NHSProviders

Briefing

August 2020

STANDING UP TO THE TEST

Learning lessons for the next phase of the national COVID-19 testing strategy

Key points

- From the outset of the pandemic, the government has failed to set out a coherent testing strategy which inspired confidence. Only 18% of trust leaders agreed that the government has had the right approach to testing to meet the needs of trusts and the communities they serve.
- The current approach to testing – introduced in May – has inspired slightly more confidence among trust leaders, with 32% saying it will meet the needs of the communities they serve over the next one to three months, though this is still outweighed by those who disagree with this statement (37%).
- Only four in ten (40%) trust leaders believe their stated priorities for testing are deliverable in the next one to three months.
- Trusts are working hard to provide testing to their communities and are delivering under the current national COVID-19 testing strategy. Significant work has gone into the steady increase in testing capacity, and 83% of trust leaders believe they are meeting testing requirements under current government guidance.
- A minority of trusts are still struggling to meet current requirements. Generally, these trusts are not in the acute sector and have not had the benefit of access to sufficient resources, including on-site testing laboratories.
- Turnaround times for testing are encouraging overall, with 70% of trusts 'usually' or 'always' receiving results the next day. However, trusts using laboratories in partnering organisations, or Lighthouse Labs, are far less likely to receive a quick turnaround in results.
- Variation in turnaround times continues to block progress in recovering non-COVID services. Insufficient capacity to quickly test staff and patients, and a shortage of supplies are the largest barriers to resuming services. If resources for more testing were available, over three quarters of trust leaders (77%) assigned a high priority to improving the current standard of testing (including turnaround time) for symptomatic patients and staff.
- There needs to be greater local involvement and buy-in for national plans, particularly as the next phase of the pandemic is focused on responses to local outbreaks. A large majority of trust leaders (70%) are eager to take on a greater role in co-ordinating testing for health and care within their local area.

1 Introduction

On 16 March, in response to the coronavirus outbreak, the prime minister announced the UK government's advice for all people to avoid "all unnecessary social contact". As the potential scale of the pandemic started to become clear – with national lockdown officially announced one week later – it became apparent that the UK was not fully prepared for the programme of mass testing required to identify prevalence and effectively control the spread of the virus.

In the early weeks of the pandemic, testing capacity for NHS services was strictly limited. Having flagged at an early stage the need to test significant numbers of staff for COVID-19 to limit the proportion of the workforce needing to self-isolate, trusts were formally instructed by national bodies to use all capacity for patient testing. This requirement was phased out in late March/early April, at which point the first signs of a national strategy emerged via an intervention from the health and social care secretary. He announced a five-pillar plan, led by Professor John Newton, "bringing together government, industry, academia, the NHS and many others, to dramatically increase the number of tests being carried out each day." An ambitious target of 100,000 tests per day was promised by the start of May and ultimately said to have been reached, although the accuracy of this figure was not universally recognised (Full Fact, May 2020).

At the time of writing – four months since the 100,000 tests announcement – the number of tests completed or sent to individuals each day has far surpassed this mark, with over 260,000 made available on 11 August.

These figures, however, do not tell the full story. The five-pillar plan (Department of Health and Social Care, April 2020) released on 4 April did provide a relative sense of improved order and direction to the national testing programme. Efforts to increase capacity over a short period of time were welcome, particularly as trusts had been reporting ongoing shortages of swabs, plastic testing kits and chemical reagents needed to complete the tests at this stage. These shortages were exacerbated by the fact that there were a number of different testing equipment manufacturers, with consumable swabs, reagents and plastic kits often tied to a particular testing platform (NHS Providers, April 2020). Equally, and certainly prior to early April, efforts to bring together a coherent national strategy for testing were also hampered by a confusing split in responsibility between government departments and their national arm's-length bodies. Simply put, responsibility and accountability for testing was diffuse and unclear.

Despite the gradual increase in overall numbers of tests available since April, the more detailed arrangements needed to address a series of priorities which have been slow in coming together, such as:

- mass testing of symptomatic and asymptomatic staff
- testing key workers outside the NHS
- testing asymptomatic patients to enable on-site infection control and non-COVID care
- population-based measures (test and trace, antibody testing).

In particular, trusts have indicated that their aspirations to resume a pre-pandemic level of service delivery had been made difficult in the intervening weeks due to the lack of a clear, national plan for regular testing of patients and staff. Likewise, the slow emergence of the national test and trace programme hampered efforts to better understand and control community transmission from the centre. Despite calls for a national contact tracing system from senior parliamentarians including Jeremy Hunt and Jonathan Ashworth in March (Hansard, March 2020), the government's test and trace service was not officially launched until 27 May under Baroness Dido Harding (Department of Health and Social Care). Trusts have also noted that their ability to provide more tests at a faster rate has been largely dependent on their access to a testing laboratory within their own trust – a fact which leaves the 'have nots' in this area facing inevitable delays, with a knock on effect on the range of services that can be provided to their communities.

This briefing explores these issues in detail by analysing trusts' responses to our testing survey. It presents views on:

- the government's overall testing strategy during the pandemic as well as its current approach
- the extent to which providers are able to deliver testing under current national guidance
- opportunities to deliver, and barriers preventing the level of testing to resume non-COVID services
- assessments of population-based testing priorities, including the test and trace programme.

This briefing also presents trusts' perspectives on their role in the evolving national testing strategy, with a suggestion that the public would benefit from a greater level of coordination and local involvement from trusts.

About the survey

NHS Providers conducted a survey of chief executives and chief operating officers in all trusts between 25 June and 15 July 2020, to gather feedback on trusts' experience of the current COVID-19 testing regime, as well their views on the role testing will play in resuming services in the coming months.

The survey included questions on the following:

- current testing arrangements for COVID-19
- trust testing capacity to resume services
- wider population testing and tracing
- the role of trusts and other organisations in testing in the future
- reflections on the government's approach to testing.

The survey received 122 responses from 112 trusts, or 52% of the provider sector, with all regions and trust types represented in the data.

Reflections on the national testing strategy

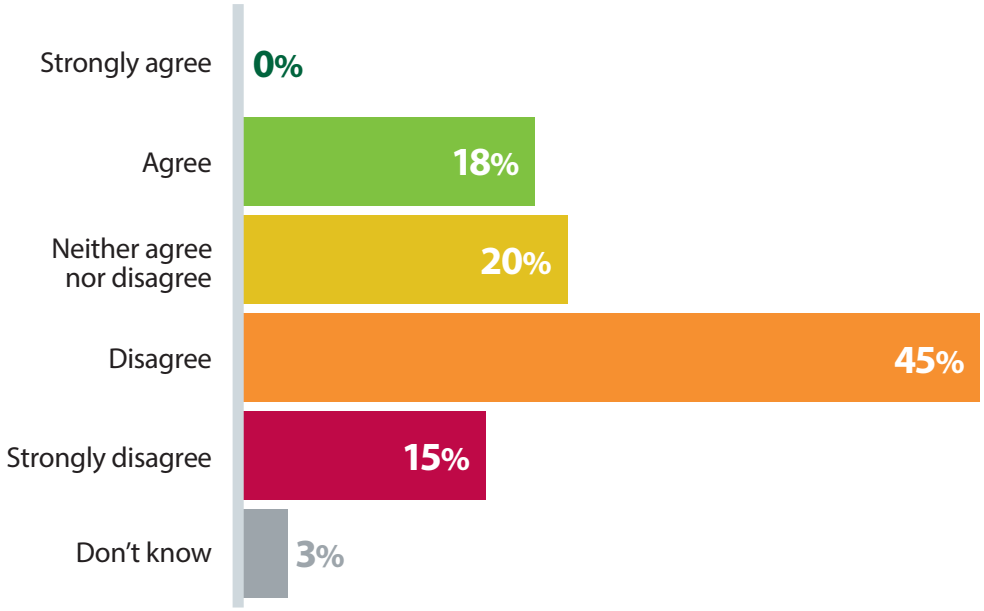
2

From the outset of the pandemic, the government's testing strategy has failed to inspire confidence among trust leaders. This view is clearly reflected in the survey findings, with only 18% of respondents agreeing that the government has had the right approach to testing to meet the needs of trusts and the communities they serve. Six in ten either disagreed (45%) or strongly disagreed (15%) that the government has taken the right approach.

Figure 1

The government has had the right approach to testing to meet the needs of trusts and the communities they serve up until now

(n=114)



Our survey deliberately asked trust leaders for their views on the national testing strategy in two separate contexts. Firstly, we asked whether they were happy with the overall national strategy since the outbreak. Secondly, we questioned whether trust leaders support the current approach, to reflect a sense we've been given from some trusts that some improvements have been made in recent weeks. This was particularly the case following the appointment of the current national leadership group within the testing programme in May, alongside the eventual launch of test and trace.

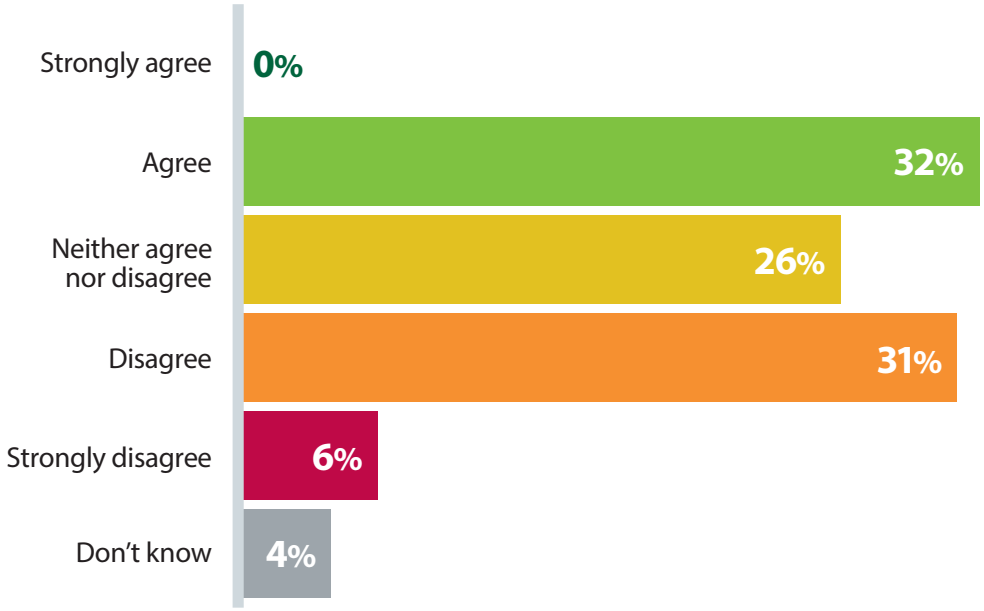
However, even this positive impression has been accompanied by a wider sense of concern over a lack of coherence in approach. The feeling that there has been no single clear and consistent national strategy for testing is supported by the experience of three seemingly distinct phases. First with multiple national bodies and senior figures contributing in response to the outbreak in March, second under the guidance of Professor Newton and third under the leadership of Baroness Harding, accompanied by the introduction of test and trace. If recent reports (Health Service Journal, July 2020) about a further change in leadership are to prove accurate, the national testing programme could soon enter a fourth phase of direction.

The government's inability to ensure a clear strategy from the outset, or to effectively overcome the inevitable challenges that have arisen since then, is still affecting confidence in the national plan. While the proportion of trust leaders who agree with the current approach to meet testing needs in the next one to three months is higher (32%), a greater proportion still disagree or strongly disagree (37% combined) that the government's current plans for testing are adequate.

Figure 2

The government's current plans for testing will meet the needs of trusts and the communities they serve over the next one to three months

(n=115)



A range of reasons were cited by respondents for their lack of confidence in the government's approach, with recurring themes around a focus on meeting targets or numbers "rather than quality or impact":

- the need for wider testing and community contact tracing earlier in the pandemic
- a lack of clarity in messaging and about who is responsible for what
- a persistently slow turnaround times for testing.

"We just don't know what the plans are or what is being asked of us. We are left to make the best decisions we can for our patients. This would matter less if every trust had its own lab and we were dealing with a hospital-based problem. However, we are not. This is a population health issue that we cannot address most effectively as individual providers."

Chief Executive, acute trust

"It has been shambolic. The whole pandemic has been run from a government perspective around the 5pm briefing. Delays in staff testing at the beginning... then logistical issues with labs, equipment, reagent etc. which caused lengthy delays in results."

Chief Executive, mental health/learning disability trust

"[The government] has overestimated the benefits of centralised and national systems... at the same time the contribution of trusts and public health departments on the ground has been undervalued and (consequently) under-used. We could have mobilised mass antigen testing by the end of March. We could have been testing residents and staff in care homes at that stage. We could have had effective contact tracing in place before then. We should have been testing asymptomatic staff at the height of the pandemic to manage nosocomial spread. With the benefit of hindsight these were MAJOR oversights. What is important now is to learn these lessons properly."

Chief Executive, acute trust

Delivery of COVID-19 testing in the NHS

3

Trusts are working hard to provide testing to their communities and are delivering under the current national COVID-19 testing strategy. Significant work has gone into the increase in testing capacity in recent weeks at national, system and local level. Whereas daily tests made available hovered around 100,000 in late April and early May, the number is now routinely more than twice that level (Department of Health and Social Care, June 2020).

Our survey found the vast majority of trust leaders (83%) are confident in their ability to meet testing requirements under current government guidance – 30% strongly agree they have the capacity to complete all required tests, 52% agree, and only 13% either disagree or strongly disagree. Current guidance prioritises testing for all patients admitted for emergency care, elective procedures, or those discharged to other settings. It requires testing for all symptomatic patients and staff, but not wider testing to identify asymptomatic staff (NHS England and Improvement, June 2020).

Trusts have consistently underlined the importance of fast turnaround times for results within their efforts to deliver effective testing regimes. A high degree of variability in turnaround times between trusts was a theme from our survey, based predominantly on whether trusts have access to on-site laboratories. This speaks to some trusts operating with 'patchwork quilt' testing arrangements – putting separate pieces together to form a whole testing programme for patients – as organisations without on-site laboratory access are forced to rely on laboratories at other trusts, Lighthouse Labs (new diagnostic facilities created in partnership between the Department of Health and Social Care and a number of medtech organisations), as well as other independent facilities.

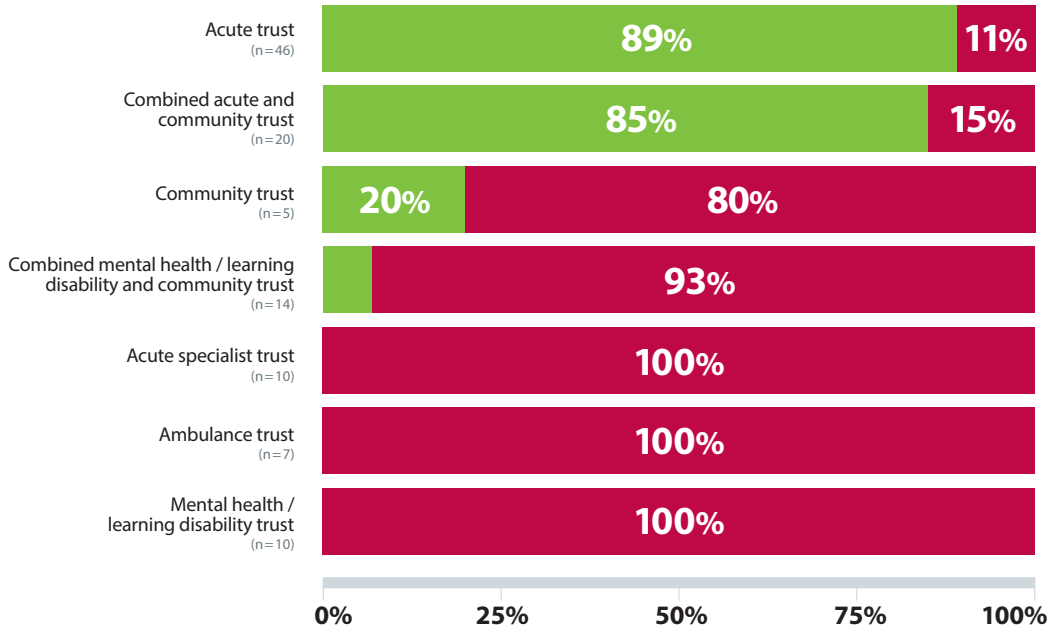
We asked whether trusts are using one or more of:

- a laboratory within their own trust
- a laboratory at another NHS trust
- Lighthouse Labs or another independent facility.

Just over half of trusts (54%) said they use a laboratory within their own trust, with most acute trusts (89%) and combined acute and community trusts (85%) being able to do so. Other trust types are far less likely to have this option, with only one community trust and one combined mental health/learning disability and community trust indicating they use a laboratory within their own trust. A significant minority of trusts with their own labs still use other trust labs for testing (40%), but they do so less frequently than using their own facility.

Figure 3

Proportion of trusts who use a laboratory within their trust for COVID-19 testing, by trust type



Just over two thirds of trusts (68%) said they use laboratories at other trusts, with a large proportion of these (68%) doing so because they do not have a laboratory within their own trust. This was true for all mental health/learning disability trusts, acute specialist trusts and ambulance trusts who responded to the survey, as well as most combined mental health/ learning disability and community trusts (93%) and community trusts (80%).

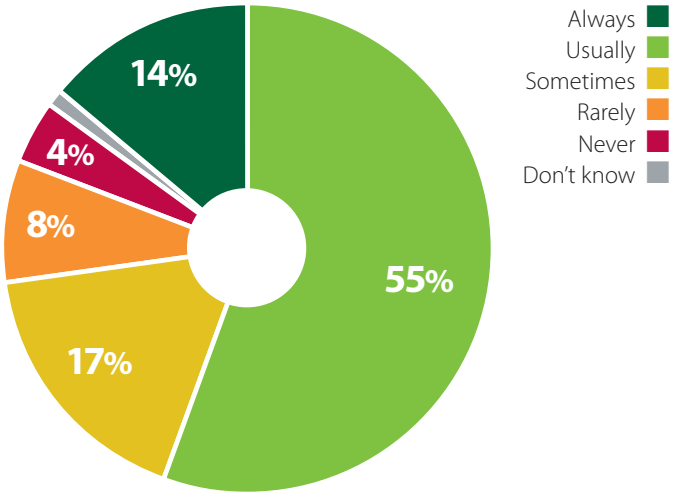
A small proportion of trusts told us they are using Lighthouse Labs or other independent testing facilities (18%). In all of these cases this was in addition to either using a lab within their trust or at another NHS trust, and those using this source of testing tended to use it less frequently.

There are some encouraging points looking at overall turnaround times for results, with 70% of trusts telling us they 'usually' or 'always' receive results the next day. Only one in eight trusts (13%) 'rarely' or 'never' receive results the next day, indicating an overall picture of efficiency in turnaround times for testing across the country.

Figure 4

Overall, how frequently do you receive the results from antigen testing the next day?

(n=112)



However, turnaround times do depend significantly on the 'source' of testing for trusts. Whereas over three-quarters (78%) of trusts have an average turnaround time within 24 hours when using on-site laboratories, when trusts use labs in other trusts only 16% report an average turnaround time within 24 hours, and this falls to 10% when using Lighthouse Labs.

It is clear that mutual aid and strong collaborations between providers is playing a huge part in the national testing effort, though the low take up and variable turnaround times of the much-publicised Lighthouse Labs is concerning. Access to on-site laboratories is not the only factor influencing turnaround times. Other common reasons identified included transport for off-site tests, a lack of reagents (testing kit material) and lack of staff.

"[We have] sufficient capacity based on current guidance and current numbers of admissions. If criteria change then this may become problematic. Similarly, if [the] trust was to take on board testing for primary care/care homes then meeting this requirement would prove challenging."

Chief Operating Officer, acute trust

"We have had to adopt 24-hour working and waste time swapping testing onto different platforms due to a shortage in reagents. We need a consistent supply of Cepheid Inc reagents."

Chief Operating Officer, combined acute and community trust

Meeting national priorities: testing to resume services and protect the public

4

While the vast majority of trusts are confident in their ability to deliver the level of testing required under current guidance, there is significantly less certainty when looking forward to meeting the needs of local patients and communities in the coming months.

Our *Recovery position* (2020) briefing, published in late June, reflected a high degree of uncertainty around trusts' capacity to return to 'normal' service delivery in general. While 50% of respondents were 'fairly confident' that their trust was able to return to meeting the needs of all patients and service users, only a very small minority (5%) were very confident, and the wide range of estimated timeframes for recovery was telling: 24% said they could do so within one to three months, with an almost identical figure for three to six months, 19% said they didn't know and 12% feared they would never be able to return to previous levels. These findings are reflected in our testing survey, where only just over half (56%) of trust leaders agreed that they have the necessary capacity to test patients that will need testing when paused services resume.

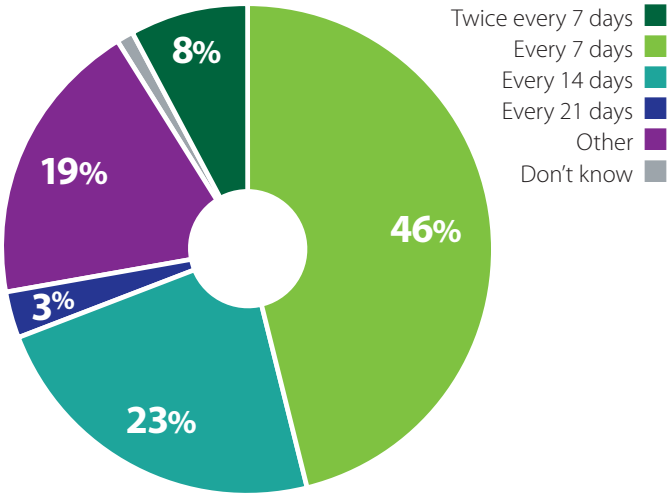
These themes are also further supported by our conversations with trusts – and responses to this survey – on the barriers presented by limited testing capacity. In particular, there is persistent concern around how providers can significantly step up service delivery where they are not able to regularly test all patients and staff. Coupled with this, the need to follow strict infection prevention and control (IPC) guidelines and ensure staff self-isolate when they are identified through test and trace as a 'close contact' of an individual or individuals who have tested positive for COVID-19 places additional pressure on the trust workforces. Indeed, we have been told of instances where the majority of – or whole – teams of staff have gone into isolation, leading to a temporary shutdown of a particular specialist service.

Definitions of what regular testing means – or the required frequency of testing at least – varies between trusts, with over half of trust leaders (54%) calling for testing for all patient-facing staff at least every seven days, and 23% calling for testing every 14 days.

Figure 5

How often do you feel you should be testing all your patient facing staff (including asymptomatic staff) to be confident in protecting staff safety, ensuring effective infection control and resuming services over the next one to three months?

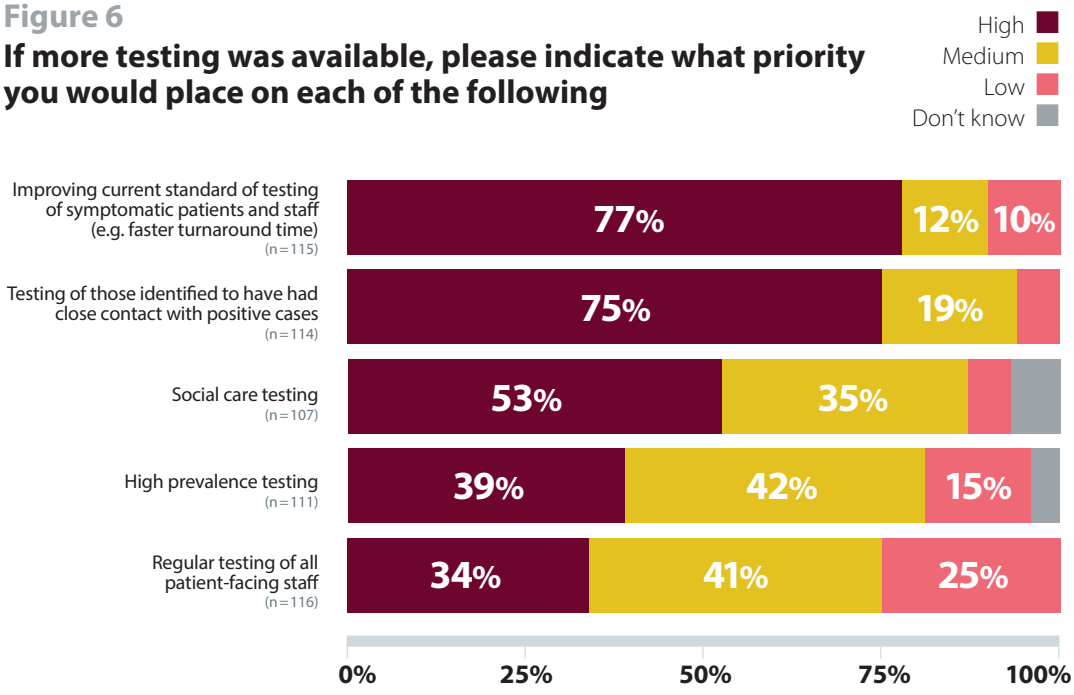
(n=114)



The NHS is rightly emphasising the importance of rigorous IPC within trust sites. Legitimate concern has been raised over the risk of transmission (The Guardian, May 2020) from staff to patients, or from staff to staff within hospital settings, and managing this risk has an obvious impact on the resumption of paused planned services. The 'phase 3' instructions for the NHS, released in a letter to all trust chief executives and chairs at the end of July called for an acceleration of the return to near-normal levels of non-COVID health services.

Trust leaders tell us that efforts to significantly step up the delivery of services would be helped by greater testing capacity, with over three-quarters (77%) of respondents to our survey assigning a high priority to "improving current standard of testing of symptomatic patients and staff (e.g. faster turnaround times)" if more testing was available. "Insufficient capacity to quickly test staff" was cited as one of the three most common barriers to resuming non-COVID services in trusts (by 30% of respondents), alongside "insufficient capacity to quickly test patients admitted for non-COVID care" (31%) and a "shortage of supplies" (34%).

Figure 6
If more testing was available, please indicate what priority you would place on each of the following



Turnaround times recur as an issue for trusts throughout the text responses in the survey, reflecting concerns raised to us by trust leaders throughout the pandemic. However, reaching the 'gold standard' of 24-hour turnaround times feels unattainable for some organisations, particularly for those outside of the acute sector and where trusts are relying on support from neighbours and independent facilities to meet testing demand. The recent government announcement (August 2020) of two new 90-minute tests to be rolled out across hospitals, care homes and labs is significant, as demand is expected to continue to increase in the months approaching winter. At the time of writing, it remains to be seen what the impact of the new tests will be.

4

The importance of antibody testing, at various stages held up by the government as a key plank of the wider testing strategy, has since been called into question (British Medical Journal, June 2020), and only a third of trust leaders in our survey (33%) said testing staff and patients for antibodies should be a priority for the NHS at this time. The tests are clearly popular with staff as they gain perceived assurance from the results. Many trust leaders express frustration about the inability to use the results to plan services or deploy staff differently due to incomplete understanding of the effects of immunity, and some note that it may even lead to a false sense of security amongst staff and poor behaviours around PPE and IPC.

Overall, trusts are struggling to see how all the necessary elements to ensure a significant step up of non-COVID care will come together, and indeed how their stated priorities in relation to testing will be provided for. Only four in ten trust leaders are confident that testing in their identified priority areas will be deliverable in the next one to three months. As well as improving the current standard of testing of symptomatic cases, three quarters of trust leaders (75%) also assigned a high priority to testing those identified to have had close contact with positive cases, and the lack of confidence in expanding and improving the way testing is carried out is a reminder of the challenges ahead. The general lack of confidence is reflected towards another piece of the testing puzzle – the national test and trace service, with only 18% saying they believe test and trace arrangements are currently set up to operate effectively in their local area and 39% 'not confident' or 'not confident at all'.

"It is the speed of turnaround that is the issue. We are a hot spot and trying to place and manage patients without their status being known, is problematic."

Chief Executive, acute trust

"Don't feel there is a lack of available testing. The issues relate to the purpose of the test and speed of obtaining results... As test and trace service plays a key role – particularly the speed and accuracy of test and trace service – we would not be confident in being able to test quickly enough (or isolate) those who have been in contact with a positive case."

Trust leader, combined mental health/learning disability and community trust

Local buy-in: the role of trusts in the evolving testing strategy

5

One of the key lessons learned from the evolution of testing during the pandemic is the need for greater local involvement with and buy-in to national plans. Indeed, this lesson is relevant to a number of challenges over the past few months, including the provision and supply of PPE. While the testing framework has been developed and managed nationally, and credit needs to be given to the government for recent sustained increases in daily capacity and positive trends through the test and trace service, the story of the next few months will be centred around local resilience and response.

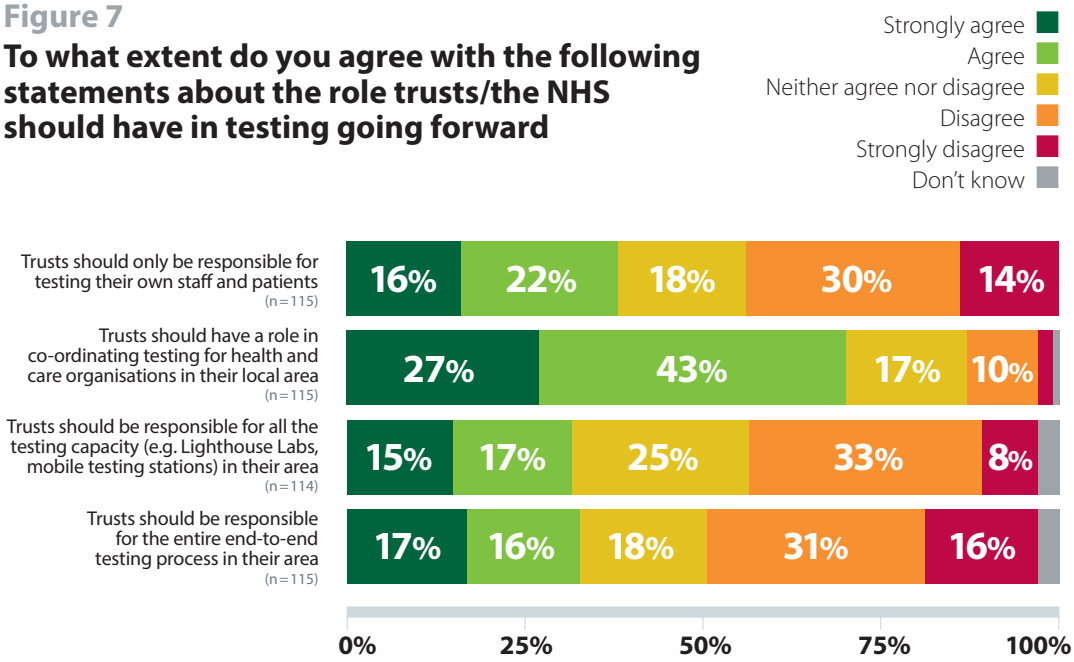
This has already come to light through the focus on local outbreaks and local management of spikes in transmission in Leicester, Blackburn and, inevitably, elsewhere. Trusts have emphasised the need for greater coordination between the national testing service – including test and trace – and local public health teams and systems. The delays in sharing critical, detailed testing data (Financial Times, June 2020) with local officials did not help Leicester as its leaders sought to respond to the city's outbreak, and this approach should not be repeated if and when outbreaks emerge in other parts of the country.

Our survey clearly showed that trusts want to take on a greater role in the management of testing locally, with a strong majority of respondents (70%) agreeing that their organisation should have a role in co-ordinating testing for health and care within their local area. More significant involvement for key local partners was also a development many would support, including for primary care providers (67% of trust leaders agreed they should have a bigger role), and local authorities (58% agreed).

However, it should be noted there is a clear message in feedback from trusts that, while greater involvement and coordination of testing for their organisations and local partners would be beneficial, shifting responsibility entirely to each local area would not be favoured as a solution. Less than a third of respondents (32%) felt trusts should be responsible for all the testing capacity (e.g. Lighthouse Labs, mobile testing stations) in their area, and similarly less than a third (32%) said trusts should be responsible for the entire end-to-end testing process in their area.

Figure 7

To what extent do you agree with the following statements about the role trusts/the NHS should have in testing going forward



When looking in more detail at those who did indicate a desire to take on responsibility for all the testing capacity or the entire end-to-end process in their local area, the same trust leaders responded positively to both statements. However, there was no clear split between acute trusts (who are more likely to have their own testing facilities and subsequently receive results much faster) and other trust types, suggesting the appetite for greater oversight is driven by a range of reasons, some of which are likely to be specific to local conditions and relationships.

Another indication of the range of opinions towards testing held by trust leaders was seen in responses to the question about current involvement in surveys or research on antibody testing (e.g. Public Health England SIREN study). Two thirds (67%) said their trust is taking part, but many expressed doubts about the immediate value in the short term and the services they are trying to deliver. Wider epidemiological benefits were recognised, and participation was noted in having a positive effect on staff confidence, but the time and effort required at a time when resources are scarce brings into focus the difficult balancing act faced by trusts.

6 Conclusion

Testing is an essential part of the national strategy to combat COVID-19, both to track the spread of the virus in the community and to enable the health service to deliver care safely to all who require it. After a difficult start where testing capacity for NHS services was limited, trusts have responded strongly and the majority are currently meeting government guidance for the testing required of them. However, it is clear that more is needed, and our survey shows that only a third of trust leaders are confident in the government's plans for testing in the next one to three months.

Despite recent progress in some areas, turnaround speed of test results is a key issue that many trusts would like to see further improved. If resources were available, the majority of trusts would like to see more testing of those identified to have had close contact with positive cases, but with less than one in five trust leaders confident in the national test and trace programme there is some way to go.

Trusts are ready and willing to take on a greater role in co-ordinating testing locally, alongside local partners, and continue to seek ways to be at the forefront of the response to the next phase of the pandemic. If trusts are to be able to deliver the required acceleration of a return to near-normal levels of non-COVID health services, they need to be confident that a comprehensive and responsive national testing strategy will both enable and support their efforts locally.

Your feedback is very welcome.

For any comments or questions please contact

policy@nhsproviders.org

For more information:

www.nhsproviders.org/standing-up-to-the-test

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