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COVID-19 Testing Strategy for Aotearoa New Zealand

November 2021

Purpose

The purpose of the COVID-19 Testing Strategy is to provide clear guidance to align COVID-19 testing with the transition from an Elimination Strategy to a Minimisation and Protection Strategy (of which the **COVID-19 Protection Framework (CPF)** will be part). It is anticipated that both the nature of COVID-19 and the testing options available will change over time, requiring adaptation. This Testing Strategy will be reviewed and updated as required.

The Strategy is a national guidance document on testing, which should be used to determine local and regional testing plans. It is based on public health recommendations for COVID-19 testing of different groups in differing scenarios. Central to the recommendations is ensuring that those who are at greatest risk of poor outcomes are prioritised, and that results are delivered in a timely manner.

The Testing Strategy also outlines the factors needing to be considered in determining which testing approach to take and suggests how to apply this approach to different groups. Some notes on implementation and laboratory prioritisation are also included. Other operational, policy and legal matters are outside of the scope of this Testing Strategy.

The testing response to COVID-19 needs to be adaptable and flexible to account for different scenarios (see **Testing Strategy Framework**), including varying rates of prevalence, specific community needs and differing rates of vaccination. Equitable access to and options for testing are central to this Testing Strategy. While, not suitable for all purposes, rapid antigen testing (RAT) is a key addition, which has not been a part of previous testing plans. This will help to support access to testing by providing another option, including as a 'self-test.'

Context

The Testing Strategy will inform the basis of an ongoing discussion between the Ministry of Health and the testing sector, as the overall COVID-19 management approach is updated. This will include continuing work to build sufficient and sustainable testing capacity within each region of the country to ensure equitable and timely diagnosis of COVID-19, to both support individual clinical care and the public health response.

This Testing Strategy is designed to be implemented alongside the CPF. A testing approach is defined for each of three scenarios, which are linked to the three levels of the CPF. The testing approach may not, however, always be aligned with the CPF level. For example, a change in testing approach could be adopted in advance of a framework level change to quickly respond to an emerging situation.

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Assumptions and Principles

Assumptions and principles of a future state that underpin the Testing Strategy are outlined below.

Assumptions about the context

- Aotearoa New Zealand is transitioning from an Elimination Strategy to a Minimisation and Protection Strategy (of which the COVID-19 Protection Framework will be part).
- The national approach to case and contact management has been changed in the COVID-19 Protection Framework.
- Despite an overall high rate of vaccination, there will remain pockets of communities and settings at higher-risk of poor outcomes from COVID-19, due to lower local vaccination rates and/or other factors e.g., social deprivation, poor health system responsiveness, and insufficient health system capacity.
- There will be lower rates of symptomatic cases and higher rates of asymptomatic cases in the vaccinated population compared to the unvaccinated population.
- Protecting the health system capacity is a priority as the overall volume of hospitalisations is likely to increase.
- Some regions will have lower rates of ongoing transmission and therefore fewer active cases than others, due to population density, local rates of vaccination and other factors.
- International borders will remain managed, with testing requirements for border entrants.
- Boundaries may, in some circumstances, be employed to reduce transmission from higher prevalence regions to low prevalence regions, or for movement into regions with higher vulnerability (e.g., due to low vaccination rates, socioeconomic deprivation, health system capacity). Crossing boundaries may require testing either for all or for specific groups (e.g., those that are unvaccinated).
- There is limited sample collection and test processing capacity, both regionally and nationally, which, while capable of supporting ongoing testing for COVID-19, needs to be utilised effectively and in a sustainable manner.
- Work is underway to increase the laboratory testing capacity from approximately 19,000 to approximately 60,000 laboratory tests per day. Despite this, there will remain a need to carefully manage laboratory capacity, including prioritising test analysis based on need.

Testing Principles

- The testing aim will be different in different contexts. In settings where COVID-19 is already prevalent, the principle aim of testing will be identification of cases in those who are at most risk, including at risk for poor outcomes in themselves or others. This helps to safeguard against severe illness and protects the healthcare system.
- The objective of testing is to both diagnose illness that may require management and to support efforts to reduce the risk onward transmission.

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- Rapid detection of infectious cases in those with risk factors of serious illness and infectious individuals at risk of transmitting the virus to large numbers of others and/or to at risk individuals and communities is fundamental to mitigating the impacts of COVID-19.
- Timeliness of testing is affected by a range of factors, including transportation of samples, the method of receipting the sample at the laboratory and, notably, the volume of samples that are already waiting to be analysed. Therefore, public laboratory-based test capacity must be utilised effectively through prioritisation, particularly if demand exceeds capacity.
- Prioritisation should be determined by risk of serious illness to individual, as well as the risk of transmission to large numbers of others and to individuals and communities at highest risk.
- As prevalence increases, the relative risk posed to different groups undergoing surveillance testing shifts. Notably, the risk posed to those caring for COVID-19 positive patients increases as prevalence increases.
- In healthcare settings surveillance protects staff, patients and service continuity, which has a further benefit to the care of patients.
- The testing in any given region is dependent, at least in part, the prevalence of symptomatic cases nationally, given the connected nature of the laboratory network and supply chains.
- The more sensitive, nucleic acid amplification testing (NAAT) should be predominantly utilised for symptomatic testing, though RAT may be used for timely case detection when appropriate (e.g., high prevalence areas, remote/rural areas), at the same time as the sampling for NAAT.
- RAT is more likely to be more effective in higher prevalence settings and so their use is not recommended in low prevalence settings. When prevalence is high, RAT can help to prevent healthcare and laboratory systems from becoming overwhelmed.
- Positive RAT results should be confirmed using NAAT where possible. At very high prevalence levels, this will become less necessary as positive predict value improves and re-testing individuals become less feasible.
- RAT is most effective for surveillance when used at a higher frequency, as this helps offset the lower sensitivity of a single test.
- RAT is generally more effective when administered by trained individuals. However, when this is not possible, self-administered RAT will be utilised.

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Te Tiriti o Waitangi and Equity Considerations

Te Tiriti o Waitangi in this Testing Strategy

- *Equity*: COVID-19 has inequitably impacted Māori throughout the pandemic, particularly in the current Delta outbreak. This Testing Strategy seeks to improve the inequities through encouraging healthcare providers to work closely with Māori leaders and communities to implement testing options which uphold the principle of Te Tiriti.
- *Active protection*: Māori should be actively engaged by the health system to protect themselves, their whānau and their community from the impact of COVID-19. This requires the Crown, and its Te Tiriti partners, to be well informed on the extent, and nature, of Māori health outcomes and recognise the substantial efforts required to achieve Māori health equity in relation to testing.
- *Options*: Sample collection and testing options, including testing modality and options of providers, will be prioritised for Māori and communities at greatest need, such as flexibility for those who are less able to leave their homes independently or easily.
- *Partnership*: The journey of this Testing Strategy will continue to be in partnership with Māori through advisory groups, including the COVID-19 Lived Experience Rōpū, as well as community engagement.
- *Tino rangatiratanga*: Māori-led and iwi providers will be prioritised in local and regional tactical approaches and overarching decision-making by the health system. This is to ensure that the needs of their communities are central to the Testing Strategy, and that a 'by Māori for Māori' approach can be facilitated.

Pacific Peoples in this Testing Strategy

- COVID-19 outbreaks continue to show that Pacific communities are especially vulnerable to COVID-19 and are therefore inequitably impacted.
- This Testing Strategy seeks to improve the inequities of Pacific people through leadership by Pacific providers, and ongoing engagement with Pacific community groups and networks. They will be critical to ensuring the system is informed and accessible enough to meet the ongoing needs of Pacific families and communities, particularly those affected by COVID-19.
- Pacific providers should be actively engaged by the health system to protect themselves, their families, and their community from the impact of COVID-19.
- Sample collection and testing options, including testing modality, options of providers, will be prioritised for Pacific people and communities at greatest need, such as flexibility for those who have a range of comorbidities.
- The journey of this Testing Strategy will continue to be in collaboration with Pacific leadership through the establishment of expert advisory mechanisms, existing groups and community engagement.
- Pacific providers should be prioritised in local and regional tactical approaches and overarching decision-making by the health system to ensure that the needs of their communities are central to the Testing Strategy and that a Pacific ethnic specific approach can be facilitated where appropriate.

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Disabled communities in this Testing Strategy

- COVID-19 outbreaks continue to show that disabled people are especially vulnerable to COVID-19, with significantly higher death rates than other groups.
- This is across all types of disability, including physical, intellectual, sensory, cognitive, accident and age-related disabilities, people with mental health and addiction issues, and people with long-term health conditions.
- Central to improving the response to disabled people is enabling the prioritisation of sample collection and testing, particularly for those at greatest risk of poor outcomes.
- Testing needs to be fit-for-purpose for disabled communities to access on an equitable basis. Reasonable accommodations for disabled communities need to be integrated into system design.
- Local advisory groups of disabled people, carers and support providers should be engaged with to provide tactical advice on how the system in each region can best respond to disabled people and their whānau.

Other high-risk populations in this Testing Strategy

- In addition to Māori, Pacific, and disabled people, we also acknowledge under-served populations that are also at greater risk of poor outcomes due to COVID-19.
- The expectation is that local and regional plans will find meaningful and durable ways to embrace and engage groups, including migrants & refugees, remote and rural people, the homeless and those in transitional housing, and other groups experiencing disadvantage through the system.
- Local and regional plans should also address seniors and those with significant long term health conditions as groups known to be at high risk of poor outcomes from COVID-19.
- This Testing Strategy seeks to improve the inequities of high-risk populations through provider leadership, subject matter experts and ongoing engagement with community groups and networks. They will be critical to ensuring the system is informed and accessible enough to meet the ongoing needs of communities and families, particularly those affected by COVID-19.
- Sample collection and testing options, including testing modality, options of providers, will be prioritised for communities at greatest need.
- The journey of this Testing Strategy will continue to be in collaboration with the Health & Disability sector, working with our most underserved communities through connecting to existing networks and community engagement.
- Providers and community intermediaries should be prioritised in local and regional tactical approaches and overarching decision-making by the health system to ensure that the needs of their communities are central to the Testing Strategy.

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Application of Principles for Testing

At an individual and whānau level, testing needs to:

- Be convenient, accessible, as comfortable as possible and provide a timely result.
- Provide an easily accessible record of testing for individuals, including digital by choice.
- Be reliable in the notification of results, including communication of what to do in the event of an indeterminate test result.
- Build trust, including supporting informed decision making and working with communities to support principles of Te Tiriti o Waitangi, including choice and availability of trusted, culturally safe providers.

At a provider level:

- Testing approaches need to be informed by modelling of potential demand for tests.
- Laboratory capacity needs to be supported in a sustainable manner to meet demand.
- Testing supply chains are managed effectively to enable the system to work to requirements.
- Testing Strategy and guidance needs to learn from provider experience and be informed by provider workforce capacity.
- Be culturally safe and, wherever possible, delivered by an appropriate provider for an individual's and family's cultural needs.
- Innovation needs to be supported where aligned with the Testing Strategy, including new technologies and approaches to support testing.
- Ensure equity of access to testing in both urban and rural settings, and to communities and individuals COVID-19 inequitably impacts.

At a health system level:

- There needs to be national active leadership and stewardship.
- Testing needs to align to wider COVID-19 response and strategic intent, including the 'COVID-19 Protection Framework' and the 'Surveillance Strategy'.
- Innovation, such as new testing modalities or technologies, needs to be supported and promoted where aligned with the Testing Strategy.
- The introduction of new testing modalities needs to be planned carefully considering provider intelligence on operational considerations and test result capture.
- The Testing Strategy needs to be sustainable, flexible and feasible.
- Te Tiriti o Waitangi should be upheld by working in partnership with Māori to actively support access to testing.
- Support equity, inclusion and prioritisation for Pacific peoples, disabled communities and other people who experience COVID-19 inequity.
- IT infrastructure ensures test results are captured from across all providers and software systems.
- Collaboration occurs between community health providers and DHBs, the Ministry of Health or other agencies according to their specific needs.
- Where testing resources might become limited, allocation must be equitable and prioritise testing for individuals and communities at most risk of serious illness to ensure that test results are timely.

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Testing Modalities

This Testing Strategy includes the following testing modalities:

1. Laboratory Nucleic Acid Amplification Testing (NAAT) – Reverse Transcription-Polymerase Chain Reaction (RT-PCR) testing is the form of NAAT currently in most widespread use for COVID-19 in Aotearoa New Zealand
2. Rapid NAAT – Often referred to as ‘Rapid PCR’. The reagents for these tests are in short supply globally and therefore use is highly limited, currently mostly to acute hospital-based scenarios.
3. Rapid Antigen Testing (RAT) - Of which there are many different types, a limited number of which have to date been authorised for use in Aotearoa New Zealand. This is likely to expand as use and utility increases.

The sample types used for NAAT include nasopharyngeal swabs, combined oropharyngeal and anterior nasal swabs, and saliva. RAT in use in Aotearoa New Zealand currently use nasal swab samples, although saliva sample rapid antigen tests exist and are likely to be considered for use soon.

Introduction of new testing technologies

This Testing Strategy is based on the availability of COVID-19 testing technologies at the time of writing. As new technologies emerge and the availability of testing technologies develops, further iterations the Testing Strategy are likely to be made. Of note, as new Rapid NAAT technologies becomes more available there is potential for them to play more of a role in providing highly sensitive testing rapidly, at the point of care.

Whole Genome Sequencing

As COVID-19 has become more prevalent nationally, there has been a shift away from undertaking whole genome sequencing (WGS) on all positive samples. The main function now is to monitor genomic diversity, for emergent variants with clinical or public health significance (either locally emerging or imported), and as part of local source investigation if deemed necessary.

Wastewater Testing

Wastewater monitoring can identify outbreaks, allowing mitigation measures to be put in place, and can characterise outbreak trends, i.e., whether an outbreak is increasing to decreasing. However, wastewater testing cannot estimate the numbers of cases.

The future use of wastewater will include:

- Monitoring the presence of infection in a community
- Tracking trends of infection in a community
- Screening for infections targeted at specific sites or institutions, e.g., aged-care facilities.

Wastewater testing can also be used to characterise outbreaks in under-served populations, where there may be less individual testing. These communities may be at higher risk of outbreaks if there are lower rates of vaccination.

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Testing Strategy Framework

The Testing Strategy framework is a matrix, which includes three different testing approaches and applies to several different testing groups.

Testing approaches

Local and regional testing plans should be adaptable and change in response to the current situation. The Testing Strategy is centred around three different potential scenarios, where COVID-19 is either **contained**, **spreading** or **unsustainable**. In each of these scenarios a different testing approach is required.

In identifying what scenario a region is in and deciding which testing approaches to utilise, it is suggested that the following four key factors are considered

1. The COVID-19 Protection Framework
2. The health system's ability to manage the situation
3. The prevalence of cases of COVID-19 in the community
4. The laboratory network's workload and the consequent average test turnaround time

This is summarised in Table 1 below, which also sets out what the primary aim of testing is likely to be in each of the three scenarios.

Table 1: Factors for consideration when deciding which testing approach to utilise

Factor	Scenario		
	Contained	Spreading	Unsustainable
Health system	Hospitalisations are manageable and the health system is ready to respond.	Increasing pressure on health system, which is focusing resources but can manage.	Health system facing unsustainable numbers of hospitalisations.
Prevalence of cases	Limited community transmission.	Increasing community transmission.	High or very high numbers of cases.
Laboratory workload	Manageable, with all samples able to be analysed quickly.	Workload high due to increasing symptomatic testing. Prioritisation increasingly important so high priority samples reported quickly. Other testing options necessary	Workload very high. Prioritisation essential to report on most urgent samples quickly. Other testing options increasingly necessary.
Likely CPF Level	Green	Orange	Red
Primary testing aim	Quickly find new clusters of cases	Detect spread, particularly amongst high-risk groups	Protect individuals and communities at highest risk and essential systems

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Broadly, it is expected that these factors will move in alignment. In a scenario in which the prevalence of cases of COVID-19 in the community is high, it would be expected that the healthcare system is under strain, the COVID-19 Protection Framework level is elevated, and laboratory workload is high and turnaround times are affected.

In some circumstances, however, the testing approach may not be aligned with the Protection Framework. A change in testing approach may, for example, be adopted in advance of a Framework level change to quickly respond to an emerging situation.

A Protection Framework Level is dependent on several factors, including prevalence, vaccination rates, socioeconomic deprivation, and health system capacity. Therefore, a lower prevalence situation may still require a higher Framework level.

The decision about the most appropriate local and regional testing approach will be made by local and regional healthcare system leadership mechanisms in association with national protocols. In addition to the four key factors outlined above, specific local or regional factors should inform this decision.

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Testing groups

A different approach to testing is suggested for each of several different groups, which are as follows:

Symptomatic individuals

The purpose of testing this group is to identify whether symptoms in individuals are caused by COVID-19. The Ministry has **published guidance** on COVID-19 symptoms.

Asymptomatic surveillance testing

There are various categories of individuals who are recommended to undergo regular testing due to the risk associated with their work. This includes the risk to themselves of contracting COVID-19 and the risk of them potentially transmitting COVID-19 to the people they work with. This broad category is divided into four sub-groups as follows:

- **Group 1** - Those coming into regular contact with people known to have COVID-19. This group includes hospital and correction facility workers, as well as those caring for people with COVID-19 in the community, who are deemed to be in sufficiently close contact with COVID-19 positive individuals regularly. Given that this group has known contact with COVID-19 positive individuals, regular testing is recommended to identify if they have contracted COVID-19. This is to protect themselves, the people they work with, their whānau and their communities. Quarantine facility workers are addressed separately below, as Border Workers.
- **Group 2** - Those working with people with a higher chance of having COVID-19. This group includes people engaging with individuals with a higher index of suspicion for COVID-19, such as staff working with undifferentiated patients in emergency departments. Given that this group has known contact with individuals who are at higher risk of having COVID-19, regular testing is recommended to identify if they have contracted COVID-19. This is to protect themselves, the people they work with, their whānau and their communities. In a low prevalence context, given that the likelihood that an individual has COVID-19 is lower, testing might only be performed in the context of where there is a higher risk of exposure. This would include working in a poorly ventilated environment or where there is a lack of access to or breaches in the use of appropriate PPE etc.
- **Group 3** - Those working with individuals at highest risk of serious illness. These includes those working in Aged Residential Care facilities as well as some other health, social workers, as identified by their employers. Given that this group has known contact with individuals who are at higher risk of poorer outcomes from COVID-19, regular testing is important to identify if the workforce has contracted COVID-19 prior to them passing it on to the people they work with.
- **Group 4** - Those who are regularly in contact with large groups of people, including communities at greatest risk of high levels of transmission and/or severe illness. This group includes vaccination centre, pharmacy and other healthcare workers, corrections workers, and others. In deciding whether and how frequently to test, relevant factors may include local rates of vaccination and other preventative measures, such as access to PPE. This could be self-directed, or employer directed testing, depending on the context.

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Set out in Table 2 below is a summary of the testing framework recommended for these groups. The testing frequencies specified below are recommended minimum frequencies, that are subject to local decision making.

Table 2: COVID-19 Testing Framework for Symptomatic and Surveillance Testing

	Contained	Spreading	Unsustainable
Symptomatic testing	NAAT when required	NAAT when required. RAT as an interim test if helpful in specific scenarios.	NAAT when required. RAT as an interim test if helpful. At very high prevalence, RAT could be used first with just positive tests confirmed by NAAT.
Surveillance testing group 1 Those coming into regular contact with people known to have COVID-19	NAAT Suggested frequency: 2/week	RAT Suggested frequency: daily	RAT Suggested frequency: daily
Surveillance testing group 2 Those working with people with a higher chance of having COVID-19	NAAT Suggested frequency: 1/week	RAT Suggested frequency: 3/week	RAT Suggested frequency: 3/week
Surveillance testing group 3 Those working with individuals at highest risk of serious illness	NAAT Suggested frequency: 1/week	RAT Suggested frequency: 3/week	RAT Suggested frequency: Daily
Surveillance testing group 4 Those who are regularly in contact with large groups of people, including communities at greatest risk of high levels of transmission and/or severe illness	None	RAT Suggested frequency: 3/week	RAT Suggested frequency: 3/week

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Essential and mandatory testing

Testing for other groups is an essential or mandatory requirement and should be conducted as required. This is summarised in table 3 below:

Table 3: Essential and Mandatory Testing Regimes

Contacts of cases	Testing is as per contact tracing ' Actions for contacts ' or as directed by a Medical Officer of Health.
International Arrivals	Testing is required as per the COVID-19 Public Health Response (Air Border) Order (No 2) 2020 or COVID-19 Public Health Response (Maritime Border) Order (No 2) 2020 .
Border workers	Including managed isolation and quarantine facility workers and those working at the air and maritime borders. They are required to be tested under the COVID-19 Public Health Response (Required Testing) Order 2020 . Schedule 2 of this order sets out the frequency of testing required for various groups of workers.
Boundary crossing	Those crossing an 'alert level boundary' before 15 December 2021 must be tested in accordance with the COVID-19 Public Health Response (Alert Level Requirements) Order (No 11) 2021 . From 15 December, those travelling out of Auckland who are not fully vaccinated must test negative 72 hours before departure.
Education workers	Education workers who are not fully vaccinated, are mandated to be tested under the COVID-19 Public Health Response (Vaccinations) Order 2021 up until 1 January 2022.

Testing for patients and hospital visitors

Testing of asymptomatic individuals interacting with healthcare facilities and aged residential care facilities, including outpatients, admissions and visitors should be considered by those managing those facilities in situations where there are cases of COVID-19 in the local community, and particularly where the scenario is that COVID-19 is 'Spreading' or 'Unsustainable'. This will be particularly important for those interacting with areas with vulnerable patients, including intensive care units, oncology wards or units, rehabilitation wards, dialysis units, delivery suites etc.

In lower prevalence regions and for planned interactions, NAAT testing within 72 hours of arrival is advised. For unplanned interactions, a triage of whether there is sufficient risk to warrant a rapid NAAT should be undertaken, noting the limited capacity for these tests. In higher prevalence regions RAT at the point of arrival is an alternative option.

For settings where regular interactions occur, including regular treatment such as dialysis, or regular visitation such as parents coming to neonatal intensive care unit, a surveillance testing regime can be established, such as RAT every other day, or every day in higher prevalence regions.

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Testing Strategy Implementation

The table above sets out the recommended testing regime for different groups based on their likely risk of having COVID-19, or potentially being exposed to COVID-19. For those for whom testing is mandatory (such as border workers), it should be delivered as prescribed in the relevant COVID-19 order. For other groups, those organising testing should apply the principles as fits with their local context.

Providing testing that individuals can and want to access is essential in ensuring those who need to be are tested.

Principles for implementation

Local and regional application of this Testing Strategy will need to consider the best approaches to sample collection for the local population, including:

- Monitoring trends in community testing and adapting the location of testing centres accordingly.
- Employing mobile testing units to address equity issues by delivering testing as close as possible to places with known cases and individuals who may find it harder to access other methods of testing.
- Working with a range of healthcare providers and community groups, including Māori health providers and Iwi.
- Engaging with community groups (e.g., Māori, Pacific, Disability communities) to provide information about testing, especially as new testing options are made available, and build trust.
- Recognising that some communities will have different testing needs, noting relevant factors including one or more of the following (which may create additional risk and necessitate more testing):
 - local vaccination rates.
 - high proportions of people at highest risk of serious illness.
 - high proportions of community members employed in work at higher risk of contracting COVID (such as healthcare or quarantine facility workers).
- Testing may be encouraged by community leaders for visitors who enter certain settings (e.g., maraes, retirement village, places of worship etc). The logistics of this will need to be organised by the local or regional community and health authorities.
- It should be noted that in some communities multiple of these factors will intersect to create additional risk, perhaps necessitating a different approach to testing. For example, a community may have lower local vaccination rates, higher proportions of community members in high-risk workplaces and a higher proportion of people at higher risk of serious illness.
- Using RAT under the guidance of someone who has been trained in how to use the test kit accurately will give the best results and so is preferable. In some contexts, however, self-testing may be the only alternative to not being able to test an individual.
- The availability of the reagents used for Rapid NAAT is limited by highly restricted global supply. Therefore, these tests should be reserved for use in urgent hospital-based and related settings.

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Prioritisation of testing

Accurate recording of the reason for testing is essential to ensure that laboratories can prioritise the most urgent tests. SURV codes may be of some use for this purpose, but local providers need to work closely with their laboratories to ensure a suitable system is in place

A local and regional prioritisation policy should be developed, informed by local knowledge of populations at highest risk within the region. In collaboration with local laboratories, protocols for de-prioritising lower priority testing should be agreed, including how long to set aside lower priority tests in favour of higher priority tests.

General principles for an order of prioritisation are as follows:

1. Those that are symptomatic and are at highest risk should be given highest priority
2. Other symptomatic testing and those most likely to have been exposed (including close contacts) are given medium priority
3. Routine, asymptomatic surveillance testing is a lower priority