and Innovation Advisory Group with Professor Robin Miller of the University of Birmingham. Members of the Advisory Group are listed in its final report. The Group met on 17 July 2020 to discuss sector challenges and opportunities, generating a long list of recommendations. It then split into three sub-groups—focused on guidance, good practice, and innovation—to refine more specific recommendations. The report from the advisory group that was submitted to the Taskforce is exhibited here. The Advisory Group's work did not continue after the report was submitted. [KS/63 - INQ000058073]

106. The Taskforce's final report was published by the UK Government, and it included the three key recommendations from our Advisory Group cited below. As we were not involved in the Taskforce's deliberations or the UK government's formal decision-making, we cannot explain why selected recommendations from the Advisory Groups were accepted and others were not within the final report.

- Recommendation 19: Establish a central, easily accessible site for all COVID-19-related social care guidance, available in various accessible formats with links to supplementary evidence. *(Action: government communications)*
- Recommendation 20: Ensure all guidance is developed collaboratively with the sector, using efficient and effective protocols. *(Action: DHSC)*
- Recommendation 21: Expand the remit of the SAGE sub-group to cover the entire social care sector. *(Action: Deputy Chief Medical Officer)*

107. According to the final report, the DHSC was expected to review and formally respond to the recommendations. SCIE did not track this response, and I cannot comment on the Taskforce's overall impact on government policymaking or winter planning, including the adoption of specific recommendations.

108. However, through our regular DHSC grant, SCIE was already addressing aspects of the recommendations, such as updating and promoting Covid-19 guidance and best practices via our hub. The second Covid-specific grant, awarded in November 2020 and covering December 2020 to March 2021, funded the updating of guidance in line with changes to government Covid-19 policies. These included guides for individuals with learning disabilities and autism, best interest decisions, drug and alcohol rehabilitation services, an infection control e-learning course, and lessons-learned resources for care homes and

home care. The grant also funded updates to guidance for delivering safe, face-to-face adult day care.

SCIE's review of the Government's Hospital Discharge Policy: *"What were the early effects of the Discharge to Assess policy on Social Care?: A rapid review of qualitative evidence" (2021)*

109. Before discussing our research in detail, I will set out the context for SCIE's review of the UK government's hospital discharge policy in three ways. First, I will discuss the pre-pandemic experience of the health and social care sectors with early hospital discharge practices and the evidence underpinning the model of care. I will then describe what happened when the UK government adopted the model as official policy to manage hospital bed capacity during the pandemic. Finally, I will explain the purpose and scope of the review SCIE undertook on behalf of the Chief Social Worker, our principal findings and the impact of our recommendations.

110. The foundations of the NHS's "discharge to assess" policy predate the pandemic. Reducing the length of stay for hospital patients has been an aim of NHS policy for decades. For a variety of reasons, hospitals have struggled to discharge long stay patients with complex needs in a timely fashion. Delays have been attributed to in part to a lack of capacity in social care. Long stays in NHS hospitals have the effect of reducing bed capacity and patient through-put, creating pressures on resources and waiting lists for critical acute services. Resolving delayed discharges is considered a "whole system" problem, requiring both NHS and social care organisations to work effectively together.

111. Another reason to reduce hospital stays is for improving the health of patients. People with prolonged hospital stays (three weeks or longer) are known to have poorer healthcare outcomes, increased vulnerability to infections and to experience deconditioning, which is the loss of mobility and independence due to inactivity and bedrest. An estimated 350,000 NHS patients spend over three weeks in hospital each year, and most of these patients are older, frail adults.

112. Before the pandemic, the UK government was tracking delayed hospital discharges for every acute trust and local authority, month-by-month, using Hospital Episode Statistics. This included data on the reasons for delayed transfers, including waits for social care

placements and care packages, as well as continuing non-acute healthcare. In a letter to the NHS on 27 March 2020, the NHS England's chief operating officer suspended data collection and reporting for delayed hospital discharges.

113. The discharge to assess model adopted nationally to address long stays was in part based on research conducted by Professor John Bolton ("Reducing delays in hospital transfers of care for older people: key messages in planning and commissioning", Institute for Public Care, 2018). Bolton's study population was people older than 65 years of age, and his research identified four discharge pathways, suggesting most patients could and should be discharged safely to their own homes (pathways 0 and 1 below). Bolton assigned estimated percentages to each pathway.

114. The model's four discharge pathways and estimated percentages are described as:

- Pathway 0: Simple discharges to a person's home that require no further input from health or social care (50%)
- Pathway 1: Discharge home with support to recover, including input from health and/or social care (45%)
- Pathway 2: Short-term rehabilitation in a bedded setting (4%)
- Pathway 3: Discharge to a care home following a life changing event, where home is not an option (1%)

115. Before the pandemic, Professor Bolton's research observed that the currency of "delayed discharges" rather than improving people's care outcomes has limited the discharge to assess model's effectiveness and impact. A separate limiting factor had been higher numbers of discharges to care homes (pathways 2 and 3) in localities with insufficient capacity in community services, such as intermediate care. Bolton noted that the model's feasibility and affordability depended on local systems having adequate supply of the right types of care and support at the point of discharge.

116. The discharge to assess model was formally promoted by the NHS and local government leaders for several years before the pandemic. Evidence about the model's potential efficiency gains was widespread following a study by Newton Europe called "Why Not Home? Why Not Today?", which was commissioned by the UK government's Better Care Fund Support Programme in 2017. Their report also acknowledged that community

services capacity is essential to achieving the Discharge to Assess model's promised efficiencies, and it discussed the commissioning of intermediate care services in its section on "Fixing Delays".

117. NHS England expanded on the Newton Europe study's findings in their guidance for social care professionals: "Why not home? Why not today: A guide for social care professionals". The guidance addressed the entire patient hospital journey, advocating for specific actions at the point of admission, during a patient's stay on a hospital ward and at the end of the stay before the discharge. Included in the guidance was reference to other best practices, such as planning for discharge at the time of admission, involving patients and families in discharge decisions, specific steps to support care needs of people with frailty, embedding social care professionals in multidisciplinary team reviews of discharge decisions, and prioritising a "home first" approach.

118. Prior to the pandemic, the widespread promotion of the Discharge to Assess model built on this evidence and is best understood as one of nine inter-dependent, practical interventions that local health and care partners were actively deploying. These interventions were first promoted in 2015 as part of the Local Government Association's High Impact Change Model (HICM) (LGA 2020) and later adopted by UK government policy makers as part of the government's Continuing Healthcare Guidance in 2018 and the requirements for the Better Care Fund (HM Government 2019). The intention of the HICM was for local health and care systems partners to reduce long-term hospital stays by implementing a "Home First" approach for hospital discharges. The components were designed to work in tandem to enable this to happen, including system-wide monitoring of patient discharges, expanding the capacity of community and home care services, offering assessments at home with families and carers and providing packages of support for rehabilitation and reablement. As updated in 2019, the HICM identified nine system changes expected to have the greatest impact on reducing delayed hospital discharge. Extensive HICM guidance and detailed implementation resources were disseminated to local authorities and NHS trusts though NHS England, the LGA and the UK government. When the UK government's Covid-19 discharge policy was published, it did not include all the components of the HICM, and though we cannot say for certain why some components were set aside, our reflection is that the top priority was to "save the NHS". This meant the main objective was to create hospital capacity for an expected surge of Covid-19 patients by rapidly discharging long-stay patients to their home or care homes.

1. *early discharge planning:* initiating planning at the time of admission, especially for patients with complex needs involving health and social care
2. *systems to monitor patient flow:* management information systems for hospital and local government leaders to track patient demand in different parts of the health and care system and to tackle bottlenecks.
multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector: meeting the holistic needs of patients by incorporating the perspectives of health and care professionals into discharge decision-making
4. *home first/discharge to assess:* assessing the ongoing care needs of patients at home after a hospital stay
5. *seven-day services:* ensuring discharges could occur throughout the system no matter what day of the week
6. *trusted assessment:* using an interface team of a nurse, physiotherapist, occupational therapist and social worker to offer an initial assessment while a person is still in hospital, then undertaking long-term assessments of ongoing care needs for patients discharged to a care home after the hospital stay
7. *focus on choice:* providing patients with information about their discharge options and honouring their choices
8. *enhancing health in care homes:* ensuring primary care services are readily available to people living in care homes, aiming to address urgent healthcare needs and prevent unplanned hospital admissions
9. *housing and related services (added in 2019*): providing preventative home adaptations and early intervention support services to support patients who are discharged home.

119. The original HICM's emphasis on assessing older people's needs after discharge likely led to more appropriate recovery and reablement support before the pandemic. However, the model was never intended to be used for all discharges; neither was it focused on medical fitness alone. Discharge planning decisions were expected to start at the point of hospital admission, to support people's choices, to involve social care professionals in assessing and addressing the complex needs of patients with social care needs, to prioritise transfers to a person's home and to consider factors such as home safety and safeguarding.

120.Fundamentally, the Discharge to Assess model adapted for the pandemic as "Covid-19 Hospital Discharge Service Requirements" was not the HICM the care system was

accustomed to. Anticipating a pandemic-related surge in demand for NHS hospital care, the objective shifted away from reducing delayed discharges to freeing up inpatient and critical care beds in hospitals.

121. Starting with a directive to all NHS acute trusts on 17 March 2020 and followed by formal policy published on 19 March 2020, the UK government directive was issued a few days before the nation's first lockdown (23 March 2020). This initial directive set out how patients would be "discharged safely from hospital to the most appropriate place" and how they would "continue to receive the care and support they need after they leave hospital". The guidance described detailed operational procedures and criteria for discharging patients deemed medically or clinically fit for a safe discharge, including people with long hospital stays.

122.Based on medically agreed "criteria to reside in hospital", acute hospitals were expected to maintain "live" lists of patients ready for transfer and to make these lists available to partner agencies on a daily basis, including local government leaders and social care providers. In recognition of the higher severity of illness of people discharged, people requiring ongoing care and support would be "discharged to assess".

123. Non-medical criteria, such as social care needs, were not considered relevant for discharge decisions within the UK government's policy directive. Social care and continuing health care assessments (CHC) would no longer be undertaken in hospital, as previously, but would occur after the transfer out of hospital, either in a care home or their own home. Other good practice formerly part of the HICM was also not included, such as the emphasis on patient choice, multidisciplinary discharge teams involving social workers, early discharge planning, trusted assessment, enhanced health in care homes and home improvements. The initial directive also did not include a requirement for testing patients who were to be transferred out of hospital.

124. As Bolton's research and the Newton Europe report established, the smooth operation of the discharge to assess model depends on having sufficient capacity in community services, such as intermediate care. Yet the social care system was poorly prepared for how the policy directive was implemented during the pandemic. The pandemic exposed the limitations of community services to support post-discharge recovery and reablement. These services were under-resourced and inadequate because of lack of investment and workforce

shortages. In contrast to the policy's "home first" approach, more people were discharged to care homes than back to their community or home environments.

125.The sector's ability to deal with Covid-19 outbreaks in care homes was insufficient as well. As reported widely in the media, the directive led to poorer care outcomes for many people, including unmet post-discharge care needs, hospital readmissions, an increase in Covid infection rates and excess deaths.

126. As part of the new arrangements, enhanced discharge funding was provided by the UK Government, making funds available through the NHS to cover the costs of new or additional post-discharge care. Initially, these payments covered post-discharge care for up to six weeks, until March 2021. From April 2021, the discharge funding was reduced by the government to support only up to four weeks of care. This funding was seen to smooth the transfer of patients from hospital beds, although it may have contributed to more patients transferring to care home beds rather than to their homes.

127. A study assessing the effects of the UK government's hospital discharge policy on social care was commissioned from SCIE by the interim Chief Social Worker of England in January 2021. Based on our internal records, the research was intended to be a rapid assessment, using qualitative methods, to complement and inform a formal evaluation of the policy's impact to be commissioned by NHS England. My understanding is that the specification for the UK Government's formal evaluation did not fully address concerns arising from the social care sector about the ways the policy was being delivered locally, how this was affecting people drawing on social care and the cost implications to local care systems. [KS/13 - INQ000560939].

128. The request to SCIE may also have emerged from legitimate concerns about the long-term feasibility and affordability of the UK government's discharge policy, as plans for a permanent NHS policy were mooted. Based on media coverage from this time, it appears that both Directors of Adult Social Services and NHS leaders were increasingly worried that, despite the pandemic continuing, the UK government's provision of extra discharge funding would cease by the end of March 2021.

129. This funding was being used for packages of up to six weeks of post-discharge care. Rumours were circulating that the Treasury was pressuring the DHSC to demonstrate value

for money with the discharge fund. The extra funding had reportedly “greased the wheels” of the discharge guidance, enabling local partners to overcome previous barriers to early discharge and safe transfers. However, the directors were concerned about short-term placements turning into long-term placements, increasing financial risks for local authorities.

130. Directors of Adult Social Services were also alarmed about the possible imposition of performance metrics linking percentages of discharges to each of the four discharge pathways. Based on John Bolton’s work, the percentages for each pathway were never intended to be strict metrics but a general guide. For the directors, the risk was that revised national guidance would dictate who gets what support rather than enabling local judgements based on needs and service capacity.

131. Public concerns about the discharge policy were also mounting following the joint British Red Cross and Healthwatch study of people leaving hospital, published in October 2022. This study suggested 4 out of 5 people discharged from hospital did not receive a follow-up visit or assessment; nearly two-thirds of those discharged at night were not asked if they needed transport support; 61% did not receive information about the new discharge process during their hospital stay; and 30% of those who were tested for Covid-19 did not receive test results before they left hospital.

132. This politically charged context sets the scene for SCIE’s research. Entitled “What were the early effects of the Discharge to Assess policy on Social Care?: A rapid review of qualitative evidence”, this study was commissioned by the interim Chief Social Worker in January 2021, included a literature review and stakeholder interviews to gather evidence during February and March 2021, and a draft report submitted to the Chief Social Worker’s team at the end of March 2021.

133. In addition to the Chief Social Worker’s team, SCIE’s draft findings and report were shared with DHSC colleagues who were leading the discharge to assess policy at that time and the team leading the NHS-commissioned evaluation. A formal meeting to sense check SCIE’s findings and receive feedback was held on 19 April 2021. Subsequently, we strengthened the evidence on the experiences of people with learning disabilities with additional interviews. Revisions were made and a final report with recommendations was submitted to the DHSC at the end of April 2021.

134. The objectives of the rapid review were to assess how the policy has been implemented in different settings and by different providers during the pandemic; to review available evidence to determine the effects on social care and to identify good practice in delivering the policy; and to make recommendations for improving the policy's delivery. The evidence was collected through semi-structured interviews with leaders from local government, the NHS and social care charities.

135. SCIE's research was intended to be the first phase of a two-stage review, including the production of case studies and learning events for phase two. These local case studies were expected to illustrate emerging good practice for the sector, such as effective management of a discharge hub; prioritising "home first" and "right length" care packages; management information systems that track patients and care outcomes; effective approaches to increasing community service capacity; and pooling budgets across health and social care. The UK government did not commission the second phase of the review, and we were not provided with an explanation as to why plans were changed.

136. Without reiterating the findings and recommendations of the full report, I will focus on those that we think made an impact on the UK government's revised discharge to assess policy and practical improvements on the ground, starting from August 2021. As we were not part of the UK government's decision-making, we cannot address why specific recommendations in our report were adopted and others were not.

137. In relation to implementation and effects on local systems, SCIE's research found that the Discharge to Assess policy was viewed as a positive step forward and largely consistent with previous best practice guidance. However, the policy emphasised hospital bed management, and discharge decision-making was dominated by clinical criteria, with too much focus on the hospital "back door". Those we interviewed expressed considerable unease about the poor outcomes people experienced during the earliest months of the pandemic -- facts that were already well established.

138. Based on the evidence, the report raised concerns about the core principles of recovery and independence being overlooked; discharge decisions being too focused on pathways, not people; the appearance of risk-averse discharge behaviours leading to too many short-term bed-based placements (Pathway 2) with short-term placements turning

unnecessarily into costly, long-term placements; and higher acuity levels of people discharged home, with unmet needs (Pathways 0 and 1).

139. From our findings, we argued that judging the success of the policy in terms of bed capacity, hospital lengths of stay or discharge delays would be incorrect. Discharge to Assess was never intended to be just a 'bed management tool'. This narrow view challenged the origins of the care model and the fundamental principles of effective social care, i.e., that people should be supported safely after a hospital stay to recover and regain their independence. We concluded that it was important to be clearer about what successful outcomes look like involving Discharge to Assess. We recommended an in-depth review of the appropriateness and reliability of Pathway 2 placements, with the aim of improving local discharge decisions and better commissioning to address the long-term cost and care implications of too many discharged patients transferring to care home beds.

140. We also examined the policy's compliance with good social work practice, especially safeguarding. We found that the interface between health and social care remained a blind spot within the UK government's discharge guidance. Our evidence suggested that, under Covid-19 conditions, social workers', carers' and others' ability to advocate on people's behalf was diminished because visiting was not allowed on the wards. Those we interviewed raised specific concerns about discharges occurring before safeguarding issues were addressed; people's long term social care needs being overlooked – especially people with learning disabilities; an absence of carers' assessments with assumptions about their ability to care for discharged patients at home; and concerns that the post-discharge care packages were creating a perception of an entitlement to publicly funded care.

141. Our recommendations specifically addressed the safeguarding issues and called for revisions to the guidance's discharge criteria so that the needs of people with learning and physical disabilities, and their carers, were accounted for in the discharge decisions. The role of a social care-led discharge hub in addressing these issues was described. We further suggested that the revised policy reassert the core principles of recovery and independence. We recommended reinstating the good practice of discharge planning at the point of hospital admission so that the people with existing social care packages or unmet needs could be readily identified.

142. We also noted that our review could not make a full assessment of the policy's impact social care resources, provision and sustainability. This was not feasible because of the lack of a comprehensive, comparative national dataset. However, we found geographic variation in social care provision was contributing to decisions for post-discharge placements, i.e., local markets with more care home beds had more discharges to care homes. If continued, this would create additional financial pressures on local authorities. We raised the risk that attempting to get people out of hospital too quickly meant they in fact were ending up where there was capacity rather than where their needs were best met. We recommended improving management information across health and social care to support local discharge arrangements and to track outcomes, citing emerging good practice we found through the study.

143. The availability of funding to support post-hospital care was cited as instrumental to the rapid adoption of the policy. Removing the question of "Who will pay?" meant that health and social care partners had few disagreements about discharge decisions, care packages and pathway destinations. We recommended formally capturing examples of emerging best practices for managing local social care resources. At the time of our study, uncertainty about the continuation of the extra funding generated considerable doubts about the discharge policy's sustainability because it was seen to be creating a financial burden for both local authorities and people funding their own care.

144. Our initial draft report recommended urgent attention to the potential loss of the extra discharge funding. By the time our report was submitted to the DHSC, however, the issue had been partially resolved, with the UK government announcing (on 18 March 2021) an extension of the discharge fund after March 2021 for another six months. The new funding for up to 6 weeks of post-discharge care was expected to continue through 30 June 2021 and then reduce to up to 4 weeks of post-discharge care until the end of September 2021. We were not involved in the UK Government's decision to extend the fund; neither can we comment on the rationale for reducing the number of weeks of post-discharge care.

145.We expected SCIE's review of the discharge policy to be published in June 2021, but publication was delayed for reasons we lack the full knowledge to comment on. SCIE's report was eventually published in December 2021 with a forward by the Chief Social Worker. It was shared through the principal social worker network and SCIE's own networks, rather than as an official government publication. [KS/64 - INQ000560990]

146. Despite the delay and more limited circulation, we uncovered evidence of the report's impact on the government's official discharge guidance when it was revised in August 2021, especially changes that were intended to improve the experiences of vulnerable people with social care needs. This included the re-establishment of rights to assessment and personalised care with the ending the Care Act's easements from 1 September 2021; improvements to the communication with patients and their carers about discharge choices; and restoration of the principles of supporting people's recovery and reablement at home or in the community.

147. As the Chief Social Worker confirmed in her forward to the SCIE report, "The report's findings contributed to improvements to the government discharge to assess policy last summer and supported social care staff involved in working with hospital trusts to ensure that the best decisions were made in transferring people out of hospital into safe and supportive arrangements, either to their home or into a care setting."

148. At SCIE, we applied the findings from our research to our commissioning guides, especially for discharge to assess arrangements. We included extensive examples of good practice from many local authorities to illustrate key concepts, from assessment and care planning to capacity and demand modelling. These guides can be found on SCIE's website.

SCIE Research about Inequalities in Pandemic Experiences (2022)

149. A separate piece of SCIE-led research, funded by the Lottery Fund and initiated during 2022, examined the inequalities in pandemic experiences and outcomes for people with learning disabilities. During the pandemic, people with learning disabilities were six times more likely to die from the virus. Co-produced with a group of people with learning disabilities and autism, our research aimed to identify critical learning from people's experiences and to apply the learning to professional skills training, practical reforms to providers' services and guidance for commissioners.

150. This work extended beyond June 2022, and formal guidance was recently published on SCIE's website in January 2025, with outputs including a film ("Am I Invisible?"), learning materials and workshops for care professionals and commissioners. Relevant to this Inquiry

were people's descriptions of how their lives were turned upside down during the pandemic. Along with worrying about catching and dying from Covid-19, they described how access to essential health and care services was difficult or made impossible by the need to isolate at home; how personal choices to support their independence were no longer possible, especially in healthcare settings and hospitals but also in day services and community support services that vanished during lockdowns; and how fear and loneliness were everyday emotions. Our research especially highlighted the challenges people had in accessing consistent care and support in their own homes during the pandemic. [KS/65 - INQ000560987]

Learning from the pandemic

151. SCIE is an organisation dedicated to improvements and innovation in social care. In reviewing our support to the sector during the COVID-19 pandemic, it seems clear to me that we, too, were learning and adapting as our collective understanding of the virus and its effects on the social care sector were better understood. Given the potential for future pandemics, there are some important final remarks I would like to make based on what we learned.

152. First, the sector's fragility remains, and in many respects, with five additional years of constrained resources, it may be less able today to respond to a pandemic comparable to Covid-19. Whilst this Public Inquiry cannot resolve the sector's future by recommending wholesale policy reforms, we would encourage its findings to acknowledge the essential role of social care as a partner to the public sector, especially during a public health emergency. That would mean involving the sector, especially local authorities, in pandemic preparedness planning and identifying the strengths and weaknesses across different geographic areas, provider types and workforce capabilities, so that government actions can be modelled, "stress tested" and evaluated for their impact on local people who draw on care and support and also the care workforce. Social care should never again be an afterthought, e.g., in relation to infection control measures. The long-standing struggles of the sector – its unstable funding, the workforce crisis, the lack of community services capacity -- are a reality and must be fully factored into pandemic planning and responses.

153. Because the sector is not monolithic like the NHS, pandemic preparedness should consider how best to re-balance decision-making responsibilities between local leaders, the

NHS and national government. Their shared goal should be to reduce or avoid unnecessary harm. Based on what we observed and learned during Covid-19, local flexibility to deliver national policy would enable this goal to be achieved. Existing NHS policies already acknowledge the inter-dependence of health and social care services. This reality needs to be baked into our pandemic preparedness, and with the advent of integrated care systems, there should be real scope for allowing innovative local responses that draw on the diversity of local resources. During a future health emergency, we would advocate for statutory partners working closely with the sector and local community organisations to build on existing good practice and innovation. We saw some of these innovations emerge during the pandemic, from virtual assessments, social worker-led discharge hubs and community social networks.

154. Most important, any future government pandemic response should consider the impact of emergency decisions on some of society's most vulnerable people, particularly given what we know about health inequalities and disparities in access to care and support. We have learned from publicly available evidence, such as Covid-19 mortality data published by Public Health England, the CQC and the UK Health Security Agency (in 2020 and 2021), that rapid hospital discharge, especially in the early months of the pandemic, resulted in deaths, trauma, limits to people's freedom and choices, and many people not getting support that was right for them. Some of the most devastating effects of Covid-19 affected older and disabled people, people from Black, Asian and minority ethnic (BAME) communities and care workers.

155. People lacked protections when their statutory rights were suspended. The effects of the Care Act easements included removing local authorities' obligations to assess care needs and offer choice to people drawing on care and support. This affected people's post-hospital care, with many people ending up on the wrong discharge pathway in relation to their needs. People deemed extremely vulnerable were also placed on "shielded" lists, with their mobility further restricted; this included older people living with dementia and others with learning disabilities. Restrictions on visits in and out of care settings placed additional limits on the ability of individuals to maintain contact with their family and friends. In losing opportunities for social connections, fear and confusion contributed to negative effects on many people's mental health, including loneliness and anxiety.

156. The global Covid-19 pandemic was a period of uncertainty, strain and resilience for the UK's social care sector. Throughout, we endeavoured to fulfil SCIE's mission of a society which enables people who draw on social care to live fulfilling lives. Working to the best of our abilities, we supported the care sector by disseminating evidence-based guidance based on the latest knowledge available. Our learning materials and training modules encouraged the uptake of practical approaches for managing the pandemic's effects on people, care providers and care professionals. For these reasons, it is with a profound and deep sense of humility that I submit this evidence for your consideration.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Date: 28/03/2025

Annex 1- Witness statement of Kathryn Smith on behalf of the Social Care Institute for Excellence

Key topic	Name of guidance, quick guide, training programme or other resource	Is a copy available ?	Who it was aimed at (e.g., care homes, commissioners, etc.)	Published date	Last check/ update	Still available on SCIE website?
Infection prevention and control	Coronavirus (COVID-19) infection control for care providers quick guide	Yes	Care providers	Apr-20 (KS/66 - INQ000582926)	Mar-22 (KS/67 - INQ000582927)	No
Infection control	Infection prevention and control e-learning	Yes	Care providers in care homes and home care	May-20 (KS/68 - INQ000582928)	Feb-21 (KS/69 - INQ000582929)	No
Care at home	Supporting people who are isolated or vulnerable	Yes	Social workers, homecare staff, PAs	Apr-20 (KS/70 - INQ000582930)	May-20 (KS/71 - INQ000582931)	No
Care at home	Providing care and support at home to people who have had COVID-19	Yes	Home care staff and personal assistants	Nov-20 (KS/72 - INQ000582932)	Nov-20	No
Day care	Delivering safe, face-to-face adult day care	Yes	Day care managers, social workers, commissioners and providers	Jul-20 (KS/73 - INQ000582933)	Mar-23 (KS/74 - INQ000582934)	Yes
Practice examples for care homes and supported living	Care homes and supported living: Learning and sharing following the COVID-19 lockdown	Yes	Care home and supported living staff	Aug-20 (KS/75 - INQ000582935)	Jul-22 (KS76 - INQ000582936)	No
Safeguarding	Safeguarding adults during COVID-19	Yes	Care providers and staff	Apr-20 (KS/77 - INQ000582937)	Mar-22 (KS/78 - INQ000582938)	No
Safeguarding	Safeguarding children and families during the COVID-19 crisis	Yes	Care providers and staff	Apr-20 (KS/79 - INQ000582939)	Mar-22 (KS/80 - INQ000582940)	No

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Safeguarding	Domestic violence and abuse: Safeguarding during the COVID-19 crisis	Yes	Professionals and Organisations	Apr-20 (KS/81 - INQ000582941)	Jan-22 (KS/82 - INQ000582942)	No
Safeguarding	Safeguarding adults with dementia during the COVID-19 pandemic	Yes	Care providers and staff	May-20 (KS/83 - INQ000582943)	Mar-22 (KS/84 - INQ000582944)	No
Safeguarding	Safeguarding in faith-based organisations during COVID-19	Yes	Faith-based organisations	May-20 (KS/85 - INQ000582945)	Sep-21 (KS/86 - INQ000582946)	No
Drug and alcohol services	COVID-19 guide for drug and alcohol residential rehab and detox services	Yes	Drug and alcohol residential rehab and detox services	Jul-20 (KS/87 - INQ000582947)	Jul-21 (KS/88 - INQ000582948)	No
Domestic Violence	Impact of easing COVID-19 lockdown restrictions on domestic violence and abuse	Yes	Social care professionals	Jul-20 (KS/89 - INQ000582949)	Jan-22 (KS/90 - INQ000582950)	No
Dementia	Dementia in care homes and COVID-19	Yes	Care providers and staff	May-20 (KS/91 - INQ000582951)	Feb-22 (KS/92 - INQ000582952)	No
Mental Capacity Act	Mental Capacity Act (MCA) and the COVID-19 crisis	Yes	People across social care and health settings	Apr-20 (KS/93 - INQ000582953)	Jul-21 (KS/94 - INQ000582954)	No
Best interests	Best interests decisions: A COVID-19 quick guide	Yes	People across social care and health settings	Jul-20 (KS/95 - INQ000582955)	Jul-21 (KS/96 - INQ000582956)	No
Adults with learning disabilities and autistic adults	COVID-19 guide for social workers and occupational therapists supporting adults with learning disabilities and autistic adults	Yes	Social workers and occupational therapist	Apr-20 (KS/97 - INQ000582957)	Mar-22 (KS/98 - INQ000582958)	No
Adults with learning disabilities and autistic adults	COVID-19 guide for care staff supporting adults with learning disabilities or autistic adults	Yes	Care providers and staff	Apr-20 (KS/99 - INQ000582959)	Mar-22 (KS/100 - INQ000582902)	No

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Adults with learning disabilities and autistic adults	COVID-19 guide for carers and family supporting adults and children with learning disabilities or autistic adults and children	Yes	Carers	Apr-20 (KS/101 - INQ000582903)	Mar-22 (KS/102 - INQ000582904)	No
Use of technology	Technology checklist for video calling an adult or carer	Yes	Social Workers and Social Care Pracitioners	Jul-20 (KS/103 - INQ000582905)	Jan-21 (KS/104 - INQ000582906)	Yes
Working with people	Matching interventions and people: A decision-making tool to establish the best means of working with people	Yes	Social Care Pracitioners	Sep-20 (KS/105 - INQ000582907)	Feb-23 (KS/106 - INQ000582908)	Yes
Working with people	Original name: Building rapport and establishing meaningful relationships using technology in social work New name: Social care practice, strengths-based practice and meaningful relationships in hybrid working)	Yes	Social Workers and Social Care Practitioners	Oct-20 (KS/107 - INQ000582909)	Mar-23 (KS/108 - INQ000582910)	Yes
Risk assessment	Original name: Risk identification and virtual interventions for social workers New name: Risk assessment process and key points to risk identification in virtual interactions	Yes	Social Workers and Social Care Practitioners	Nov-20 (KS/109 - INQ000582911)	Mar-23 (KS/110 - INQ000582912)	Yes
Commissioning	Commissioning during COVID-19 and beyond	Yes	Commissioners	Jun-20 (KS/111 - INQ000582913)	May-22	Yes

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Commissioning	Understanding the impact of COVID-19 responses on citizens	Yes	Commissioners and providers	Jun-20 (KS/112 - INQ000582914)	May-22	Yes
Commissioning	Commissioning and COVID-19: Legal and policy context	Yes	Commissioners	Jul-20 (KS/113 - INQ000582915)	May-22	Yes
Commissioning	Challenges and solutions: commissioning social care during COVID-19	Yes	Commissioners	Jul-20 (KS/114 - INQ000582916)	May-22	Yes
Commissioning	The future of commissioning for social care	Yes	Commissioners	Aug-20 (KS/115 - INQ000582917)	May-22 (KS/116 - INQ000582918)	Yes
Hospital Discharge	Hospital discharge and preventing unnecessary hospital admissions (COVID-19)	Yes	Commissioners	Aug-20 (KS/60a - INQ000582919)	Jan-22 (KS/60b - INQ000582920)	Yes