Clinical Senate Council Meeting

Thursday 24th September 2020
South West Clinical Senate Council: Future Test and Trace Strategy for the South West

Deliberative Topic

"What should be the future Test and Trace Strategy for COVID 19 in the SW and how can we influence it?"

Overview
Following discussion with the regional PHE team and with input from the COVID response cells within NHSEI in the South West; the Clinical Senate were asked to convene a session in order to provide recommendations on the future test and trace strategy in the South West, noting the current widely publicised issues with access to tests for COVID 19 and the need for a regional strategy in relation to pillar 2 testing, how best to respond to national policy and the Senate's role in offering an independent clinical perspective on this. The Clinical Senate have also made some recommendations that would assist in controlling the spread of the Covid-19 virus which were considered important to include.

To inform discussions, the Senate Council heard from PHE, Local Authority, the South West Citizens' Assembly and the pathology and infection control cells in the South West, in addition to reviewing the existing principles for outbreak management and current pathology guide to testing. The Clinical Senate Council members and expert colleagues discussed both the opportunities for a regional testing strategy and held focus groups to discuss the testing priorities for health, social care, the community and educational settings.

Background

Public Health Data

- PHE use data to inform and contain virus spread alongside health protection teams but they do not manage testing.
- To date the South West region has had the lowest incidence of COVID 19. Recently there has been a sharp rise in cases as with elsewhere.
- An enormous increase in capacity and infrastructure for testing has taken place since March but this is not meeting demand, primarily due to lab capacity to process tests rather than there being a lack of tests themselves.
- Contact tracing in the South West is working with 83.3% of cases complete compared to 77% nationally and approximately 3 contacts identified per case.
- Pillar 2 testing capacity has been reduced through the diversion to other regions with higher demand and rates of COVID 19.
- The 7 day incidence of the disease as shown through testing results is used as a key comparator to track progression. However, the use of testing data for the South West is becoming less accurate as testing capacity is both diverted to other regions and there is also a false ceiling on incidence data as well as a lag in reporting when capacity does not meet demand.
- It is clear through the tracking and tracing of outbreaks that the spread of COVID 19 is taking place in informal community and private settings whereas PPE, staff testing and infection prevention and control support to formal settings such as care homes, workplaces and venues is working.

- If testing capacity cannot meet demand then alternative sources of data to manage incidence, understand concentration of infections and prioritise utilisation of testing capacity need to be supported.

Local Authority Learning

- It's important to understand that there is a limit to the ability of testing alone to control COVID 19 and it must not be seen as a panacea.
- Local Authorities are playing a key role in developing Local Outbreak Management Plans (LOMPs), managing care homes, co-ordinating testing and running outbreak engagement boards alongside running hundreds of other local services. It was noted that there is much variation between councils and testing arrangements can be complex and fragmented and where private sector testing has no knowledge of health there is very poor co-ordination and data flow.
- Local Authorities are managing a range of challenging issues in relation to COVID 19 including supporting businesses, illegal events, schools and universities re-opening, homelessness and the increased tension around social behaviour.
- Community transmission is becoming widespread whilst there is increasing resistance within some communities to follow rules.
- The effects of COVID 19 are increasing the existing health inequality gaps with those in lower socio-economic groups both more likely to be exposed to the virus and more susceptible to the non covid consequences of lockdown.
- The impact of managing COVID 19 has brought to light some excellent local leadership and strong collaboration across health and social care organisations who have gone the extra mile.

Pathology and Infection Control

- You should only get tested if you have COVID-19 symptoms or if you've been advised to get tested by a health professional. The Government has announced a list of those who should be tested: https://www.gov.uk/government/publications/allocation-of-covid-19-swab-tests-in-england/allocation-of-covid-19-swab-tests-in-england
- There are different priority turnaround time for results ranging from 2hrs, 4hrs and 24hrs using different platforms. It was noted that patients need to be tested within 5 days of showing symptoms.
- There are different pillars to the testing programme as follows; Patient and NHS Staff, Essential Workers, Antibody Testing, PHE Surveillance, Diagnostics, Pathology Maintenance and Development.
- Testing staff need to be supported given the current pressures.
- Across the South West there are currently 19 mobile units with some kept in reserve and 3 as strategic reserve to mobilise quickly in an outbreak.
- Pillar 2 tests are issued to match lab capacity as if there is a lab backlog then tests become unviable.
- There is daily reprioritisation of lab capacity while demand exceeds supply, as it does currently. There is some ringfenced capacity but significantly more will be needed to meet increasing demand, noting that there are already some plans in place to do so.
- Testing should be used as a priority to support clinical decision making and maintain the recovery of healthcare pathways and services, particularly to vulnerable people. This will become more important as incidence rises again and services move into winter management alongside other outbreaks such as flu and norovirus.

Patient and Public Perspective

- Public support for and compliance with a test and trace strategy (and subsequent isolation) is crucial.

- For the public to have confidence in the system it needs to be easy to understand and navigate with good responsive local access when appropriate.
- The public would support prioritisation if it was clear and felt that the system was working.
- There is currently little awareness of the impact of tracing and whether it is happening however the new app, out 24th September, may help with this.

Recommendations

Overall

1. **There is a need for simple, clear and consistent messages on testing, bubbles and need for isolation for all stakeholders.**

2. **There should be an acknowledgment that testing should not be developed in isolation from the other elements of a track and trace system including laboratory and tracking capacity.**

3. **For a test and trace system to be effective the capacity must always be greater than demand.**

4. **An intelligent testing strategy is needed to manage the conflict between want and need for a test when demand outstrips capacity.**

5. **South West Trusts should comply with the PHE COVID-19 Hospitalisations in England Surveillance System (CHESS). This provides demographic, risk factor, treatment, and outcome information for patients admitted to hospital with a confirmed COVID-19 diagnosis.**

6. **Regional testing capacity and utilisation data should be shared across the system to inform a local response to emerging outbreaks.**

7. **Some testing capacity should be ringfenced for allocation by regional PHE teams to be deployed based on local intelligence.**

8. **There must be clear and consistent public messaging on when and how to access a test.**

Health and Social Care

1. Given the increase in community transmission, some testing capacity should be allocated for clinicians in primary care to request, on the basis of clinical presentation.
2. Use of testing capacity should prioritise clinical and diagnostic needs over epidemiological needs.
3. ED pathways should have access to early rapid testing when clinically indicated.
4. Approaches to clinical prioritisation of pillar 1 testing, such as that developed in University hospitals Bristol should be evaluated and spread.
5. Social distancing in healthcare settings should be supported with the provision (or restoration) of covid compliant facilities, such as rest areas provided to protect staff and services.
6. When capacity is available regular routine testing of all clinical staff should be considered. Until sufficient capacity is available for this regular testing of particular groups such as those working with immunosuppressed patients should be considered.
7. The human cost of responding to the testing challenge should be acknowledged. The support for frontline staff is well articulated but support is less vocal for those responsible for the testing and tracing and local authority work, including laboratory staff.

8. Local surveillance approaches using GP and 111 presentation data and hypoxia monitoring should be supported and evaluated.

Community Settings

1. There should be clear and consistent guidance on the discharge of patients to care homes.
2. Patients attending A&E from care homes should not be unneccessarily admitted whilst awaiting a COVID test before returning to the care home, and unless admitted for clinical reasons should be able to return directly to the care home without a test result.
3. Support should be made available to care homes to enable them to manage the relative risk of covid and other non covid conditions including the emotional impact of isolation from friends and relatives.
4. Good access to PPE and staff testing across community and social care must be maintained, including for carers who look after people in their own homes.

Educational Settings

1. The Department of health helpline for schools should be promoted as a source of clear and consistent advice used to staff, parents and students.
2. There is reported inconsistency in approach to risk across educational settings to testing. Testing and isolation should be consistent with guidance for education and institution specific testing and isolation approaches should be discouraged.
3. Testing capacity should be prioritised for symptomatic teachers and students to minimise disruption on education and the consequent impact on the ability to work of other key workers.
4. There should be clear guidance on the use of emergency tests provided to educational institutions and the capacity and timescale to process these when used.
5. Clear guidance should be provided to schools regarding use of PPE and bubbles for school buses.
6. Testing rates for schools should be monitored.
7. The use of technology for tracing including the new track and trace app should be promoted in those populations where uptake is likely to be high, such as university populations and high compliance amongst their student population should be sought.
8. Each higher education institution should clarify in their Local Outbreak Management Plan how they would respond to immediately mobilise in the event of an outbreak.
9. Certain cohorts of university students could be prioritised for testing in order that they can progress with their development (eg. health care professions to maintain the keyworker pipeline.)

Next steps

These recommendations will be shared via PHE with the Regional test and trace enablement and containment Board. They will also be shared with the COVID response cells within NHSEI, the regional medical director, local authorities in the South West, other Senates nationally, the South West Citizens' Assembly and published at www.swsenate.nhs.uk

Pre-Reading

1. South West Pathology Guide for Testing, V3, 2020, NHSEI
2. Principles for Making Outbreak Management Work, 2020, PHE

Presentations from the meeting can also be accessed by emailing Rachel.perry12@nhs.net