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**Report of:** Greg Fell, Director of Public Health

**Report to:** Cabinet

**Date of Decision:** 16 December 2020

**Subject:** Update on COVID-19 Testing and Vaccination strategies

Is this a Key Decision? If Yes, reason Key Decision:-	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
- Expenditure and/or savings over £500,000	<input type="checkbox"/>	
- Affects 2 or more Wards	<input type="checkbox"/>	
Which Cabinet Member Portfolio does this relate to? Cabinet Member for Children and Families		
Which Scrutiny and Policy Development Committee does this relate to? Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee		
Has an Equality Impact Assessment (EIA) been undertaken?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
If YES, what EIA reference number has it been given? <i>(Insert reference number)</i>		
Does the report contain confidential or exempt information?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below:-		
<i>"The (report/appendix) is not for publication because it contains exempt information under Paragraph (insert relevant paragraph number) of Schedule 12A of the Local Government Act 1972 (as amended)."</i>		

## Purpose of Report:

This report:

- advises Cabinet of the current position regarding COVID-19 testing and vaccination strategies in Sheffield; and
- seeks support to continue this work.

**Recommendations:**

- Support the Sheffield testing strategy, which prioritises testing people with symptoms over people who are asymptomatic, as this has maximum impact on reducing disease transmission.
- Note that testing is only effective as part of a whole programme with all other interventions in place and working well, such as contact tracing and the ability to isolate.
- Agree that the approach to identifying cohorts for asymptomatic targeted testing will be based on a clear rationale.
- Support the piloting of asymptomatic targeted cohort testing with winter resilience business critical staff
- Support the decision not to pilot community (whole town) asymptomatic testing at the moment, based on evidence from the Liverpool pilot
- Note the significant resource implications of doing asymptomatic targeted cohort testing.
- Continue to seek funding and identify other means of support for people to self-isolate, recognising that increasing adherence to self-isolation is the key to successful transmission interruption.
- Support communications and engagement work about vaccination programmes including the need to continue to maintain other preventative measures.
- Support continuing messages on the basic prevention measures such as social distancing, limiting contact with others, face coverings and handwashing, as these remain critical to controlling the disease over the next 4-6 months.

**Background Papers:**

None

Lead Officer to complete:-		
1	I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.	Finance:
		Legal:
		Equalities:
<i>Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</i>		
2	<b>EMT member who approved submission:</b>	Greg Fell, Director of Public Health
3	<b>Cabinet Member consulted:</b>	Cllr Julie Dore
4	I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Decision Maker by the EMT member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.	
	<b>Lead Officer Name:</b> Susan Hird	<b>Job Title:</b> Consultant in Public Health
	<b>Date:</b> 8/12/20	

## 1. INTRODUCTION

- 1.1 Sheffield City Council, alongside our partners in the statutory, business, education and Voluntary, Community and Faith sectors, has been working since the start of the COVID-19 pandemic to keep people safe, protect the vulnerable, re-open Sheffield when possible, and to follow Government guidance.
- 1.2 At the end of May 2020, every upper tier local authority was asked by central government to develop an Outbreak Control Prevention and Management Board and an Outbreak Control Plan. The purpose of the Sheffield Board and Plan is to:
- Prevent COVID-19 from spreading;
  - Know what is happening in our communities;
  - Respond to outbreaks if and when they do occur; and
  - Create confidence in partners and residents in the city that a plan is in place for the city to prevent, know and respond to COVID-19.
- 1.3 The Outbreak Control Plan (<https://www.sheffield.gov.uk/home/your-city-council/preventing-and-managing-covid-19>) is being implemented through the Prevent, Test, Trace and Isolate programme of work. This programme now includes a vaccination theme, which covers the delivery of a COVID-19 vaccination programme.
- 1.4 The overall strategy of keeping people safe, protecting the vulnerable, and reopening Sheffield remains intact. There is no single intervention that could be termed a silver bullet. The outbreak control plan is based on where the evidence tells us we can have biggest impact in terms of reducing transmission. The plan is split into themes with named leads for each theme:
- Prevention – messaging, comms, approach to events and gatherings, enforcement (hard and soft)
  - Management of incidents and outbreaks across multiple settings
  - Develop testing sites to enable people with symptoms to get rapidly tested, and minimising the delay between the development of symptoms and getting a test
  - Optimising contact tracing speed and coverage – especially in some of our communities where we know we have rates of infection.
  - Optimising isolation, broader community support to vulnerable groups and providing support to those who are shielding - we know 80% of people recommended to self-isolate don't manage this for the full length of time.
  - Ensure we have good local epidemiology about the spread of the virus and operational intelligence about the performance of our services.
  - Communications - we have maintained a focus on consistent messaging, simplifying communications based on consent and

consensus.

- Enforcement of regulation and guidance
- Focus on settings of concern, for example schools, universities, care homes.

1.5 This paper provides an update on COVID-19 testing strategy, covering symptomatic and asymptomatic testing; and the COVID-19 vaccination programme which is being led by the NHS.

## 2. SHEFFIELD'S COVID-19 TESTING STRATEGY

2.1 Cabinet members will be aware of recent government proposals for mass or 'whole population' asymptomatic testing. We already have mass **symptomatic** testing in place through our current arrangements including local testing sites, mobile testing units and a home testing option for those with symptoms. We also have asymptomatic care home testing, outbreak testing and testing for some groups of key workers.

2.2 Testing is not an end in itself - it is only effective as a public health intervention where the following conditions are met:

- Isolation is fully adhered to after a positive result
- Effective contact tracing takes place quickly
- A negative result doesn't increase complacency and risky behaviour

2.3 We know that infectiousness is linked to symptom severity and most onward infection comes from people who are symptomatic. However it is estimated that only around 25% of those with symptoms get a test. We know that 70% to 80% of people with COVID-19 have symptoms. It is therefore clear that the best way to reduce transmission is to focus on symptomatic community transmission.

2.4 Therefore our strategy for testing people for COVID-19 remains, in order of priority:

- People with symptoms of COVID-19; then
- People without symptoms of COVID-19:
  - Where transmission of infection has biggest impact eg care homes, domiciliary care, other high risk settings
  - Where transmission of infection is most likely eg well contacts of positive cases, for example within households
  - Key workers, to enable business continuity

2.5 There may be a role for targeted asymptomatic testing as long as there is a clear rationale for doing so and it is part of a wider strategy. Doing asymptomatic testing can cause harm (eg through false negatives – people who have the disease but test negative, therefore are falsely reassured they don't have COVID-19). Any programme needs to ensure that the balance of benefit to harm to cost (including opportunity cost) is favourable.

2.6 Potential targeted cohorts for asymptomatic testing is a fast-developing

situation as the government continue to announce national programmes eg testing of care home visitors, domiciliary care workers, etc. These schemes use Lateral Flow Devices (LFDs), which are the tests which give a result in 30-60 minutes without needing processed in lab.

- 2.7 We have considered our options for community asymptomatic testing (previously called mass testing or whole town testing) and for targeted cohort testing (sometime also called 'DPH testing'). We have chosen for now not to pursue community asymptomatic testing, as we think we will have bigger impact with our current resources by continuing to focus on mass symptomatic testing, and piloting asymptomatic testing in some targeted staff cohorts. This decision was informed by evidence from the Liverpool mass testing pilot, which showed it had no impact on overall infection rates in the city, and potentially widened inequalities as people who can least afford to self isolate did not come forward for asymptomatic testing.
- 2.8 Instead we would like to pilot LFDs with some of our business critical mobile staff, such as drivers and repairs staff, and similar staff in partner organisations such as Veolia and Amey. The rationale for this is that these staff are often in close proximity to each other eg in the cab of a lorry or other vehicle so can spread COVID more easily, but are critical winter resilience staff. By doing asymptomatic testing of these staff regularly (eg twice a week), we may be able to prevent infection from spreading between staff which will be beneficial for the health of staff as well as helping business continuity. Information and guidance from DHSC on piloting LFDs is changing frequently, including whether we need to set up a central testing hub for people to attend for weekly testing, or whether test kits can be distributed to services for staff to use at home. We are anticipating being able to start a pilot scheme in January 2021 and will aim to evaluate its effectiveness.
- 2.9 Regardless of which targeted staff cohort is chosen, there are significant logistical, pathway, clinical, communications and scientific issues to address. These include:
- Delivery – whilst there will be specific sites set up for processing of swabs using LFD in one or more locations, the transportation to get people there from specific cohorts needs to be addressed by other services.
  - Communications – expectations, separating symptomatic and asymptomatic testing, understanding, interpretation of test results, unintended changes to behaviours.
  - Clinical governance and quality assurance– who is responsible for errors? Who will be clinically responsible for this?
  - Data and systems – who gets notified, what happens to results, how are results communicated? Interpretation of result, accuracy of result.
  - Competing priorities require consideration– vaccine roll out, contact tracing, community engagement
  - Fit of any asymptomatic testing into the whole pathway - Contact tracing, isolation and support. The test and trace system is not as

effective as it needs to be in slowing the spread (e.g. only 60% of contacts identified). Adding to that system without working on the basics will increase the likelihood of failure. Despite the self-isolation payments, many people in our most deprived communities and particularly those who are in work but in low paid jobs are really struggling to self-isolate.

- Testing Station Ergonomics – How people move through the whole process from registration, walk ins, testing, awaiting results etc. Consideration must be afforded to making these locations work for those being tested and those testing.
- Duration and frequency of asymptomatic testing
- Coordination with COVID-19 vaccination programme
- Evaluation

2.10 We are also working with South Yorkshire Local Resilience Forum on plans for targeted cohort testing, and we are learning from the pilots of community testing in Liverpool, Stoke-on-Trent and elsewhere. We will keep our intentions around community testing and other targeted asymptomatic cohort testing under review.

### **3. COVID-19 VACCINATION PROGRAMME**

3.1 News that one COVID-19 vaccine (the Pfizer vaccine) has been approved for use, and a number of other vaccines are going through the regulatory process to be approved for use is very welcome and encouraging. This is a rapidly changing and moving situation with different vaccines at different stages of the approval process.

3.2 The NHS via NHS England have been asked to lead the complex and extensive roll out of this vaccination programme. Locally Sheffield Teaching Hospital (STH) are the lead provider for the programme on behalf of South Yorkshire and Sheffield Clinical Commissioning Group (CCG) and working with Primary Care Networks (PCNs), which are groups of GP practices, to get ready for the roll out of the vaccine.

3.3 The priority groups for vaccination are set nationally by the UK Joint Committee for Vaccination and Immunisation (JCVI) and the early priority groups include:

- Care home (older adult) residents and staff
- Over 80 year olds
- Over 75 years olds
- Over 70 year olds and people who are extremely clinically vulnerable
- Over 65 year olds
- Frontline Health and Social Care Workers
- The groups then work down in 5 year age gaps

3.4 These groups have been chosen because these people are at greatest risk of dying from COVID-19 (care home residents and the over 65s), or from spreading infection to the most at risk people via the workplace

(NHS and social care staff). Vaccinating these groups in this order will have the biggest impact on saving lives. People who are not in one of these priority groups will also benefit though, as once the more at-risk people are vaccinated, the more potential there is for all of us to be able to slowly return to a more normal life.

3.5 The logistics for delivering vaccination to these groups are extremely complex partly because of the requirements for the distribution and storage of the vaccine. Currently the approved vaccine (Pfizer) is not suited for use with care home residents because of the number of doses in each 'pack' (over 900), the need to not waste vaccine and the need to store the vaccine at -70 degrees Centigrade. However it could be used to vaccinate staff who could travel to a designated venue identified by STH where a large number of people can be vaccinated. However this is a constantly changing picture and depends on the vaccines being approved as well as whether changes can be made to the distribution of the Pfizer vaccine to make it more appropriate for use in smaller settings.

3.6 Sheffield City Council are offering a wide range of support to our NHS partners to support the successful roll out of the vaccination programme. We are working at speed to link our NHS colleagues into appropriate teams within the council and with our partners in the voluntary community and faith sector. This includes but is not limited to:

- Support with identifying appropriate sites and logistics e.g. traffic management
- Providing a link into our adult social care team so that our staff and the staff in care settings we commission can be invited for vaccination when it is available
- Further support that we may be able to provide for example transport, interpreting support
- Comms and engagement support

3.7 Communications and engagement are a key component to successful vaccination programmes. We know that we do not start from a neutral position in relation to vaccination. Sheffielders have a range of views on vaccination from keen to hesitant to resistant. NHS England have instructed NHS organisations that no communication or engagement work should take place until the vaccination programme is ready to start.

3.8 As a council we are seeking to support and be led by our NHS colleagues in relation to the detail of the vaccination programmes. We also are aware that engagement and preparation work is required to support and strongly encourage our communities to take up the offer of vaccination. We are therefore currently rapidly considering our position on communications and what work we can do as a council with partners now.

#### **4. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION**

##### **4.1 Equality of Opportunity Implications**

4.1.1 There are no Equality of Opportunity implications

#### 4.2 Financial and Commercial Implications

4.2.1 We will need to use our current grants from Government (eg Contain grant) to fund our targeted cohort asymptomatic testing. A paper with resourcing implications will be produced shortly.

#### 4.3 Legal Implications

4.3.1 There are no legal implications

#### 4.4 Other Implications

4.4.1 There are resource implications including staffing/HR for our pilot of targeted cohort asymptomatic testing. A paper with resourcing implications will be produced shortly.

### **5. ALTERNATIVE OPTIONS CONSIDERED**

5.1 No alternative options were considered for the COVID-19 vaccination programme, as this is being led by the NHS under direction of NHS England.

5.2 Alternative options were considered for the asymptomatic testing strategy. These were:

- Doing no asymptomatic testing
- Doing community asymptomatic testing (eg like Liverpool)
- Doing targeted cohort testing (the recommended option)

### **6. REASONS FOR RECOMMENDATIONS**

6.1 As discussed in sections 2.4 and 2.5, asymptomatic testing needs to be done as part of an overall testing strategy, and as part of a comprehensive programme that includes contact tracing and self isolation. Asymptomatic testing can also do harm as well as having benefit, so in considering options we also took into account current evidence of the balance of benefit to harm to resource required to deliver an asymptomatic testing programme.

6.2 We discounted doing no asymptomatic testing, as the current evidence suggests there may be a favourable balance of benefit to harm to cost from doing frequent repeated testing in targeted cohorts of people.

6.3 We discounted doing community testing, as the current evidence, particularly from Liverpool, suggests the balance of benefit to harm to cost is not favourable. The evidence on LFDs does not support one-off

use with large numbers of asymptomatic people, as it does not seem to have any meaningful impact on overall infection rates at a city level, and the potential to do harm (through false negatives, false positives, and widening inequalities) is too great.



Author/Lead Officer of Report: Keith Leyland: Covid Response Hub Service Manager

Tel: 07880784436

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Report of: Greg Fell, Director of Public Health  
Eugene Walker, Executive Director, Resources

Report to: Cabinet

Date of Decision: 16<sup>th</sup> December

Subject: COVID-19 COMF Grant Approval

Is this a Key Decision? If Yes, reason Key Decision:-	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
- Expenditure and/or savings over £500,000	<input checked="" type="checkbox"/>	
- Affects 2 or more Wards	<input checked="" type="checkbox"/>	
Which Cabinet Member Portfolio does this relate to? Cabinet Member for Children and Families and Cabinet Member for Finance, Resources and Governance and Deputy Leader		
Which Scrutiny and Policy Development Committee does this relate to? Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee		
Has an Equality Impact Assessment (EIA) been undertaken?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
If YES, what EIA reference number has it been given? TBC		
Does the report contain confidential or exempt information?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

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Purpose of Report:

- a) To inform Cabinet of additional funding received from the Department of Health and Social Care (DHSC) towards expenditure incurred in relation to the mitigation and management of local outbreaks of COVID-19 for public health purposes to break the chain of transmission and protecting the most vulnerable from catching the virus.
- b) To approve the acceptance of the Contain Outbreak Management Fund (COMF) and to seek authorisation for the Executive Director Resources, in consultation with the Director of Public Health, to expend the DHSC funding.
- c) To approve the acceptance of future COMF Funding being received January to March 2021.

Recommendations:

It is recommended that Cabinet:-

- a) Note that in October, November and December, Sheffield City Council (SCC) was allocated a number of grants known as the Contain Outbreak Management Fund (COMF) totalling over £8million, from DHSC towards expenditure incurred in relation to the mitigation against and management of local outbreaks of COVID-19.
- b) Note that £8.020m of COMF grant has already been received.
- c) Approve the acceptance of the £8.020 COMF Grant.
- d) Approve acceptance of up to £7.020m of COMF grant funding being received (Jan – Mar 2021)
- e) Approve the expenditure of the COMF grant (up to £15.040m)
- f) Delegate the authority to finalise future allocations of COMF grant to Executive Director of Resources, in consultation with the Director of Public Health.
- g) To delegate authority to the Executive Director Resources, in consultation with the Director of Public Health, to make the final decisions regarding the use of this fund, in consultation with the Cabinet Member for Public Health.

Lead Officer to complete:-	
1	I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.
	Finance: Mark Wassell
	Legal: Tim Hoskin
	Equalities: Adele Robinson
<i>Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</i>	
2	EMT member who approved submission:
	Greg Fell, Director of Public Health  Eugene Walker, Executive Director Resources
3	Cabinet Member consulted:
	Councillor Terry Fox, Cabinet Member for Finance, Resources and Governance and Deputy Leader
4	I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Decision Maker by the EMT member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.
	Lead Officer Name: Keith Leyland
	Job Title: Covid Response Hub Service Manager
Date: 8 <sup>th</sup> December 2020	

## 1. Introduction

On September the 23<sup>rd</sup> the Cabinet approved the report entitled “COVID-19 Test, Track & Isolate Programme Funding”. This report described the funding available at that time and the Investment Plan of how that funding was intended to be used.

<http://democracy.sheffield.gov.uk/ieListDocuments.aspx?CId=123&MId=7548&Ver=4>

Since the Cabinet Report in September was approved, further funding has been announced, and provided to SCC with conditions for its use. This fund known as the Contain Outbreak Management Fund (COMF) is provided from DHSC towards expenditure incurred in relation to the mitigation against and

management of local outbreaks of COVID-19 for public health purposes to break the chain of transmission and protecting the most vulnerable from catching the virus.

To date the Council has received £8.020m of the COMF grant. It also expects to receive up to £7.020m of COMF grant in Jan – Mar 2021 taking the total amount of the COMF grant up to £15.040m.

## 2. **Contain Outbreak Management Fund (COMF)**

Key features (not exclusive) of the now 3 x allocations of Contain Outbreak Management Fund (total: £8.020m) are summarised below (detailed spending plans to be developed).

### 2.1 **COMF Grant for National Lockdown (up to £4.68m)**

Based on the funder's initial guidance the estimated funding per Covid Alert Level using Sheffield's current population levels (585,000) are summarised below:

<b><u>Table 1: Estimated Funding per Covid Alert Level</u></b>	<b><u>£m</u></b>
Medium (£1 per head)	0.585
High (£3 per head)	1.755
<b><i>Very High (£8 per head) Actual SCC allocation:</i></b>	<b>4.680</b>

The actual allocation that SCC received for the national lockdown was £4.68m

### 2.2 **Additional COMF Grant Post National Lockdown**

Post national lock down the Contain Outbreak Management Fund has been extended to provide monthly payments to Local Authorities facing higher restrictions until the end of the financial year. Authorities under the highest level of restrictions will receive £4 per head of population per month from the end of national restrictions. This will be reviewed in January 21 with further details to follow, but it is anticipated that SCC will need to approve further COMF allocations if /when they are announced in the new year.

Sheffield's actual tier 3 funding post national lock down is summarised below.

<b>Table 2: Additional COMF Grant Post National Lockdown</b>	<b>£m</b>
Up to £4 per head (Tier 3 post December 2nd)	2.34
Additional Top Up Funding (one off?)	1.00
<b>Total COMF Grant (post national lockdown)</b>	<b>3.34</b>

### 2.3 **Potential COMF Allocations Jan to March 2021 (up to £7.2m).**

Future COMF allocations will be reviewed by the government in January 2021 with further details to follow, but it is anticipated that SCC will need / receive further allocations depending on what monthly tier SCC falls into between January and March 2021.

Depending on the monthly tier that SCC is allocated to then the maximum COMF grant that SCC can potentially expect to receive (Jan-Mar) is up to £7.020m and this is the figure that SCC would provisionally need to approve in addition to the already allocated £8.020m (total £15.040m)

## 3. **Risk Analysis and Implications of the Decisions**

### 3.1 **Equality of Opportunity Implications**

The overall proposal is supportive of the aims of the Public Sector Equality Duty, established through the Equality Act 2010, which requires the Council, in the exercise of its functions to have due regard to the need to:

- (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

It will be particularly effective in reducing discrimination against and victimisation of people who are experiencing more than one disadvantage.

The Public Sector Equality Duty (S149 of the Equality Act 2010) requires us to pay due regard when making decisions. An Equality Impact Assessment has been carried out and highlights the impacts of COVID-19 on people with a protected characteristic and how the Councils Covid Response will have a positive impact in mitigating the impacts of health inequality, poverty and multiple levels of deprivation.

## 4 **Financial and Commercial Implications**

**Grant Terms and Conditions**

Key features (not exclusive) of the COMF grant allocations are summarised below:

- Comply with funder's monitoring requirements / templates.
- From 12/10/20, Local Authorities are eligible for grant from the Contain Outbreak Management Fund to support proactive containment/intervention measures:
- Grant of up to £1 per head of population given to LAs in Local COVID Alert Level - Medium. Paid when Public Health activities are agreed with the Regional Convenor.
- Where Local Authorities move to Local COVID Alert Level - High /Very High grant will automatically be increased to £3 per person and £8 per person respectively.
- National Lockdown Funding is one-off, incremental, not additional and repeated movements between Local Alert Levels will not enable reoccurring grant support.

Financial support for LA's at Local COVID Alert Level Medium and High is to fund the following activities:

- a. Targeted testing for hard-to-reach groups out of scope of other testing programmes.
- b. Additional contact tracing.
- c. Enhanced communication/marketing e.g. towards hard-to-reach groups and other localised messaging.
- d. Delivery of essentials for those in self-isolation.
- e. Targeted interventions for specific sections of population and workplaces.
- f. Harnessing capacity within local sectors (voluntary, academic, commercial).
- g. Extension/introduction of specialist support (behavioural science, bespoke comms).
- h. Additional resource for compliance with, and enforcement of, restrictions and guidance

Local COVID Alert Level - Very High has a broader scope, to support local economies/public health and includes activities such as (not exclusive):

- i. Measures to support the continued functioning of commercial areas and their compliance with public health guidance.
- j. Funding Military Aid to the Civil Authorities (marginal costs only).
- k. Targeted support for school/university outbreaks.
- l. Community-based support for those disproportionately impacted such as the BAME population.

- m. Support for engagement/analysis of regional areas to assess and learn from local initiatives.
- n. Providing initial support to vulnerable people classed as Clinically Extremely Vulnerable who are following tier 3 guidance.
- o. Support for rough sleepers.

The above criteria will evolve over time, with updated guidance to follow.

## **5 Commercial Implications.**

There are no direct commercial implications arising from this report. Any procurement activity associated with the grant award will be reported separately.

All public sector procurement is governed by and must be compliant with both European Legislation and UK National Law. In addition, all procurement in SCC must comply with its own Procurement Policy, and internal regulations known as 'Contracts Standing Orders' (CSOs).

Contracts Standing Orders requirements will apply in full to the procurement of services, goods or works utilising grants. All grant monies must be treated in the same way as any other Council monies and any requirement to purchase/acquire services, goods or works must go via a competitive process.

The Grant Manager will need to read, understand and comply with all the grant terms and conditions and ensure that there are no unfunded, ongoing costs after the grant has ended.

## **6 Legal Implications**

The Contain Outbreak Management Fund is a Department of Health and Social Care fund set up to support Local Authorities during the Covid-19 pandemic.

There is currently a lack of formality in the DHSC documentation of the grant. However, it is likely to be made under section 31 Local Government Act 2003, and it is expressed to be ring-fenced to public health purposes, specifically to breaking the chain of transmission and protecting the most vulnerable from catching the virus. Whilst the specific public health activities that can be funded are at the Council's discretion, a list of activities that this funding could be used for has been provided by DHSC.

The grant is payable on the basis of amounts per head of population, in relation to periods during which the authority is in lockdown or at the different Covid Alert Levels, under the previous Health Protection regulations or under the Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020, going forward.

The Council will have discretion as to spending of the grant, in the exercise of its general public health functions (including those under the Health and Social Care Act 2012), and also in the exercise of the special, Covid-19

related powers (including those under the Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020). To the extent necessary, the Council can also rely on its powers under the Localism Act 2011.

The primary condition on funding is agreement that authorities provide information to Contain (NHS Test and Trace) on how the funds are spent. The expenditure of the grant by the Council will be subject to public procurement and state aid law, and the Council's constitution.

## **7 Alternative Options Considered**

This report describes what officers believe to be the best way of preventing, mitigating and controlling the virus in Sheffield. However, this will be kept under review and the approach described may need to change

## **7 Reasons for Recommendations**

The recommendations described in this report will enable Sheffield City Council to expend funds incurred in relation to the mitigation and management of local outbreaks of COVID-19 for public health purposes to break the chain of transmission and protect the most vulnerable from catching the virus.