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FROM: **DAVID STERLING**
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DATE: **63 APRIL 2020**

TO: **PS/FIRST MINISTER**
PS/DEPUTY FIRST MINISTER

copy recipients listed below

TESTING: KEY WORKER PRIORISTATION

Summary

Issue	**Following consultation across departments, this note sets out the a proposed approach that will be taken to testing non-health service workers and the wider population when the supply of tests is sufficient to enable it.**
Timing	**Routine.**
FoI implications	**This will be disclosable.**
Recommendation	**That Ministers note agree:** **The proposed approach being taken to prioritisinge tests for those outside the Health Service.**

Background

The issue of testing has had a high profile over recent weeks and you will know from the CCGNI meetings that work is being done on various fronts to make progress on this issue. Earlier today the Executive considered the The Department of Health's is developing a testing strategy paper which will set out the current availability of tests

~~and the plans to expand that provision through work with Randox, the universities, AFBI and the forensic science laboratory~~ which advises on short term (1-4 weeks), medium term (4-8 weeks) and long term (8-16 weeks) testing approaches. The focus here is on the antigen tests currently being carried out – when the antibody testing comes on stream, we would need to consider how best to distribute those.

2. Everybody is agreed that the first priority for testing are those who are believed to have contacted the virus and are significantly unwell. ~~It is also widely agreed that a~~ The Strategy is also predicated on a high proportion of any tests available after that ~~should be~~ being for frontline health and social care staff. Further work has now been done to identify how any tests available outside the health sphere should be allocated. You will be aware that, at present, there is not enough capacity for this to happen but the wider work going on is designed to improve that situation as we go forward.

3. The Health Minister has, in conversation with his GB colleagues, agreed that there should be a similarity of approach across all jurisdictions. The approach set out below is broadly similar to that being proposed for other jurisdictions too but, importantly given our scale, we will want to reserve the right to adjust the provision based on the level of need in real time. It is for that reason that we have set categories using examples rather than seeking to be definitive. In addition it does not follow that all of one category needs to be fully tested before moving onto others. Indeed, if some critical part of the food supply chain or our capacity to conduct burials was affected by significant self-isolation among funeral directors while first responders could cope well, we might choose to divert tests to those areas for the short term even if there were unmet needs in the higher categories. In addition, when there are tests available for distribution we would most likely proportion out the tests between the groups to achieve the best overall outcome. This will be an operational decision but once we are able to offer tests outside the health sector we would report how they have been distributed.

4. I recognise that there is a strong desire to be able to offer tests to members of the community and that remains our ambition. However, it is a sensible and proportionate strategic approach to ensure first that critical services continue during the height of this crisis.

5. In setting out the way forward, the UK Government has said it would be helpful to have some common principles. The version below has been reviewed by colleagues here and make sense.

Objectives and prioritisation principles

The main objective is to recover the maximum number of key worker days from the number of available tests across the UK, but using targeting to give first priority to the most critical of the key worker populations that need to be returned to work to support the response and essential services.

The suggested rationale for the prioritisation is to assess in real time:

a. **How critical the workforce is to preserving life (first and foremost) and/or sustaining key public services and utilities**;

b. **How severe impacts have been on the workforce**, reflecting both current excess absence rates and any increase or decrease in the total workload of the sector (resulting in some assessment of how close to capacity the service is);

c. **The ability of the sector to rapidly identify and prioritise workers who are self-isolating** and provide the information to get them tested at the very beginning of their absence period, when symptomatic testing provides the greatest workforce benefit;

d. **How unique/irreplaceable individual workers skills are** - i.e. how readily can any absences be backfilled; and

e. **How important is it for the workers to have physical contact with others** or whether they can continue to operate from home whilst displaying symptoms.

6. The list of categories is set out below. They have deliberately been written in general terms recognising that it would be hard to define precisely every category without risking missing some important area. The approach has been endorsed by Permanent Secretaries.

1. **First responders** who keep people safe (eg Police, Fire) but are self-isolating/show symptoms in sufficient numbers to impact service levels adversely;

2. **Those serving/living in enclosed communities** at high risk of serious COVID-19 outbreak (eg prisons, care homes) but are self-isolating/show symptoms at a scale which will impact service levels adversely;

3. Those necessary to enable the **critical national infrastructure** to continue to operate where the numbers self-isolating/showing symptoms mean that a significant adverse reduction in, or failure of, infrastructure would be likely (eg utility sector);

4. Those necessary **to support the health and wellbeing of the community** directly where the numbers self-isolating/showing symptoms mean that there is a direct risk to community health or well-being because of service failure (eg funeral directors, refuse collectors, critical food production or supply pinchpoints, etc);

5. **Those being shielded and those in vulnerable** categories – again with symptoms;

6. **Wider community testing** for those with symptoms/self-isolating.

[Note for categories 1-5, it may be the worker or a household member showing symptoms who are tested]

7. Subject to your agreement, ~~I intend to invite Permanent Secretaries colleagues to make their Ministers aware of~~ I will advise departments of the approach to prioritisation as set out here. It would be premature to publish the list at this stage because it will create expectations that we are not in a position to meet.

Recommendation

8. That ~~Ministers note~~ you agree the proposed approach ~~being taken~~ to prioritis~~e~~ing tests for those outside the Health Service.

DAVID STERLING