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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		No	x
- Expenditure and/or savings over £500,000				
- Affects 2 or more Wards				

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		No	x

If YES, what EIA reference number has it been given? *(Insert reference number)*

Does the report contain confidential or exempt information?	Yes		No	x

If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below:-

*"The (**report/appendix**) is not for publication because it contains exempt information under Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended)."*

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

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<tr><th colspan="4">Lead Officer to complete:-</th></tr>
<tr><td rowspan="4">1</td><td colspan="2" rowspan="3">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.</td><td>Finance:</td></tr>
<tr><td>Legal:</td></tr>
<tr><td>Equalities:</td></tr>
<tr><td colspan="3">Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</td></tr>
<tr><td>2</td><td>EMT member who approved submission:</td><td colspan="2">Greg Fell, Director of Public Health</td></tr>
<tr><td>3</td><td>Cabinet Member consulted:</td><td colspan="2">Cllr Julie Dore</td></tr>
<tr><td rowspan="3">4</td><td colspan="3">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.</td></tr>
<tr><td>Lead Officer Name:
Susan Hird</td><td colspan="2">Job Title:
Consultant in Public Health</td></tr>
<tr><td colspan="3">Date: 8/12/20</td></tr>
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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 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 <u>Equality of Opportunity Implications</u>

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.