Document Details	
Title of Document:	CM Covid-19 Testing and Swabbing Priorities
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Purpose:	To set out agreed priorities for Covid-19 Testing covering Health, Economic and Test, Trace & Contain imperatives.
Consultation Group(s):	C&M Hospital Cell C&M Out of Hospital Cell NHS Northwest ICC via Clinical Cell Cheshire LRF via Test, Trace and Contain Cell Merseyside LRF via Test, Trace and Contain Cell C&M TTCE Intelligence Group
Governance	This set of priorities is developed for Cheshire & Merseyside by the Testing and Swabbing Group under direction of NHS ICC and both our local System Resilience Forums.

Version Control				
Version	**Date**	**Author**	**Status**	**Comments**
0.1	03/06/2020	T Whalley	Draft for Comment	Initial draft for discussion
0.2	04/06/2020	T Whalley	Draft for comments	Feedback from C&M Testing Cell on 4th June, from C&M TTCE Group members, from NHSE/I region.
0.3	08/06/2020	T Whalley	Draft for comments	Feedback from C&M Testing Cell.
0.4	11/06/2020	T Whalley	Draft for comments	Feedback from Merseyside LRF SCG, from C&M TTCE Group, from Merseyside TTCE Cell, from Cheshire TTCE Cell
0.5	12/06/2020	T Whalley	Working Draft	Comments from C&M TTCE Intelligence Group incorporated. Draft to be published as a working draft.

1. Context

It is essential that we have a clearly defined set of priorities for who is tested and why, ensuring best use of a finite testing resource to meet our 3 core imperatives;

- Health protection imperative – protecting people from infection and saving lives
- Care services imperative – ensuring non-COVID19 care services are recovered
- Economic imperative – securing people's jobs and future livelihoods

This document summarises our priorities. It draws from multiple sources of emerging national guidance, and from our extant Testing Strategy.

Effective testing needs clarity over who is going to be tested, when, for what purpose and how often. In addition to this, we need to be clear as to the mode of swabbing / testing. Contextualising national policy for Cheshire & Merseyside we have the following routes: -

1. **Pillar 1 NHS** rapid / near patient testing for the most urgent cases (<4 hours turnaround time, but very limited numbers).
2. **Pillar 1 PCR** testing in local NHS / PHE labs (<24 hours turnaround time).
3. **Pillar 2 Commercial** testing in national mega labs (SLA 72-hour turnaround time, with Government commitments to improve to 24 hours by end of June).
4. **Pillar 3 Antibody** testing to help understand the proportion of the population who have been infected. Antibody testing has no current clinical indication and does not infer 'immunity' from future infection, so we have not included priorities for Pillar 3.

This document sets out our preferred options but not the detailed appraisal of them.

2. Demand for Testing

The reason we must prioritise our testing is that our estimated demand for testing far exceeds the confirmed capacity we have available to us. We anticipate rising demand due to a number of factors (this list does not infer any prioritisation): -

1. In addition to continued symptomatic testing of patients, increasing volume of precautionary testing of hospital admissions (elective and non-elective) and continued testing of symptomatic patients. ~ 2,000 more tests per day.
2. New Test, Trace, Contain, Empower (TTCE) measures: ~ 2,500 more tests per day.
3. To maintain COVID-19 secure environments to keep people safe, potential need for routine (weekly) testing of over 168,000 key Health and Social Care workers. For frontline NHS workers alone, we would need ~ 6,000 more tests per day.
4. More preventative measures in care homes and other high-risk residences. Due to the reseeding of community transmission from hospital and care home settings we need all admissions/discharges from these settings swabbed and vigorously contact-traced, and workers who transit between high-risk settings swabbed regularly.
5. For care homes alone, assuming fortnightly asymptomatic testing for residents and workers, we will need ~ 7,000 more tests per day.
6. Potential additional routine testing of vulnerable cohorts ~ numbers being estimated.

7. Potential additional testing to keep economically enabling and socially important facilities open, including schools ~ numbers being estimated.
8. In addition, it may be necessary to reserve tests for future outbreaks

3. Priorities

To help build our priorities, there are some **principles** that we agree upon: -

1. We will generally prioritise **symptomatic** testing over **asymptomatic** testing.
2. We will prioritise keeping people safe and saving lives over other considerations – this includes responding to outbreak situations.
3. We will avoid inflating inequalities across our region through equitable testing / swabbing and mutual aid where required.
4. We will maximise Pillar 1 utility for higher priority testing and use Pillar 2 as needed.

More granular details are set out in appendix 1[1], but in simple terms our priorities for swabbing/testing are;

1. NHS Patients, Care Home residents, Vulnerable cohorts[2] who are **symptomatic.**
2. **Symptomatic** NHS and Social Care Staff, and /or their **symptomatic** household members.
3. All those being admitted to a Hospital or Residential setting with vulnerable residents even if **asymptomatic**.
4. All those in vulnerable settings in an Outbreak situation, and those affected under local Outbreak arrangements.
5. Key **symptomatic** workers in Schools, Emergency Services & other essential services**.**
6. Anyone else who is **symptomatic**
7. Routine testing of the most vulnerable hospital patients and care home residents even if **asymptomatic** as a preventative measure to reduce risk of outbreaks.
8. Routine testing of front-line health & social care workers, and other agreed essential key workers, even if **asymptomatic** as a preventative measure.
9. Individuals identified through TTCE who may be at risk having been in contact with a known COVID-19 positive case, even if **asymptomatic**.
10. Anyone else not listed above.

We will prioritise our modes of swab/testing as follows: -

1. Rapid and / or available near patient testing for the most urgent cases, which may include transfers to vulnerable settings, emergency admissions, outbreak investigations.

[1] This is currently in our Testing Strategy document, but will need refreshing once this set of priorities is agreed in principle
[2] Vulnerable cohorts will include those not just in residential settings, but also those with Learning Disabilities, Autism patients in their own homes or placed in the community, Homeless, Asylum seekers, BAME groups and other groups where evidence points to vulnerability.

2. Pillar 1 testing at NHS Labs for cases where a sub 24-hour turnaround time is important. Generally, this could include cases 1,2,3 and 5 above.
3. Pillar 1 testing at PHE Labs for Outbreak related cases where a sub 24-hour turnaround time is important. Generally, this would include case 4 above.
4. Pillar 2 capacity via supported / supervised swabbing centres where while we would prefer sub 24 hour, we are prepared to use the capacity even if TAT is longer. Generally, scenarios 6, 7, 8, 9 and 10 above where volume may be available even if TAT is slower.
5. Pillar 2 unsupervised / home testing where unsupervised poor swabbing technique may increase risk of false negative results, generally only used for scenario 10 above.