WHC/2022/011

WELSH HEALTH CIRCULAR

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Title: Patient Testing Framework – Updated guidance

Review: June 2022

For Action by:	**Action required by:**
All Health Boards, NHS Trusts	Immediate

Sender: Professor Chris Jones, Deputy Chief Medical Officer / Medical Director NHS Wales

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Enclosure(s): 1

Dear Colleagues,

The Welsh Government's 'Framework for COVID-19 testing for hospital patients in Wales' was first published in March 2021. In light of widespread vaccination, the Wales long-term Covid-19 transition from pandemic to endemic plan published 4 March and PHW advice, we have reviewed these arrangements.

Current Context:

Vaccination is proving to be highly effective at reducing the risk of symptomatic illness, severe disease, hospitalisation and mortality. Alongside the vaccine, new anti-viral treatments are available that can help to reduce the severity of disease, particularly for those who are most likely to be at risk of adverse outcomes. We saw a relatively modest impact on hospital admissions and mortality during the high community incidence of SARS-CoV-2 during the Omicron peak and the extent of nosocomial associated mortality was significantly reduced during the Omicron wave.
This means the risk to the NHS from being overwhelmed is reduced for any given level of community infections and the direct harms from Covid may well be outweighed by the indirect harms and specifically the negative impacts arising from measures to reduce transmission.

Update to Framework:

Within this current context, this update to guidance set out in Annex 1 is based on the need to introduce proportionate and effective changes which balance the risks from SARS-CoV-2 against the need to deliver routine and emergency healthcare safely, and the impact that testing regimes have on patients.

This guidance is based on the best scientific, public health and expert evidence we have available to us at this time but also recognises the importance to allow for local decisions to be made about where or when testing may need to be increased or decreased depending on nosocomial rates, community transmission rates, or vulnerability of patients.

Yours sincerely,

Professor Chris Jones,
Deputy Chief Medical Officer / Medical Director NHS Wales

Annex 1

Patient Testing Framework

Pre-admission testing for elective procedures

Pre-admission testing is maintained, but the type of test advised is based on the patient's individual risk from infection.

- Asymptomatic patients who are having a surgical procedure or chemotherapy should have an individualised, multidisciplinary risk assessment which should include consideration of the benefit of knowing the patient's COVID-19 infection status and whether pre-operative testing is required. If so, the patient should be tested using a NAAT (nucleic acid amplification test such as a PCR or Point of Care Test (POCT) which has a high sensitivity and specificity) 72 hours before admission and self-isolate until their procedure.
- For some asymptomatic low risk patients being admitted for low risk procedures, a negative LFD on or just before admission may be sufficient. The use of LFDs allows for more responsive service provision for some patients based on local risk assessment.

Testing on unscheduled admission

- Patients with respiratory symptoms should be tested using NAAT for SARS-CoV2, Influenza, RSV or a full multiplex as clinically indicated. Further testing will be determined by the patient's clinical state if initial result is negative.
- Patients without respiratory symptoms should be tested for SARS-CoV2 only, using a LFD on admission. An appropriate rapid NAAT should be used if a LFD is not available.

Post admission testing of patients

Asymptomatic testing.

- No further routine asymptomatic testing is advised unless required on the basis of a local decision.

Symptomatic testing.

- Patients who develop symptoms should be tested with NAAT for SARS-CoV2, Influenza, RSV or a full multiplex as clinically directed.

Testing for discharge to a closed setting

The testing requirement for discharge to a closed setting is based on symptom resolution and the time elapsed from a positive test.

This testing guidance can be considered as part of an assessment prior to discharge. Testing requirements shouldn't prevent discharge if the assessment supports discharge and other measures are considered appropriate.

We would encourage health boards to work with care home providers on discharge testing arrangements.

- Patients who have tested positive for COVID on or since admission can assume non-infectivity when:
    - Symptoms have resolved, PLUS
    - 20 days have elapsed, OR
    - 10 days have elapsed with either a negative LFD or a negative or low positive NAAT.
- Asymptomatic patients who have not previously tested positive for COVID to be tested within 24 hours of planned discharge to the care facility. Appropriate rapid NAAT for SARS-CoV-2 can be used in the absence of LFD testing.

	Symptomatic / Asymptomatic	**Test**	**Timing**
Pre-admission	Asymptomatic Pre-surgical / chemotherapy	NAAT LFD	NAAT - 72 hours before admission and self-isolation or LFD on admission for low risk patients and pathways
	Asymptomatic Non-surgical / chemotherapy	LFD	LFD on day of admission
Unscheduled admission	Symptomatic	NAAT*	On admission. If negative, further testing determined by clinical state
	Asymptomatic	LFD or NAAT	On admission.
Post admission testing of inpatients	Symptomatic	NAAT*	
	Asymptomatic	N/A	No further routine asymptomatic testing unless required on basis of a local decision.
Pre discharge to closed setting	Asymptomatic but COVID positive on or since admission	Possible LFD or NAAT	Assume non-infectivity when: • Symptoms have resolved, PLUS • 20 days have elapsed, OR • 10 days have elapsed with either a negative LFD or a negative or low positive NAAT.
	Asymptomatic and not COVID positive within admission	LFD or NAAT	Within 24 hours of planned discharge to care facility.

* NAAT for SARS-CoV2, Influenza, RSV (full multiplex as clinically indicated)