Cheshire & Merseyside
Health & Care Partnership

Document Details	
Title of Document:	CM Covid-19 Testing and Swabbing Strategy
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Purpose:	C&M Patient, Staff & Index Case Testing, strategy for testing and swabbing.
Consultation Group(s):	C&M Hospital Cell C&M Out of Hospital Cell Northwest Clinical Cell Northwest Workforce Cell CCG Accountable Officers NHS Trust CEOs HCP Executive
Governance	This strategy is developed for Cheshire & Merseyside by the C&M Covid19 Testing Group within the authority of the Local Resilience Forums (Merseyside and Cheshire) North West Clinical Cell, which in turn is part of the Covid-19 Incident Coordination Centre (ICC) and the EPRR National Level 4 Incident Response.

1. Context

It is essential that we have a clearly defined strategy for how we continue to test patients and our key workers for Covid-19, as well as the most vulnerable groups. It is also essential that we make the best use of mass testing which will be key to any successful easing of lock down measures and preventing any significant subsequent wave of infection

This document describes our Cheshire & Merseyside Testing and Swabbing Strategy, both in terms of swab tests for people with symptoms[1] to see if they have coronavirus and antibody tests to demonstrate if they have had the disease. Our strategy is aligned with the national strategy[2]

As part of our Testing Strategy, 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 approach, principles and 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.

To ensure ongoing alignment to and a voice at national forums, Joe Rafferty is the Chief Exec Lead and Terry Whalley is the Testing Incident Director.

We also link this strategy to current national eligibility criteria.[3]

We anticipate that this testing strategy will be required over a number of years, and so we will plan for the long term to ensure adequate capacity. At the same time, this is an evolving strategy in what is a fast-paced situation.

As and when work progresses, we expect to add further elements relating to Test & Trace (TT) programme, rapid testing options, local swabbing centres, antibody testing, outbreak testing

[1] https://www.nhs.uk/conditions/coronavirus-covid-19/check-if-you-have-coronavirus-symptoms
[2] government coronavirus-covid-19-testing-strategy.pdf
[3] https://www.gov.uk/guidance/coronavirus-covid-19-getting-tested#who-can-be-tested

and surveillance testing and other national developments that have benefits for Cheshire & Merseyside.

2. Objectives of our Testing Strategy

Our primary objective is to Protect Lives and Protect Livelihoods by **minimising the overall harm caused by the Covid-19 pandemic** and enabling lockdown restrictions to be eased. This includes:

i. **Minimising the number of people that come to harm through contracting Covid-19**

- Mitigating the risk of future peaks of Covid-19 cases as lockdown measures are eased.
- Ensuring that the most vulnerable people in society are shielded from Covid-19 once lockdown measures are eased.
- Minimising the risk for vulnerable patients of hospital-acquired infection or having potent therapies whilst carrying the virus.

ii. **Minimising the number of people that come to harm due to non-Covid-19 conditions because of the impact of the pandemic on the health and care system**

- Allowing wider health and care activity to resume, increasing the number of individuals without Covid-19 treated for both mental and physical health conditions, including elective procedures.

iii. **Minimising the wider social harm caused by the pandemic** (e.g. the impact on the economy, living standards, inequalities etc.)

- Minimising short-term harm as a result of lockdown measures (e.g. domestic violence, mental health conditions).
- Allowing people to return to work and education, minimising longer-term harm and the economic impact of lockdown measures.

3. Principles

The principles which underpin this strategy and that are used to steer our testing priorities are:

1. We will generally prioritise **symptomatic** testing over **asymptomatic** testing. See **appendix 2** for principles relating to 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.

4. Prioritisation of testing capacity

Testing must be prioritised as we expect the demand for testing will far exceed the confirmed capacity that is available to us. We anticipate rising demand due to a number of factors (this list does not infer any prioritisation): -

- 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.
- New Test & Trace (TT) related testing: ~ 2,500 more tests per day.
- 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.
- 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.
- For care homes alone, assuming fortnightly asymptomatic testing for residents and workers, we will need ~ 7,000 more tests per day.
- Potential additional routine testing of vulnerable cohorts ~ numbers being estimated.
- Potential additional testing to keep economically enabling and socially important facilities open, including schools ~ numbers being estimated.
- In addition, it may be necessary to reserve tests for future outbreaks

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

1. NHS Patients, Care Home residents, Vulnerable cohorts[4] 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.
10. Anyone else not listed above.

[4] 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.

Our prioritised mode of accessing swab/testing is 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.
2. Pillar 1 testing at NHS Labs for cases where a sub 24-hour turnaround time is important.
3. Pillar 1 testing at PHE Labs for Outbreak related cases where a sub 24-hour turnaround time is important.
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.
5. Pillar 2 unsupervised / home testing where unsupervised poor swabbing technique may increase risk of false negative results.

The prioritised groups for each mode of testing is described in summary below along with a detailed list in appendix 1.

It is worth noting that as a region we are not currently empowered to fully implement our prioritisation as national test booking routes, including the self-referral portal, are used to allocate much of the pillar 2 test appointments at present. We are able to manage the use of pillar 1 testing capacity and this must be used for the highest priority groups where capacity allows.

5. NHS Swab Testing (Pillar 1)

We will generally use our NHS / PHE Lab capacity by undertaking **swabbing** in hospital settings for the following priorities, subject to capacity: -

1. NHS Patients, care home residents and other vulnerable cohorts 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 Care Home or other setting with vulnerable people 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**.**

Demand for Pillar 1 testing in line with the above list may at times be greater than the capacity available and while we aim to grow our Pillar 1 capacity, Pillar 2 assisted swabbing should be used where Pillar 1 is unavailable.

We will direct other key workers to community swabbing hubs that each CCG has been asked to establish. The list of these swabbing sites is published on each Local Resilience Forum (LRF).

We will seek to reduce the turnaround time for the more urgent test results by utilising the following testing options;

1. Local Hospital Rapid Testing Platforms where available. These offer results in around 2 hours and should be used for the most urgent cases. We will, in our Cheshire & Merseyside Pathology Network, seek to distribute supplies and/or platforms to maximise rapid coverage across our Hospitals. This is not a mass testing option; it is low volume but fast turnaround time.
2. Local Hospital Pathology Labs that are able to perform Covid-19 testing on site, and where turnaround time is typically under 24 hours and can be as low as 4 hours for certain platforms. Our lab colleagues will continue efforts to diversify extraction methods and detection assays to reduce the risk of impact associated with continued national shortage of supplies.
3. Regional Pathology Labs (PHE Manchester) where turnaround time is currently 24-48 hours, to support Outbreak related testing in line with PHE protocols[5].
4. Other National NHS/PHE Labs and Private Labs where capacity is available and/or turnaround time under extant arrangements contributes to local Trusts' ability to undertake required testing.

We will maximise regional testing capacity by collaborating with Laboratories in GM and in Lancashire & Cumbria. This will include sharing daily sit-reps, mutual aid (for example on scarce reagents / consumables) and on presenting a single NW perspective on priorities to national Pathology Incident Directors' forum.

In addition to the above, work is ongoing to roll-out Community Swabbing Teams across the region. These teams will be primarily resourced from within NHS Community Trusts, who are tasked with identifying potential capacity to support this mode of testing. These Community Swabbing Teams will offer further access to testing for those who are unable to leave their house and travel to one of the Regional or Satellite Testing sites.

Where the evidence base is still emerging in relation to these test or groups, we will continue to respond and, where possible, contribute to it. At each stage, we will ensure clear communication between system partners and out to staff, patients and the public so that they understand the purpose of the programme, our individual responsibilities, eligibility for and access to testing, and the actions required by all involved.

6. Commercial Swab Testing (Pillar 2)

The National Commercial Testing Programme provides Covid-19 tests in one of the super laboratory hubs created as part of Pillar 2 (Belfast, Milton Keynes, Alderley Edge & Glasgow). This does not use extant NHS / PHE Lab capacity.

Access to swabbing is through a range of options that includes;

- Regional Testing Centres (RTC), located at Liverpool John Lennon Airport, Haydock Park and Manchester Airport and offer assisted, self-swabbing or both. Access for eligible booking is via www.gov.uk

[5] https://www.gov.uk/government/publications/wuhan-novel-coronavirus-guidance-for-clinical-diagnostic-laboratories/laboratory-investigations-and-sample-requirements-for-diagnosing-and-monitoring-wn-cov-infection

- Satellite Testing Centres (STC), located in Birkenhead (Bidston Station), Crewe (Leighton Hospital Site), Chester (Countess of Chester Site) and Liverpool (Hunter Street Car Park Site). Access for eligible booking is via local arrangement. STCs largely provide a self-swabbing or supervised swabbing service but are encouraged to offer assisted swabbing to any staff attending who support vulnerable people at their place of work. This is intended to negate issues with testing efficacy associated with self-swabbing not being undertaken effectively. In particular, this applies to staff who work in care settings with people who are ill and those over 65, for example Hospital staff and Care Home workers.
- Mobile Test Centres (MTC), located in a pop-up fashion at a number of designated sites across Cheshire & Merseyside offering a self-swabbing service. Access for eligible booking is via www.gov.uk.
- Home Testing, Self-referral booking routes are now available for anyone meeting the eligibility criteria via https://self-referral.test-for-coronavirus.service.gov.uk to apply for a test.

We will prioritise access to this commercial swab testing as follows:

- NHS patients not tested under Pillar 1
- Anyone who is **symptomatic** that is not able to access Pillar 1, including all other essential workers, over 65s, those on the Government 'shielding' list or caring for someone on that list, and people that need to go into work because they can't work from home.
- Routine testing of the most vulnerable hospital patients and care home residents even if **asymptomatic** as a preventative measure to reduce risk of outbreaks.
- Routine testing of front-line health & social care workers, and other agreed essential key workers, even if **asymptomatic** as a preventative measure.
- Individuals identified through Test & Trace who may be at risk having been in contact with a known COVID-19 positive case, even if **asymptomatic**.
- Anyone who has **symptoms** and lives with someone who meets any of the above criteria
- Community Testing; there is emerging evidence of disproportionate, increased severity of Covid-19 in certain cohorts of the population, including BAME communities, people with long-term conditions (e.g. hypertension, diabetes, obesity) and other groups (e.g. smokers) and the socially vulnerable. As part of this strategy, we will take an evidence-based approach to community testing for defined populations. Where required, we will involve our public engagement teams to determine how we best offer and undertake testing within local communities, as well as providing advice on social distancing and isolation. This is In line with our focus on health inequalities and issues being highlighted within our BAME communities.

More detail information on the types of workers who may now be eligible for testing can be found at http://www.gov.uk/coronavirus-get-tested.

Any employer that has any queries can contact their local resilience forum, national government department/agency, or the Department of Health and Social Care (opshub@dhsc.gov.uk).

There remain concerns as to the efficacy and sensitivity of self-swabbing mode due to risk of poor swabbing technique. This could increase the risk of false-negative results. We currently advise an approach to stratify cohorts of key workers and offer employers some guidance to the most appropriate testing option to reduce this risk (see employers guide or Resilience Direct). In particular, those key workers in contact with cohorts of vulnerable people should not rely only on a home swab before returning to work.

It is advised that the key workers Highest Priority group (appendix 1) do not rely solely on an unsupervised self-swab at home when determining if it is safe to return to work.

Guidance on interpreting test results can be found:

https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings

7. Antibody Testing (Pillar 3)

Antibody testing commenced during May 2020, with an expectation of 40,000 tests/day nationally by end of May ramping up to 140,000 tests/day by end of June. This equates to in the region of 1,000 day initially in C&M, increasing to close to 5,000/day by end of June.

Antibody testing at this stage is useful primarily for epidemiological reasons; to understand the prevalence of past infection with Covid-19, to understand the degree of asymptomatic cases previously unrecorded and to improve our understanding therefore of mortality / morbidity. Antibody Testing will **not** at this stage enable any kind of judgement on potential immunity or decisions on Key Worker safety.

To avoid undue pressure on phlebotomy services and absent clinical utility, we will begin roll out of antibody testing in NHS settings where blood is already being taken for other purposes. We will also offer NHS Staff eligible for Flu vaccine the option to take a test. As volumes become available, we will further refine and update our Testing Strategy to include more eligible cohorts for antibody testing. If and when the utility of these tests includes predictor of immunity, we will consider a shift in priorities to reflect this.

Ends.

Appendix 1 – Testing Eligibility and Priorities

A further, more detailed list of those eligible for testing, and our current view of priorities for testing where capacity may be constrained.

Highest Priority (Rapid and / or available near patient testing for a small number of the most urgent cases where turnaround time in approx. 2hours)

This may include:

- transfers to vulnerable settings
- emergency admissions
- outbreak investigations

High Priority (Pillar 1 testing at NHS Labs or PHE Labs for outbreak related cases where a sub 24-hour turnaround time is important, where capacity allows.)

- NHS Patients, Care Home residents, Vulnerable cohorts who are **symptomatic,** including:-
  - Anyone over 65
  - those with learning disabilities and/or autism
  - patients in their own home or cared for in the community
  - homeless
  - asylum seekers
  - BAME groups
  - Other groups where evidence points to vulnerabilities
- **Symptomatic** NHS and Social Care Staff, and /or their **symptomatic** household members, including: -
  - With immunocompromised patients (e.g. oncology, haematology, transplant patients) in acute settings.
  - in infectious disease and respiratory medicines wards/departments
  - in acute / emergency medicine (ITU / ICU / A&E / ambulance paramedics / emergency dental) and district nurses working with complex cases (e.g those ventilated in community settings).
  - Doctors, nurses, midwives, paramedics, social workers, care workers, and other frontline health and social care staff including volunteers
  - The support and specialist staff required to maintain the UK's health and social care sector including defence staff deployed in this role
  - Those working as part of the health and social care supply chain, including producers and distributors of medicines, and medical and personal protective equipment
  - NHS Blood and Transplant frontline staff (blood donation staff, specialist nurses for organ donation, staff running therapeutic apheresis services in NHS hospitals)
  - Those providing ancillary support to NHS workers (such as hotel accommodation for NHS staff)
  - All those **symptomatic** and **asymptomatic** in vulnerable settings in an Outbreak situation, and those affected under local Outbreak arrangements, including, care

homes, supported living, reablement, refuges and **asymptomatic** NHS Workers covered in outbreak/untoward incidents/high prevalence scenarios[6]

Medium Priority (Where Pillar 1 is unavailable, Pillar 2 capacity via assisted / supervised swabbing centres where, although we would prefer sub 24 hour, we are prepared to use the capacity even if TAT is longer.)

Key **symptomatic** workers in Schools, Emergency Services & other essential services and / or their household members, including:

- Ministry of Defence civilians, contractors and armed forces personnel (those critical to the delivery of critical defence and national security outputs and critical to the response to the coronavirus pandemic), including defence medical staff not directly deployed to frontline health and social care.
- Essential public services staff, including:
  - Prisons, probation, courts and tribunals staff, judiciary
  - Religious staff
  - Charities and workers delivering critical frontline services
  - Those responsible for the management of the deceased
  - Journalists and broadcasters covering coronavirus or providing public service broadcasting
  - Public health and environmental staff, such as specialist community public health nursing
- Public safety and national security staff, including:
  - Police and support staff
  - Fire and rescue service employees (including support staff),
  - National Crime Agency staff, those maintaining border security, prison and probation staff and other national security roles, including those overseas
  - British Transport Police and the Maritime and Coastguard Agency
- Transport workers, including:
  - Those who keep the air, water, road and rail passenger and freight transport modes operating during the coronavirus response
  - Those working on transport systems through which supply chains pass
- Education and childcare workers, including:
  - Support and teaching staff
  - Social workers
  - Specialist education professionals
- Critical personnel in the production and distribution of food, drink and essential goods, including:
  - Those involved in food production, processing, distribution, sale and delivery

[6] Healthcare Associated COVID-19 Infections – further action 24 June 2020

  - Those critical to the provision of other essential goods, such as medical supply chain and distribution workers, including community pharmacy and testing (such as PHE labs), and veterinary medicine
  - Workers critical to the continuity of essential movement of goods
- Local and national government staff critical to the effective delivery of the coronavirus response, or delivering essential public services, such as the payment of benefits
- Public and environmental health staff, including in government agencies and arm's length bodies
- Funeral industry workers
- Frontline local authority staff and volunteers, including
  - Those working with vulnerable children and adults, victims of domestic abuse, and the homeless and rough sleepers (and hotel staff supporting these groups)
  - Voluntary sector organisations providing substance misuse treatment
- Utilities, communication and financial services staff, including:
  - Staff needed for essential financial services provision (including but not limited to workers in banks, building societies and financial market infrastructure)
  - The oil, gas, electricity and water sectors (including sewerage)
  - Information technology and data infrastructure sector and primary industry supplies to continue during the coronavirus response
- Essential staff working in the civil nuclear, chemicals, telecommunications (including but not limited to network operations, field engineering, call centre staff, IT and data infrastructure, 999 and 111 essential services), postal services and delivery, payments providers and waste disposal sectors
- Unpaid carers and volunteers
- Anyone else who is symptomatic and/ or their household members.
- Routine testing of the most vulnerable hospital patients and care home residents even if **asymptomatic** as a preventative measure to reduce risk of outbreaks including
  - Care homes
  - Supported living
  - Reablement
  - Refuges
  - Looked After Children's homes
- Routine testing of front-line health and social care workers, and other agreed essential key workers, even if **asymptomatic** as a preventative measure.
- Individuals identified through TTCE who may be at risk having been in contact with a known COVID-19 positive case, even if **asymptomatic.**

Low Priority (Pillar 2 unsupervised / home testing where unsupervised poor swabbing technique may increase risk of false negative results)

- Anyone requiring Test, Track & Trace related testing not in a category above.
- Anyone else not listed above.

Appendix 2 – Asymptomatic testing: principles (July 2020)

Background

- Cases of coronavirus infection range from severe illness with characteristic symptoms of fever, cough and anosmia (lack of smell or taste) to a complete lack of symptoms.
- Evidence has now shown that people infected with COVID-19 who are either pre-symptomatic[7] or have very mild or no respiratory symptoms (asymptomatic)[8] can transmit the virus to others without knowing. Based on limited data, the virus load in asymptomatic cases is not markedly lower than that seen in symptomatic cases. Studies in health and social care settings have identified substantial numbers of cases among staff and patients or residents who are asymptomatic or have trivial symptoms.
- A systematic NERVTAG review in mid-May showed that estimates of the proportion of infections that are asymptomatic or have few symptoms vary very widely (4-50%) but the overall figure is likely to be in the range of 10-35% (moderate confidence).[9]

Testing

- Currently, anyone is eligible for a swab test **if they have symptoms**. Given the need both to control the spread of the virus and to demonstrate safety for health and care services, institutional settings, business and social activities, there is strong demand for programmes to identify asymptomatic cases through regular testing.
- However, **the effectiveness of swab testing in picking up infection is highly dependent on when someone is tested**. Swab testing is very effective when used on people who are recently symptomatic or in the two days prior to the onset of symptoms. If someone has Covid-19 and has symptoms it is extremely likely the test will give a positive result.
- However, if someone is asymptomatic, it is difficult to ascertain where in the infection cycle they are. This creates a real risk that asymptomatic testing could provide **false reassurance** in a number of ways:
    1. **Someone may test negative even if they are infected**, if they are not yet within two days of the onset of symptoms; that same person may well go on to be significantly infectious to others prior to being aware of any symptoms. Tests are also more likely to come back negative if someone is in the later stages of symptomatic disease (typically beyond 7 days after symptom onset).
    2. When prevalence of the virus is very low (less than 0.5%), there is a risk asymptomatic testing may generate **significant numbers of false positive results.** [10] It has even been argued, though this view is not universally accepted, that at current disease prevalence in the general population a false positive could occur almost as often as a true positive when testing an asymptomatic member of the general public.[11]

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/890236/s0267-nervtag-assessment-pre-symptomatic-transmission-covid-19-300420-sage30.pdf
[8] Chau NVV, et al. The natural history and transmission potential of asymptomatic SARS-CoV-2 infection. medRxiv 2020.04.27.20082347; doi: https://doi.org/10.1101/2020.04.27.20082347
[9] NERVTAG-Asymptomatic SARS-CoV-2, Andrew Hayward, Peter Horby, 13/05/2020
[10] False positives are rare but do occur due to errors, contamination or use of unusually high CT values in some labs.
[11] 'Understanding the utility and limitations of current SARS-COV2 PCR assays', Susan Hopkins, 28/06/2020

- The problem of false positives is significantly less of an issue, however, when the individuals being tested have a substantially higher probability of infection than members of the general public. This could be because they have relevant discriminatory symptoms or because they are in settings or populations where there is strong reason to believe prevalence is high, for example amongst the household or contacts of a known case.
- **Large scale testing of asymptomatic people could potentially produce misleading results and should be undertaken with a clear rationale in mind and an appropriate sampling strategy.**

Principles for asymptomatic testing

- For these reasons, asymptomatic testing has only been approved for use by the Chief Medical Officer in some circumstances and **not for mass screening** of large sections of the population.
- Asymptomatic testing is primarily of value in helping us to learn more about the virus, such as through surveillance studies. It can also help to manage risk for particular high-risk groups and settings. Under certain conditions, it can have a useful role to play in providing some reassurance – not to an individual that they are 'safe', but rather to groups, to demonstrate that overall risk levels are low.
- The CMO/DCMOs are clear that **one-off asymptomatic testing should not be used as a tool for action** on an individual basis (i.e. to enable a specific change in activity or behaviour on the basis of a negative result) because **it does not guarantee that someone does not have the virus**. It is possible that individuals who test negative might possibly be incubating the virus and may go on to develop symptoms.
- Asymptomatic testing is likely to provide little or no valid reassurance unless repeatedly and very frequently deployed.
- Asymptomatic testing may only be used where:
    1. The objective is to increase understanding about the spread of the virus – for example studies to establish prevalence within a given area, setting or group;
    2. A new population is being introduced into a high-risk, closed setting;
    3. Where there is a strong reason to believe that prevalence may be higher than it is in the general population; and/or
    4. To manage an outbreak (to mitigate spread of infection)
- For these reasons, the Chief Medical Officer is currently **unlikely to support** cases for the use of asymptomatic testing where:
    1. The main rationale for asymptomatic testing is as a tool for individual action (i.e. to enable a change in activity or behaviour on the basis of a single negative result).
    2. There is no clear reason to think that prevalence may be higher than the general population (prevalence is considered 'high' at values >1%).
    3. Clear information is not given on population size, detail of setting and circumstances of population (including rationale, in light of the above, on why asymptomatic testing may be appropriate) and timescales.
    4. The proposal is to test a very large subset of the population (i.e. it is insufficiently targeted) or demand is likely to exceed current available testing capacity.

Appendix 3 – Version Control

Version Control				
V.	**Date**	**Author**	**Status**	**Comments**
0.1	13/04/2020	T Whalley	Draft for Comment	Initial draft based on early adoption at speed
0.2	14/04/2020	T Whalley	Working Draft	Feedback from ICC North West Clinical Cell
0.3	16/04/2020	T Whalley	Working Draft	Feedback from ICC North West Workforce Cell. Specific information on first 3 STCs.
0.4	17/04/2020	T Whalley	Working Draft	Update in line with HM Government paper published 17/4/20.
0.5	18/04/2020	T Whalley	Working Draft	Feedback from Hospital Cell, addition of patient testing (non-elective and elective admission testing)
0.6	30/04/2020	W Ivatt	Working Draft	Update to reflect latest guidance and progress with site set-up
0.7	30/04/2020	W Ivatt	Working Draft	Update to include section on Mobile Testing Centres,
0.8	03/05/2020	T Whalley	Working Draft	Refinements throughout based on national guidance and emerging Test, Track & Trace needs
0.81	08/05/2020	T Whalley	Working Draft	Feedback on priorities from NHSE/I Deputy MD
0.82	12/05/2020	T Whalley	Working Draft	Addition of unpaid carers into list of priorities, minor amends to priorities.
0.9	18/05/2020	T Whalley	Discussion Draft	Significant updates to incorporate aspects of Test, Track & Trace Strategy.
0.10	16/06/2020	L Malcolm	Discussion Draft	Updated with information from the Testing and Swabbing Priorities v0.5 paper
0.11	23/06/2020	T Whalley	Discussion Draft	Final comments included ahead of review by Testing & Swabbing Cell
0.12	23/06/2020	L Malcolm	Working Draft	Endorsed by Testing Group. Links to further guidance added.
0.13	02/07/2020	T Whalley	Working Draft	Addition of NHS asymptomatic testing within appendix 1
0.14	15/07/2020	T Whalley	Working Draft	Addition of appendix 2, principles for asymptomatic testing, and to reflect guidance issued[12]

[12] https://www.england.nhs.uk/coronavirus/publication/healthcare-associated-covid-19-infections-further-action/