THE COVID-19 INQUIRY

MODULE 6 CLOSING STATEMENT ON BEHALF OF THE UNITED KINGDOM HEALTH SECURITY AGENCY

INTRODUCTION

1. The United Kingdom Health Security Agency (UKHSA) is an executive agency of the Department for Health and Social Care (DHSC) and carries out certain statutory functions for the Secretary of State for Health and Social Care (Secretary of State). Fully operational from October 2021, UKHSA's role is to protect the public not only from infectious diseases but also from external hazards such as chemical, radiological, nuclear and environmental threats. It brings together expertise from predecessor organisations including Public Health England (PHE), NHS Test and Trace (NHSTT), the Joint Biosecurity Centre (JBC) and the Vaccine Task Force (VTF)[1].

2. Module 6 has examined the impact of the COVID-19 pandemic on publicly and privately funded adult social care (ASC) across the four United Kingdom (UK) nations. Professor Dame Jenny Harries, formerly Chief Executive of UKHSA, provided a statement in her capacity as Deputy Chief Medical Officer. Professor Susan Hopkins, previously Chief Medical Advisor to UKHSA and, as of 7 August 2025, its Chief Executive, provided a corporate witness statement on behalf of the Agency. Both gave evidence during the module hearings.

PHE/UKHSA'S ROLE IN RELATION TO THE ASC SECTOR

3. The Inquiry has received extensive evidence on the breadth and diversity of care and support settings within the sector and about those who use its services. The care offered

[1] Further detail on the organisational structure of UKHSA is found in corporate witness statements (CWS) provided in earlier modules. See M1 CWS of Professor Dame Jenny Harries [INQ000148429/6-11] §§21-41, [INQ000148429/11-41] §§42-150, M2 CWS of Professor Harries [INQ000251906/7-9] §§26-33, M3 CWS of Professor Susan Hopkins [INQ000410867/14-16] §§40-50.

extends beyond residential and nursing care to include reablement services, domiciliary care, daycare services and familial and other unpaid carers.

4. Organisationally, the sector is complex. Unlike the NHS in England, there is no command and control structure. Private companies of varying size, regulated by the Care Quality Commission (CQC), are substantial providers of ASC whether commissioned by a public body or on a private basis. There is also non-regulated paid care and unpaid carers including family members and friends. This diversity in structure and in the risk environment, combined with the multitude of provider representation bodies and stakeholders (for example Care England, The National Care Forum and Skills for Care) impacts the way in which guidance can be applied across the sector. Historically, central government has had limited oversight of the sector with reliance placed on local actors to tailor national guidance to local circumstances. The complexity of the sector is compounded by systemic issues. Witnesses described the sector as '*fragile*' and '*fragmented*' with long-standing problems of under-resourcing, a low paid workforce, and a high turnover of staff[2].

5. PHE did not, and UKHSA does not, have direct responsibility for the delivery of ASC nor for its regulation. Rather, the role of PHE and later UKHSA, including during the pandemic, was much more discrete. It is one that is unlikely to change even with substantial reform of the sector. In outline, the role encompasses:

   (a) Surveillance of pathogens (including SARS-CoV-2) and infectious diseases outbreaks;

   (b) Contributing public health advice to national guidance directly and in collaboration with government departments and other agencies;

   (c) Producing guidance to support the ASC sector, commissioners and regulators on measures to prevent and manage outbreaks of Covid-19 in care homes; and

[2] M6 CWS Professor Susan Hopkins [INQ000587772/147] §§13.3-13.10 and see for example: M6 WS of Tricia Pereira on behalf of The Federation of Ethnic Minority Healthcare Organisations [INQ000587395_0004] §§11-19; Rt. Hon. Matt Hancock (2 July 2025) [3/2/12-17]; Michelle Dyson, Director General for Adult Social Care, DHSC (16 July 2025) [11/97/1-13]-[11/98/19]; Mary Cridge, Director of Adult Social Care for CQC (7 July 2025) [5/4/7-17]; Caroline Abrahams, Age UK (16 July 2025) [11/4/17-11/5/9]; and Professor Vic Rayner, Chief Executive of the National Care Forum (3 July 2025) [4/61/7-17].

(d) Providing support at a local level via Health Protection Teams (HPTs)[3].

THE PRODUCTION OF GUIDANCE

6. Producing public health guidance is a nuanced process. PHE would consider the evidence base and scientific opinion from sources such as its own surveillance work, academic research, expert groups such as the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG), and relevant stakeholders. Guidance should reflect an assessment of benefits against harms. Wording should seek to reflect the strength of the evidence and the certainty with which any recommendation is being made.

7. Prior to the pandemic, PHE had produced guidance for the ASC sector on Infection Prevention and Control (IPC) measures to prevent and manage outbreaks of respiratory infections. As with IPC guidance for healthcare settings, guidance for the ASC sector was designed to be enabling. It followed engagement with for example PHE HPTs, Directors of Public Health, and local authority IPC teams. Necessarily such guidance had to be national in character; given the number and diversity of ASC settings it cannot sensibly be otherwise. That PHE guidance had to then be adapted to local circumstances was a concept with which the ASC sector was familiar. Guidance for managing outbreaks of acute respiratory illness for example had been available since 2012[4].

8. During the pandemic, PHE provided technical and scientific advice as required to policy makers within DHSC to inform any guidance issued by the department. It collaborated with other government bodies in producing co-badged guidance. Alongside this, PHE produced its own guidance on IPC measures to prevent and manage outbreaks of COVID-19 in care homes, as well as illustrative guides on PPE[5]. In doing so, PHE (and then UKHSA) built upon established principles[6]. These included for example, the need to isolate a sick individual, cohorting residents and staff where possible, minimising visitors as necessary, and maintaining hygiene standards.

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[3] M6 CWS Professor Susan Hopkins [INQ000587772/9] §2.16, Professor Hopkins (9 July 2025) [7/2/18]; *Remit letter addressed to PHE,* 29 April 2020 [INQ000090337]; *Framework Agreement between DHSC and UKHSA, published in January 2022* [INQ000203658]; *Remit letter addressed to UKHSA,* 13 July 2021 [INQ000203619].
[4] M6 CWS of Professor Susan Hopkins [INQ000587772/90] §7.9.
[5] Ibid [INQ000587772/73] §5.2.
[6] Professor Susan Hopkins (9 July 2025) [7/9/23].

9. As the guidance produced by PHE, and subsequently UKHSA, was addressed to all providers, those with responsibility for a particular setting would need to decide how best to apply the guidance[7] including by undertaking an appropriate risk assessment. That would draw upon '*on the ground*' knowledge of those being cared for, staffing and equipment resources, and the architecture of a setting.

10. Risk assessment is a routine aspect of daily working in the ASC sector. Health and safety requirements mandate that appropriate risk assessments be in place to ensure the overall safety of residents, staff, and visitors. The need for an assessment arises when planning and delivering individual activities such as feeding, bathing, and mobilisation as well as group activities. The CQC, as the relevant regulator, is empowered to ensure registered providers comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including having regard to the IPC Code of Practice issued under the 2008 Act[8]. Care homes routinely undertook risk assessments in the context of emerging cases and outbreaks of respiratory viruses and gastrointestinal infections, and based management decisions on them[9].

11. The Inquiry has heard that some settings faced challenges implementing guidance. Support to providers was available from local authority and NHS community IPC teams, Directors of Public Health and of Adult Social Services in local authorities and from PHE/UKHSA's nine regional HPT Teams. As to the latter, the HPTs worked closely with stakeholders in local government and with Directors of Public Health in each local authority and continue to do so. They run a 24/7 acute response advice line available all year round to provide support on the public health management of cases, clusters, and outbreaks of disease (including acute respiratory infection outbreaks)[10]. Care homes could and did call HPTs with questions during the pandemic. Relying on available guidance, the teams were able to provide advice to support a care home in delivering their risk assessments[11]. Importantly, they also provided a route, as they still do, by which issues and concerns over the implementation of guidance could reach the relevant team within PHE/UKHSA and so inform the development of further guidance. During the pandemic the CQC was able to

[7] M6 CWS of Professor Susan Hopkins [INQ000587772/49] §4.13; Professor Susan Hopkins (9 July 2025) [7/25/2].
[8] M6 CWS of Mary Cridge [INQ000584245/150] §469; M6 CWS of Jonathan Marron and Michelle Dyson, for DHSC (5th WS) [INQ000587737/12] §39.
[9] Professor Susan Hopkins (9 July 2025) [7/25/14-23].
[10] Ibid (9 July 2025) [7/4/2-23]; M6 CWS of Professor Susan Hopkins [INQ000587772/149] §13.3.
[11] Ibid (9 July 2025) [7/25/14-23].

undertake inspections[12] and took on an '*enhanced role regarding IPC'*. As Mary Cridge, Director of ASC for the CQC, put it, the regulator found that '*providers were actually managing [IPC] very well*'[13].

12. As the Inquiry is aware, PHE published its first piece of COVID-19 IPC guidance on 10 January, less than two weeks after the Chinese authorities declared the incident in Wuhan ('the January PHE guidance')[14]. This was prior to the World Health Organization (WHO) declaring a Public Health Emergency of International Concern on 22 January 2020 and a pandemic on 12 March 2020. The guidance was directed at healthcare settings as it was considered most likely that the NHS would be dealing with COVID-19 cases.

13. The 'February PHE guidance' was the first piece of COVID-19 guidance specific to the ASC sector. At that point, the UK had just 13 confirmed cases of COVID-19, none involving transmission in a care home[15]. All cases of COVID-19 were being dealt with under protocols for the rapid transfer of HCID cases to high level isolation facilities[16].

14. The guidance was commissioned by DHSC and shared in draft with the department, the Office of the Chief Medical Officer (OCMO), the Association of Directors of Adult Social Care, NHS England and NHS Improvement (NHSE&I) and representatives from the ASC sector[17]. It was developed at pace in circumstances where there was limited understanding of SARS-Cov-2 (indeed as Professor Sir Christopher Whitty, the Chief Medical Officer (CMO) explained in Module 3, there remains continued uncertainty around the dominant route of transmission of SARS-Cov-2[18]). Accordingly, the guidance was necessarily informed by what was known about other respiratory pathogens. Pre-existing guidance on care home outbreaks remained applicable and settings would have maintained pre-pandemic practices of good hygiene and ventilation as applicable to all respiratory pathogens.

[12] M6 CWS of Jonathan Marron and Michelle Dyson (5th WS) [INQ000587737/38] §204.
[13] Mary Cridge (7 July 2025) [5/46/6] – [5/47/14].
[14] M6 CWS of Professor Susan Hopkins [INQ000587772/55] §§4.30-4.33.
[15] Ibid [INQ000587772/57-58] §4.42.
[16] Ibid [INQ000587772/56] §4.39.
[17] Ibid [INQ000587772/59] §4.34.
[18] Professor Sir Christopher Whitty, Chief Medical Officer for England (26/09/2024) [12/139/22] – [12/140/6].

15. The February PHE guidance sought to explain what was known about the virus and, among other things, to provide assurance to care home staff that maintaining a two-metre barrier with a suspected infected person would reduce risk[19]. The guidance included the following: '*This guidance is intended for the current position in the UK where there is currently no transmission of COVID-19 in the community. It is therefore very unlikely that anyone receiving care in a care home … will become infected'*. It was suggested to Professor Hopkins that the second half of this statement could be read as referring to the future. The guidance was written in good faith and intended to reassure settings that community transmission and therefore care home transmission was currently not happening. In hindsight, Professor Hopkins readily acknowledged, it could have been better worded to ensure that the sector recognised the statement to be a current assessment rather than the provision of false reassurance that transmission would never happen[20]. Professor Hopkins added that guidance can always be improved and that the efforts now of UKHSA to put ASC at the '*centre of future guidance'* would bear fruit for guidance that needs to be produced in a future pandemic or as part of emerging infection preparedness[21].

16. There has been criticism of the delay between the February PHE guidance, published on 25 February 2020, and the three pieces of superseding guidance published on 13 March 2020 (collectively 'the March PHE guidance'). This needs context. PHE was commissioned by DHSC to update the February PHE guidance and separate it into three separate pieces. These addressed residential care, home care, and supported living respectively. The chronology of this commission is set out in UKHSA's corporate witness statement[22]. As that shows, the process involved consultation with DHSC, OCMO and no.10, and addressing feedback from the ASC sector. It is worth noting that decisions around the timing of publication of COVID-19 related guidance were made by the Cabinet Office as part of the next phase of the pandemic response with a view to prioritising consistency of national guidance across settings[23].

17. There will always likely be a delicate balance to be struck between acting quickly to release guidance (which if done too often can itself attract criticism) and ensuring that any guidance

[19] Professor Susan Hopkins (9 July 2025) [7/20/15-7/21/5].
[20] Ibid (9 July 2025) [7/13/25] - [7/16/23].
[21] Ibid (9 July 2025) [7/17/2] – [7/18/2].
[22] M6 CWS of Professor Susan Hopkins [INQ000587772/61-64] §§4.49 - 4.57.
[23] Ibid [INQ000587772/65] §4.59.

is sufficiently robust and evidenced to support the system properly. Guidance has to align with policy as decided by Ministers. Helen Whately MP, then Minister of State for Social Care, pointed to the fact that guidance took time to produce, knowledge of COVID-19 was evolving on a daily basis and that there was a balance between '*getting guidance out promptly*' and ensuring that it was '*worth the paper it was written on*[24].

18. As noted above, guidance was designed to be enabling. It was not intended to be prescriptive, but to give care home providers sufficient information to be able to support their staff and residents[25], including highlighting the importance of risk assessments. By way of example, the March PHE guidance was developed and published at a time where community transmission was low, but there were rising numbers in hospitals. It was therefore designed to emphasise previous advice that would have been given during winter months[26]. The guidance on residential care provision emphasised the need for care providers to review their visiting policies[27] and encouraged the continuation of well-embedded IPC practices[28] - which would include isolating those who had symptoms of a respiratory virus, of which a care home provider would be well-experienced[29].

19. The position of familial and other unpaid carers reflects the challenges of providing guidance to the ASC sector. On 8 April 2020, DHSC issued the first guidance for unpaid carers. Asked why that guidance had not recommended the use of face masks when they were being used in a clinical setting, Professor Hopkins explained that at the time face masks were not being recommended for use in the community and there was no evidence from studies to show that masks were effective in reducing the risk of respiratory viruses in the community[30]. As the Inquiry is aware, the use of Personal Protective Equipment (PPE) is sequentially the last effective measure to implement as part of the hierarchy of controls in IPC. There are negatives associated with the use of some types of PPE, including for example, ease of communication. Professor Hopkins anticipated that in a future pandemic,

[24] Helen Whately MP, Minister of State for Social Care, DHSC (17 July 2025) [12/24/8-22]; see also Professor Susan Hopkins (9 July 2025) [7/28/17-23].
[25] Professor Susan Hopkins (9 July 2025) [7/42/16-7/43/10].
[26] Ibid (9 July 2025) [7/38/4-8].
[27] *Guidance on residential care provision* dated 13 March 2020 [INQ000300278/3].
[28] Ibid [INQ000300278/4].
[29] Professor Susan Hopkins (9 July 2025) [7/40/13-21].
[30] Ibid (9 July 2025) [7/58/1-10].

face masks (cloth or paper) might be used in the community at an earlier stage than in the COVID-19 pandemic[31].

ASYMPTOMATIC TRANSMISSION

20. Three factors are fundamental to any consideration of the evolution of understanding during 2020 of the potential contribution of asymptomatic transmission.

21. First, the Inquiry is familiar with the critical distinction between asymptomatic cases and asymptomatic transmission. It is of such importance however that it is worth recalling the evidence heard previously when considering the matter in the context of this module. UKHSA endorses the evidence CMO provided to Module 2 of the Inquiry[32]:

Asymptomatic infection and asymptomatic transmission are different and care is needed not to conflate them. Asymptomatic infection is where a person has acquired the virus but does not have symptoms; it occurs in many diseases. Asymptomatic viral transmission occurs when the infected but asymptomatic person passes the virus on to someone else. Asymptomatic infection does not necessarily lead to asymptomatic transmission (though it is a prerequisite). In principle it is possible to have extensive asymptomatic infection with almost no asymptomatic transmission.

22. It follows that the utmost care is required when assessing whether a particular piece of evidence pertains to asymptomatic cases or to asymptomatic transmission.

23. Second is the fundamental nature of how scientific knowledge develops over time. It is rarely (if ever) the case that something is simply unrecognised and then becomes known[33]. Rather, there is invariably a gradual accumulation of robust evidence which supports a particular interpretation or conclusion and refutes contrary hypotheses. Over time, the scientific understanding of a particular issue evolves and the confidence which can be

[31] Ibid (9 July 2025) [7/58/11-20].
[32] M2 CWS of Professor Christopher Whitty [INQ000248853/100] §6.57; see also WS of Professor Jenny Harries [INQ000489907/22] §§6.3-6.6.
[33] Professor Christopher Whitty (22 November 2023) [24/72/21]; M2 WS of Professor Jenny Harries [INQ000273807/18-19] §§5.2-5.3, M2 WS of Professor Sir Jonathan Van-Tam [INQ000269203/77] §6.113.

placed in that understanding improves. As Lord Vallance of Balham put it in his oral evidence to Module 2[34]:

… my experience is that many people who haven't had a scientific training also view science as giving immutable facts. You know, they remember at school they were taught a lot of facts about science. The truth is that science is a process: it's a way of testing what you currently know, experimentally or observationally, overturning hypotheses, advancing and trying to increase your knowledge base, and it's a description of what you currently have, which can easily be overturned by new evidence. And I think that's not widely understood -- I mean, "understood" may be the wrong word, but it's not intuitive to many people.

24. Third, and following from the above, science cannot always simply adopt a new position as soon as new evidence emerges. Any study, particularly when viewed in isolation, will have limitations. Its findings will need to be assessed and sometimes tested. During the pandemic, the conclusions of more than one study were shown to be erroneous or of limited value upon further research becoming available. The obvious example is the studies early in the pandemic which advocated hydroxychloroquine as a beneficial treatment. It is an exercise in hindsight to suggest that an item of new evidence, ultimately shown by further extensive research to be correct, should have been adopted at the first opportunity. That would be to ignore the numerous incorrect hypotheses which were properly treated with caution initially and later proven to be flawed.

25. The consequences of adopting an unestablished scientific hypothesis can be serious. CMO's observations in Module 3 in respect of whether asymptomatic transmission had the potential to contribute significantly to the spread of COVID-19 demonstrates the issue well[35]:

... for example, quite a lot of our initial public health guidance was for symptomatic people, and the reason for that was to allow people who were not symptomatic to go about their daily businesses. Had we said everybody is at equal risk of passing something on to you from day one, we would essentially have been saying: symptoms are irrelevant; we've got no test for you; sorry. So what do you do then? You practically have got some very, very serious societal answers, and the same is true in the health system… we shouldn't assume

[34] Sir Patrick Vallance, now Lord Vallance of Balham (20 November 2023) [22/57/3].
[35] Professor Christopher Whitty (26 September 2024) [12/151/13].

that that is a cost-free decision. It is not. It comes with quite significant societal and other costs.

26. In the case of a novel disease such as COVID-19, it is self-evident that at the outset there would be no accurate knowledge of the extent of any potential contribution of asymptomatic transmission. A NERVTAG meeting of 21 January 2020 noted '*that there are currently no data on infectiousness in relation to symptom onset and whether asymptomatic or subclinical patients are infectious*'[36]. It would take until the Autumn of 2020 for that uncertainty to be resolved.

27. PHE recognised the possibility of asymptomatic transmission as early as 28 January 2020, submitting a paper which was discussed at the fourth SAGE meeting on 4 February 2020[37]. The minutes recorded[38]: '*Asymptomatic transmission cannot be ruled out and transmission from mildly symptomatic individuals is likely*.'

28. That early lack of knowledge is unsurprising. As Professor Clive Beggs noted in his expert report for Module 3, there was prior to the pandemic considerable controversy as to the ability of influenza to transmit from asymptomatic cases. Further, the most similar coronaviruses of which there was recent experience, MERS and SARS, demonstrated limited if any potential for asymptomatic transmission[39]. As CMO explained in his evidence to Module 3, that supported the initial understanding that widespread asymptomatic transmission was '*unlikely to be the case*'[40].

29. That understanding persisted throughout February and March 2020. The incipient evidence was considered by NERVTAG on 20 March 2020[41]: '*JVT noted that the previously circulated paper by MZ presented the evidence position well. There is plenty of information on asymptomatic people testing positive for SARS-CoV-2 but very little information regarding transmission. There is an ongoing process at PHE to track new information. There are sporadic reports, but the data are not convincing...*'. Throughout that period there remained

[36] Minutes of NERVTAG 2, 21 January 2020 [INQ000023119/4].
[37] M6 CWS of Professor Susan Hopkins [INQ000587772/159]
[38] Minutes of SAGE 4, 4 February 2020 [INQ000061512/4] §19.
[39] *Expert report on the physical sciences underpinning Covid-19 transmission and its implications for infection prevention and control in healthcare settings,* Professor Clive Beggs, 7 August 2024 [INQ000474276/22] §49.
[40] Professor Christopher Whitty (26 September 2024) [12/152/5].
[41] M6 CWS of Professor Susan Hopkins [INQ000587772/163].

a lack of knowledge as to the significance of asymptomatic transmission in the spread of COVID-19. The (correct) perception was that the evidence base was underdeveloped and that confident conclusions could not be drawn.

30. The importance of asymptomatic transmission remained unclear as of the start of April 2020. On 2 April 2020, PHE published version 9 of a paper entitled '*Are asymptomatic people with Covid-19 infectious?*'. Its content reflected the limited understanding[42]:

The presentation of a large proportion of COVID-19 cases is of mild illness. A small proportion of asymptomatic infections with SARS-CoV-2 have also been reported. Direct evidence for the ability of virus to transmit during the incubation period is lacking. However, emerging data of the kinetics of virus shedding from symptomatic cases demonstrates a peak and substantial viral load around the time of symptom onset, leading to the reasonable assumption virus may be shed during the late incubation period. Overall, available evidence to date suggests the possibility that some asymptomatic/presymptomatic transmission is occurring. However, whether this is occurring on a significant scale and how it contributes to the overall transmission dynamics of the pandemic, remains uncertain. Detailed epidemiological and virological studies from cases and contacts, that combine viral genomic analysis and serological data would provide the best evidence that transmission can occur from asymptomatic individuals or during the incubation period.

31. That there was little evidence as of April 2020 to support the proposition that asymptomatic transmission was making a significant contribution to COVID-19 spread was echoed by the WHO. On 2 April 2020, a WHO Situation Report stated: '*There are few reports of laboratory-confirmed cases who are truly asymptomatic, and to date, there has been no documented asymptomatic transmission. This does not exclude the possibility that it may occur. Asymptomatic cases have been reported as part of contact tracing efforts in some countries*'[43].

[42] *Are asymptomatic people with COVID-19 infectious?* V9, PHE Virology Cell, dated 02.04.2020 [INQ000236478]; M6 CWS of Professor Susan Hopkins [INQ000587772/163].
[43] WHO Situation Report 73, 2 April 2020 [INQ000074894]; M6 CWS of Professor Susan Hopkins [INQ000587772/163].

32. Appreciation of the significance of asymptomatic transmission improved somewhat throughout April and May 2020 as better evidence emerged, but on any reading uncertainty persisted. By way of illustration:

(a) On 3 April 2020, a paper describing a COVID-19 outbreak in a care home in Washington State identified that high viral loads found on PCR swabs taken from asymptomatic and presymptomatic COVID-19 patients gave rise to the possibility that those patients could transmit the disease. This was the first reference to evidence of pre-symptomatic and asymptomatic transmission. The study was not however able to determine the actual occurrence or extent of such transmission: '*Although these findings do not quantify the relative contributions of asymptomatic or presymptomatic residents to SARS-CoV-2 transmission in facility A, they suggest that these residents have the potential for substantial viral shedding*'[44];

(b) On 15 April 2020, data from the 'Easter 6' study, undertaken by PHE, became available[45]. The resulting research paper concluded that asymptomatic patients were a potential reservoir for on-going transmission and that '*Symptom-based screening alone is not sufficient for outbreak control*'[46];

(c) On 24 April 2020, NERVTAG concluded that '*the phenomenon of pre-symptomatic transmission exists*'. No position was arrived at in respect of asymptomatic transmission[47]; and

(d) On 14 May 2020, SAGE, at its 36th meeting, observed that the evidence in respect of asymptomatic transmission remained unclear. The minutes record: '*NERVTAG has reviewed various studies on asymptomatic infection. Many do not differentiate between asymptomatic/pauci-symptomatic individuals and pre-symptomatic individuals. SAGE noted that longitudinal sampling in the ONS study will assist in*

[44] *Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility — King County, Washington, March 2020* Kimball A, Hatfield KM, Arons M, et al., MMWR 03.04.2030 [INQ000348269]; M6 CWS of Professor Susan Hopkins [INQ000587772/29] §3.30; Professor Susan Hopkins [7/43/22].

[45] M6 CWS of Professor Susan Hopkins [INQ000587772/31] §3.31.

[46] *Investigation of SARS-CoV-2 Outbreaks in six care homes in London, April 2020,* Ladhani et al, 09.09.20 [INQ000089681]; M6 CWS of Professor Susan Hopkins [INQ000587772/31] §3.37.

[47] Minutes of NERVTAG 15*,* 24 April 2020 [INQ000120161]; see also M6 CWS of Professor Susan Hopkins [INQ000587772/165].

clarifying this difference going forward but needs to include more than "asymptomatic on the day of infection". Taking all evidence into account, between 10% and 35%> of individuals may be truly asymptomatic (low confidence), and many more may have few symptoms. Review of ONS data will help refine the estimate. It is possible that asymptomatic individuals are less infectious, but this cannot currently be quantified. There is a key knowledge gap concerning how positive testing correlates with the presence of live, recoverable virus (i.e. infectiousness), although PHE is currently investigating this.'[48]

33. It is worth pausing to observe that even as of May 2020, the proportion of asymptomatic *cases* was being described as '*between 10 and 35%... (low confidence)'*. As to the position in respect of asymptomatic transmission, NERVTAG's view was that it simply '*cannot currently be quantified*'.

34. Uncertainty in the scientific understanding was not unique to the UK. Again, the position of the WHO is illustrative:

    (a) On 9 June 2020, the WHO's technical lead on the pandemic, Dr Maria Van Kerkhove, commented that rates of asymptomatic transmission were not yet known[49]; and

    (b) A WHO briefing on 10 July 2020 observed, '*Based on what we currently know, transmission of COVID-19 is primarily occurring from people when they have symptoms, and can also occur just before they develop symptoms, when they are in close proximity to others for prolonged periods of time. While someone who never develops symptoms can also pass the virus to others, it is still not clear to what extent this occurs and more research is needed in this area.*' [50]

35. Ultimately, as Professor Beggs identified, SAGE did not definitively confirm the occurrence of asymptomatic transmission until its meeting on 10 September 2020[51]. Even then, he acknowledges that the extent to which such individuals contributed to overall transmission

[48] M2 CWS of Professor Christopher Whitty [INQ000248853/104].
[49] Ibid [INQ000248853/100] §6.55.
[50] WHO Situation Report 172, 10 July 2020 [INQ000652343].
[51] Minutes of SAGE 56, 10 September 2020 [INQ000061564/5].

remained unclear[52]. Indeed, as CMO observed, there was '*no single instance'* where it became obvious that asymptomatic transmission was happening in a certain percentage of cases[53].

HOSPITAL DISCHARGE AND CARE HOMES

36. Timely hospital discharge is not a novel concept and is established best practice. Prolonged stays in hospitals can lead to higher risk of infection, mental and physical deconditioning, and increased risk of falls. The consensus is that if an individual is fit for discharge, remaining in hospital is not usually beneficial[54].

37. On 17 March 2020, Sir Simon Stevens[55] and Amanda Pritchard, then respectively the Chief Executive and the Chief Operating Officer of NHSE&I, jointly requested that every part of the NHS in England free-up the *'maximum possible inpatient and critical care capacity'* by '*urgently discharging all hospital patients who were medically fit to leave*'. In a system that usually '*runs hot'*, the intent was to release at least 30,000 from a complement of 100,000 acute and general beds. Trusts and Clinical Commissioning Groups were asked to work with local authority partners to ensure additional capacity was commissioned[56]. The Government's COVID-19 Hospital Discharge Service Requirements followed two days later. This set out the actions to be taken to enhance discharge arrangements As Dr Amanda Doyle, NHS England's National Director for Primary Care and Community Services, explained, this guidance '*provided health and social care providers with the flexibility to reach discharge solutions deemed adequate and appropriate to the relevant patient and local social care sector capacity … [it] did not (and could not) require any care home to accept any particular patient discharged from hospital'*[57].

[52] *Expert report on the physical sciences underpinning Covid-19 transmission and its implications for infection prevention and control in healthcare settings,* Professor Clive Beggs, 7 August 2024 [INQ000474276/22] §49.
[53] M3 CWS of Professor Christopher Whitty [INQ000410237/39].
[54] M6 WS of Claire Sutton, Royal College of Nurses [INQ000587657/90] §90; M6 CWS of Professor Susan Hopkins [INQ000587772/89] §7.4; M6 WS of Dr Amanda Doyle OBE, National Director for Primary Care and Community Services, NHS England [INQ000587682/59-60] §232.
[55] Now Lord Stevens of Birmingham.
[56] Letter from Sir Simon Stevens (NHS Chief Executive) and Amanda Pritchard (NHS Chief Operating Officer) to Chief Executives of all NHS trusts and Others [INQ000087418].
[57] M6 WS of Dr Amanda Doyle [INQ000587682/78] §297.

38. The Hospital Discharge Service Requirements was the product of DHSC, MHCLG and NHS England with input from the CQC, local government bodies and care home associations[58]. This guidance was developed at a time when those involved were aware that, as from 12 March 2020, the Government's testing strategy was one of prioritisation. By that date, as agreed between PHE, DHSC and NHS, and endorsed by the Secretary of State, those who would receive tests were organised according to clinical and epidemiological need into six groups[59].

39. The 17 March letter and the discharge requirements are referred to herein as 'the March discharge policy'. PHE was not formally consulted on the March discharge policy nor made aware of it prior to 17 March 2020[60]. Matt Hancock, then Secretary of State, described the policy as having been '*driven'* by Sir Simon and developed through Cabinet meetings and internal discussions within DHSC and No.10[61]. Mr Hancock explained the rationale for the policy as follows: *'the challenge was that hospitals were very likely to become overwhelmed, and that hospitals were very dangerous places because of the spread of the disease*' [62]. Dr Amanda Doyle described the decision as *'the only available option*'[63].

40. Professor Hopkins, while acknowledging that it would not have necessarily altered the decision taken, agreed that it would have been preferable for PHE to have been aware of the discharge policy in advance. She explained that a '*single clearance system*' (whereby guidance or a policy decision was distributed to those who needed to see it in advance of any announcement) was not in place at that time; the need for such a system was a learning point implemented during the pandemic[64].

41. Following the announcement of the policy, DHSC commissioned PHE and the NHS to develop guidance on how to best to manage admissions into care homes safely. The result

[58] Ibid [INQ000587682/74-76] §282-286.
[59] M6 CWS of Professor Susan Hopkins [INQ000587772/77] §6.12-6.13; M2 CWS of Professor Harries [INQ000251906/97] §430; M6 WS of Dr Amanda Doyle [INQ000587682/63] §242.
[60] Professor Susan Hopkins (9 July 2025) [7/42/6-7]; M6 CWS of Professor Susan Hopkins [INQ000587772/89] §7.2.
[61] Rt Hon. Matt Hancock (2 July 2025) [3/46/15- 3/48/18]; see also M6 WS of Lord Stevens of Birmingham [INQ000587793/5-9] §§17-30.
[62] Rt Hon. Matt Hancock (2 July 2025) [3/49/10-12].
[63] M6 WS of Dr Amanda Doyle [INQ000587682/70] §269; see also M2 WS of Professor Christopher Whitty [INQ000251645/102] §§7.128-7.132.
[64] Professor Susan Hopkins (9 July 2025) [7/102/21-25 -7/103/7].

(the April Admissions Guidance[65]) was a collaboration between PHE, DHSC, CQC and the NHS and co-badged accordingly. PHE's contribution was informed by internal guidance which the agency had been developing. Professor Hopkins acknowledged readily that this internal guidance was more restrictive in its language but pointed out that it was an early draft which would likely have been subject to further change[66]. The April Admissions Guidance reflected a consensus position intended, as best as possible, to support an already announced Ministerial policy. It sought to strike a difficult balance between the risk to care home residents of remaining in hospital at a time of increasing nosocomial infection and the risk that discharge might contribute to the introduction of the virus to a care setting. It reflected the scientific consensus as to transmission in advising isolation for symptomatic residents[67]. The effect would be that, should a care home manager accept a person discharged from hospital in circumstances where the home already contained symptomatic residents (including because of an outbreak), then those residents would have been in isolation. Notably the CQC made clear to providers that they could still refuse an admission[68].

42. The April Admissions Guidance was published at a time when testing capacity remained limited and before DHSC published a strategy to scale testing capacity[69]. According to Dr Doyle however, it appears that by 1 April 2020, '*a large number of hospitals*' may have moved to testing all symptomatic (and some asymptomatic) before discharging them to a care home[70].

Studies on the routes of ingress

43. PHE played an active role in developing the evidence base relating to the ingress of SARS-CoV-2 into care homes. This included not only undertaking its own studies and reviews but commissioning independent studies, such as VIVALDI 1[71]. Consistent with its role, PHE took account of relevant studies undertaken in other UK nations and internationally[72].

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[65] *Admission and Care of Residents during COVID-19 incident in a Care Home*, V1, published 2 April 2020 [INQ000528401].
[66] Professor Susan Hopkins (9 July 2025) [7/48/16-7/54/2].
[67] M6 CWS of Professor Susan Hopkins [INQ000587772/102-103] §7.30-7.33.
[68] M6 CWS of Mary Cridge [INQ000584245/221-222] §§669-676.
[69] M6 CWS of Professor Susan Hopkins [INQ000587772/78] §6.13.
[70] M6 WS of Dr Amanda Doyle [INQ000587682/89] §332.
[71] Professor Laura Shallcross (1 July 2025) [2/145/7-13]; Professor Laura Shallcross [INQ000613177/4] §10.
[72] M6 CWS of Professor Susan Hopkins [INQ000587772/105-106] §7.41-7.43; Professor Susan Hopkins (9 July 2025) [7/87/13-18].

44. Seven potential routes of ingress of COVID-19 into care homes have been identified[73]. Of these, the extent to which hospital discharge had the effect of seeding the virus in care homes has prompted public concern and rightly been a key issue in this module. Understanding the extent to which different routes might play a role in a future pandemic caused by a respiratory pathogen is important. The Chair may conclude that the best evidence as to the contribution of different routes, including hospital discharge and staff movement, to infection rates in care homes comes from the various research studies undertaken between 2020 and 2022. To assist the Inquiry, these studies and their findings are summarised in the table found at the end of this closing statement.

45. These studies demonstrate the extent to which scientists, including within PHE, strove to understand the nature of the virus, its mode of transmission, and its impact in care settings. Inevitably, any study will have identified and identifiable limitations. At no point during the pandemic was any one study therefore treated as scientific confirmation of a binary conclusion. Rather, the studies contributed to an ever-developing evidence base.

46. VIVALDI 1 illustrates the risk of taking one study in isolation. As Professor Laura Shallcross, who led the study, explained, while VIVALDI 1 sought to examine the various potential routes of ingress, data limitations meant that it was not possible to give a definitive view as to the relative importance of different routes. Professor Shallcross was able to say that '*Vivaldi provided evidence supporting the important role of staff in transmission of infection*[74].

47. Professor Shallcross also confirmed that the findings of VIVALDI 1 were *'compatible'* [75] with the consensus statement issued by the SAGE Social Care Working Group (SCWG) on 26 May 2022. Indeed, as a participant in SCWG, Professor Shallcross was an *'author'* of the statement. It drew on a range of different studies in concluding that some care home outbreaks were either caused (partly or wholly) or intensified by discharges from hospital, but that this could not be said to be the dominant route[76]. It described hospital discharge,

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[73] *Consensus statement on the association between the discharge of patients from hospitals and COVID in care homes*, issued by the SAGE SCWG, 26 May 2022 [INQ000215624].

[74] M6 WS of Professor Laura Shallcross [INQ000613177/17-21] §38-43; Professor Laura Shallcross (1 July 2025) [2/175/8] - [2/179/20], [2/180/7-25], [2/183/5].

[75] WS of Professor Laura Shallcross [INQ000613177/20] §42; Professor Laura Shallcross (1 July 2025) [2/182/16-18].

[76] M6 CWS of Professor Susan Hopkins [INQ000587772/106-107] §7.44; *Consensus statement on the association between the discharge of patients from hospitals and COVID in care homes*, issued by the SAGE SCWG, 26 May 2022 [INQ000215624].

which connects the environment of a hospital to a care home, as an '*uncommon event relative to many other elements of care home connectivity. Care home staff and visiting professionals are likely to dominate routine connectivity'* (involving as it would a greater frequency of contact). The consensus statement notes the lack of *'good quality routine data in social care'*, compared to the NHS. This reflected '*longstanding weaknesses in social care data collection*' such that it was not possible to routinely identify who was resident in a care home.

48. What can be said with certainty is that no study concluded hospital discharge to be the dominant route of ingress of COVID-19 into care homes. The studies showed a correlation between care home outbreaks and rates of community transmission and that staff living in the community and moving in and out of, and between, settings was an important route of ingress.

49. As Professor Hall observed understanding, the dominant route by which COVID-19 came into care homes is a *'complex and nuanced issue and it would change over time'*[77]. To reach a conclusion that staff movement played an important role in transmission is not to cast blame. Nor is it to reject the potential contribution of hospital discharge, which might in a future pandemic require preventative steps such as priority testing or ensuring the effective use IPC through training or monitoring. However, restricting movement, and thus contacts, between different settings is one mechanism which might need to be considered to reduce the spread of a virus. How that is achieved is not straightforward. Several witnesses, including Professors Hopkins and Harries, Michelle Dyson (on behalf of DHSC)[78], and Matt Hancock[79], spoke of the difficulties associated with restricting staff movement during a pandemic. When rates of infection in staff are broadly in line with the community, restricting movement between settings would not entirely eliminate the risk of infection if there were still movement between the community and care homes.

50. Introducing a measure that limits movement of staff prompts additional questions such as the need of added financial support and sufficient staffing levels if agency staff are not used[80]. As Professor Harries pointed out, there is a balance of risks because a lack of

[77] Professor Ian Hall (10 July 2025) [8/91/17-19].
[78] Michelle Dyson (16 July 2025) [11/115/17-24].
[79] Rt Hon. Matt Hancock (2 July 2025) [3/96/15-18].
[80] M6 WS of Professor Laura Shallcross [INQ000613177/15] §31.

workforce to care for individuals may be worse than the risk of infection, and that there needs to be systemic change to address some of the issues that were highlighted in the pandemic[81]. Ultimately, how the balance is to be struck will fall to elected decision makers.

51. Finally, it has been suggested that PHE had an oppositional attitude to the VIVALDI 1 study. The allegation does not withstand even cursory scrutiny. It runs counter to the recognised contribution of PHE's experts, amply evidenced throughout this Inquiry, to the scientific analysis of data for, for example, advisory committees such as NERVTAG. It ignores that VIVALDI was initiated by Professor Hopkins and sponsored by PHE[82]. Professor Hopkins spoke of the ethical standards expected of PHE's scientists. While she recognised that, particularly in an emergency, there may be moments of frustration, Professor Hopkins made clear how hard so many worked to establish VIVALDI[83].

52. Those new to government or without a science or technical background might find the need to follow proper processes or scrutinise data frustrating. However, Professor Shallcross did not speak of VIVALDI 1 being undermined or impeded. First approached on 8 May 2020, she was reporting to the SCWG (not just PHE) by 19 May 2020[84]. The sole example canvassed with witnesses as to the alleged difficulties with VIVALDI was the transfer of PHE data into the NHS Foundry. This was not a symptom of any reluctance to share data but of the need to ensure that patient data was shared lawfully. As Professor Hopkins explained, a Control of Patient Information Notice needed to be in place to allow for data transfer[85]. Indeed, Professor Shallcross recalled that PHE and others were *"focused on trying to get the data that was required ... people just wanted data to inform policy*"[86].

VISITING RESTRICTIONS IN CARE HOMES

53. As Counsel to the Inquiry noted in her opening statement, questions as to visiting restrictions in care homes were among the most difficult encountered in the ASC sector's response to COVID-19[87]. The desire to keep care home residents and staff safe by

[81] Professor Jenny Harries (9 July 2025) [7/203/23-7/204/6].
[82] M6 WS of Professor Laura Shallcross [INQ000613177/6] §13.
[83] Professor Susan Hopkins (9 July 2025) [7/86/5], [7/113/18-115/25].
[84] Professor Laura Shallcross (1 July 2025) [2/175/5-7].
[85] Professor Susan Hopkins (9 July 2025) [7/76/12].
[86] Professor Laura Shallcross (1 July 2025) [2/144/24], [2/146/18].
[87] Opening statement of Counsel to the Inquiry (30 June 2025) [1/30/3].

restricting or preventing visits had significant and lasting consequences, which need to be acknowledged:

(a) While end-of-life visits were permitted, the practical effect of how guidance was interpreted on the ground was that many died without the comfort of their friends and family;

(b) Individuals, particularly those with dementia, deteriorated more rapidly than might otherwise have been the case; and

(c) Residents were deprived of the love and support of their families and friends, the care those individuals might have provided, and were otherwise kept from normal social interactions.

54. The tension between minimising the risk of a vulnerable resident contracting COVID-19 and the desire to facilitate opportunities for visiting reflects both the harsh realities of the pandemic and how balancing the benefits and harms of any intervention in the ASC sector was rarely easy to resolve. It is useful to make the following observations:

(a) First, as explored with Professor Hopkins, there was even as of winter 2020 a lack of evidence as to the risk of ingress of infection posed by visiting[88]. It should be stressed that such a lack of evidence is not the same as evidence of absence. Professor Hall explained that studies to establish the contribution of visitors are technically particularly difficult to perform[89]. Nevertheless, that there was a real risk of transmission posed by and to visitors cannot be dismissed[90];

(b) Second there was an equivalent absence of evidence as to the quality-of-life impacts which arose from visiting restrictions[91]. These included restrictions on leaving the home, which had a particularly significant impact on daily life in care homes for people with learning disability. The consequence of that deficit cannot be overstated.

[88] Professor Susan Hopkins (9 July 2025) [7/87/6]; and see M6 CWS of Professor Susan Hopkins [INQ000587772/114] §8.22.
[89] Professor Ian Hall (10 July 2025) [8/93/2].
[90] Professor Susan Hopkins (9 July 2025) [7/87/19].
[91] Professor Ian Hall (10 July 2025) [8/56/22]; Professor Susan Hopkins (9 July 2025) [7/89/18].

Evidence as to quality-of-life impacts would have provided advisors and decision makers with insight into how those using ASC balance their own mortality against the value they place on personal relationships and freedoms. The consequence of that evidence gap was that there was little to no evidence to help inform guidance which touched on fundamental matters which are deeply personal to individuals;

(c) Third, the need to balance harms makes risk assessment vital. As already noted, undertaking that exercise would necessarily fall to those operating a particular setting involving as required the local Director of Public Health[92];

(d) Fourth, a further potential driver of a restrictive approach adopted by some care homes would be the conditions and expectations of their insurers[93]; and

(e) Fifth, the matter is further complicated by the impact one person's decisions and behaviours could have on other residents who may hold different personal views and have different risk appetites. As Professor Harries explained that tension is difficult to resolve and falls to be treated as a broader societal question[94].

55. In the circumstances, the balancing of non-COVID and COVID-19 harms brought about by visiting restrictions represented one of the most difficult challenges of the ASC response and one which may well arise again in a future pandemic. There is therefore a need for caution in concluding that advice as to visiting restrictions failed to adequately balance the difficult tensions between the risk of mortality and non-COVID harms. Looking forward, UKHSA has published guidance setting out principles to support safe visiting during outbreaks of infectious illness in ASC[95]. That guidance gives effect to the CQC requirement that, save in exceptional circumstances, visits must be facilitated[96]. Importantly however, and as discussed in the next section of this closing statement, this is an area where further research is vital.

[92] M6 CWS of Professor Susan Hopkins [INQ000587772/113] §8.18.
[93] Professor Jenny Harries (9 July 2025) [7/220/3-9].
[94] Professor Jenny Harries (9 July 2025) [8/192/25], M6 WS of Professor Jenny Harries [INQ000587394/61] §9.11.
[95] M6 CWS of Professor Susan Hopkins [INQ000587772/155] §13.30.
[96] Regulation 9A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

PREPARING FOR A FUTURE PANDEMIC

56. The establishment of a dedicated ASC Team has been and is key to the changes which UKHSA has implemented in response to the pandemic and to the Agency being able to fulfil its operational remit as regards the ASC sector[97]. Working with colleagues in UKHSA HPTs, the ASC Team leads on engagement with the ASC sector. It has committed to inter-agency working for example through MOCHHO meetings and an annual symposium[98]. The HPTs work '*on the ground*' sharing information locally (including surveillance data) but also relaying information back to the ASC Team in the centre[99]. This approach allows UKHSA to hear from representative voices within the ASC sector[100] and to share its own work. That work includes UKHSA activity in other areas of wider relevance to the sector such as the identification of priority pathogens[101]. Critically, such an approach better allows for the development of national sector-specific guidance (including the forthcoming integrated ASC IPC guidance) which uses appropriate language, remains sufficiently flexible to account for the different environments in which it might need to be applied[102] and takes account of what Professor Hopkins described as '*the lived view'* [103]*.*

57. UKHSA recognises the need to respond to the needs of the whole sector. To that end, the Agency has undertaken research into the needs of those in domiciliary care and commissioned insight studies into health protection needs of those living with dementia. The availability of social care data is patchy and that is particularly so for those receiving care in their own home. Nonetheless, the ASC team have sought to collate a range of sources on the demography and needs of those living in a range of social care settings. This will better inform the development of '*principles documents*' to underpin guidance.

58. There have been arguments during this Module for fundamental change to the ASC sector. These issues fall outside UKHSA's remit, and the Chair will have in mind the

[97] M6 CWS of Professor Susan Hopkins [INQ000587772/150] §13.14ff; Written Opening Statement on behalf of UKHSA dated 16 June 2025; Oral Opening Statement for UKHSA, 30 June 2025 [1/174/5].
[98] M6 CWS of Professor Susan Hopkins [INQ000587772/152] §§13.22-13.24.
[99] M6 CWS of Professor Susan Hopkins [INQ000587772/153] §13.25.
[100] Professor Susan Hopkins (9 July 2025) [7/98/2].
[101] M6 CWS of Professor Susan Hopkins [INQ000587772/151] §13.18.
[102] M6 CWS of Professor Susan Hopkins [INQ000587772/53] §4.24, [INQ000587772/150] §13.17, [INQ000587772/153] §13.24, [INQ000587772/153] §13.26-30.
[103] Professor Susan Hopkins (9 July 2025) [7/101/4].

potential overlap with the Casey Commission, whose terms of reference envisage Baroness Casey of Blackstock continuing her work into 2028. Whatever the outcome of that review, seeking to take practical steps now to better improve the pandemic preparedness of the ASC sector is only likely to bring benefit. With that in mind, UKHSA invites the Chair to consider the following when making recommendations in this Module.

59. First, there is wide agreement, at least in principle, on the need for improved collation and sharing of data concerning the ASC sector as well as better linkages to NHS data[104]. As a general observation, data sharing improved during the pandemic, facilitated, in part, by legislative change[105]. That legislative framework no longer applies. As Professor Hopkins observed[106] much of the data sharing that occurs now has returned to pre-pandemic baselines. That data gaps exist in relation to the ASC sector is recognised. Thus, the care home capacity tracker collects aggregate data on the size of resident and staff population but not data on resident's health status[107]. As regards domiciliary care, there is no data on those using such services.

60. As the Chair is aware, the argument that preserving and improving the UK's capabilities in the use and sharing of data could prove crucial to pandemic preparedness is one which UKHSA has advanced in earlier modules. It raises fundamental questions of governance and consent which are better addressed outside an emergency.

61. Data is pivotal to UKHSA's operational role. However, the Agency can only collect and use that allowed by law. The Agency has sought to put in place the foundation for the better use of data. UKHSA published its first data strategy in September 2023, which sets out a strategic approach to the collection, analysis, sharing and storage of health data. It has data sharing agreements in place with local authorities and public health agencies in for example the Devolved Administrations to allow for the safe sharing of data. It has created the Local Authority Data Access Platform (LADAP) to disseminate

[104] See for example, M6 CWS of Professor Sir Ian Diamond, Chief Executive of the UK Statistics Authority and Chief Statistician [INQ000553814/63] §227; M6 CWS of Professor Vic Rayner OBE, CEO of the National Care Forum [INQ000475131/64] §10.15.
[105] Professor Christopher Whitty (20 January 2025) [5/50/12-23].
[106] Professor Susan Hopkins (9 July 2025) [7/91/20].
[107] M6 CWS of Professor Susan Hopkins [INQ000587772/138] §11.22; M6 WS of Michelle Dyson [INQ000587739/9] §41.

key public health data to Upper-Level Local Authorities. It continues to develop the ASC dashboard[108].

62. Professor Hopkins observed that very real challenges arise in relation to collecting data in relation to domiciliary care[109]. However, the VIVALDI suite of studies[110], commissioned by UKHSA and in which UKHSA scientists including Professor Hopkins have participated and published, demonstrate the value of seeking to obtain ASC data. In particular, the VIVALDI social care study has involved the linking of resident data with a range of health data to gain information about the resident population in a sample of care homes[111].

63. The wider UK health data structure is developing rapidly, and it is imperative that these advances should not leave the ASC sector behind. Improving data infrastructure is, as with everything, subject to funding. However, not every step requires a bespoke system or significant financial resource. It should be possible to make simple changes which have immediate benefit. A ready example was given by Professor Hopkins who spoke of the difficulties PHE/UKHSA encountered in confirming whether an individual was in a care home or not and the consequent need to use postcode linkage[112].

64. As a first step therefore, there must be a systematic effort beginning with care homes to utilise existing data sources to enable a real time understanding of the health status and demographics of those receiving care, as well as those who work in the sector[113].

65. Second, funding research into ASC should not be perceived as of less importance than studies of healthcare. While there is some overlap, the profound difference between social care and health makes understanding the interface between the two of particular importance. In particular, there is a need for further research into the quality-of-life considerations which can impact policy and guidance for ASC settings. While not a research funder, UKHSA has used its academic commissioning route to support a study on the impact of outbreaks and outbreak measures on quality of life in care homes using

[108] M6 CWS of Professor Susan Hopkins [INQ000587772/156] §13.34.
[109] Opening statement of Counsel to the Inquiry (30 June 2025) [1/9/1]; Professor Susan Hopkins (9 July 2025) [7/97/6].
[110] M6 CWS of Professor Susan Hopkins [INQ000587772/35] §3.48.
[111] M6 CWS of Professor Susan Hopkins [INQ000587772/157] §13.38; M6 WS of Professor Laura Shallcross [INQ000613177/31] §62.
[112] Professor Susan Hopkins (9 July 2025) [7/92/7].
[113] M6 CWS of Professor Susan Hopkins [INQ000587772/0157] §13.40.

the Adult Social Care Outcomes Toolkit (ASCOT). This has included considering the benefit and harms associated with visiting[114].

66. Studies which result in a better understanding of the benefit and harms of different Public Health and Social Measures (PHSM - previously termed non-pharmaceutical interventions or NPIs) inform policy, result in an approach which puts '*person-centred care*'[115] at the core when writing guidance and allows for the use of more tailored interventions. UKHSA continues to seek further opportunities to advance knowledge in this area, both by contributing to funding bids, and by highlighting the topic as a priority to the funders of research.

67. Finally, mechanisms such as: ensuring isolation or cohorting facilities and policies are in place; a universal and routine vaccination offer to staff and users; the availability of IPC training relevant to a setting; and providing training in supportive care during episodes of less serious infectious illness all contribute to risk reduction and the effective management of routine infections. As such, they strengthen the ASC provider's readiness for a pandemic. To that list should be added optimising ventilation.

68. Ventilation is recognised as one of the most effective interventions in IPC control, not least because it is not person dependent. Given the health needs of those who use the ASC sector and the harms that can flow from a reduction in contact or restrictions in communication, the importance of ventilation as a mitigation should be prioritised. UKHSA supports greater focus on ventilation in future guidance. Going forward, the design and operation of residential ASC settings need to have proper regard to ventilation. Perhaps more importantly, pandemic planning at local level should give proper attention to the use of temporary ventilation measures.

CONCLUSION

69. UKHSA thanks the Chair for the opportunity to provide this Closing Statement and trusts that it will assist in her Module 6 investigation. While the ASC sector presents unique

[114] Professor Susan Hopkins (9 July 2025) [7/89/13]; M6 WS of Professor Ian Hall [INQ000587822/22] §§ 86—87, Professor Ian Hall (10 July 2025) [8/96/17]- [8/97/8].
[115] Professor Susan Hopkins (9 July 2025) [7/90/19].

challenges, many unrelated to the questions of public health that fall to UKHSA, it must never be forgotten that each setting is first and foremost a home. Ensuring that those using the sector are safe in their homes, particularly in terms of pandemic preparedness, will require a whole system approach. UKHSA will continue to contribute to that outcome by fulfilling its public health remit as effectively as possible.

Bilal Rawat KC
Lissy Verrall-Withers
Thomas Hayes
Ayesha Omar
8 September 2025

Date	Study	Purpose	Findings
2 July 2020	*Easter 6 Study*[116]	Investigated six London care homes over the Easter weekend to record outbreaks of COVID-19.	The investigation found that across the six care homes, 105 of 264 (39.8%) residents were SARS CoV-2 positive, and only 28 of the 105 (26.7%) were symptomatic at the time of testing. Additional follow-up identified 10 of the 105 (9.5%) as post-symptomatic, 21 (20%) as pre-symptomatic, but 46 residents (43.8%) remained asymptomatic throughout the studied period. Case-fatality was highest among symptomatic SARS-CoV-2 positive residents (10 of 28 or 35.7%), compared to asymptomatic residents (2 of 46 or 4.4%). Of the staff who were SARS CoV-2 positive (53 out of 254 (20.9%), 26 (56.9%) remained asymptomatic throughout the follow up period. Subsequent Whole Genome Sequencing (WGS) found multiple '*lineages*' in each of the six care homes studied, suggesting that in each outbreak there had been multiple introductions of the virus. Each cluster included a member of staff, indicating a strong likelihood that staff played a critical role as a vector of transmission of the virus.
3 July 2020	*VIVALDI 1*[117]	Analysed survey responses from 5,126 care homes for the over 65s in England. The care homes were asked to report on the total number of confirmed cases among staff and	The study concluded that regular use of temporary staff, who work in multiple settings, was an important risk factor for infections in both residents and staff. Staff were more likely to transmit infections to residents than residents to staff, although transmission in both directions could occur. Limited data and an inability to adjust for all factors meant that the study could not provide robust evidence that

[116] [INQ000089681]; M6 CWS of Professor Hopkins [INQ000587772/29-31] §§3.31-3.37.
[117] [INQ000106159]; M6 CWS of Professor Hopkins [INQ000587772/35-37] §§3.48-3.54.

		residents. since the start of the pandemic.	the number of new admissions, and residents returning to care homes from hospital, was a confirmed risk factor for infection in residents and staff so it was highlighted as a potential signal requiring further investigation
12 November 2020	*Clinical Analysis of Discharge Patterns from HSC Hospitals in Northern Ireland*[118].	Analysed discharge patterns from HSC hospitals across Northern Ireland in early 2020 and any link with COVID-19 outbreaks in care homes.	There was no evidence to support the proposition that ministerial/departmental decisions around discharge during the first pandemic surge, including decisions to discharge people into care homes, changed consultants' clinical decisions to discharge on a case-by-case basis. The study found that the timing of COVID-19 outbreaks in care homes during the first pandemic surge correlated with COVID-19 admission rates (i.e., in line with general community transmission) than with hospital discharges.
21 April 2021	*Discharges from NHS Scotland Hospitals to Care Homes between 01 March - 31 May 2020*[119].	The study identified and reported on discharges from NHS hospitals to care homes during the first wave of the COVID-19 pandemic. This involved collating several data sources to create a comprehensive register of discharges of people aged 18 and over who were discharged	The size of a care home was the strongest predictor for an outbreak of SARS-CoV-2. It found that there was no statistically significant correlation between hospital discharge and the occurrence of a care home outbreak. The study noted that this was in line with the analysis undertaken by Public Health Wales.

[118] [INQ000348240]; M6 CWS of Professor Hopkins [INQ000587772/105] §7.41.3.
[119] INQ000591537]; M6 CWS of Professor Hopkins [INQ000587772/105] §7.41.1.

		to a care home and were admitted to hospital during the specified period.	
May 2021	*Risk Factors for Outbreaks of COVID19 in care homes following hospital discharge - national cohort analysis*[120].	Examined 3,115 hospital discharges to 1,068 care homes and subsequent outbreaks of COVID-19 between 22 February and 27 June 2020.	Outbreaks in care homes in Wales during the first pandemic surge correlated with general community transmission and infection rate. The study did not find exposure to hospital discharge to be associated with a significant increase in risk of a new outbreak.
1 July 2021	*A data linkage approach to assessing the contribution of hospital-acquired SARS-Cov-2 infection to*	Commissioned in response to concerns about the role of hospital-associated SARS-Cov-2 infections in persons discharged to care homes and ensuing outbreaks experienced in those homes.	From 30 January to 12 October 2020, 43,398 care home residents tested positive for COVID-19, as confirmed by a laboratory test. This equated to 8.4% of the 514,428 of the laboratory confirmed positive COVID-19 tests in that period. Of these 43,398 positives, 35,740 (82.4%) cases were linked to a care home outbreak, equivalent to a total of 5,882 outbreaks. 1.6% of these outbreaks were identified as being potentially seeded from hospital associated COVID-19 infection. This comes to 97 outbreaks and a total of 804 (1.2%) care home residents with confirmed infection associated with these outbreaks.

[120] [INQ000213185]; M6 CWS of Professor Hopkins [INQ000587772/105] §7.41.2.

	care home outbreaks in England 30 January to 12 October 2020[121],	The study analysed address and hospital record-matched COVID-19 cases to assessment the extent of the contribution of hospital discharge.	The majority of these potentially hospital-seeded care home outbreaks were identified in March to mid-April 2020, with none identified from the end of July until September where a few recent cases emerged. The study noted that, given the timescales, changes to hospital discharge testing policy may have supported the decline. The study was limited by the data that it was able to obtain – for instance, care home cases with poor or no address data in NHS records impacted the address matching process and some cases may have been lost. The Inquiry heard from Professor Hopkins that the data linkage paper relied on testing in hospitals and was necessarily affected by asymptomatic infection during a period of limited testing[122]. The study was continued throughout the pandemic so that results could be analysed over time.

[121] INQ000234332]; M6 CWS of Professor Hopkins [INQ000587772/104-105] §7.37-7.40.
[122] Professor Susan Hopkins (9 July 2025) [7/84/1-12].