

## Spotlight on...

# TESTING QUESTIONS IN TESTING TIMES

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £84bn of annual expenditure and employing more than one million staff.

**This is the second in a new series of *Spotlight on...* briefings, aimed specifically at sharing key information on the impact of the coronavirus pandemic on NHS trusts.**

This briefing is structured into four sections and sets out:

- the trust perspective on testing
- what trust leaders believe is needed from an effective testing regime
- a brief recap of what has happened so far on testing
- the questions trust leaders now need answered to ensure they can help create the fit-for-purpose testing regime that is required.

## Key points

- Testing, along with PPE, is one of two areas where NHS trust leaders would have liked the English health and care system to have been able to perform better as part of the response to coronavirus.
- A successful testing regime requires:
  - a clear, effective and well-communicated strategy
  - clarity on who will be tested, for what purpose, when, how and with what frequency
  - clarity on who will carry out the tests and appropriate capacity and access to reliable tests for those needing to be tested
  - given the complexity of the end-to-end testing process, excellent co-ordination across many different moving parts.

Recognising that it started from a poor position, the English health and care system has struggled with all these different elements at different points over the last two months. It will be for any subsequent public inquiry to determine why these problems have occurred and whether the response was adequate.

- Testing strategy, criteria, capacity and co-ordination are the responsibility of government. A vast amount still remains to be done to reach a testing regime that can be described as fit for purpose.
- Trust leaders believe they have done all they could to support the national testing effort. The NHS has tested as many patients as capacity allowed and it has grown its testing capacity as quickly as possible. It has tested as many staff as possible as soon as it was allowed to do so, significantly reducing staff absence rates. It has made as many staff as possible available for testing to support the government's wider testing effort. The NHS will have reached the 25,000 tests a day target it was set by the end of April.
- Trust leaders need clarity and detail on how the testing regime will develop. At the moment, they feel on the end of a series of frequent tactical announcements extending the testing criteria to new groups of people with no visibility on any long-term strategy. They are being expected, at the drop of a hat, to accommodate these changes with no advance notice or planning, despite the fact that many of the changes have significant operational impact. Some trusts are also frustrated that the needs of acute hospitals may have been excessively prioritised over the needs of ambulance, community and mental health trusts and primary and social care.
- The government's 4 April plan needs to be urgently updated to reflect the stage we have now reached as a nation – successful negotiation of the first peak of coronavirus demand and working out how to exit lockdown, carefully manage spread of the virus, avoid a second spike and allow the economy to restart. The newly updated plan needs to answer the following six questions:
  - 1 When will every patient and health and care staff member with suspected COVID-19 symptoms who needs a test be able to consistently access that test within an appropriate turnaround time, as promised in the 4 April plan?
  - 2 Given current problems with access to the key worker testing promised on 4 April, what are the government's immediate plans to rapidly improve access for this core testing group?

- 3 How quickly does the government now expect swab, antigen, test capacity to further expand and how will it prioritise the use of this capacity once created?
  - 4 What is the plan to return to tracking and tracing any new outbreak of the virus as part of progressively exiting lockdown?
  - 5 Given the need to control the risk of cross infection in healthcare settings, what are the detailed plans to move to systematic regular testing of all NHS and care staff?
  - 6 Given current uncertainties over whether patients who have had COVID-19 will acquire permanent immunity and test reliability, what role does the government now expect antibody testing to play?
- The recent public focus on whether 100,000 tests will be performed on 30 April is a red herring. While it may have had a helpful, initial galvanising effect, it is an isolated measure of capacity at a single point in time and is therefore a distraction from the key issue of how the government's testing strategy needs to develop. All six questions outlined above are just as important and relevant on 1 May irrespective of whether 50,000, 75,000 or 100,000 tests are performed on 30 April.
  - Trust leaders are also worried that the current focus on reaching the arbitrary "100,000 tests by 30 April" target is distorting the testing approach in three key ways:
    - it may be preventing the development of a proper, next stage, testing strategy and debate on what should be in that strategy
    - it may be driving testing for testing's sake – maximising the number of tests on 30 April – as opposed to ensuring that each test is done for the right purpose and delivers appropriate value
    - it may be driving an excessive focus on the number of tests completed, as opposed to focusing on whether those who should be tested can actually get tested when required, which is the most important priority.
  - Trust leaders stand ready to play their part in creating the fit-for-purpose testing regime that is so desperately needed. But they need to know a lot more, as quickly as possible, to do that effectively.

# The NHS trust perspective on coronavirus testing



There are many different facets to, and perspectives on, testing. This briefing looks at the issue from an NHS trust perspective where trusts have a number of requirements:

- They treat COVID-19 patients, where patient testing is important to ensure patients get the right treatment but also for infection control – for example, ensuring trusts are able to separate COVID-19 and non-COVID-19 patients.
- Some trusts operate testing laboratories, conducting tests on their own behalf but also for other trusts. In addition, local facilities at NHS trusts contribute to the testing effort for patients and staff.
- Trusts are employers, where staff testing is important – to support staff who need to know if they have the virus, and for infection control, identifying if there are asymptomatic staff that are at risk of spreading the virus. Testing also enables those who believe they, or a member of their household, may have the virus, but in fact do not, to carry on working.
- Trusts also have a strong interest in ensuring testing is an appropriate part of an effective approach to exit the current lockdown, control demand on the NHS going forward, and ensure the eventual long term control of the virus.

For all these reasons, the trust leaders that NHS Providers represents have a strong interest in an effective, fit-for-purpose coronavirus testing regime, underpinned by a clear and detailed strategy.

# What is needed to create an effective testing regime?

Operating an effective coronavirus testing regime is complex. It requires clarity on, and alignment of, four interlinked factors:

- the right strategy
- the right testing criteria
- the right capacity and access to reliable tests
- the right co-ordination of a highly complex end-to-end process involving a very large number of different organisations and people.

## Overall strategy

The overall testing strategy needs to be clear. There are different potential groups of people to test – patients, health and care staff, key workers and the general public. Testing can be undertaken for a number of different purposes including to determine the right patient treatment, to track and assess spread of the virus, to assess whether healthcare staff are fit to work, and to ensure effective infection control in healthcare settings. Tests can be undertaken in a number of different places – in healthcare settings, in fixed drive through facilities, by mobile units and at home. There are different types of test that can be delivered in different ways. The tests can be undertaken by a number of different organisations – the NHS, Public Health England (PHE), the private sector and academic/research institutions.

Testing strategy may vary over time including preventing spread in the early phases of a pandemic and patient diagnostic and infection control once the pandemic has spread, through to identifying who has had the virus as part of the long-term control of the virus. Testing can be performed multiple times on the same individual – for example, every week on healthcare staff for infection control purposes.

The options are infinite. The overall testing strategy needs to clearly prioritise between these options. It needs to adapt to the different requirements of each phase of the virus spread. It needs to be clearly communicated to all those affected by it. And it obviously has to match the available capacity.

Within the overall strategy, there are three key detailed components to align.

## Testing criteria – who should be tested for what purpose, when and how frequently?

As outlined above, an effective testing regime needs to be clear about who is going to be tested when, for what purpose and how frequently. Particularly if capacity is limited, difficult choices need to be made between different groups, all of whom could potentially benefit from testing. Given the ability of asymptomatic (i.e. showing no symptoms) patients and staff to unknowingly spread COVID-19, there are particularly important choices to be made about when and how to test all patients and staff in health and care settings.

## Capacity, access and reliability – can those who need to be tested get access to tests whenever they need to? Are the tests processed rapidly enough and are they accurate and reliable?

An effective testing regime requires the right testing capacity – the right number of tests, the capacity to process them at the right speed, their physical availability to those who need to be tested including at the right frequency. There are a number of constraining factors on capacity. These include availability of testing materials (swabs, chemicals, reagents, testing kits) and the amount of test processing capacity.

Those to be tested need to have easy physical access to the tests when they need them. For example, there is little point in deciding to test all health and care staff regularly for infection control purposes if there is insufficient capacity close to their place of work to enable this to happen with the frequency and turnaround time required. Requiring staff to visit testing facilities that take a considerable time to reach and are only accessible by car automatically restricts access. The tests also need to be accurate and reliable. There is significant risk in asking NHS and care home staff to return to work if it turns out that the test they took, which told them they did not have the virus, is incorrect.

## Co-ordination – is the whole end to end approach to testing being appropriately co-ordinated?

The end-to-end testing process is hugely complex. The overall strategy must be based on the latest knowledge of the virus and how it transmits, which can be constantly developing. The multiple organisations actually conducting the tests, the organisations processing them, and the materials' supply chain serving the testing process must be effectively marshalled. The right capacity and form of test must be available in the right geographic location at the right volumes and the right time, including the logistics needed to transport tests between the testing sites and those processing the tests.

Those who need to be tested and their employers – potentially millions of people and hundreds of thousands of employers – need to know how they will be tested, where and when. Mass testing requires effective public communications and a robust, easy-to-use, test-booking process. There need to be sufficient staff with the right skills to actually process the tests. The right results need to reliably get back to the right people. And, depending on the phase of virus spread and testing strategy, any testing approach needs to be accompanied by an effective contact tracing approach.

The complexity, and need for excellent co-ordination, derives from the population and geographic reach required, the number of different players involved, the need to constantly evolve the strategy as the virus develops and the range and number of different processes required. This must be managed and appropriately expanded, at an extremely fast pace.

## The testing story so far

### What has happened? Starting point and responsibilities

The UK started from a comparatively weak position in trying to create an effective testing regime. Despite our strong national position in life sciences and biotechnology, the UK did not have a major diagnostics manufacturing industry to call on. It didn't have a single, well co-ordinated, pre-existing, national testing infrastructure.

Testing capacity was split across a number of different sources and control and co-ordination of that capacity was unclear. Responsibility for testing strategy and growing capacity has been split across a number of different organisations, particularly as private sector testing capacity was brought on stream with the following different arms of government involved:

- Number 10
- Cabinet Office
- Office of Life Sciences
- Department of Business, Energy and Industrial Strategy
- Department of Health and Social Care
- PHE
- NHS England.

Responsibilities and accountabilities between these different organisations have been and, to a significant extent remain, unclear.

The government has been in charge of overall strategy and the decisions on how to increase capacity. PHE has been responsible for the epidemiological testing of the population and the science behind the testing. NHS England's role has been to co-ordinate NHS testing capacity and support trusts to deliver their patient and staff testing requirements.

Testing capacity has been split across NHS trusts and their related pathology networks and joint venture partners – PHE run laboratories, the new private sector Lighthouse laboratories, and a wider range of smaller private sector, academic and research facilities such as the Crick Institute.

Trust leaders have consistently argued that the number and range of different organisations involved, the poor co-ordination between them and the lack of a clear, frequently updated, strategy have significantly contributed to the problems with testing they feel they have encountered.

### What has happened – timeline

When the pandemic was first breaking, the government adopted a 'track and trace' strategy to identify early cases and those who may have been in contact with these cases. However, on 12 March, as the government moved from the 'contain' to the 'delay' phase, PHE stopped performing contact tracing. NHS trusts were instructed to use all available testing capacity just for patients displaying COVID-19 symptoms.

On 29 March, in response to growing pressure from NHS trusts facing unprecedented staff absence rates, **national leaders allowed 15% of trust capacity to be used for staff testing**. As trusts had argued was likely to be the case, early testing showed that a significant number of staff were self isolating unnecessarily and were therefore able to return to work. An NHS England feedback exercise with NHS trust leaders led to **the 15% cap being lifted on 1 April**.

Following a significant period of public pressure, the health and social care secretary Matt Hancock announced a new testing approach – *Coronavirus (COVID-19): Scaling up our testing programmes* on April 4. This set out five different pillars to grow testing capacity with an overall objective of expanding the number of coronavirus tests in the UK to 100,000 per day by 30 April. Professor John Newton from PHE was also appointed as the overall co-ordinator of the national testing effort. As capacity grew, **on 12 April the testing offer was expanded to a wider group of NHS staff and household members outside of acute care**.

As the deadline of 100,000 tests by 30 April approached, there were a series of government announcements on expanding testing capacity and who was eligible for testing.

On 23 April, **the government announced that testing would be made available to millions of key workers and their families**, using an online portal to book an appointment at drive-through testing sites across the country, or potentially receive a home testing kit.

On 24 April, trusts were asked to test all admitted patients who required an overnight bed, irrespective of whether they showed COVID-19 symptoms or not, an estimated 10,000 patients a day. This will enable trusts to separate COVID-19 and non-COVID-19 patients. A similar approach to all elective patients will be required from the week beginning 4 May with protocols for delivering this approach currently in development. Eleven trusts are also now involved in a pilot to randomly test asymptomatic staff, and early anecdotal evidence suggests this is showing around a 10-20% infection rate.

On 26 April, **the government announced the creation of a network of mobile testing units run by the armed forces**.

On 28 April, **it announced the extension of testing to three further categories:**

- everyone aged over 65 with coronavirus symptoms together with symptomatic members of their household
- symptomatic workers who are unable to work from home
- all care home staff and residents, whether or not they have symptoms.

By 28 April, 763,387 tests had been completed since testing began. In the last four weeks, from 31 March to 28 April, across the NHS the total number of tests completed has grown five-fold – a compound daily growth rate of 6%. Expanding NHS testing capacity has played a significant role in this expansion. The data on the 28 April showed the number of daily tests had increased to 43,563, up from the 8,240 completed on 31 March (an increase of 429%).

## The NHS trust contribution

Trust leaders believe they have done all they could to support the national testing effort. They have tested as many patients as their capacity allowed. They have grown their testing capacity as quickly as possible. They have tested as many staff as possible as soon as they were allowed to do so, reducing staff absence rates. They have made as many staff as possible available to support the government's wider testing effort. They have made their testing capacity available to other local partners wherever possible. The NHS will have reached the 25,000 tests a day target they were allocated by the end of the month, as required. This has all been delivered from a standing start in less than a month.

Trusts have also tried to ensure that they have maximised the value of each test as they have extended the reach of their testing approach – from symptomatic NHS patients, to symptomatic NHS staff, and now, beginning to test asymptomatic patients and staff. They have been supported in all this work by a capable team at NHS England including a seconded, senior, experienced trust chief executive, acting as a liaison point with their fellow trust chief executives.

## The focus on 100,000 tests by 30 April – a red herring

The recent public focus on whether 100,000 tests will be performed on 30 April is a red herring. While it may have had a helpful, initial galvanising effect, it is an isolated measure of capacity at a single point in time and is therefore a distraction from the key issue of how the government's testing strategy needs to develop. All six questions outlined above are just as important and relevant on 1 May irrespective of whether 50,000, 75,000 or 100,000 tests are performed on 30 April.

Trust leaders are also worried that the current focus on reaching the arbitrary "100,000 tests by April 30" target is distorting the testing approach in three key ways:

- it may be preventing the development of a proper, next stage, testing strategy and debate on what should be in that strategy
- it may be driving testing for testing's sake – maximising the number of tests on 30 April – as opposed to ensuring that each test is done for the right purpose and delivers appropriate value
- it may be driving an excessive focus on the number of tests completed, as opposed to focusing on whether those who should be tested can actually get tested when required, which is the most important priority.

## Has this overall approach been sufficient and appropriate?

Trusts leaders believe that, despite all the work that has been delivered by their trusts, at a national level, the English health and care system has struggled to develop an effective testing regime over the last two months. It will be for any subsequent public inquiry to fully determine why these problems have occurred and whether the response was adequate.

Among the questions any COVID-19 related public inquiry seems likely to explore are:

### Strategy /overall position

- Why did the UK start in such a relatively poor position?
- Have ministers been sufficiently clear about their overall strategy, has the strategy been sufficiently consistent, has it been the right strategy and has it been updated frequently enough?
- Were the needs of acute hospitals excessively prioritised over the needs of ambulance, community and mental health trusts and primary and social care?
- Has the focus on delivering 100,000 tests by 30 April distorted the overall strategy?

### Testing criteria

- Have the right people been tested at the right time with the right frequency?
- Have the prioritisation decisions been the right ones – should NHS staff have been tested more quickly? Should infection control have been prioritised earlier?
- Have prioritisation decisions in late April over who to test been excessively driven by the need to meet an arbitrary target of performing 100,000 tests by 30 April deadline?
- Was the UK right to abandon track and trace as quickly as it did?

### Capacity

- Could testing capacity have been expanded more rapidly, in particular drawing on the range of smaller private sector, academic and research facilities earlier?
- Could the number of testing centres have been expanded more quickly to make testing more widely available and physical access to testing easier?
- Could a more decentralised approach to building capacity, as other countries have adopted, worked more effectively than the highly-centralised approach adopted in the UK?
- Could more have been done earlier to help those processing tests overcome shortages of the swabs, plastic testing kits and chemical reagents needed to complete the tests?
- Should the UK have been expanding capacity to return to 'track and trace' as part of the lockdown exit strategy earlier and more rapidly over the last few weeks?

### Co-ordination

- Should the government have been more effective, more rapidly, at co-ordinating the end-to-end testing approach?
- Was the new co-ordination approach announced on 4 April sufficient and the correct one?

## Testing questions – where next?

### Context

The government's plan announced on 4 April understandably focused on the immediate testing priorities, with a commitment to expanding capacity to 100,000 tests by 30 April. It recognised that the plan was *"an evolving document that will develop as we learn more about the virus and as we progress the work"* (p5). It was sketchy about the detail of what would follow the immediate emphasis on testing patients and NHS and care staff (and their families), followed by wider key workers, in self or household isolation. The document included comments such as *"Once widespread testing is available, we will test key workers regularly"*; *"Over time we hope to make testing available not just to NHS staff and other critical key workers, but ultimately to the whole population as needed"* and *"Should antibody tests prove to be effective our strategy will then evolve"*.

The NHS will successfully navigate the first initial spike of COVID-19 demand. The focus now is to work out how to exit lockdown, seeking to carefully manage spread of the virus, avoiding a second spike. It is time for the government to publicly update its testing strategy accordingly. Trust leaders want to see a new, updated, version of the testing strategy as quickly as possible.

They are keen and willing to play their part in building the fit-for-purpose testing regime that is so desperately needed. However, as outlined above, testing strategy, criteria, capacity and co-ordination are all controlled by the government. Trust leaders and the NHS are therefore totally dependent on government plans, particularly since much of the testing capacity they need to access is not within their control.

At the moment, they feel on the end of a series of almost daily tactical announcements extending the testing criteria to new groups of people with no visibility on any long-term strategy. They are being expected, at the drop of a hat, to accommodate these changes with no advance notice or planning, despite the fact that many of the changes have significant operational impact.

Trust leaders believe that the updated strategy needs to answer the following six questions. The first two focus on delivering the existing commitments on patient and staff testing made in the plan. The other four focus on how the vaguer 'next stage' commitments made in the plan will now actually be delivered.

## Delivering the core commitments on patient, health and care staff and key worker testing

### 1 **When will every patient and health and care staff member with suspected COVID-19 symptoms who needs a test be able to consistently access that test within an appropriate turnaround time?**

The government's 4 April plan made a central, core, commitment to "*continuing to provide tests for patients who need them*" and "*providing tests for NHS and social care staff who are in self or household isolation to support them to return to work as soon as possible, if they are well enough to do so*" (p5). Some trusts still report problems in obtaining these tests with issues around access to swabs, reagents and testing kits and insufficient capacity to turn round tests in the required time.

Frontline NHS staff, when they have needed to access non-NHS testing facilities, have stressed the difficulties caused by the location of testing centres, with some having to drive for over two hours to reach the facilities. There are also reports of staff being turned away when arriving without appointments. [The British Medical Association estimated on 22 April](#) that 100,000 staff across the UK were self-isolating with many not knowing if they have the virus or not and called for a massive extension of the number of testing facilities. With NHS staff severely stretched in responding to the pandemic, the process individuals must undergo to receive tests has varied significantly, based on proximity to key testing sites.

The government needs to set out its estimate of how and when these problems will be overcome so there can be reasonable confidence that everyone in these categories who needs a test will receive it in good time.

### 2 **Given current problems with access to key worker testing what are the government's immediate plans to improve this access?**

The government's 4 April plan also made a core commitment to testing "*wider critical key workers... in self or household isolation to support them to return to work*" (p5). While welcoming the creation of the new regime and recognising it is still in its early days, many key workers are reporting significant and frustrating difficulties in accessing tests.

There have been capacity constraints in terms of the number of tests available, with the online booking system becoming rapidly overwhelmed each day as the latest batch of testing dates becomes available. As with NHS and care staff, there are insufficient testing centres with most dependent on car access, and many key workers currently being too far away from a centre. The government needs to set out how it is going to address these problems, with a clear plan of how it will expand capacity and improve access.

## Delivering the 'next stage' commitments on testing

### **3 How quickly does the government now expect swab test capacity to further expand and how will it prioritise the use of this capacity once created?**

The government plan of 4 April rightly prioritised expansion of swab testing capacity. However, it is still unclear how quickly the government believes this capacity will expand, and how the different types of capacity (NHS/PHE labs, Lighthouse Labs and private sector labs) will be used.

Trust leaders want and need much greater clarity and detail here, including on the purpose of further testing, so that they can plan effectively. Some of the next stage testing requirements – for example regularly testing all their staff and patients, irrespective of whether they are showing COVID-19 symptoms or not – are large scale, complex, undertakings. Trusts need to know now when they should be planning to start this approach.

Trust leaders recognise that plans will evolve over time and that it is not easy to predict how future capacity will grow. However, they want a clear future direction of travel with a frequently updated estimate of when capacity will be expanded, how testing criteria will be changed/extended and what capacity, particularly the testing capacity they control, will be used for what purpose. If, for example, private sector labs will be used to support regular comprehensive staff testing, they can start to make arrangements with the appropriate laboratories now.

### **4 What is the plan to return to tracking and tracing any new outbreak of the virus as part of progressively exiting lockdown?**

A data-driven approach of mass community testing and contract tracing – such as that pursued in countries like South Korea and Germany – should form a key part of the UK's strategy for exiting the lockdown. As restrictions start to lift, it is vital that patients identified with COVID-19 symptoms are quickly isolated, and any other contacts that have been infected are isolated.

This will require a return to the 'track and trace' approach utilised as the outbreak started but stopped as the virus spread and the UK moved from 'contain' to 'delay'. The government has started to outline some of the detail including how an expanded track and trace field force will be created. But much more detail is needed as soon as possible.

For example, the government is planning to establish a second tier of temporary contact tracers, likely to be staffed by workers from across the civil service and local authorities. Recruiting rapid-reaction teams presents a major logistical challenge. Widespread contact tracing is likely to require significant resources to work effectively. It will also require strong collaboration between local and national government, ensuring that local public health teams are mobilised to enhance capacity for case detection. The government has not revealed any specific, official, plans for how it will implement digital contact tracing but this will be key. NHSX is developing a contact tracing app but there is no clarity,

at this point, on how and when this app will actually be used other than a statement at the 28 April Downing Street press conference that it will be available in mid-May.

The NHS needs to know, as quickly as possible, what detailed role it needs to play in this process so it can prepare accordingly. As the first NHS point of contact for most citizens, 111, GP surgeries and pharmacies need to understand and prepare for the role they will play. Trusts running laboratories need to know if their capacity, particularly if the constraints on swabs, reagents and testing kits can be fully overcome, will be used for this purpose.

#### **5 Given the need to control the risk of cross infection in healthcare settings, what are the plans to move to systematic regular testing of all NHS and care staff as well as patients?**

One of the features of coronavirus is that carriers of the virus can be unwitting spreaders as they can be infectious for a number of days before showing symptoms. There is therefore **a strong case for regular systematic testing of all asymptomatic health and care staff and patients**. The government's plan of 4 April states "*Once widespread testing is available, we will test key workers regularly to keep them safe and ensure they do not spread the virus*".

11 pilots have started but trusts need to know urgently what the government's plans are in this area, given the scale of task involved in regular, frequent, testing of hundreds of thousands of members of staff. The details they need to know include which staff need to be tested, how frequently, what capacity will be used for testing, when this capacity will be available, whether the approach will be a single big bang or a ramp up over time, whether the approach will be voluntary or mandated and when this will need to be started.

There also needs to be clear recognition that any approach to testing health and care staff must take full account of the needs of all types of trust and primary and social care. Reassuring staff and patients that everything possible is being done to create a safe environment in GP surgeries, for example, will be key to fully re-opening primary care in the way that is required.

#### **6 What role does the government now expect antibody testing to play?**

There has been considerable focus at various points over the last two months on the possible opportunities offered by antibody testing to identify those who have had the virus and are therefore potentially immune. However, there have been doubts over the reliability of these tests and, more recently, whether they provide any guarantee of immunity. An updated strategy needs to set out what role the government now expects these tests to play. If it does believe that these tests have a role, it needs to set out the purpose for which they would be used, when they expect this capacity to be reliably available and at what volume. It also needs to set out details of who will be tested, when, how, by whom and with what frequency. NHS trusts also need to know what role they would be expected to play in this process.

## Conclusion

Creating a robust, fit-for-purpose testing regime is central to controlling coronavirus. There is still a vast amount to do to create this regime. Trust leaders stand ready to play their part in this process. But, put simply, they need to know a lot more, as quickly as possible, to play their part effectively in these testing times.

**Your feedback is  
very welcome.**

**For any comments  
or questions  
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For more information:

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