As part of these studies, PHE assessed SARS-CoV-2 positivity in residents and staff at the care homes and followed them daily for two weeks. The resulting data found that 44.9% of the residents and staff tested had COVID-19 but were asymptomatic. It was the largest international dataset and strongest evidence to date showing that it was likely that the virus was being transmitted asymptomatically and that staff played a key role as a vector of asymptomatic transmission. The available data was analysed, and preliminary findings shared with the UK Senior Clinicians Group and DHSC as soon as these were available, in the week commencing 13 April 2020. Similar studies seeking to explore asymptomatic infection were also underway during this period, with further studies conducted in a Military Barracks (440 individuals), as well as screening of 5000 individuals across 11 hospitals.

On 24 April 2020, interim results and analysis from the enhanced care home outbreak study, the Easter 6 study and the Barracks study were presented at NERVTAG and further analysis presented to SAGE on 12 May 2020[17][18]. NERVTAG noted the evidence of the presence of virus was found in individuals without symptoms. NERVTAG concluded that there remained uncertainty around the level of transmissibility of asymptomatic cases and around cases that were truly asymptomatic as distinct from pre-symptomatic or mildly symptomatic. However, scientific advisors recommended that steps should nonetheless be taken to protect vulnerable individuals in care settings from asymptomatic transmission.

This new evidence was an important milestone in our understanding of SARS-CoV, and in respect of the social care sector this highlighted that staff and residents could be asymptomatic and potentially transmit infection. The evidence from emerging international and national studies was presented to Government and informed understanding on risk in care settings.

**g. Why did PHE not apply a more precautionary approach in conjunction with the worst-case scenario modelling?**

Reasonable worst-case scenarios are designed to provide a ceiling figure for the maximum foreseeable impacts, it is a description of a set of sufficiently severe scenarios. The design therefore includes the outer envelope of possible scenarios, even where these are not yet demonstrated in real world evidence, as in the case of asymptomatic and pauci symptomatic cases and transmission. As such reasonable worst-case scenarios support Government to plan for the upper bound of numbers of infections that might be expected but are not designed guide clinical practice or policies. The possibility of asymptomatic and pre-symptomatic transmission was therefore included in early modelling, however early evidence was of low confidence and therefore remained a possibility rather than probability until end of March / early April when robust evidence began to emerge.

**h. What was Public Health England's role in the March Discharge policy?**

Public Health England was not a formal consultee of the March discharge policy which included discharging patients into care homes to free up hospital beds and reduce the risk of nosocomial infections.

During the period 10 March and 17 March 2020, NHSE and DHSC engaged in a number of meetings with senior NHSE clinical and DHSC policy advisors, care home provider representatives and with Ministers to discuss management of discharge. This included discussions to support the preparation of operational guidance for Adult Social Care, including Infection prevention and control guidance. As part of these discussions a decision was made to ensure infection risks arising from the discharge of patients from hospital into care homes, would be managed through the effective implementation of infection control protocols within

[17] NERVTAG 15 Meeting Minutes
[18] SAGE 35 Meeting Minutes

each care home, associated with appropriate external support to care home providers through the provision of IPC training and the enhanced coordination and communication between hospital, community care and primary care providers. It should be noted that PHE were not in attendance at any of the meetings outlined above, with the exception of the National Incident Response Board on the 17 March where the operational plan for releasing hospital capacity / discharge was discussed along with the need to ensure further consideration for care homes to support safe discharge.

Following publication of the March Discharge policy, DHSC commissioned PHE to develop guidance on how best to manage admissions safely. PHE subsequently worked with NHSE/I and DHSC, as well as wider partners, to implement mitigation measures to reduce the risk of infection from admissions into care homes from both the community and other health or social care settings, which formed the April Admission Guidance.

**i. Why was testing of all individuals admitted to care homes not implemented sooner?**

Public Health England were not responsible for policy decisions in relation to testing, however over the course of the pandemic PHE has provided advice and guidance to support policy decisions as outlined below.

On 8 March 2020, PHE set out its current and projected future availability, capacity, and speed of testing[19]. At this time, it was predicted by PHE that demand for testing would outstrip supply by around mid-April and testing would need to be targeted to specific populations. A joint decision by PHE, DHSC and NHSE then ensured that testing capacity was prioritised for elderly and vulnerable residents who were hospitalised, as well as testing for a number of symptomatic residents in care homes to support diagnosis and subsequent outbreak management.

Where a person had symptoms of COVID-19 before or during their hospital stay, the policy from 14 March 2020 was that they should have been tested, subject to a clinician's view[20]. The emergence of evidence of asymptomatic transmission and increased testing capacity led to the introduction of routine testing prior to discharge from hospital on 15 April 2020.

Sufficient testing capacity was not available prior to this time[21]. In the context of extremely scarce testing capacity, there had to be an order of priority for delivering tests. *'Priority of SARS-CoV-2 (COVID-19) testing during periods of significant demand'* was developed by NHS England and Improvement and Public Health England with input from the Chief Medical Officer, and subsequently published on the 11 March 2020[22]. This advice indicated that resources should be focused on testing those with symptoms, including testing clusters of symptomatic cases in care homes[23].

Where confirmatory testing was not available guidance for care settings advised the isolation of suspected cases and contacts of COVID-19 cases for 14 days. This included advice on the management of such individuals, including the use of cohorting. This advice was extended further as part of the April 15 Action Plan, to advice the isolation of all admissions to care settings for 14 days, regardless of symptoms or test status. This offered a wider precautionary approach to that advised by WHO or ECDC.

On the 15 April as testing capacity increased, testing of all individuals discharged to care settings was implemented in line with ECDC recommendations.

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[19] PHE Response to Request from Secretary of State

[20] Feedback and Issues from NCF Members (Email Attachment); Risk framework for care homes (Email)

[21] Discharge into Care Homes - Designated Settings

[22] PHE COVID19 Priority testing during high demand Letter

[23] UK GOV High Consequence Infectious Diseases HCID; PHE PJ email regarding PPE question