BIRMINGHAM CITY COUNCIL

LOCAL COVID OUTBREAK ENGAGEMENT BOARD

WEDNESDAY, 06 OCTOBER 2021 AT 16:00 HOURS
IN ON-LINE MEETING, MICROSOFT TEAMS

A G E N D A

1 **WELCOME AND INTRODUCTION**

2 **NOTICE OF RECORDING/WEBCAST**

The Chair to advise/meeting to note that this meeting will be webcast for live or subsequent broadcast via the Council's meeting You Tube site (www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

3 **APOLOGIES**

To receive any apologies.

4 **DECLARATIONS OF INTERESTS**

Members are reminded that they must declare all relevant pecuniary and non pecuniary interests arising from any business to be discussed at this meeting. If a disclosable pecuniary interest is declared a Member must not speak or take part in that agenda item. Any declarations will be recorded in the minutes of the meeting.

5 **MINUTES** **3 - 14**

To confirm and sign the Minutes of the meeting held on the 1st September 2021.

6 **COVID-19 SITUATION UPDATE** **15 - 68**

Dr Oluwatoyin Amusan, Consultant in Public Health will present the item.

7 **VACCINATION ROLLOUT AND UPTAKE UPDATE**

Paul Sherriff, NHS Birmingham and Solihull CCG and Dr Parmjit Marok, West Birmingham will present the item.

8 **UPDATE ON LIVING WITH COVID STRATEGY**

Dr Iheadi Onwukwe, Consultant in Public Health will give an update on the item.

9 **MSOA DEATH ANALYSIS (FULL REPORT)** **69 - 100**

Dr Julia Duke-Macrae, Consultant in Public Health will present the item.

10 **PUBLIC QUESTIONS SUBMITTED IN ADVANCE**

The Chairman of the LCOEB, Councillor Ian Ward, Leader of Birmingham City Council will lead the item.

11 **TEST AND TRACE BUDGET OVERVIEW** **101 - 102**

Dr Iheadi Onwukwe, Consultant in Public Health will present the item.

12 **OTHER URGENT BUSINESS**

To consider any items of business by reason of special circumstances (to be specified) that in the opinion of the Chair are matters of urgency.

13 **DATE AND TIME OF NEXT LOCAL COVID OUTBREAK ENGAGEMENT BOARD MEETING**

To note that the next meeting will be held at 1400 hours on Wednesday 24th November 2021 as an online meeting.

BIRMINGHAM CITY COUNCIL

LOCAL COVID OUTBREAK ENGAGEMENT BOARD WEDNESDAY, 1 SEPTEMBER 2021

MINUTES OF A MEETING OF THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD HELD ON WEDNESDAY 1 SEPTEMBER 2021 AT 1400 HOURS ON-LINE

PRESENT: -

Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Deputy Chair of the LCOEB
Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care
Andy Cave, Chief Executive, Healthwatch Birmingham
Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG
Councillor Brigid Jones, Deputy Leader, Birmingham City Council
Stephen Raybould, Programmes Director, Ageing Better, BVSC
Councillor Paul Tilsley
Dr Justin Varney, Director of Public Health

ALSO PRESENT:-

Dr Julia Duke-Macrae, Consultant in Public Health
Dr Iheadi Onwukwe, Consultant in Public Health (Business & Strategy), Test & Trace Team
Errol Wilson, Committee Services

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WELCOME AND INTRODUCTIONS

217 The Chair welcomed everyone to the Local Covid Outbreak Engagement Board meeting.

NOTICE OF RECORDING/WEBCAST

218 The Chair advised, and the Committee noted, that this meeting will be webcast for live or subsequent broadcast via the Council's meeting You Tube site (www.youtube.com/channel/UCT2kT7ZRPFCXq6_5dnVnYlw) and that members of the press/public may record and take photographs except where there are confidential or exempt items.

APOLOGIES

219 Apologies for absences were submitted on behalf of Dr Manir Aslam and Dr Parmjit Morak; Mark Croxford, Head of Environmental Health, Neighbourhoods; Chief Superintendent Stephen Graham, West Midlands Police and Richard Burden, Chair, Healthwatch Birmingham

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DECLARATIONS OF INTERESTS

220 The Chair reminded Members that they must declare all relevant pecuniary and non-pecuniary interests arising from any business to be discussed at this meeting. If a disclosable pecuniary interest is declared a Member must not speak or take part in that agenda item. Any declarations will be recorded in the Minutes of the meeting.

MINUTES

221 **RESOLVED:-**

The Minutes of the meeting held on 21 July 2021, having been previously circulated, were confirmed by the Chair.

COVID-19 SITUATION UPDATE

222 Dr Justin Varney, Director of Public Health presented the item and drew the attention of the Board to the information contained in the slide presentation highlighting the main points.

(See document No. 2)

Councillor Paul Tilsley enquired whether in all the statistics that Dr Varney had produced over the last few months the comments had been that 75% of hospital admissions had either had no inoculations or just one. 25% have had their double dose of the vaccine and whether his was a correct assumption.

Dr Varney advised that Councillor Tilsley awaits the presentation of the next item as Dr Julia Duke-Macrae will be giving a presentation on hospital admissions part of which would be an explanation of the vaccination status of those admitted.

The Chair commented that it was interesting looking through the slide presentation on Agenda item 7 which Dr Duke-Macrae will take us through.

Councillor Brigid Jones, Deputy Leader, Birmingham City Council stated that in relation to the vaccination she had heard anecdotally that there were concerns that people had been turned away from vaccinations if they did not have proper identification on them. Nowhere on the Council's website it had stated that we needed identification to get a vaccination.

Dr Varney gave the following response:-

- Most of the sites particularly the mass vaccination sites at Millennium Point and Aston Villa would help with what identification was needed. Normally a piece of identification was needed and for any information we signposted people to the NHS website from the Council's website which stated that people should take some form of identification.
- This did not mean that it needed to be a passport, it could be anything such as a bill with your postcode on it. If you did not have it the people on the walk in sites would help you to find out how to register.
- The reason the identification was important was not about checking who you were, but about trying to link you to your NHS record because it was important that your vaccine when given was recorded on the NHS system and connects back to your GP so that when you needed the vaccine passport for example, to travel abroad, that data was linked.
- If it was not linked to your NHS record you had no evidence other than the little card that you ever had the vaccine.
- The NHS team got quite good at this as we did a pop-up about a month ago with the Chinese Community Centre and we had a large number of undocumented citizens that attended who had no identification and the NHS team was able to help them.
- It may be slightly if it was a GP practice or a pharmacy site, but walk-up sites were capable of helping people to navigate if they had forgotten their identification or were unable to get one.

The Board noted the presentation.

COVID-19 HOSPITAL ADMISSION AND VACCINATION

Dr Julia Duke-Macrae, Consultant in Public Health introduced the item and drew the attention of the Board to the information contained in the slide presentation.

The Chair commented that he was surprised that the number of those with two doses and admitted to hospital and ending up in ITU he thought was quite high at 37% and 27%. The Chair enquired whether anything was known about the people who ended up in hospital who had two doses and whether the majority of them were perfectly healthy individuals or whether they had some other underlying conditions meant that in spite of having two doses of the vaccine they still ended up in hospital or in some cases on ITU.

Dr Duke-Macrae advised that the data Public Health had access to did not provide that information for them to dug deeply into the data to provide an analysis to understand that. Hopefully, Public Health could work with colleagues in the NHS to do that piece of work to understand that information but the data we were given did not have that information.

Dr Varney enquired whether the ITU dataset was about patients in ITU with Covid. He added that he thought the admissions were patients who had Covid but this may not be the reason they were admitted.

Dr Duke-Macrae advised that they were all patients that were admitted with Covid as their primary.

Dr Varney commented that it was known that the vaccine was not 100% and that if you had two doses you were much less likely to end up in hospital and being severely ill. This data reinforces that, but it also reinforces that it was not perfect which was why we needed *hands, face, space*. People needed to keep washing their hands, keep wearing face coverings on public transport.

Dr Varney advised that in relation to the data presented by Dr Duke-Macrae, Public Health did not have access to the report on the length of stay. Anecdotally, what we had been told by the hospitals was that the patients that goes into hospital but did not end up in intensive care with two doses of the vaccine went home much quicker. What this was describing was that people still could get sick with Covid but they got better much faster if they had two vaccines and they go home quicker, whereas the unvaccinated stayed in hospital and got sicker.

Dr Varney highlighted that the vaccine was still doing what it says on the tin – stopping you getting severely unwell and stopping you from dying, but it was not perfect. 25% - 30% ending up in hospital was still significantly better than the flu jab which was only about 50% effective. Dr Varney then enquired whether Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG could get more access to the data from the Acute as this was the data that came from Sandwell and West Birmingham and UHBT. It was important to get the granular stuff around the length of stay as well as it reinforces that the double vaccinated was far less sick than the unvaccinated as this was what the clinicians were telling us.

Mr Jennings undertook to speak to colleagues about this as this kind of headline figure was quite powerful in terms of the average age of people in the ITU and this age was about 10 years younger than the average age of people in the last wave. If you turn the question around – if you knew the best part of ¾ of the population was vaccinated we knew that older people were much more likely to be severely be impacted by the disease. But, the average age of people in ITU was coming down, this also reinforces how powerful and effective the vaccine was. Once we did not know the actual details the anecdotal conversation with colleagues at the QE suggested that many of those in ITU with Covid had a lot of other things going on as well if they were doubly vaccinated. He added that he was happy to speak with UHB colleagues to get a structured way of giving Public Health the data without it being a burden.

The Chair commented that it would be useful to have that data as it would be more reassuring if people who were doubly dosed with the vaccine and ended up in ITU was because they had other underlying health issues. This would be more reassuring than the statistics that had been in the slide presentation. Mr Jennings responded that if you compare the number of people in hospital during this wave to the number of people who were in hospital during the last wave with the case rate it could be seen that there was a clear indicator.

Whilst we still had 200 people in the three UHB hospitals with Covid, at the levels of case rates we had a few weeks ago we would have been back where

we were earlier this year where we had in excess of 1000 people in hospital. This was another powerful indicator as we had nothing like the numbers in hospital that we had in the first wave.

Dr Duke-Macrae stated that in this particular study we were see much fewer older people who were being admitted compared to what it was previously so the vaccine was working well for that group which we were targeting initially. It was important to note that there may be a waning of the vaccine and hence the promotion of having a booster dose as well.

Councillor Tilsley commented that what was interesting on page 109 of the Agenda pack was if we look at the data the interval between the second doses and admissions after two/three months it was 44, three/four months it was double that at 87 and then four/five months it was a third of that and the point made earlier as to whether there had been any underlying conditions and were there an issue surrounding the prevalence of whichever vaccination was being given at that time.

Dr Varney stated that this was a good point and that Dr Duke-Macrae would be able to look at this and report back to the next Board. If we look at three/four months after the second dose between May and August, three/four months after your second dose – if you were admitted in August your second dose would have been in May. The majority of people under the age of 60 who had their second dose with the clinically extremely vulnerable. There were people with significant existing health conditions.

Dr Varney further stated that it was known that the vaccine in people who had immunosuppression or the very elderly did start to wain and this was the reason we were looking at the booster to pump up their immune response. This may well be behind the statistics as looking at the dates May to August the only people under the age of 60 who would have had two doses were healthcare professionals, health and social care professionals or the clinically extremely vulnerable. There may well be other complicating factors which meant that they were more vulnerable and the vaccine would not be quite as good which was the reason national government was considering rolling out the booster alongside the flu jab. We will have details of that for the next Board.

223 **RESOLVED: -**

That the Board noted the report.

VACCINATION ROLLOUT AND UPTAKE UPDATE

224 Paul Jennings, Chief Executive, NHS Birmingham and Solihull CCG presented the item and made the following statements:-

a. In terms of uptake across Birmingham we administered were just under 650,000 first doses and just over 550,000 second doses. There was still a range of rates of the vaccination.
b. We had a very young population and therefore the vaccination rates in the younger age groups were still lower than there were in the higher

age groups and this was simply because of the shape of our population and the fact that we were only able to begin vaccinating younger people towards the end of the vaccination programme.

c. We were making good progress as the figures I was sent to present at this Board meeting today suggest that we only had a vaccination rate of about 17% with the 16-17 year olds were already well ahead of that.
d. There was the likelihood of a booster vaccination but we were still awaiting the details of that to be announced.
e. We anticipated that it would be a booster vaccination for the over 80's for those who were merely compromised for those who lived in care homes along with health and social care staff.
f. We believed that this will be as far as the campaign will go, but this was based on those who were most vulnerable and least likely to be able to generate antibodies on the back of the vaccination programme and those who were most in the frontline in terms of them being exposed through health and care situations.
g. We were in the process of continuing to encourage those who work in care homes situations to be vaccinated. We announced the likelihood of an immunisation programme for Covid in schools and we anticipate that we should be hearing an announcement in respect of that formally at the end of this week.
h. We had been planning our approach which we hoped would enable us to deliver to all those who were willing to receive a first Covid vaccination between now and half-term of all the 12 – 15 year olds in Birmingham.
i. The planning for this would be detailed publicly once the announce had been made public rather than being leaked through the press. All the plans for this was currently in place.

   At this juncture, the Chair enquired whether the booster situation was continuously under review as more data emerges.

j. Mr Jennings stated that it was clear that there were those for whom the first two doses were not as effective or as long lasting as they were for others and that was where it was likely to be focussed.
k. Earlier in the year we would have heard about the booster for all those over 50.
l. We were now focussed on the conversation about those over 80. What we were also hoping to be able to do, (but we were awaiting the final go ahead) was to be able to administer a Covid booster and a flu vaccination at the same visit.
m. This would be more efficient in terms of the delivery and the logistics.

   The Chair commented that the reason he asked the question was that in Israel they were rolling out booster shots for all over 50s.

n. Mr Jennings stated that Israel were the first to begin the vaccination programme and they had vaccinated and at one point had vaccinated the highest percentage of their population of any nation.
o. They were taking a different approach whilst our approach was led by the Joint Committee on Vaccination and Immunisation (JCVI) and we were following their guidance which was generally carefully thought through.

Councillor Paulette Hamilton enquired about the vaccination in the care homes and the staffs in care homes that would be redeployed or would be asked to leave their jobs as of the 11th November 2021. Councillor Hamilton voiced concerns that this had not been well promoted and further enquired what had been put in place to ramp up the communications and the promotion so that people were absolutely clear that the government meant business on this particular point. Councillor Hamilton also queried whether it was likely for the 12 – 15 year olds to be given the vaccination before they go back to school or at least during their first week of school.

Mr Jennings responded as follows:-

I. That his understanding was that we were likely to heat the final ruling of the JCVI on Friday 3 September 2021.
II. That there were plans in place to begin the vaccination but would need to have the conversation with the school's first.
III. Schools were alerted to it and were would cooperate with the programme, but the population of 12-15 year olds in Birmingham was approaching 75,000.
IV. Practically, we could not do them within the first week of them returning to school, but had arranged to do this in the half-term.
V. In terms of the communications with care homes we had worked hard including the Council and the Adult Social Care team had been in constant dialogue and contact with the care homes.
VI. A programme was in place over this last week and a conversation with every care setting in Birmingham to bring them up to speed to help them to understand and to encourage them to supply us with the data so we could focus our needs.
VII. We had been speaking about taking a mobile vaccination units out with GPs having conversations as all the GPs had relationship with the care homes.
VIII. Every care home had a GP allocated to them as part of the scheme in place. There could be no one who could say that they did not know or understand that this was not a drill, this was serious.

Councillor Hamilton stated that she was in support of Mr Jennings' statements, but that the issue for her was the wider public. She added that she was aware that the care home work was going on, but the way this was done with the university students in terms of the promotion – as of September 2021 they could not go into any clubs etc. – this was more subdued with people in the care homes. Councillor Hamilton further added that she felt that this should be the start point for the government rolling it out to both the health service and in different parts of the community. The Government had not been as vocal with their communication so that the public was aware that this was happening. The Chair commented that he was in agreement with Councillor Hamilton's statement as there had not been very much in the way of communication nor any change at all.

Mr Jennings stated that we were in the process of trying to understand the implications in terms of those who goes into care homes. There were a lot of people who were required to go into care homes and for their jobs who will not

be able to go in in future unless they were doubly vaccinated. We were going through an exercise over the next two weeks to scope who those organisations were and the level of population they had as unvaccinated staff so we could start a structured conversation with them.

Mr Jennings further stated that Councillor Hamilton was absolutely right and this would have been much easier and clearer if the step within the NHS had been in time with the step in social care. There was a consultation in the NHS about the consultation progress and he would not be surprised if they came to the same conclusion. Doing it in two steps made it complicated for people to understand. It would be the responsibility of the manager of the care homes to check that those coming in had been appropriately vaccinated which would be a difficult task for those individuals. Colleagues in social care were working tirelessly on this. In our Programme Board for the vaccination programme, this was the main thing we had been speaking about for the last month or so and was very much the focus of our attention.

The Board noted the presentation.

ENFORCEMENT UPDATE

The Chair introduced the item and drew the attention of the Board to paragraph 3.1 of the report and advised that the report was tabled for information.

(See document No. 1)

The Chair advised that if anyone had any question on the item to please email Mark Croxford at Birmingham City Council who would be able to give a response.

225 **RESOLVED: -**

The Board noted the report.

LIVING WITH COVID STRATEGY

Dr Iheadi Onwukwe, Consultant in Public Health (Business & Strategy), Test & Trace Team introduced the item and made the following statements:-

1. From the discussions we have had especially on the presentation in relation to the Covid-19 Hospital Admission and Vaccination item, the nature of the questions and the context of how Covid had evolved and continue to evolved, the paper will articulate and mention the fact that we were moving through a phase from the emergency response to a different phase.
2. The strategy would be geared towards those new challenges. We will be drilling down more to learn about what was happening and we needed a slightly different strategy from the first phase when we were more on the emergency process.

3. The Council needed to note the fact that the emergency response had been stood down in August 2021.
4. Effectively some of those process along with the environmental enforcement were changing and this was part of the rationale for trying to have a slightly different push on how we respond and deal with pandemic.
5. It was important to note that in terms of capacity we were in a different strategy in terms of moving towards business as well as how we approach the general dynamics. These were essentially part of the rationale for trying to have a slightly different strategy to deal with the Covid response.
6. For Birmingham in particular, given the forthcoming Commonwealth Games and the challenges that would come with that and the winter pressures which would bring the norovirus and respiratory illnesses we were going to try and change the approach to tackling Covid. This was pointing out the fact that there was a change phase and subsequently a changed strategy.
7. The detail of the strategy was outlined in the report and was to strengthen the resilience and capacities through the first phase finding those capacities and then finding ways to strengthen them in the event that the changes we were now able to build on those capacities in order to be able to manage it better and to learn lessons.
8. There was some work already being done about learning lessons from the Covid so we will pick some of those lessons and try to drill down more into the Public Health response.
9. All these information will hopefully enrich the strategy that we will be presenting in more details at October's Board meeting. There will be a strategic review of what had happened during the emergency phase and we would draw lessons from that. In the process we would be discussing with both members from the Board and indebt interviews with …
10. Apart from the analysis that would pull out the data the issues the relationships and dynamics because it was an adoptive process, we need to be able to capture what made it possible for us to be able to respond in order to build on that. The finer bits of the details we would try to pick up.
11. In terms of the effectiveness of the vaccine and the implication it might have in communicating the impact of that and being able to be prepared to respond if things were to change, we will also need to be able to have that capacity.
12. All these methods and strategy in order to be able to live with Covid we would be able to have a strategy to communicate to the next Board, the lessons learnt and how we could use those lessons moving forward.

The Chair commented that the strategy would span the period from winter 2021 to Autumn 2022 which would take us through October/November 2022. The review Dr Onwukwe referred to is due to be completed by the 20th September 2021 in time for the draft strategy to be presented to October's Board meeting.

226 **RESOLVED: -**

The Board noted the report.

MSOA DEATH ANALYSIS

227 The Chair advised that this item was deferred to October's Board meeting to allow for further work to be done.

PUBLIC QUESTIONS SUBMITTED IN ADVANCE

The Chair introduced the item and advised that there had been a question which was summarised in the report.

(See document No. 1)

The Chair advised that the response was set out in paragraph 3.2 of the report.

228 **RESOLVED: -**

The Board noted the response.

TEST AND TRACE BUDGET OVERVIEW

Dr Justin Varney, Director of Public Health introduced the item and advised that we were in budget.

(See document No. 3)

Dr Varney highlighted that as the Board was aware, we had profiled our budget based on what we had given to us in the ringfenced grant to take us through to the end of September 2022. This was to ensure that we had an adequate health protection to respond to Covid and potentially other infectious diseases throughout the Commonwealth Games and any other mass international events that we host in the city between now and then. The Commonwealth Games was the largest we had and we also had several other international sporting tournaments and arts events over the spring and early summer before the games. This was important as it allowed us to test and to feedback to the Board how we were adopting our Covid response to ensure resilience for those events.

Of the £2.5m contingency we set aside in this year and the £3.5m for Phase 3 response we had drown down approximately £2m of that overall £6m already which has not yet moved onto the ledger which was the reason it was not in the report. Dr Varney stated that he wanted colleagues to be aware otherwise it looked as though we were holding a large contingency. We were now being able to move things around so that it was clear which budget lines things were coming from. He hope was that the Board would see some of that Phase 3 had actually been spent during the response to the most recent wave in this financial year. The spend from the 1st April through to now in the additional response that we did to the most recent wave of the Covid had been drawn out of the £3.5m with about £2m to come out of it.

229 **RESOLVED: -**

That the Board noted the report.

OTHER URGENT BUSINESS

230 No items of urgent business were raised.

DATE AND TIME OF NEXT MEETING

231 It was noted that the next Local Covid Outbreak Engagement Board meeting would be held on Wednesday 6 October 2021 at 1400 hours as an online meeting.

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232 ***Farewell to Mr Paul Jennings***

The Chair commented that he knew Mr Jennings for a very long time and that he was an exemplary individual of the NHS and had been particularly adept keeping all of the politicians in Birmingham's local authority and indeed the 10 Birmingham Members of Parliament (meeting with them later today) keeping us all informed and abreast with development within the NHS as they had dealt with this crisis over the last 18 months. As Mr Jennings had stated earlier, the NHS was under immense pressure and he was sure that Mr Jennings himself too came under pressure over that period. The Chair wished Mr Jennings well on behalf of the Board as he head off to his retirement

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EXCLUSION OF THE PUBLIC

233 **RESOLVED: -**

That in view of the nature of the business to be transacted which includes exempt information of the category indicated the public be now excluded from the meeting:-

Exempt Paragraph 3 of Schedule 12A.

Birmingham
Local Outbreak Engagement Board
Covid-19 Overview

Birmingham Public Health Division

06/10/2021

Overview

Covid-19 in Birmingham: Current situation and 60-day trend

Coronavirus in Birmingham

Total deaths
(Data up to 04 Oct)

2,913

Latest daily figure

0

new deaths

60-day trend
(based on seven-day averages).

Source: coronavirus.data.gov.uk

Total cases
(Data up to 04 Oct)

160,794

Latest daily figure

464

new cases

60-day trend
(based on seven-day averages).

Source: coronavirus.data.gov.uk

Hospital admissions
(Data up to 04 Oct)

22,312

Latest daily figure

31

new admissions

60-day trend
(based on seven-day averages).

Source: NHS COVID-19 Situation Operational Dashboard

Over 60's cases
(Data up to 01 Oct)

19,803

Latest daily figure

31

60+ new cases

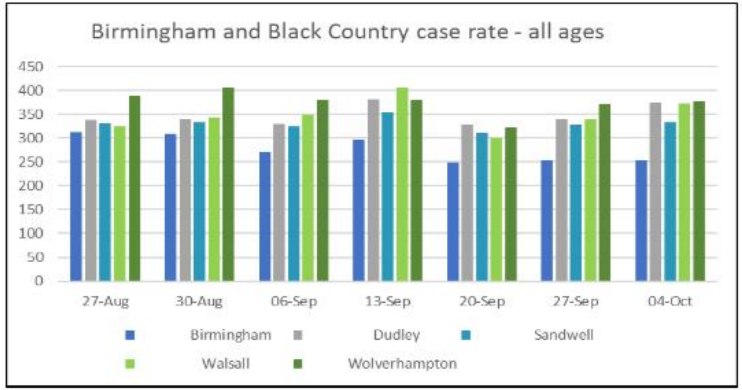
60-day trend
(based on seven-day averages).

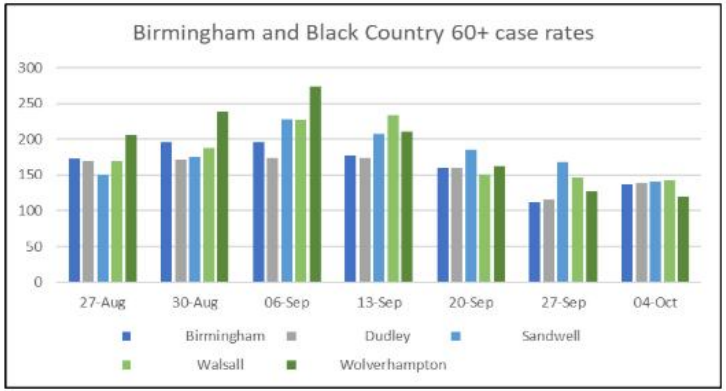
Source: PHE

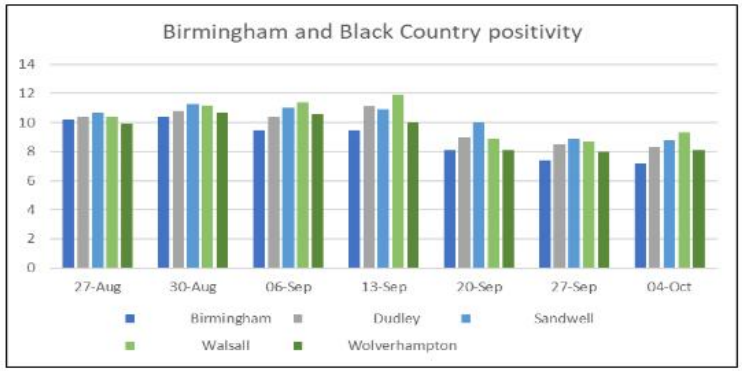
Testing & Cases Summary: 7 Days up to 2nd October 2021

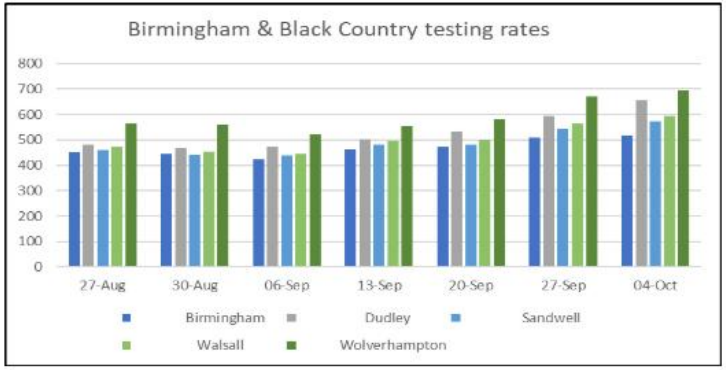
- 7 Day Rolling Case Rate to 2nd October (Pillar 1 & 2) — 240.1/100K
  - Rate on 25th Sept — 258.5/100K
  - Ranked 14th (out of 14 local authorities) in the West Midlands region, with 1 being the highest (Warwickshire (560.1)/100K)
- 7 Day Pillar 2 PCR testing rate at 2nd October — 2,441/100K
  - Rate of testing on 25th September — 2,296/100K
  - Ranked 14th (out of the 14 local authorities) in the region, with 1 being the highest
- 7 Day LFD testing rate at 2nd October — 4,358/100K
  - Rate of testing on 25th September — 4,891/100K
  - Ranked 14th (out of the 14 local authorities) in the region
- % of Pillar 2 positive PCR tests at 2nd October — 10.2%
  - Rate on 25th September — 10.7%
- % of positive LFD tests at 2nd October — 1.3%
  - Rate on 25th September — 1.3%

Birmingham & the Black Country Direction of Travel



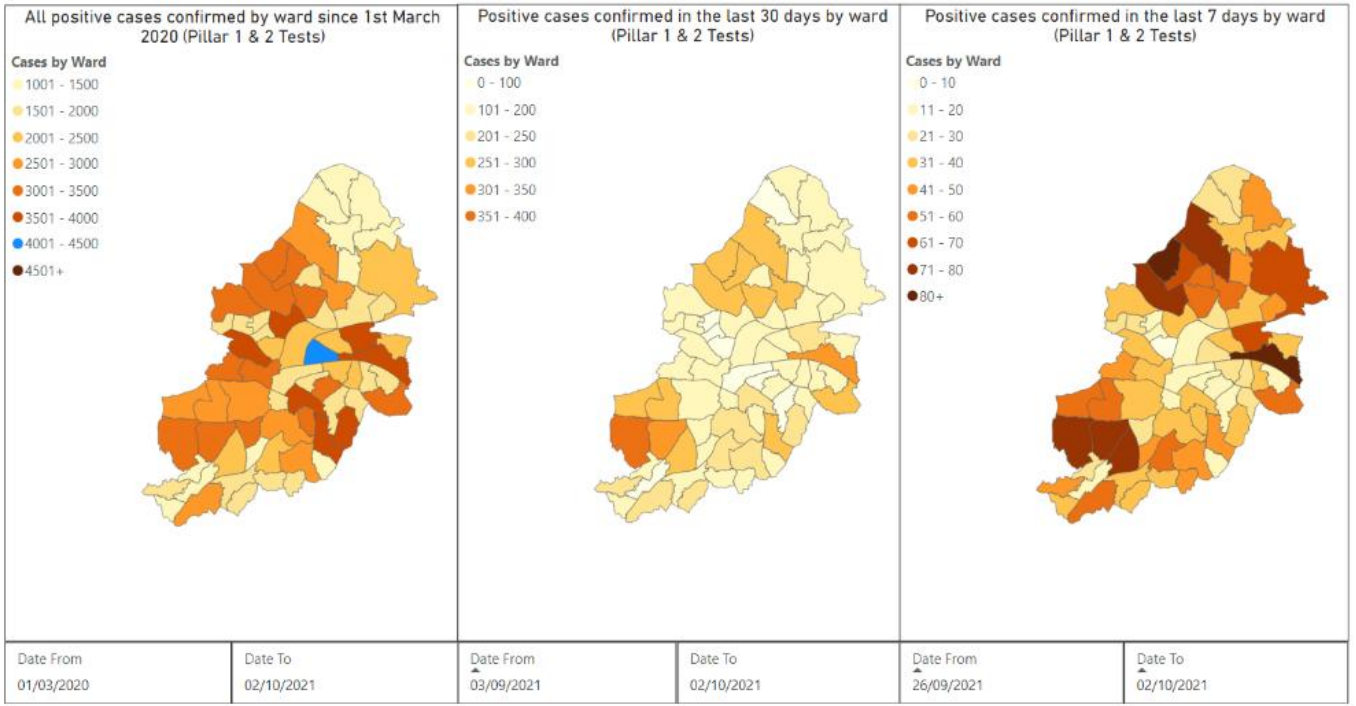






Cases by Ward: Total, Last Month & Last Week

Confirmed Cases by Ward for Pillar 1 & 2 Tests



Total | Last Month | Last Week

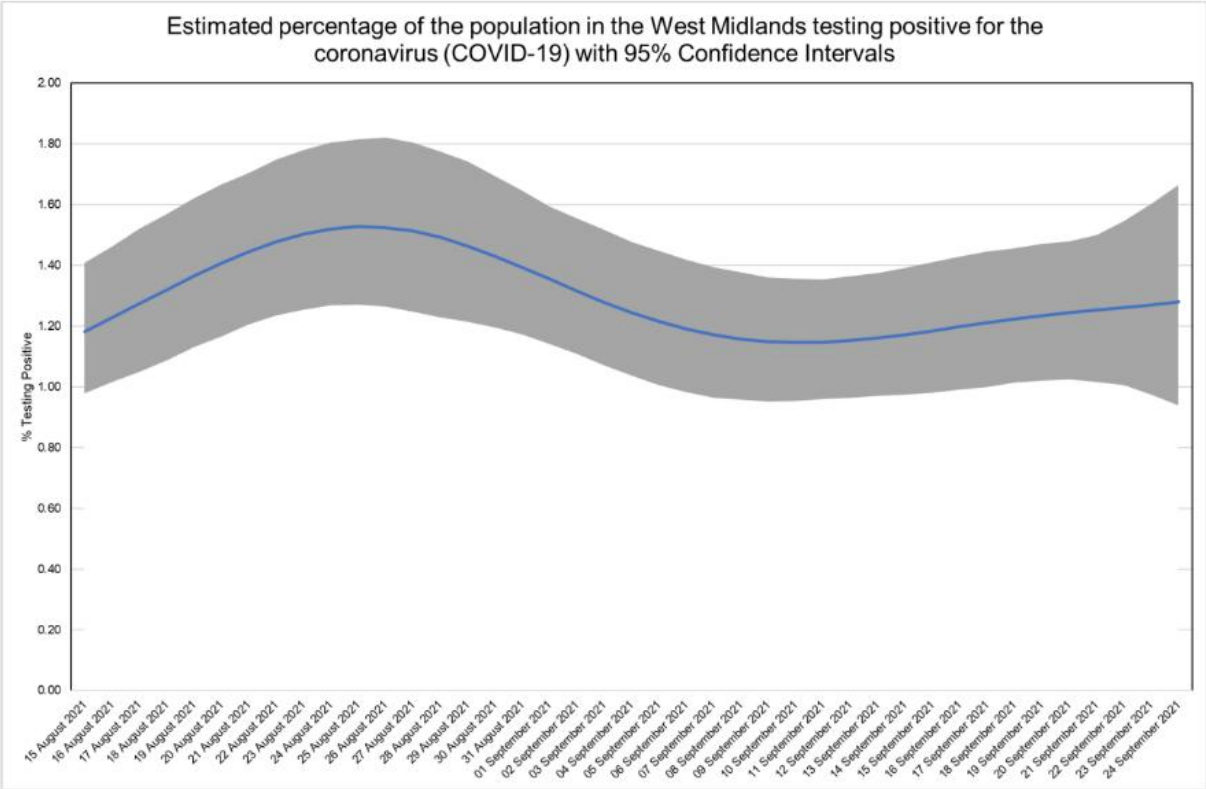
Top Ten Case Rates by Ward

Ward	Prior week (2021-09-15 to 2021-09-21)		Most recent week (2021-09-22 to 2021-09-28)		Change between last two weeks		
	Cases	Rate	Cases	Rate	%	Absolute difference *	
Castle Vale	44	456.1	53	549.3	20	93.2	→
Sutton Wylde Green	34	397.6	43	502.8	26	105.2	→
Sutton Trinity	33	355.9	46	496.1	39	140.2	→
Bartley Green	95	418.9	108	476.3	13	57.4	→
Sutton Roughley	35	303.5	54	468.3	54	164.8	↑
Bournville & Cotteridge	84	468.6	83	463.0	-1	-5.6	→
Perry Common	34	286.8	51	430.2	49	143.4	→
Shard End	57	472.6	51	422.9	-10	-49.7	→
Sutton Vesey	62	317.7	81	415.1	30	97.4	→
Frankley Great Park	32	273.1	47	401.1	46	128.0	→

Of the 69 wards in Birmingham, 4 wards have seen a statistically significant increase in case rates and 4 wards have seen a significant decrease.

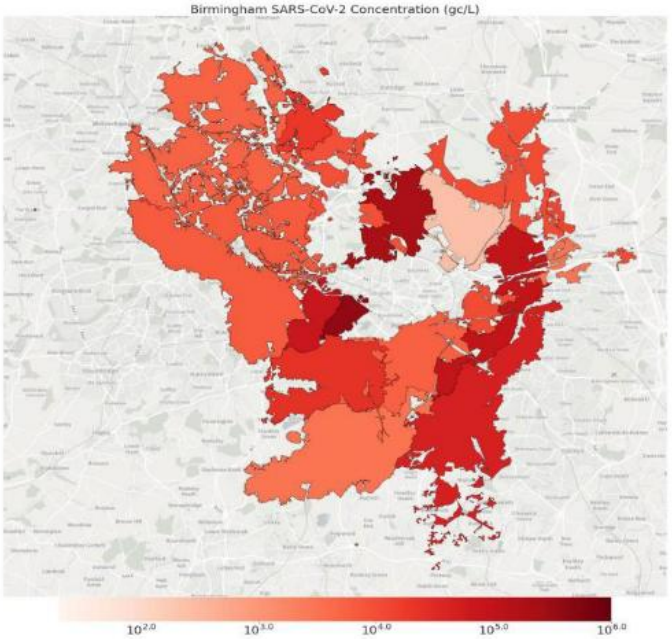
Relative change arrow based on incidence rate ratio p value <0.05.

ONS Coronavirus (COVID-19) Infection Survey, up to 25th September 2021

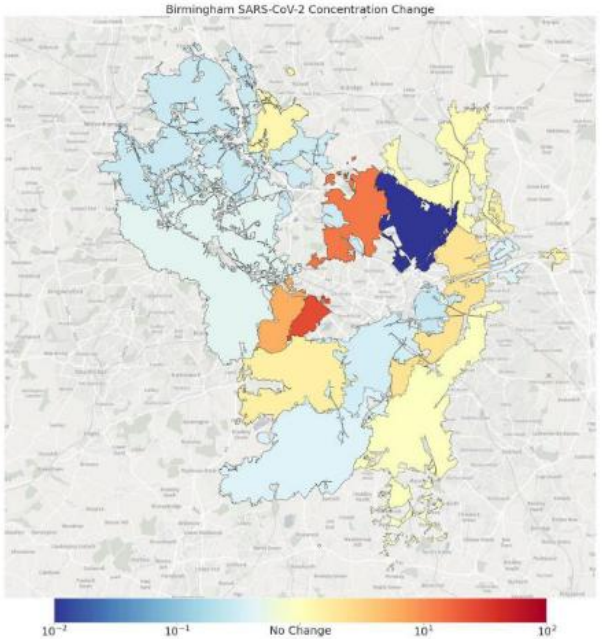


- The ONS infection survey estimates the % of the West Midlands adult population who were COVID positive on 25th September. This increased to 1.29%. The previous week's estimate was 0.88%.
- In the 7 days up to 25th September, the percentage of people testing positive increased in those aged 2 years to school Year 11 and there were early signs of a possible increase for those aged 70+. In the same week, the percentage of people testing positive decreased for those in school Year 12 to age 24 years and levelled off for those aged 35-69 years. The trend was uncertain for ages 25-34 years.
- ONS are not currently calculating sub regional estimates due to reduced estimate accuracy from low prevalence.

NHS WASTEWATER SARS-COV-2 Report 19th to 25th – September 2021



7-day average SARS-CoV-2 RNA concentration (gc/L) in wastewater. Darker shading indicate areas with a higher viral concentration. Higher concentration is associated with increased prevalence



Change in weekly average SARS-CoV-2 RNA concentration in wastewater. Measured as the difference between Log10 values of the weekly averages. Grey shading indicates areas where there was insufficient data to measure change.

Variants of Concern

Variant of Concern or Under Investigation

- Delta VOC (Indian variant) - still remains the dominant variant in B'ham and in the UK.

- Lambda -VUI-21JUN-01 (South America)
  - no more cases identified so far.

- The Mu variant (VUI-21JUL-01 lineage B.1.621) is under investigation.
  -None identified in the West Midlands.

- No new variant reported recently in Birmingham.

Testing

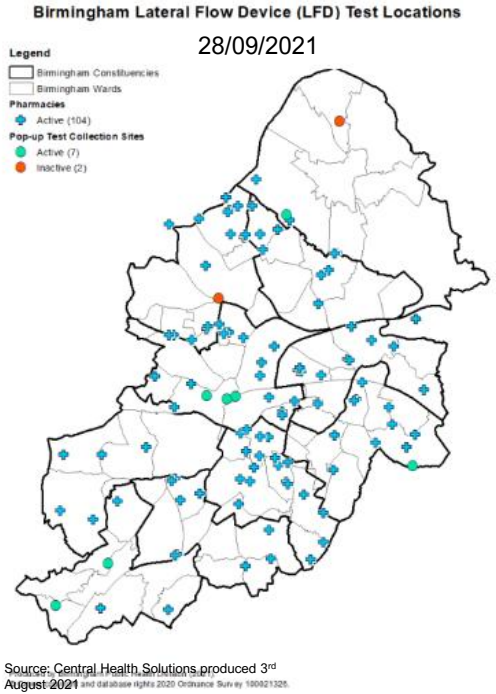
Lateral Flow Test Locations

- **Lateral flow testing and collection sites have now closed** in line with the national move to home testing.
  - Home testing kits can be ordered from govt's website.
  - https://www.gov.uk/order-coronavirus-rapid-lateral-flow-tests

- **Testing available at a network of community pharmacies**
  - 104 pharmacy community testing sites currently live.

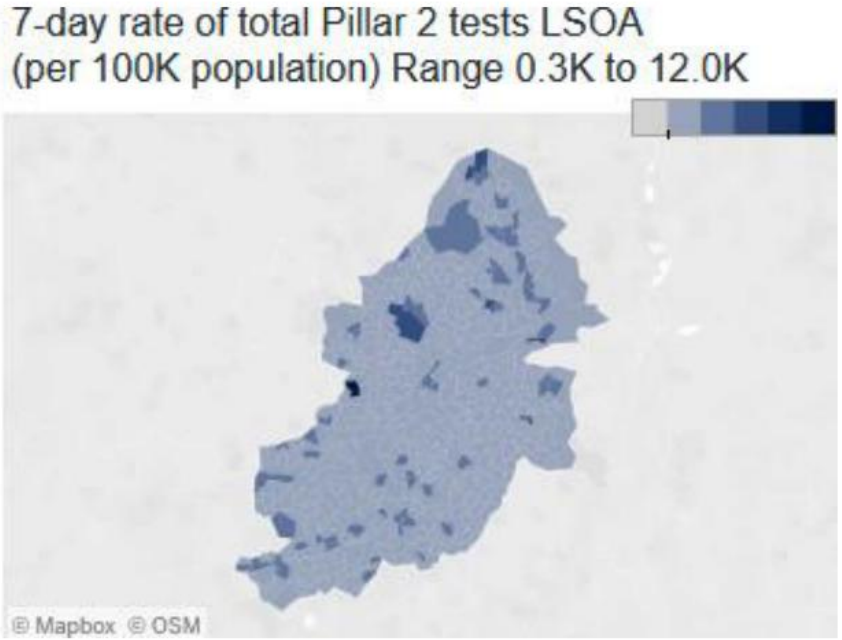
- **Pop up collection sites**
  - A series of pop up collection sites are now operating around Birmingham to increase the reach of distribution.

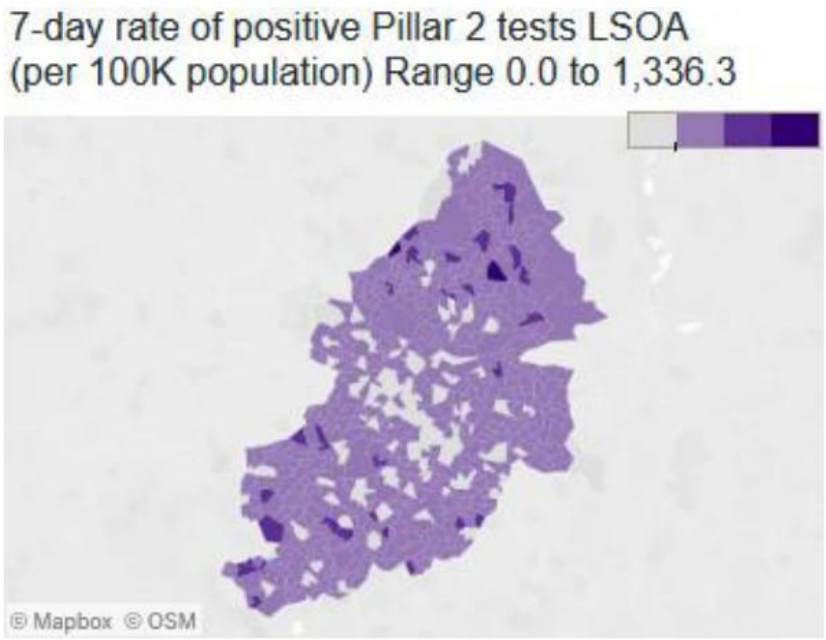
- **Lateral Flow Device (LFD) Inclusion Pilot:**
  - Engaged with homeless organisations to enable homeless citizens to collect and undertake regular LFD tests.



Source: Central Health Solutions produced 3rd August 2021 and database rights 2020 Ordnance Survey 100021326.

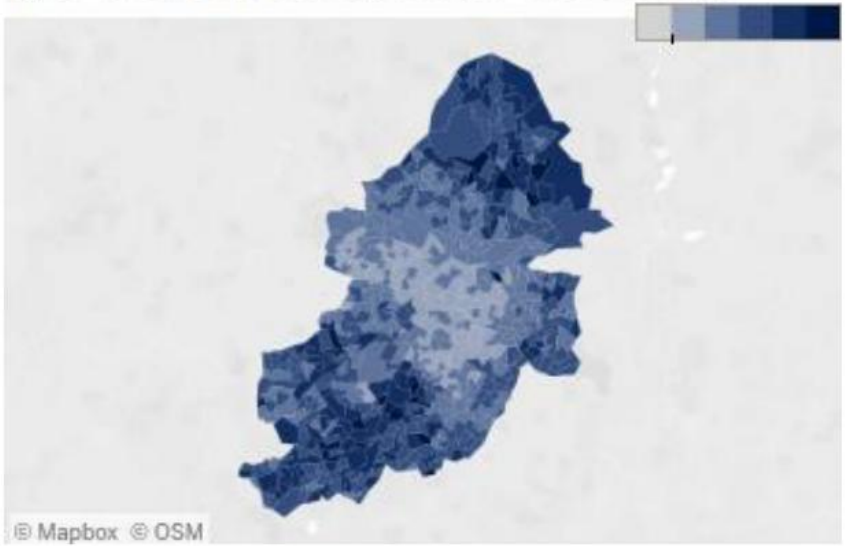
PCR Testing (Pillar 2) by LSOA: 7 Days up to 1st October 2021





LFD Testing (Pillar 2) by LSOA: 7 Days up to 1st October 2021

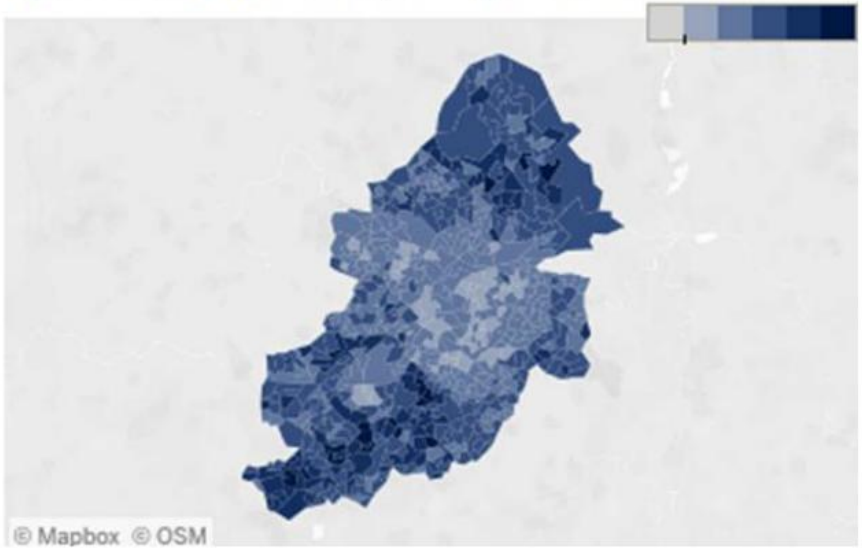
7-day rate of total Pillar 2 tests LSOA (per 100K population) Range 0.8K to 9.9K



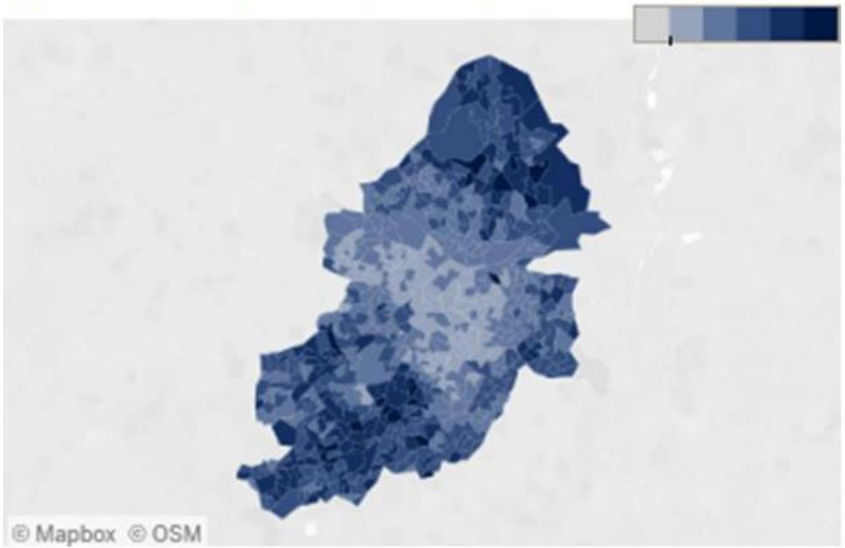
7-day rate of positive Pillar 2 tests LSOA (per 100K population) Range 0.0 to 444.7

LFD Testing Progress: 5th September to 1st October 2021

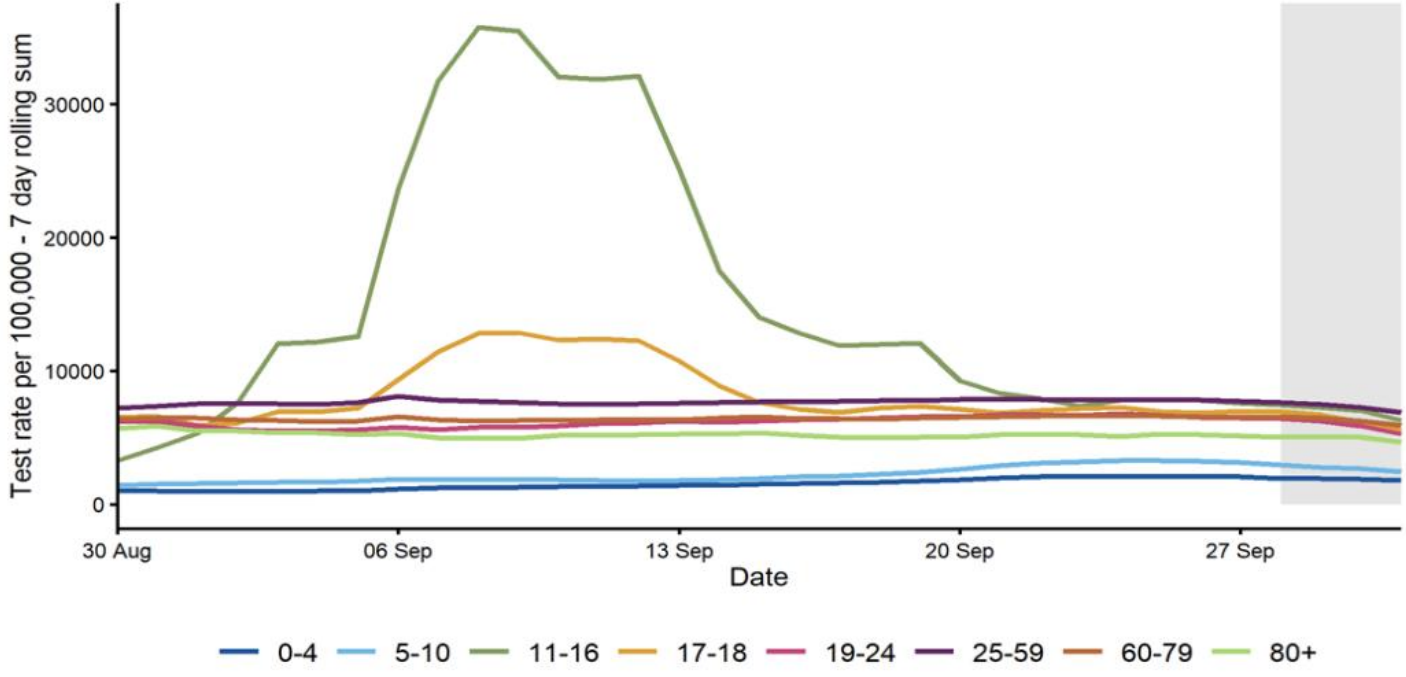
7-day rate of total Pillar 2 tests LSOA 5th Sept
(per 100K population) Range 1.0K to 11.9K



7-day rate of total Pillar 2 tests LSOA 1st Oct
(per 100K population) Range 0.8K to 9.9K



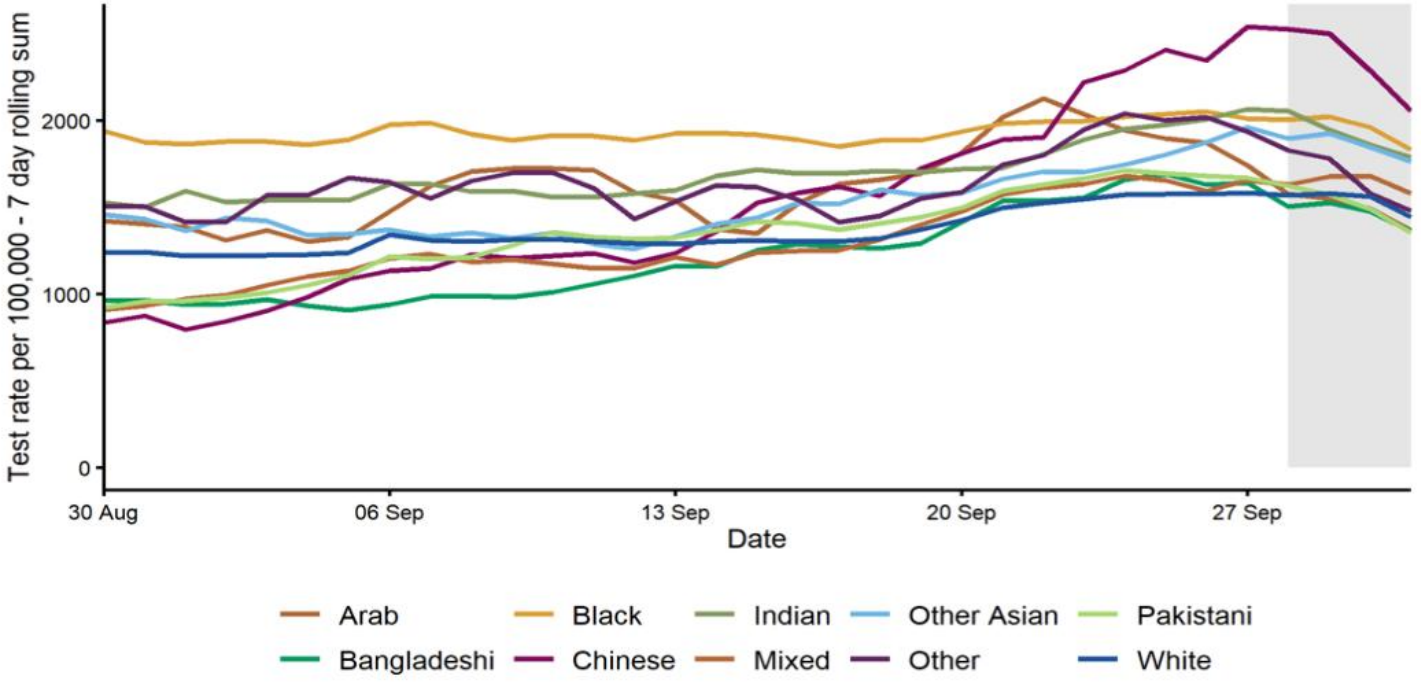
Age-specific 7-day rolling average Pillar 1 & 2 Test Rates per 100,000 Population Among Residents of Birmingham: 30th Aug to 2nd Oct 2021



The 4 most recent days are provisional – indicated by a grey background.

Excluding 1007 tests with missing age data.

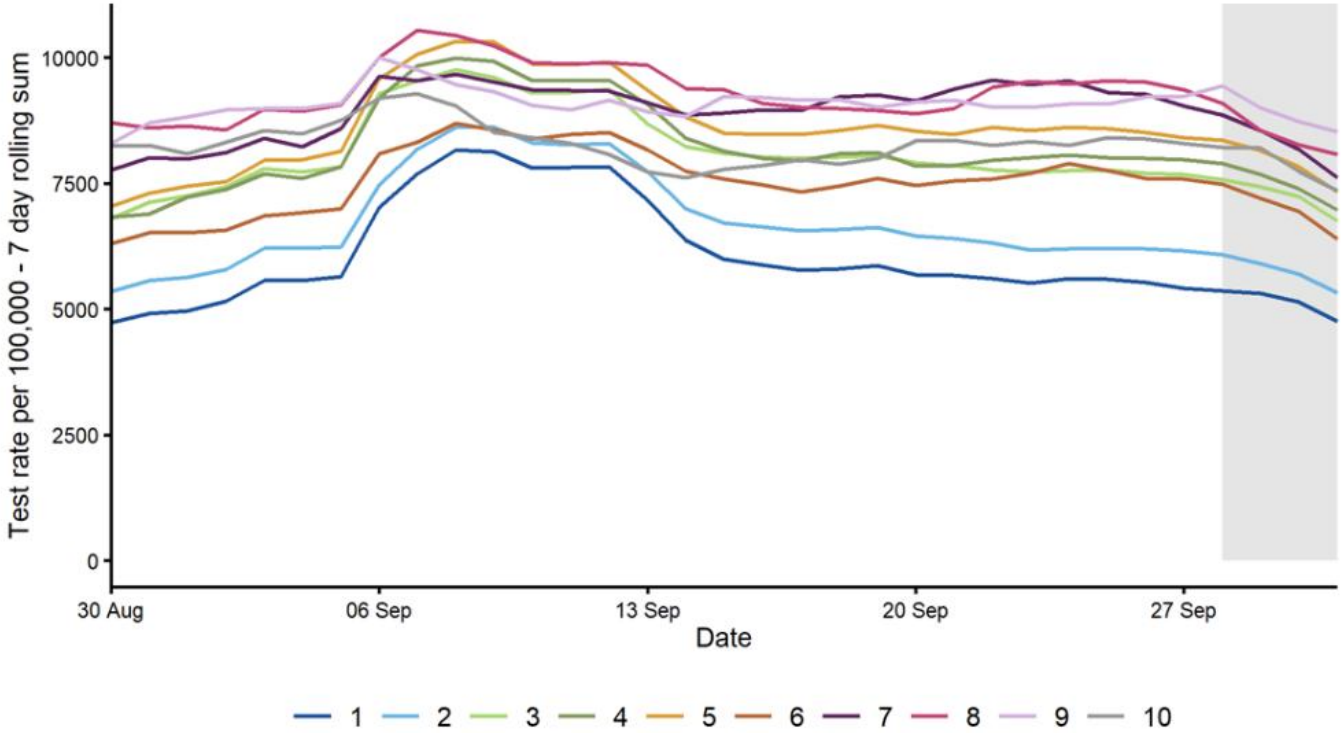
Ethnicity-specific 7-Day Rolling Average Pillar 2 Test Rates per 100,000 Population Among Birmingham Residents: 30th August to 2nd October 2021



The 4 most recent days are provisional – indicated by a grey background.

Excluding 236186 pillar 2 tests with missing ethnicity data.

IMD-specific 7-Day Rolling Average Pillar 1 & 2 Test Rates per 100,000 Population Among Birmingham Residents: 30th August to 2nd October 2021



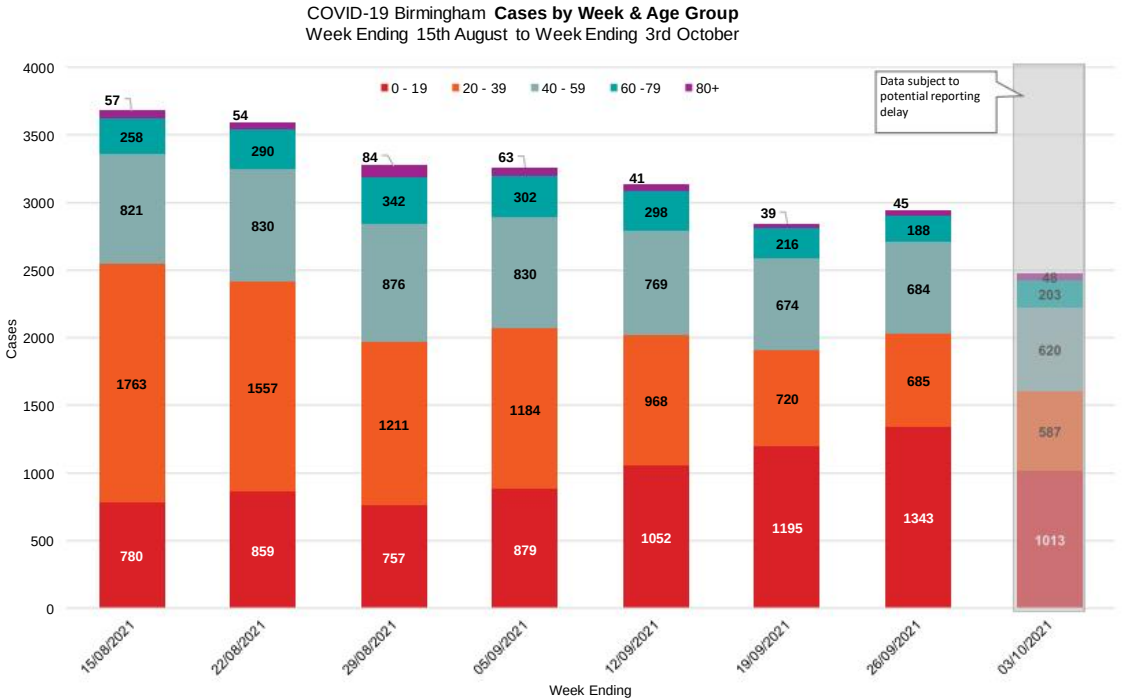
Using Index of Multiple Deprivation (IMD) of LSOA of usual residence (1 = most deprived; 10 = least deprived).
Where an IMD is not present in local denominator data, it is not shown.

The 4 most recent days are provisional – indicated by a grey background.

Case Demographics

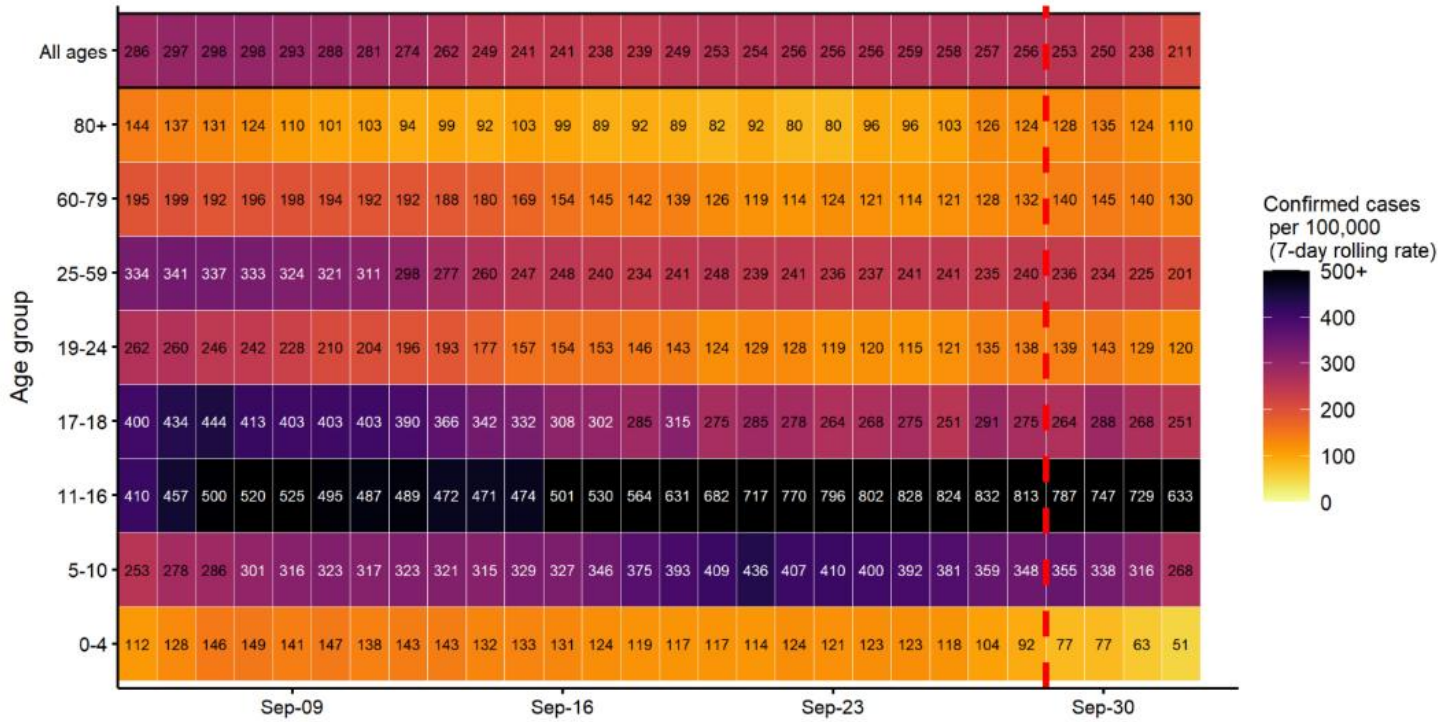
Cases by Week & Age Group

- The overall number of cases have fallen by 16.1%, from 2,945 in week ending 26 September to 2,471 cases in current week ending 3rd October.
- The age group with most cases was the 0-19 year olds. This age group also had the largest fall this week, 24.6% compared to previous week ending 26th September.
- Cases in the 20-39 age group decreased by 14.3% compared to the previous week, and a 9.4% fall was seen in the 40-59 age group during same period.
- In contrast, cases in the 60-69 age group were up 8% in week ending 3rd October, compared to previous week.



Cases for week ending 3rd Oct 2021 are likely to be under-estimated due to time lags in reporting.

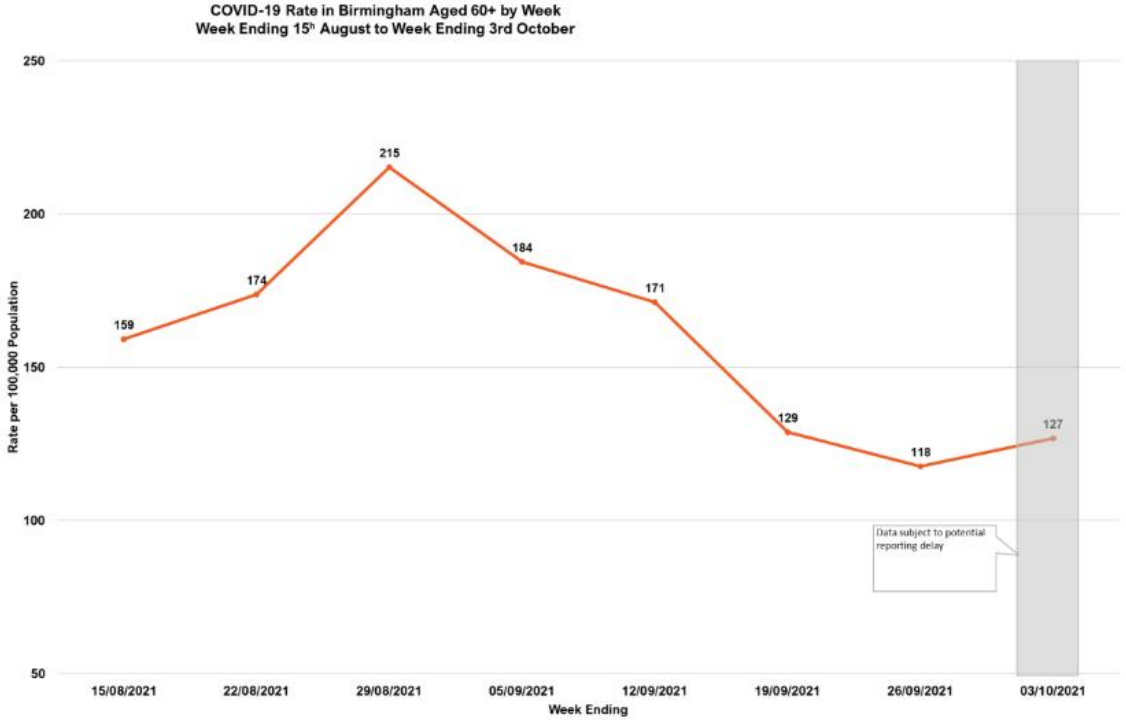
Age-Specific 7-Day Rolling Case Rates per 100,000 Population in Birmingham: 5th September to 2nd October 2021



The red dashed line denotes the 4 most recent days data are provisional.

Case Rate in Population aged 60+ years

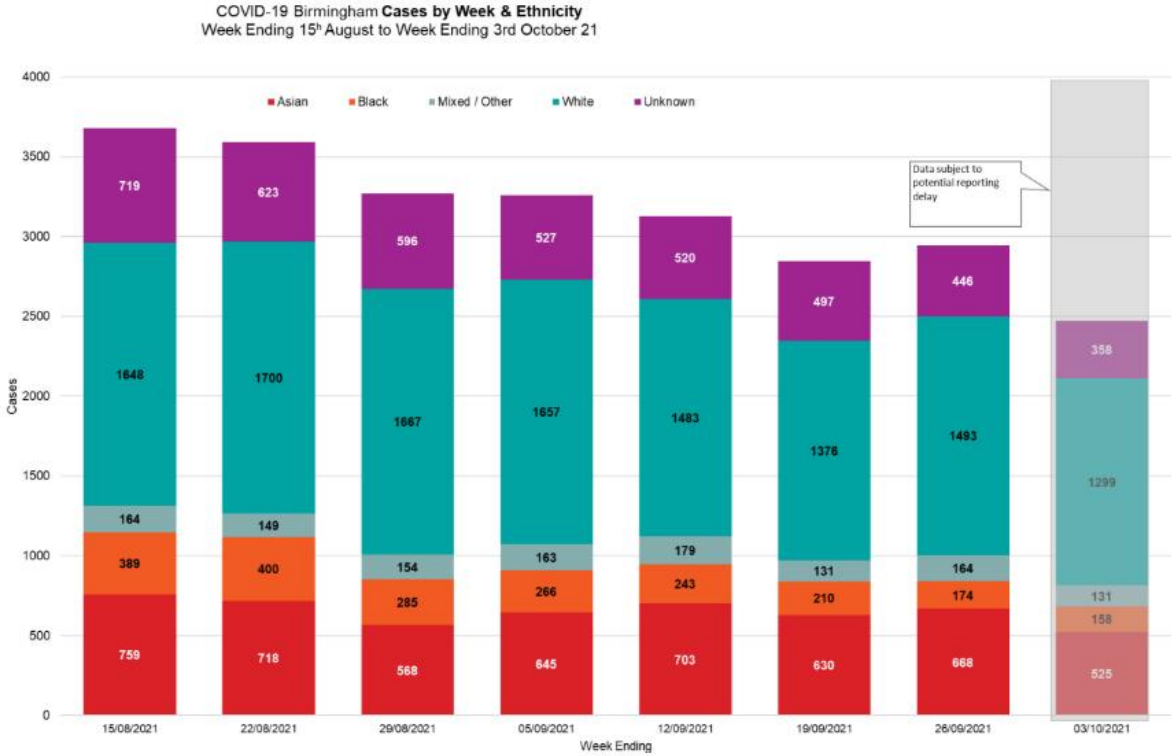
- Case rates in the over 60s have increased by 7.7% in the week ending 3rd October, to 127/100k, compared to the previous week (26 Sep).
- The previous 5 weeks (29 Aug to 26 Sep) had seen a pattern of decreasing case rates in the over 60s.



Cases for week ending 3rd Oct 2021 are likely to be under-estimated due to time lags in reporting.

Cases by Week & Ethnicity

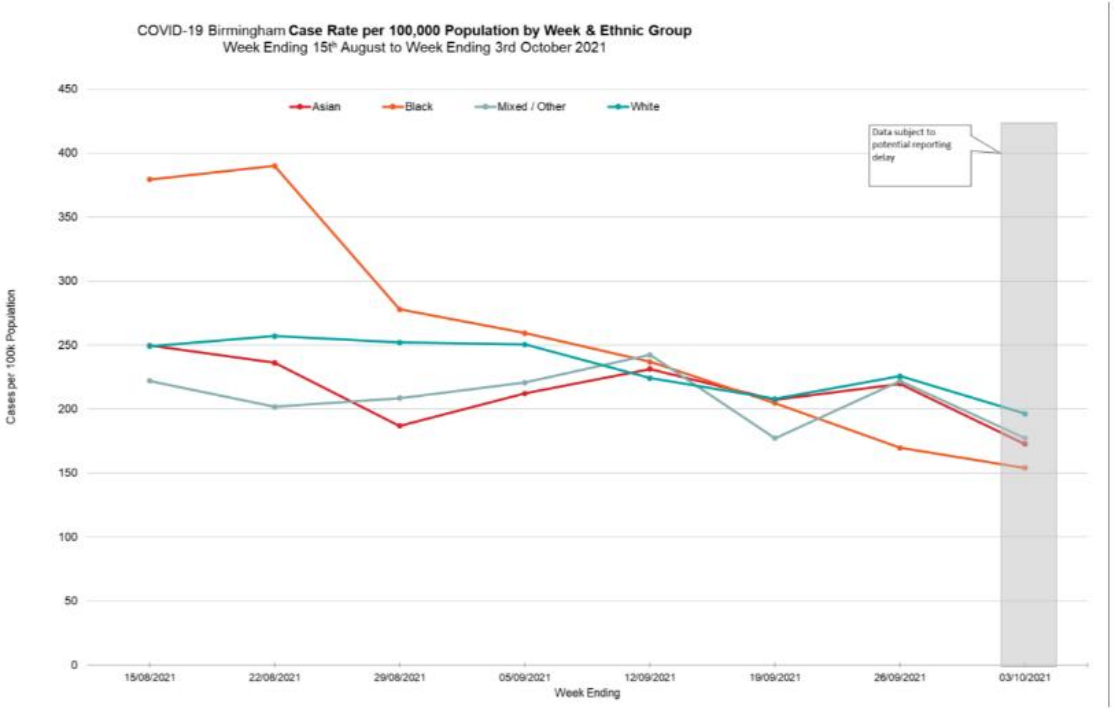
- Cases continue to fall across all ethnic groups
- As with previous weeks, the White ethnic group, has the highest number of cases, although the most recent week has seen a 5% fall in case numbers compared to previous week ending 26th September.
- Asian ethnic group remain second highest in number of cases.



Cases for week ending 3 October 2021 are likely to be under-estimated due to time lags in reporting.

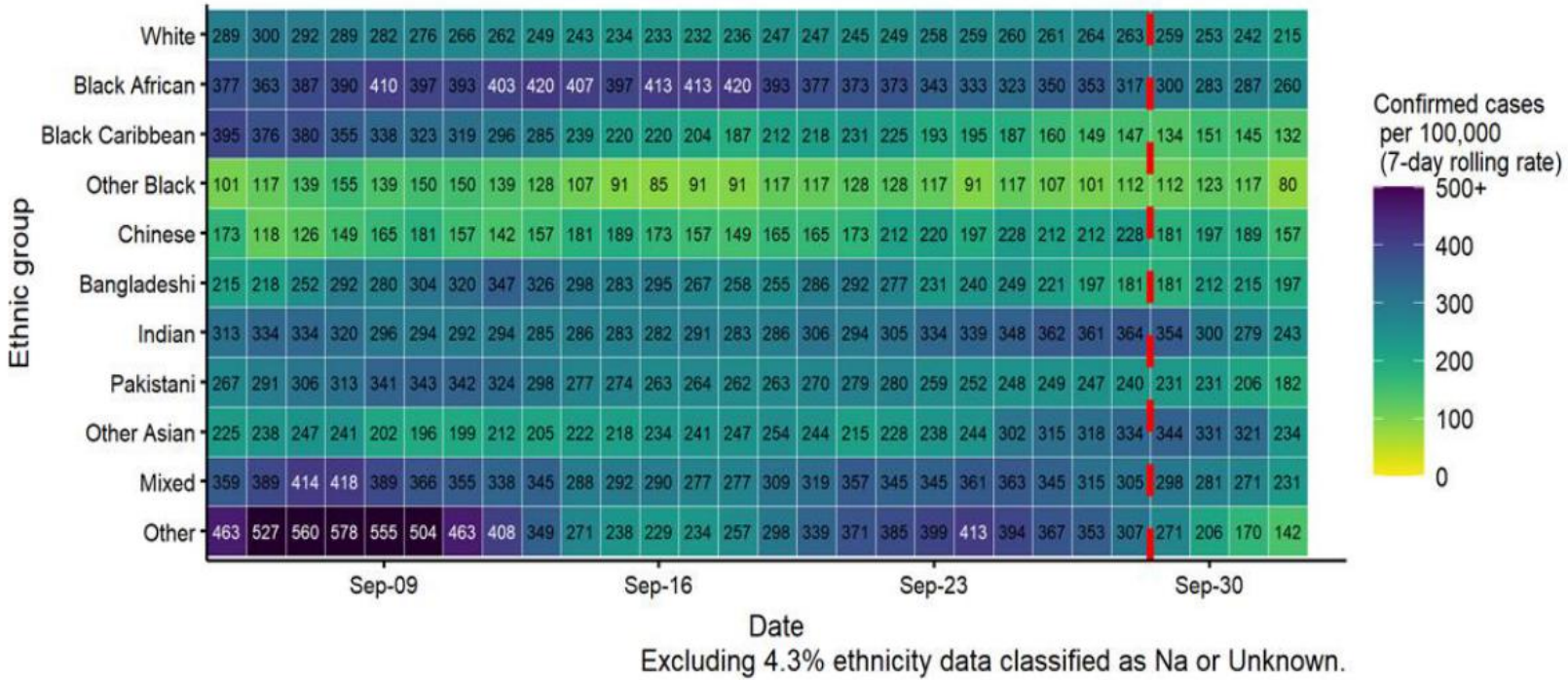
Case Rate by Ethnicity

- The Asian ethnic group saw the largest decrease this week – falling 21% from 220/100k in week ending 26th September, to 173/100k in the week ending 3rd October.
- This was followed by the Mixed/Other ethnic group, which decreased by 20%, from 222/100k to 177/100k.
- Case rates in the White ethnic group fell 13% from 226/100k to 196/100k, although case rates remain highest in this group.
- In the Black ethnic group, case rates remain the lowest at 154/100k, a 9% decrease compared to 170/100k in the previous week.



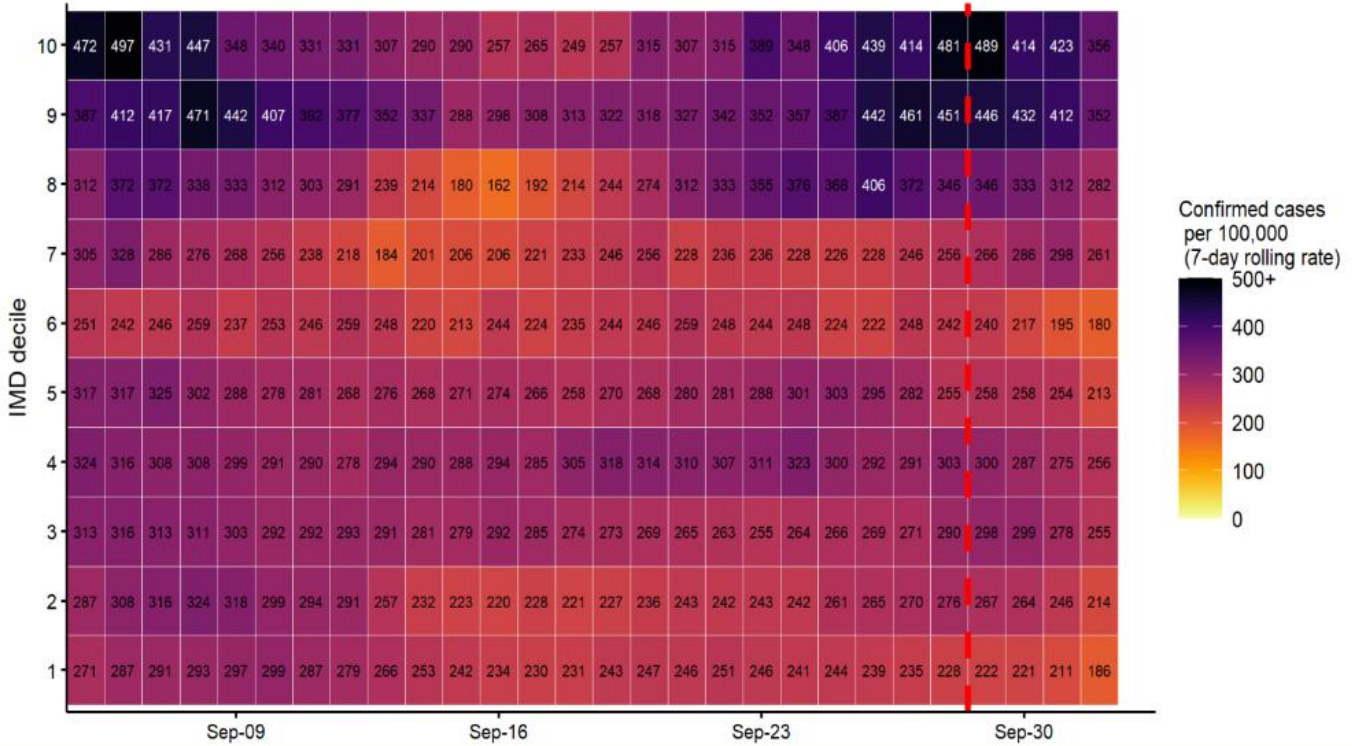
Cases for week ending 3rd October 2021 are likely to be under-estimated due to time lags in reporting.

Ethnicity-Specific 7-day Rolling Case Rates per 100,000 Population in Birmingham: 5th September to 2nd October 2021



The red dashed line denotes the 4 most recent days data are provisional.

Index of Multiple Deprivation-Specific 7-Day Rolling Case Rates per 100,000 Population in Birmingham: 5th September to 2nd October 2021



Using Index of Multiple Deprivation (IMD) of LSOA of usual residence (1 = most deprived; 10 = least deprived).
Where an IMD is not present in local denominator data, it is not shown.

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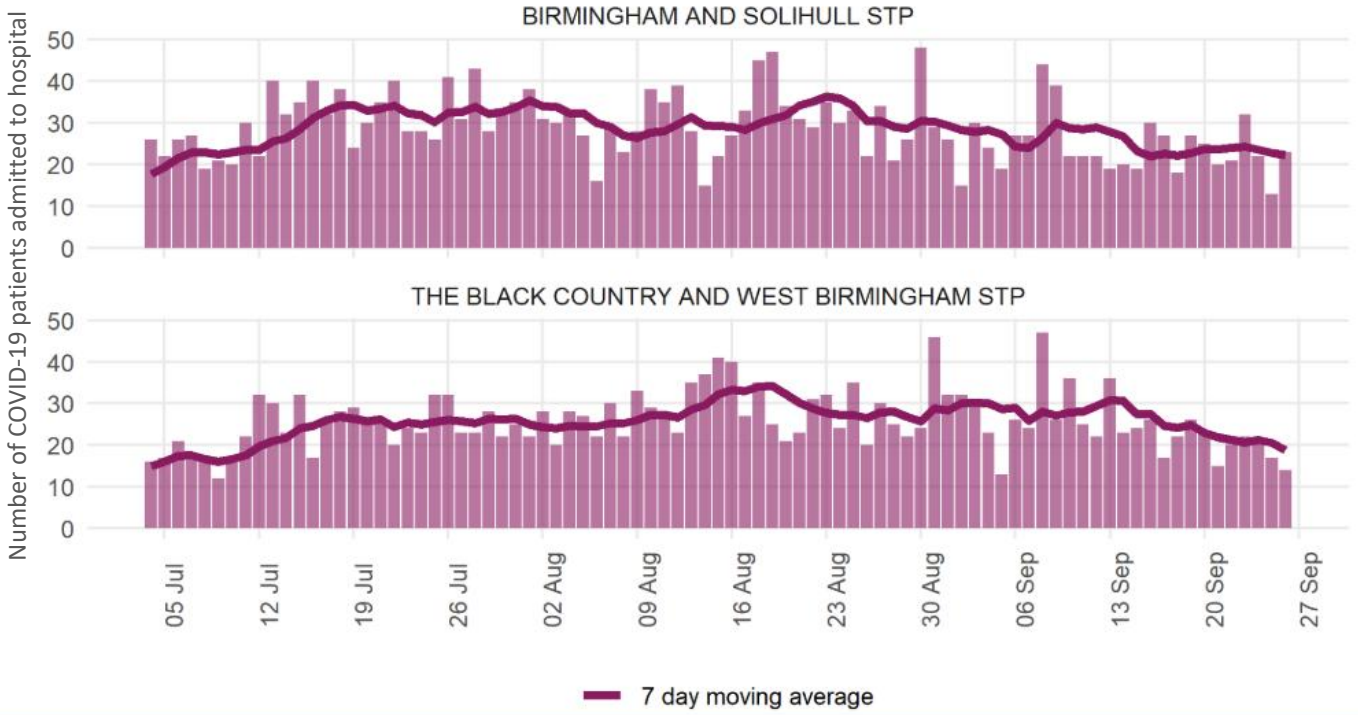
NHS Situations

Hospital Metrics Data

Hospital Trust	C-19 daily admissions 26/09	Hospital in-patients 28/09	Patients in Mechanical ventilation 28/09
University Hospitals Birmingham NHS Foundation Trust	18	152	26
Sandwell & West Birmingham Hospitals NHS Trust	5	55	5
Birmingham Community Healthcare NHS Foundation Trust	2	1	NA
Birmingham Women's & Children's NHS Foundation Trust	2	4	1
Birmingham & Solihull Mental Health NHS Foundation Trust	1	1	NA

Daily number of COVID-19 patients admitted to hospital in the Sustainability & Transformation Partnerships (STPs) associated with Birmingham, 4th July to 26th September 2021



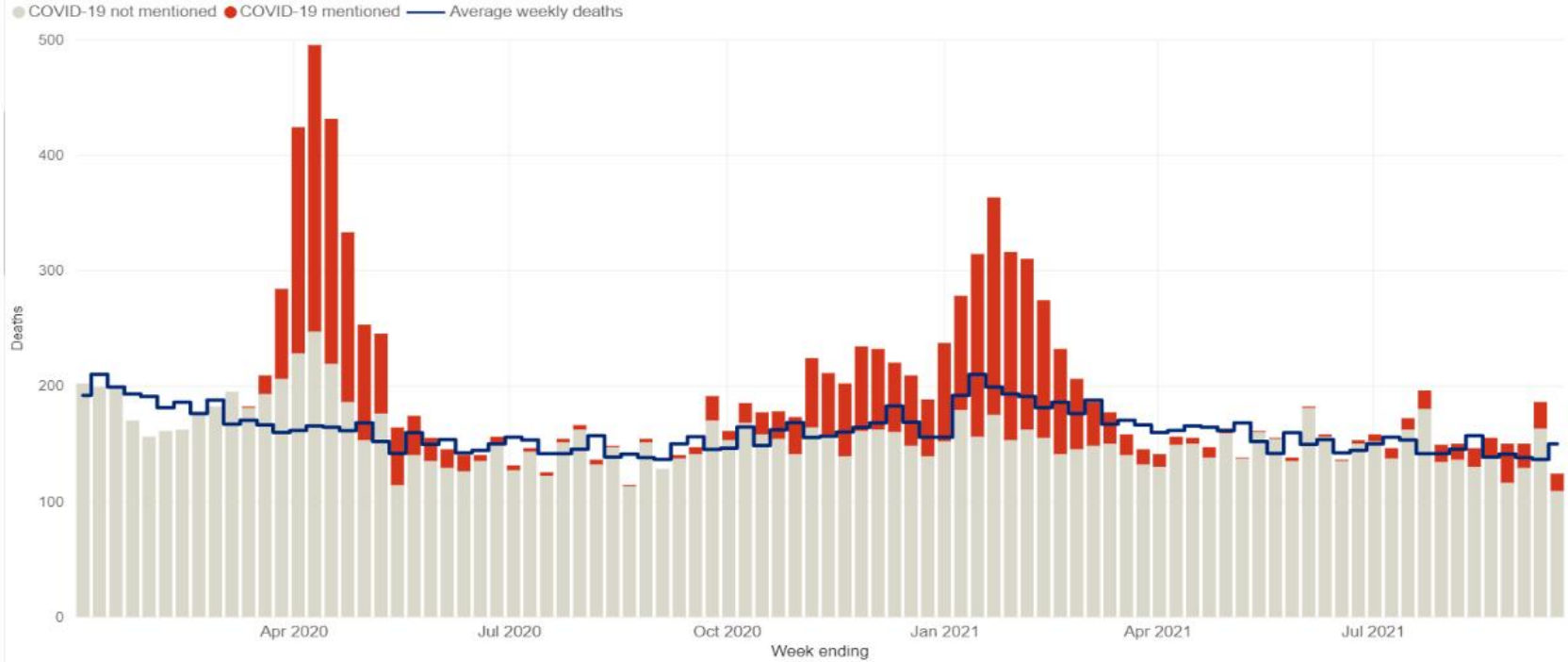
Deaths

Death Data

- Recent death data, where death occurred within 28 days of a positive Covid-19 test for the week ending 3rd October, reported **8 deaths,** equivalent to a death rate of **0.7**/100k population.

- More accurate data based on Covid-19 being mentioned on the death certificate is more historical. The most recent week reported is for week ending 17th September, which reported **28 deaths** registered in Birmingham. Of which, 24 occurred in hospital and 4 at a care home.

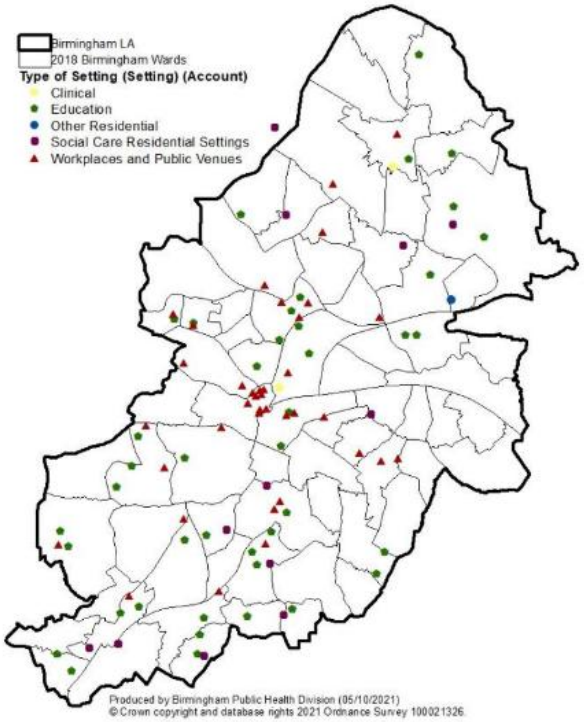
Excess Death: All Deaths up to 17th September

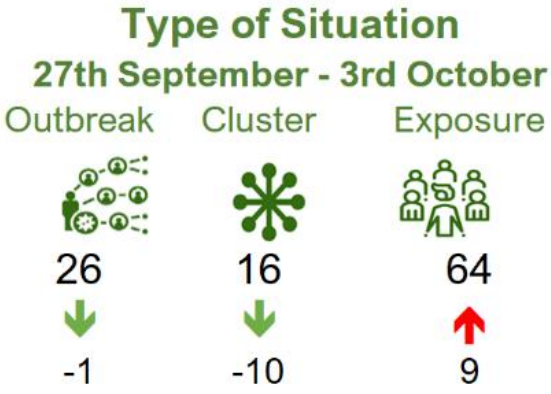


COVID deaths remain low and there have been no excess deaths (deaths above the 5 year average) in Birmingham in the last reported week.

Situations

Confirmed Situations in Birmingham: for the most recent 7 days





- **106 situations** were reported in the week ending 3rd October 2021: 26 Outbreaks, 16 Clusters and 64 Exposures.

- **Education** settings reported **50** situations.
- **Workplace and Public Venues** settings reported **41** situations.
- **Social Care and Residential** settings reported **12** situations.
- **Clinical settings** reported **2** situations.
- **Other Residential** settings reported **1** situation.

Cases for week ending 3rd October 2021 are likely to be under-estimated due to time lags in reporting.

Weekly situation narrative
27th September – 3rd October 2021

- The HPR Team updated 191 notifications on the App during the week 27th September – 3rd October. Of these, 106 were current situations.

- Education notifications had 50 current situations. There were 25 outbreaks, of which 8 had 10 cases or more.

- Clinical, Residential & Adult Social Care had 15 current situations. There was 1 outbreak in a Social Care Residential Setting.

- Workplace & Public Venue had 41 current situations. There were no outbreaks.

Common Exposure Events Reported by Cases Resident in Birmingham

Number & percentage of weekly exposures by setting: 25th July to 2nd October 2021

- Over the last week, most common exposures occurred in the **Education 12 to 17 yrs old** setting, followed by the **Education <12 yrs old** and **Education 18+ yrs old** settings. Many other settings that have been stable for the last 3 weeks are now increasing.

- Common exposures **are not** proof of transmission in a setting but provide evidence of where transmission **might** be taking place.

Reported in the 2-7 days before symptom onset, where at least 2 cases visit the same property 2-7 days before symptom onset and within 7 days of each other, by setting type and date of event. Data is grouped by 7 day period. The most recent 14 days may not have complete data yet.

Contact Tracing

Contact Tracing Local Authority Partnership

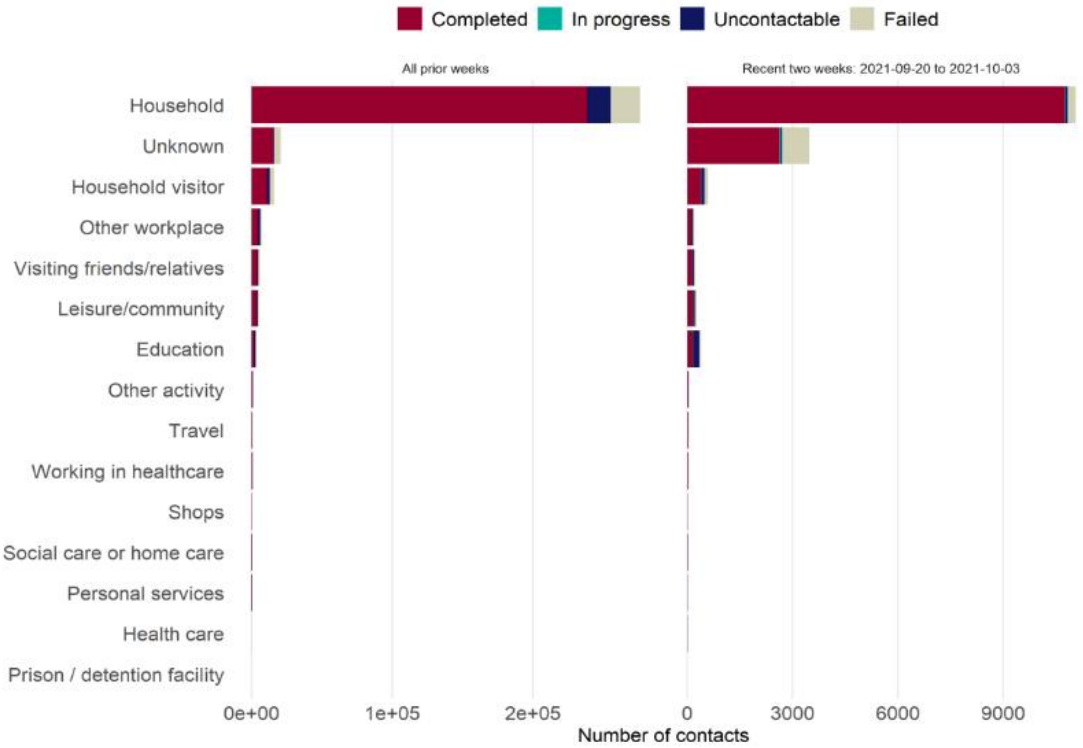
Service Highlights

- Contact Tracing Service now **covers all Birmingham wards in LTP and 14 wards in Local-4** and is currently **operating in Hybrid mode.**
- A team **providing face-to-face visits** is in place for positive cases that:
  - **cannot be reached by telephone** (3 attempts, including voicemail and texts). These are referred to Environmental Health for follow-up (approx. 2-3 cases/day at present)
  - **refuse to self-isolate**. These are referred to Environmental Health for follow-up visits (approx. 4 cases/day) and if necessary escalated to the Police
- The service also **provides support and welfare services to those who require food, financial or general support** during their isolation
- The **Integrated Tracing System** (ITS) which was due to replace the existing CTAS NHS system **has been postponed until further notice**

Latest Updates

- **Case Tracing**: For the **previous 7 days we have handled 980 cases** vs 1035 cases in the previous week. 713 of those had a successful outcome giving us a **completion of 73%.** The drop in cases is within normal fluctuation tolerance.
- **Welfare Support**: For the **previous 7 days we handled 241 support cases** vs 184 in the previous week.
- The **current estimated halving time in Birmingham is 53 days**. With an effective reproduction no of 0.95 vs previous week with a doubling time of 14 days and r number of 1.2 the previous week. Cases are stable overall in Birmingham however increasing within our Local-4 ringfence.
- At present we estimate **we would require 20 agents case tracing every day to return to the full Local-4 model**. In total we currently have 17 agents with approx. 12-14 on per week day and 4-6 per weekend. We are currently recruiting to backfill 2 leavers.
- **Hybrid Local-4 coverage changed to 14** wards from previous 19. This is due to an increase in cases in our selected wards. Our ringfence includes wards which are common university hot spots so that we can capture those cases and escalate them to the relevant teams within BCC. We have also seen the number of citizens autocompleting their form has dropped. We continue to cover all wards within an LTP model.

Test & Trace Contacts by Exposure/Activity Setting & Current Outcome: 28th May 2020 to 2nd October 2021



- Over the past 2 weeks, the most common exposure/activity setting has been the **Household**, followed by the **Unknown Category.**
- An increase in the **Household** and **Unknown** categories has been observed in the last two weeks. The 'Unknown category' is where data on exposure/activity setting were not provided.
- In the past two weeks, over 14,500 contacts were successfully completed, i.e. asked to self-isolate.

Data collected by NHS Track & Trace (NTAT).
Uncontactable cases: insufficient contact details provided to contact the person.
Failed contact tracing: contact tracing team attempted but did not succeed in contacting an individual.

Communications & Engagement

Digital Engagement: September 2021

Communication Channels

Sharing useful contents using tools such as community videos promoting personal responsibility since ‘COVID-19 is not over’, featuring key stakeholders across the city in education, champions, businesses, faith and ethnic groups.

Online and Community Q&As, Radio, Podcasts & TV (with Dr Justin Varney or Public Health Consultant)
Wednesday 1st September - Q&A with Bahu Trust about vaccines within the Muslim community.
Friday 3rd September – New Style Radio interview on isolation updates and vaccine uptake within the city.
Tuesday 7th September – BBC WM interview on the drive time show about COVID-19 rates and return to education.
Tuesday 14th September – BBC WM Q&A on the latest COVID news.

Emails & Newsletters: Vaccines offer to various age groups, locations/sites for vaccine access, Birmingham vaccine survey, vaccine toolkit, testing, new guidance and isolation rules, long COVID-19 and any health priorities for communities.

Verbal: Word of mouth communication via communities about ‘COVID-19 is not over’, personal responsibility, 16-17, 18+ vaccination, testing, new isolation rules and support for education settings reopening in September 2021.

Digital Engagement: March to September 2021

Social Media – Healthy Brum
August 25th – September 28th

Instagram
Reach – 4.3k
Impressions – 4.6k

Facebook
Post reach – 7.5kk
Engagement – 77

Twitter
Post engagements – 153
Post traffic (clicks) - 2.3K

Website
Over 500,000 visits to COVID-19 pages

Website Updates:
- Translated Vaccine toolkit and Isolation support.
- Accessible BSL resources
- Champions COVID-19 dashboard
- Latest COVID-19 guidance and updates
- New Education guidance for reopening in September

Partner Website Updates
- Latest vaccination mobile van https://www.birminghamandsolihullcovidvaccine.nhs.uk/walk-in/
- Available communications shared: https://www.birminghamandsolihullccg.nhs.uk/get-involved/campaigns-and-toolkits

Social media Key messages

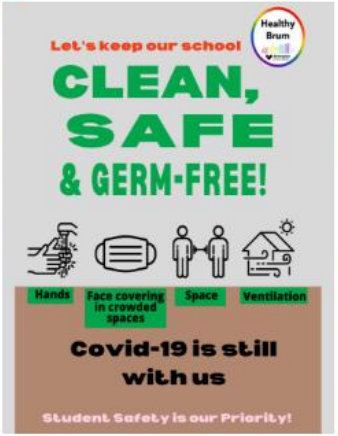
COVID-19 risks and Safety tips
- Continued caution with relaxed restrictions (H-F-S-V)
- Return to education settings
- During Birmingham Pride
- Testing (LFD, PCR)

Vaccination
COVID-19 Q&As, safety, pregnancy, mandatory Care home staff & visitors, 12-15 years,16-17 years and 18+, Survey, Flu vaccine, eligible vaccine age groups webpage.

Wider Public Health topics
Mental Health, Creating a Bolder Healthier City, Sickle Cell Awareness

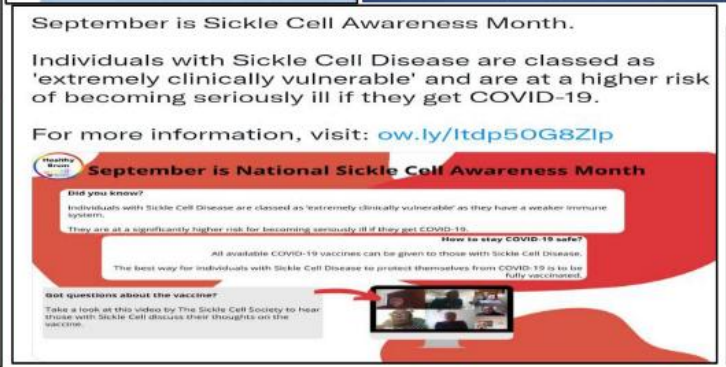
Communication and Engagement updates 28th September 2021

A selection of social media content published



If you work in a care home, it is a legal requirement to be double vaccinated by 11 November 2021. If you haven't already had your first vaccination, you will need to have it by 16 September.

Search 'COVID Vaccination Birmingham and Solihull'.



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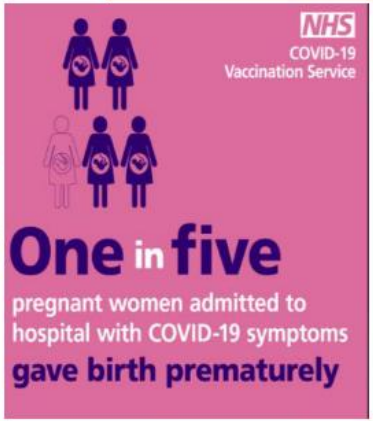
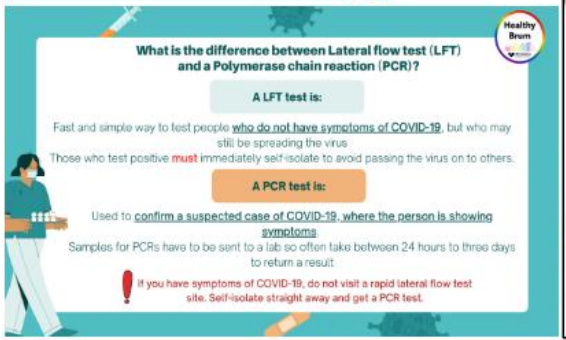




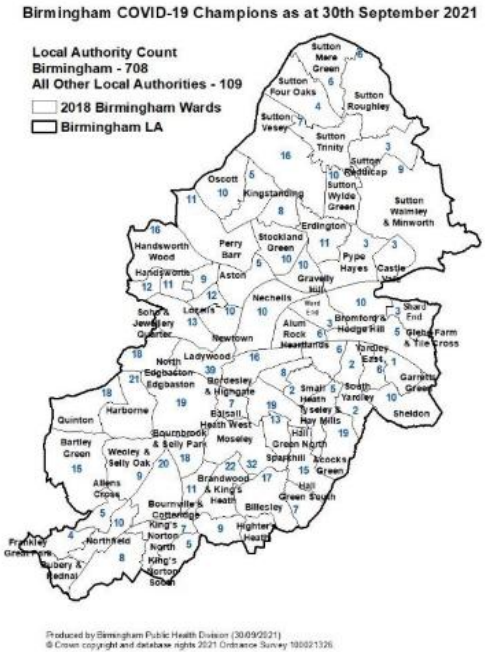
COVID Champion Programme

Coverage of champions across all 69 wards – at 28th September 2021

- 817 Community Champions + 65 Youth Champions + 20 Business Champions

Ongoing work:

- Collaboration with champions to obtain feedback about communities.
- Raise awareness on COVID-19 updates, continued caution and personal responsibility.
- Analysis of representation at ward and demographic level for recruitment plan.
- Thematic analysis of key themes (inbox, webinars & social media).
- Engagement via fortnightly webinars (next one 29th September).
- Vaccination Toolkit co-created to support champions and their communities.
- Recruitment of new champions and engagement via regular meetings.
- Independent review of champions programme ongoing, reviewers held focus groups and individual interviews with champions. Awaiting findings.
- Good representation of people from different faiths and LGBTQ+ communities. Underrepresentation from the following groups; males, Bangladeshi community, Black Caribbean community, young people and people with disabilities.
- Top topics: Vaccines: safety, booster, 12-15 years, GP access issues, Covid rates.



Healthy Brum

Want to become a COVID Champion?

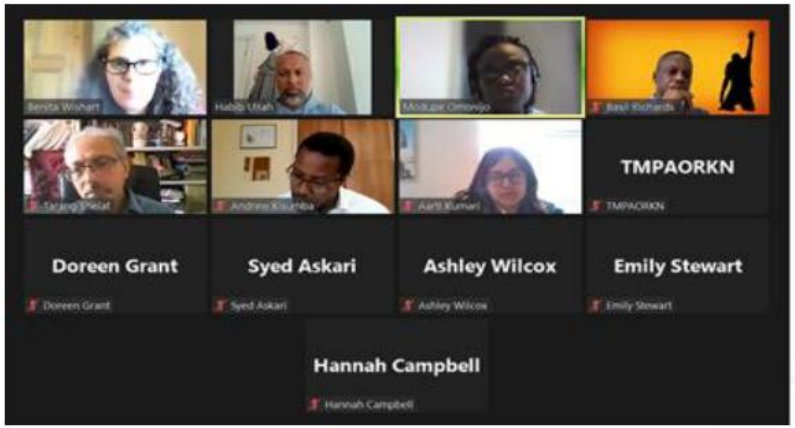
Follow the link below:

https://www.birmingham.gov.uk/info/50231/coronavirus_covid-19/2256/covid-19_community_champions/3

Engagement with Faith Groups

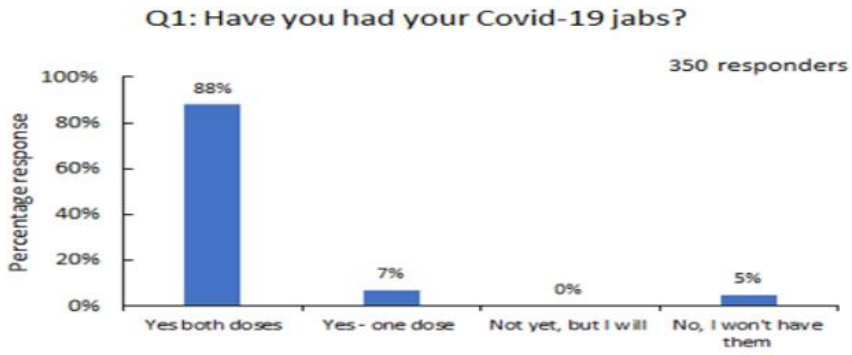
Over the last month we have continued to

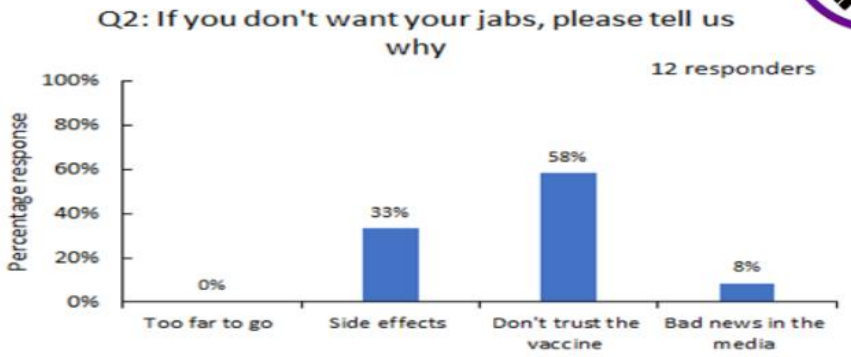
- Birmingham Masjids, Black Led Churches and Interfaith group fortnightly meetings to share COVID-19 updates.
- Increased awareness about vaccines including safety, boosters, 12-15 vaccine roll out, new COVID-19 guidance, isolation rules and testing.
- Increased messaging about mobile vaccination van and the wards being deployed and target engagement to increase uptake.
- Working with and supporting Black Faith Leaders to offer mobile vaccine vans within West Birmingham areas with low vaccine uptake and address concerns such as violence towards NHS staff.
- Share resources with accurate information and interpret faith group guidance to inform congregations and support addressing misinformation.
- Continue to share examples of COVID -19 messaging materials and resources produced by faith groups on social media and other channels.
- Fortnightly meeting with places of worship in partnership with Environmental Health to support with operational issues, day to day communal worship, cleaning, risk assessments etc
- COVID Charter: https://www.birmingham.gov.uk/info/50231/coronavirus_covid-19/2336/covid_charter_for_faith_settings

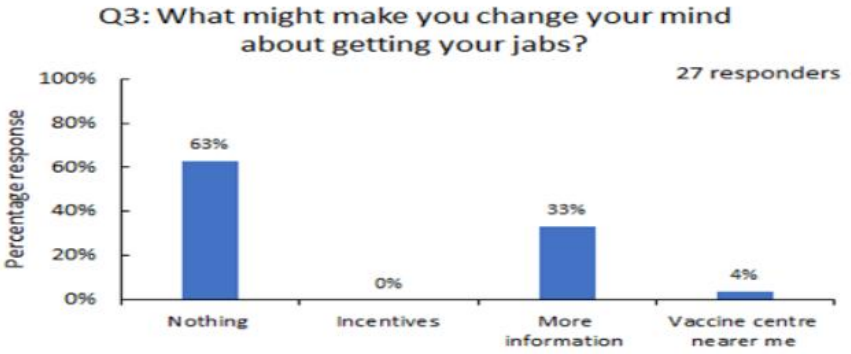


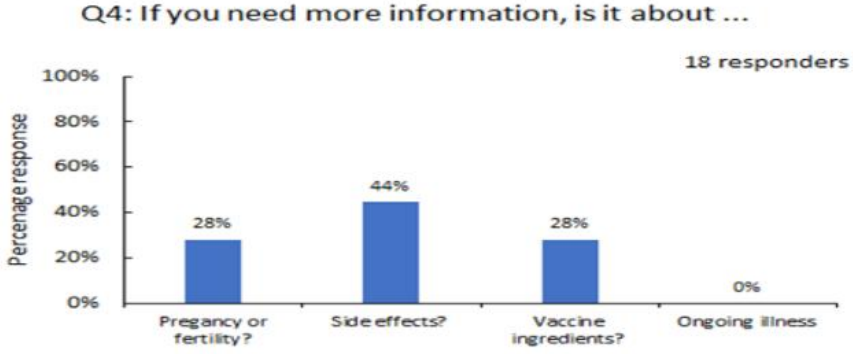
Community and Partnership engagement

Feedback from 1-min Birmingham vaccine online survey via Survey Monkey & Twitter from 12/08/21 to 26/08/21









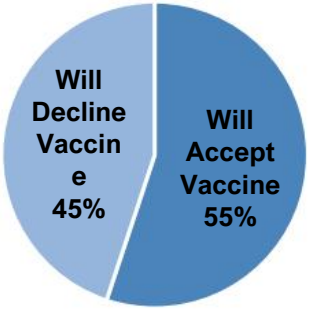
Community and Partnership engagement

Community vaccine engagement by Solutions4Health from 15th July to 12 August 2021

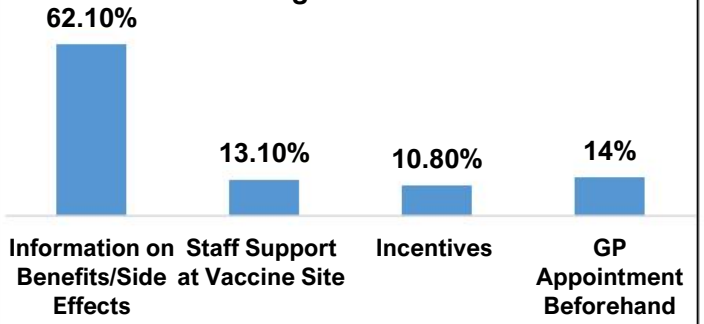
1,474 people across **208** postcode areas.
Wards covered: Small Heath, Bordesley Green, Ladywood, Winson Green, Bordesley & Highgate, Newtown, Aston, Nechells, Soho & Jewellery Quarter, Birchfield, Perry Barr, Handsworth, Holyhead, Lozells.
Continuous sharing of learning with key stakeholders including champions and faith groups.

COVID-19 Vaccination engagement campaign by commissioned partner to understand the views of diverse citizens across different occupations, ethnicities and targeting wards with low vaccine uptake.

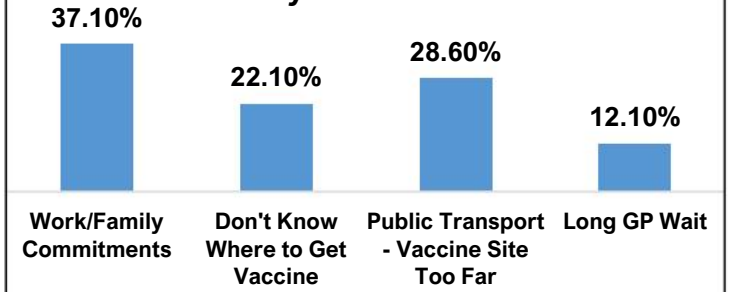
Vaccine Acceptance Amongst all Participants



"Would anything change your mind about taking the COVID-19 vaccine?"



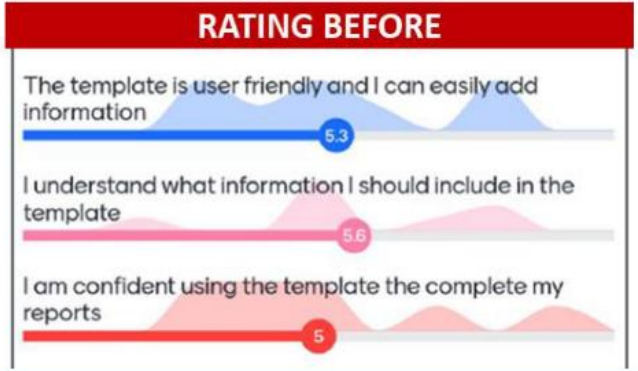
What obstacles are you facing to access your vaccination?

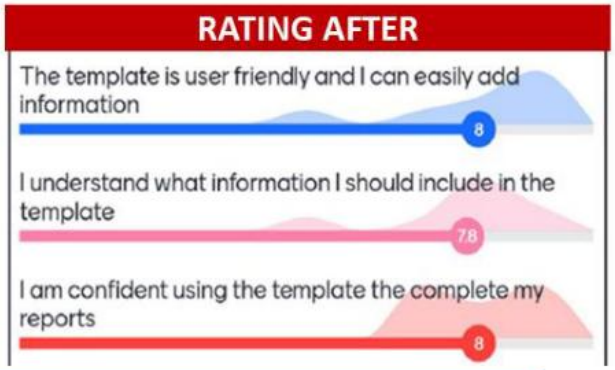


Community and Partnership engagement

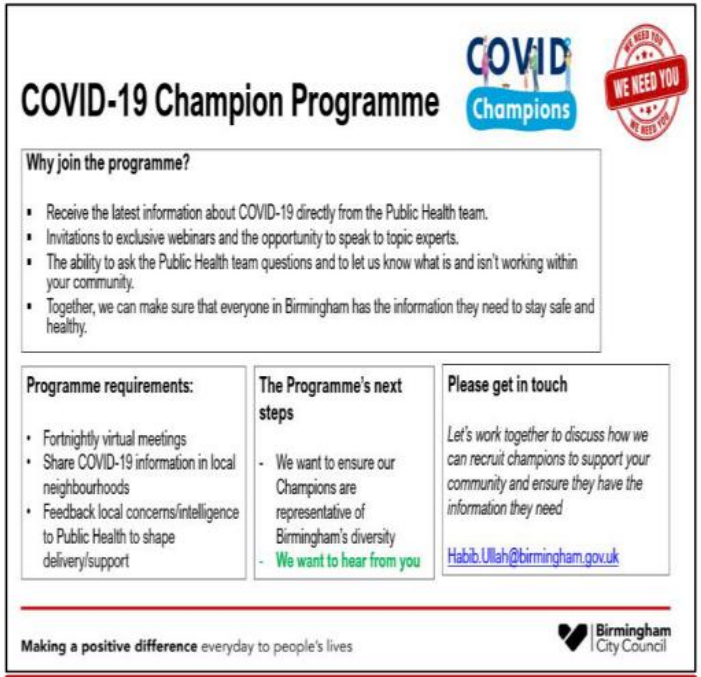
Community Provider Training- Online Workshop on 24th September 2021

- **Aim:** to improve the quality of reporting from commissioned providers.
- **8 representatives attended** the workshop.
- Attendees were either individuals who work directly on the project reports or delegated team members who would feedback information to appropriate people.
- Learning was shared via slides with all commissioned providers.
- Provider feedback was collected at the start and after the workshop.
- Average rating increased by **2.6 points** after the workshop which indicates that the providers found the workshop helpful.





Community and Partnership engagement



Working with communities and commissioned providers to drive recruitment of COVID-19 Champions and increase representation.

Black History Month content developed to celebrate the Black scientists behind the COVID-19 vaccine.

12-15 years vaccine content was created in response to provider feedback and requests for targeted content for CYP.

Further Work in Development

- **Representation**
  - Continue to working partnership and strengthening of relationships with our 18 existing commissioned partners and encourage the delivery of a minimum of 10 befriending/non-digital channels for those communities with limited digital access.
  - Accelerate existing engagement to support understanding and the uptake of testing, vaccination, recovery and any emerging themes working with all communities directly or via partners and key stakeholders.
  - Asset mapping of 69 wards including demographic information, COVID cases, vaccine uptake by ward, commissioned provider summary, main community needs/PH concerns, important contact information to highlight gaps in our current engagement work, scope and commission further partners if required to reach underrepresented communities.
- **Reach**
  - Review the COVID Champions network and recruitment to enhance communications and engagement and local asset leverage to improve relationships with communities and their understanding of vaccines, testing and ‘learning to live with Covid’.
  - Champions Feedback. Encourage champions to share stories on the Newsletter ‘Champions’ corner’ to support with wider reach across communities.
  - Working with communities and partners to support and focus on more engagement across the City.
  - Conversations with influencers within the Black Community to address low uptake of COVID-19 vaccine.
- **Response**
  - Collating responses from champions and faith settings in relation to Vaccine toolkit and isolation pack.
  - 'You Said, We Did' – WhatsApp communication set-up.
  - Progressing on monitoring commissioned partners fund through Ministry of Housing and Local Communities (MHCLG) grant for Communications and Engagement programme to strengthen our relationships with groups during the pandemic.

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	Agenda Item: 9
Report to:	**Local Covid Outbreak Engagement Board**
Date:	**6th October 2021**
TITLE:	**EXCESS MORTLAITY AND FACTORS ASSOCIATED WITH COVID-19 DEATHS IN BIRMINGHAM**
Organisation:	**Birmingham City Council**
Presenting Officer:	**Dr Julia Duke-MacRae**

Report Type:	**For information**

1. Purpose:

1.1 To present to the Board information the results of the study on the analysis of excess mortality and the impacts of covid-19 during the pandemic.

2. Recommendation:

2.1 The Board is asked to note the content of this report

3. Report Body:

3.1 Attached is the report on Excess Mortality and Factors Associated with Covid-19 Deaths in Birmingham

The report covers:

- Covid-19 deaths from April 2020 to March 2021.
- Excess mortality at ward level within Birmingham
- Possible factors/drivers associated with Covid-19 Deaths
- An explanation of the differences in Covid-19 mortality between the wards

4. Risk Analysis:

Further delay in publication. Changes suggested at presentations.

Risk

Identified	**Likelihood**	**Impact**	**Actions taken**
None			

Appendices:
Excess Mortality and Factors Associated with Covid-19 Deaths in Birmingham presentation

The following people have been involved in the preparation of this board paper:

Dr Julia Duke-MacRae Consultant in Public Health (Test & Trace)

Remi Omotoye Service Manager (Test & Trace Intelligence & Governance)

Birmingham Local Outbreak Engagement Board

Excess Mortality and Factors associated with Covid-19 Deaths in Birmingham

Birmingham Public Health Division

06/10/2021

Overview

Background: Why the pandemic hit some communities harder than others in Birmingham?

- There have been concerns about variations in excess mortality from Covid-19 among different communities in Birmingham following ONS publication on excess deaths.

- This informed the need to investigate possible factors/drivers associated with Covid-19 deaths and determine how these factors may have contributed to differences in the patterns of death in the communities.

Excess Mortality in Birmingham

Objectives:

- Determine the excess mortality at ward level within Birmingham.
- Investigate the possible factors/drivers associated with excess mortality from Covid-19 deaths.
- Explain the differences in Covid-19 mortality between the wards.

Methods

- Period of analysis (April 2020 to Mar 2021).
- Sources of Data: ONS, CSU,PHE Local Health, NOMIS, NIMS, Census Data.
- In this study,

  Excess mortality is defined as the number of registered deaths during pandemic (Apr 2020- Mar 2021) compared to expected numbers based on the average deaths of previous 5 years (2015-2019).

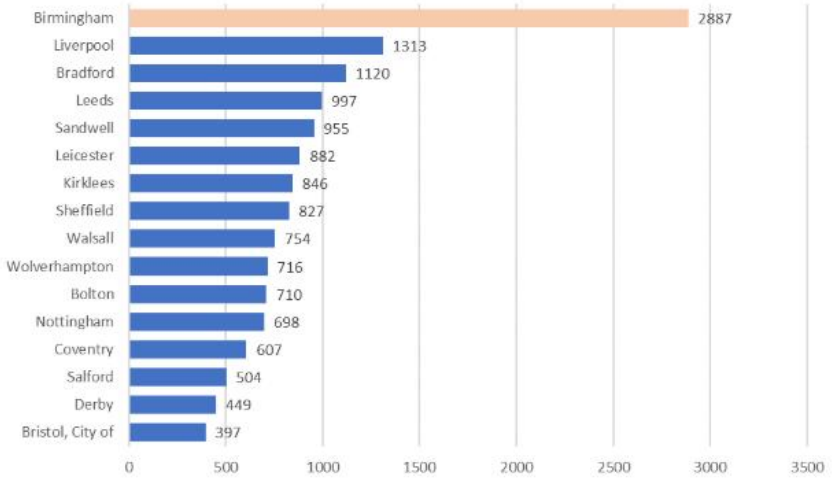
- Factors associated with Covid-19 deaths were investigated by evaluating the impact of these factors among Covid-19 deaths and/or at ward level.

- The factors investigated were:

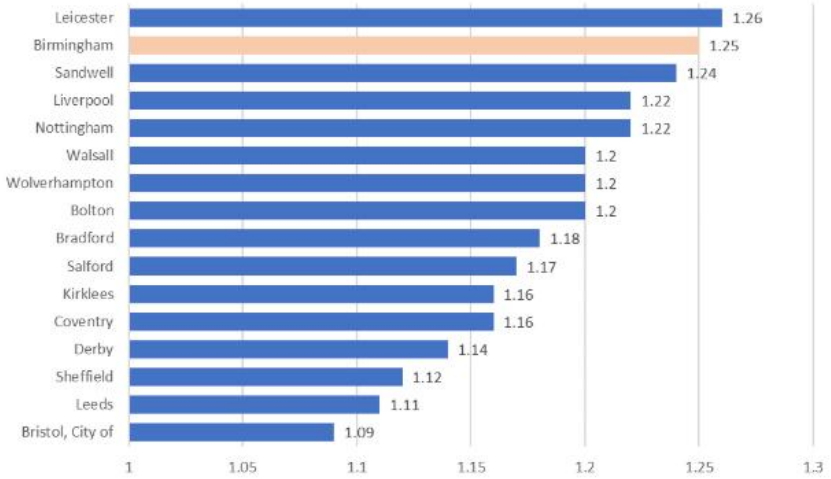
➢ **Personal** : Age, Gender, Ethnicity, Comorbidities & Occupation.
➢ **Socio-economic**: Deprivation, Population Density.
➢ **Health Services**: Uptake of Health Interventions, Place of Death.

Excess Mortality Mar 2020 to August 2021 showing Birmingham highest amongst peer/comparator areas

Excess deaths (Registered – Expected deaths)



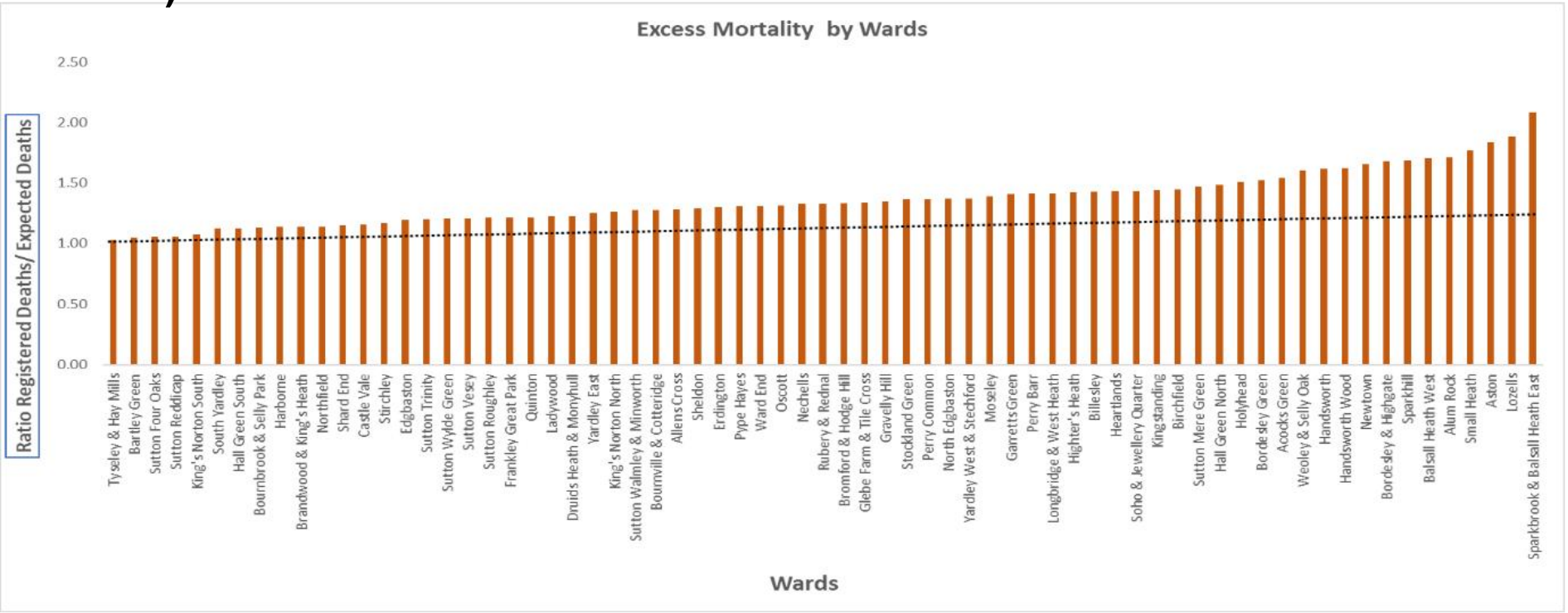
Ratio of registered to expected deaths



Excess deaths (a measure of excess mortality) from Covid-19 is limited in making comparisons between areas because it does not take into account the background populations. The ratio of registered to expected deaths allows for a more objective comparison between areas.

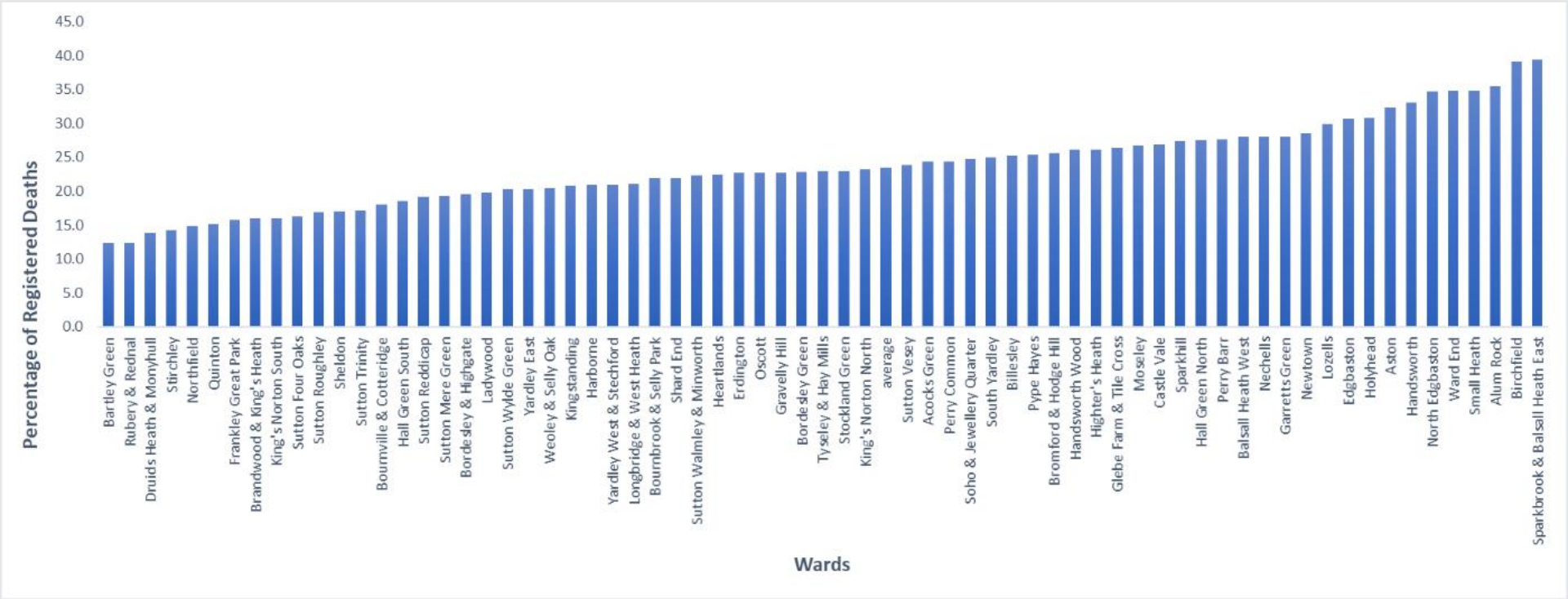
Source : ONS

Ratio of Registered Deaths/Expected Deaths by Wards (Apr 2020 –Mar 2021)



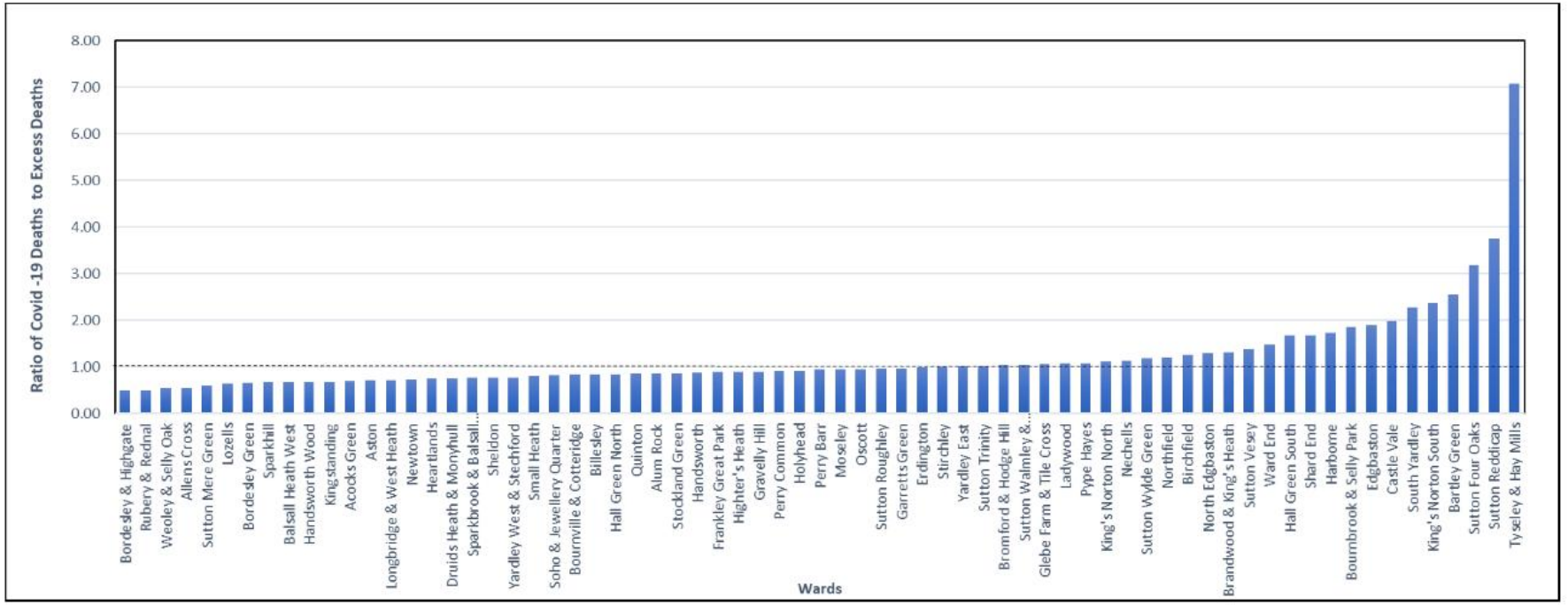
Registered deaths increased between 3% to 100% above the expected deaths across wards in Birmingham. The average increase was 35%.

Proportion of Covid-19 Deaths in Relation to All Registered Deaths



The proportion of Covid-19 deaths in relation to all registered deaths across all wards ranged from 12.2% -39.4%. On average, Covid-19 deaths contributed 23.5% to all registered deaths.

Covid-19 Deaths as a Proportion of Excess Deaths by Wards



Excess deaths were due to Covid-19 and other causes of deaths. A ratio above 1 as observed in 28 out of the 69 wards suggests that Covid-19 contributed more than other causes of death. This suggests a reduction in the cause of death from other causes. As the ratio decreases below 1 (41 out of 69 wards), this suggests an increasing contribution to excess deaths from causes other than Covid-19.

Relationship between all Covid-19 Deaths and Age Groups

Age Group (years)	All Covid-19 Deaths
15- 64	416
> 65	2117
Total	2533

$X^2 = 642.71$ $df = 1$, $p < 0.001$ (statistically significant)

- There were more deaths in those over 65 years and this was statistically significant.

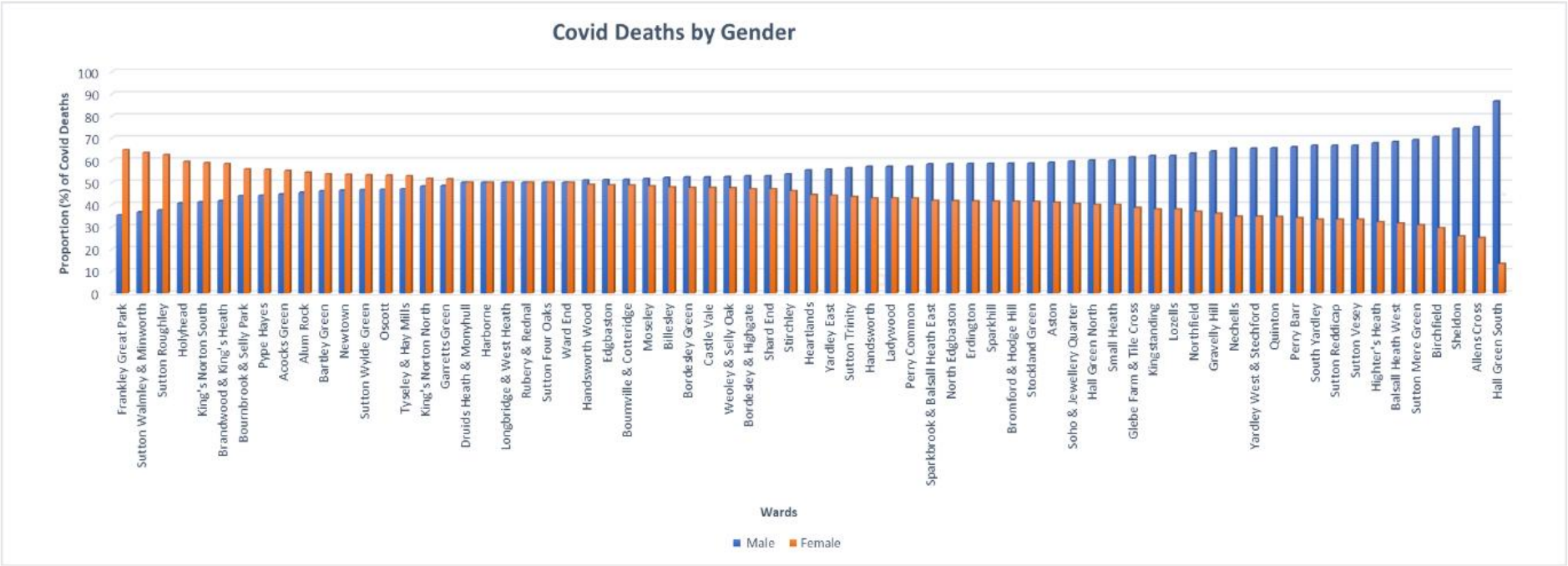
Relationship between All Covid-19 Deaths and Gender

Gender	All Covid-19 Deaths
Male	1405
Female	1128
Total	2533

$X^2 = 15.19$ $df = 1$, $p < 0.001$ (statistically significant)

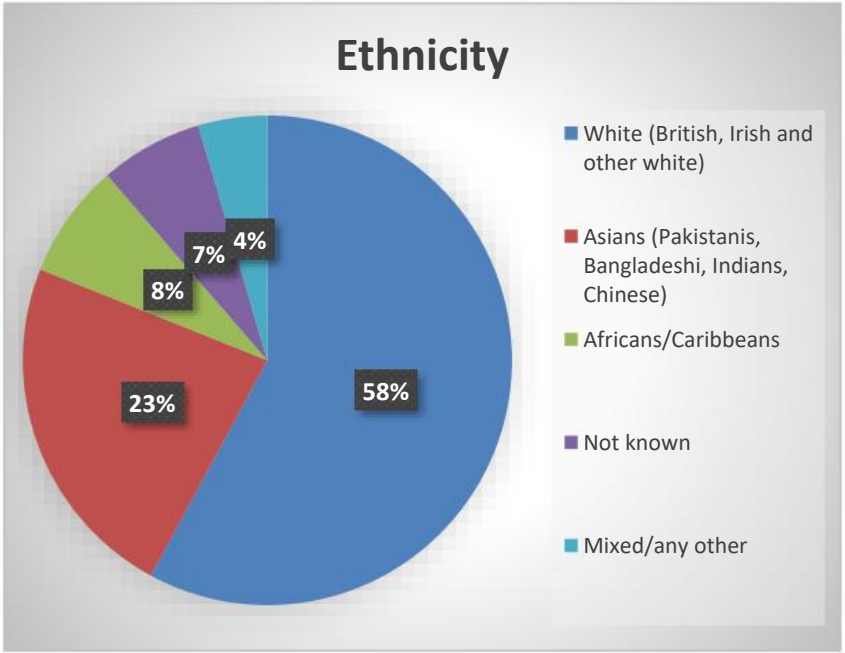
- There were significantly more deaths in the male population than female population in Birmingham.

Proportion of Covid-19 Deaths by Gender in Birmingham Wards



In the majority of wards (46 out of 69; 66.7%), there were more male than female deaths. However, in 17 out of 69 wards (24.6%), there were more female than male deaths.

Relationship between Covid-19 Deaths and Ethnicity

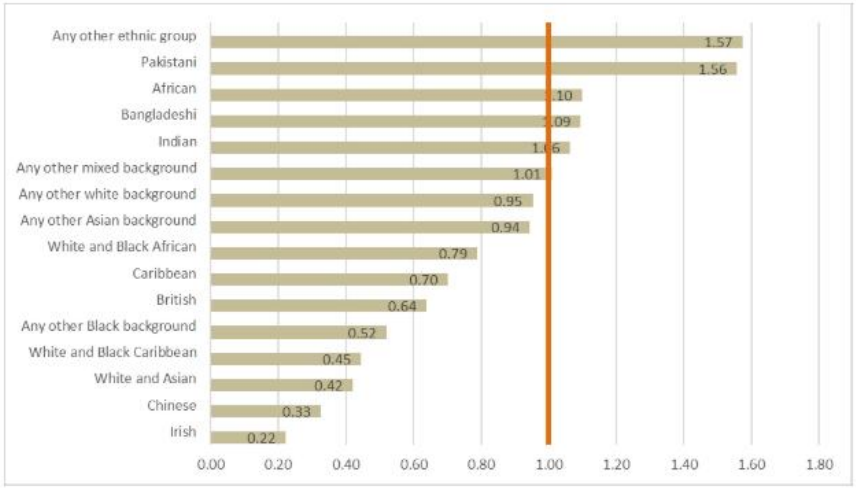


Ethnic Groups	Number (%)
White(British, Irish and other white)	1611 (58%)
Asians (Pakistanis, Bangladeshi, Indians, Chinese)	644 (23%)
African/Caribbean	211 (8%)
Not Known	189 (7%)
Mixed/Any other	127 (4%)

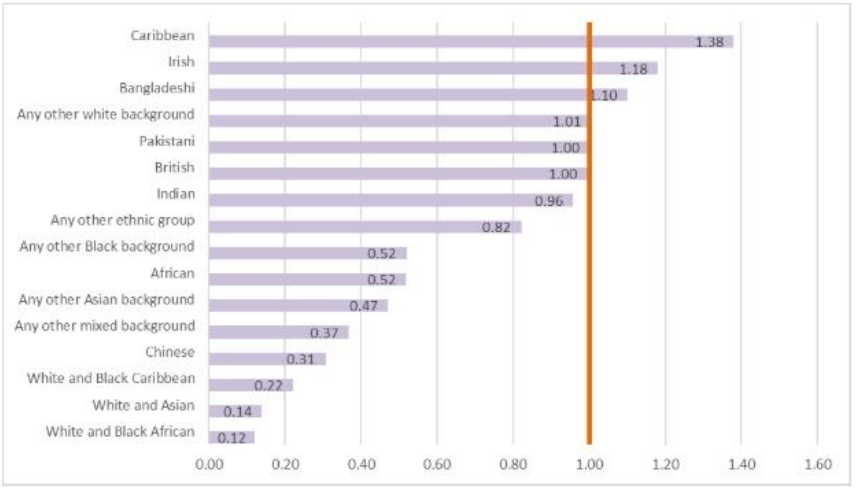
The majority of those who died from Covid-19 were from the white ethnic groups (58%), followed by the Asian ethnic groups (23%).

Covid-19 cases and deaths in Birmingham (by ethnicity)

Ratio of covid-19 cases and resident population by ethnicity

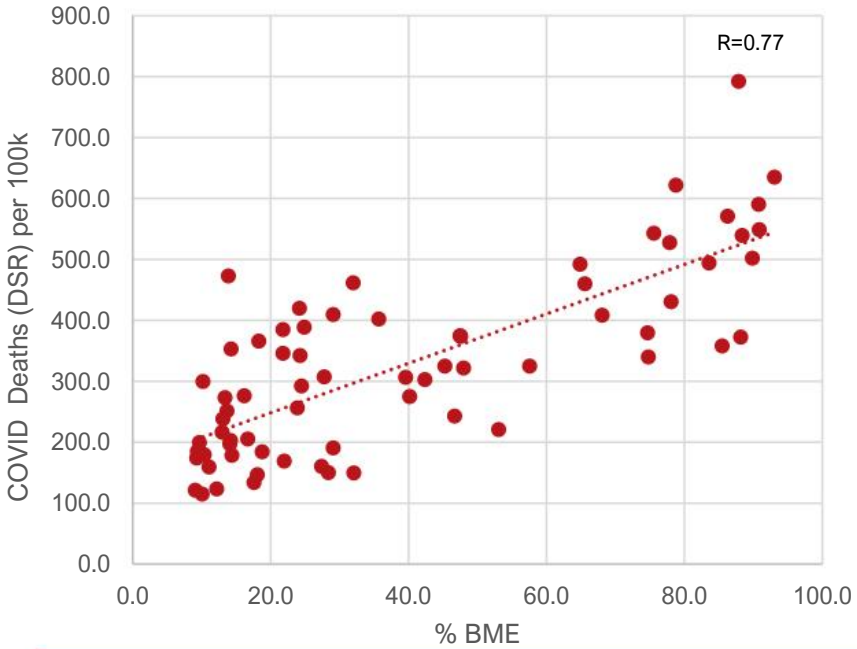


Ratio of covid-19 deaths and resident population by ethnicity



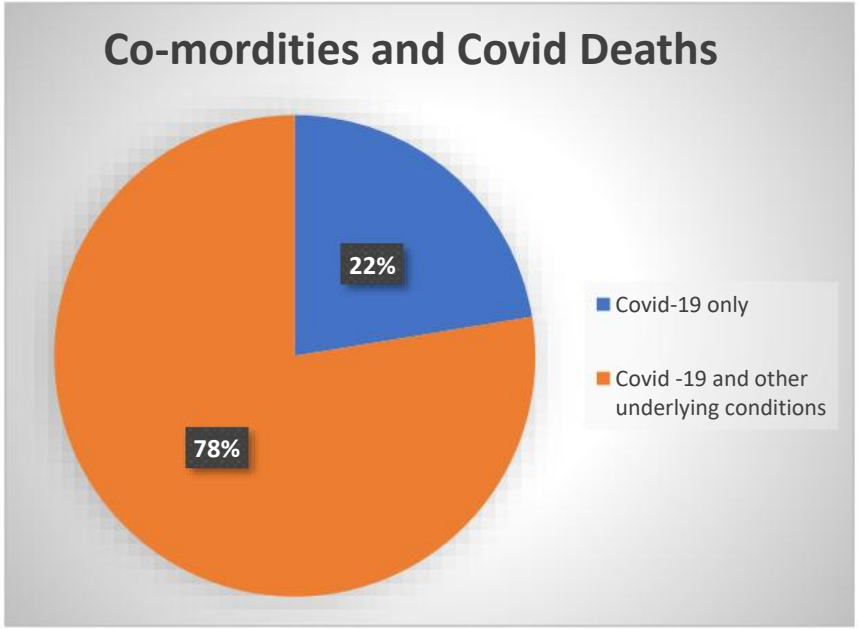
This chart highlights the disparity between cases and deaths in different ethnic groups. As illustrated above, while some ethnic groups (Caribbean, Irish) had a low number of cases for their population, they recorded a higher number of deaths. The converse was also true for some ethnic groups (African). Some groups had both high number of cases and high number of deaths for their population (Bangladeshi). Among the white ethnic group (British), there was an increase in Covid-19 deaths when compared to the number of cases, although this fell within the expected number of deaths for that population.

Relationship between Proportion of BME Population by Ward and Covid-19 Deaths.



- There is a strong positive correlation between Covid-19 deaths and the proportion of BME across the wards.
- The age adjusted death rate due to Covid-19 increases with the proportion of the BME group in the wards.

Relationship between Co-morbidities and Covid-19 Deaths



$X^2 = 462.98$ *df* =1 , p< 0.0001 (statistically significant)

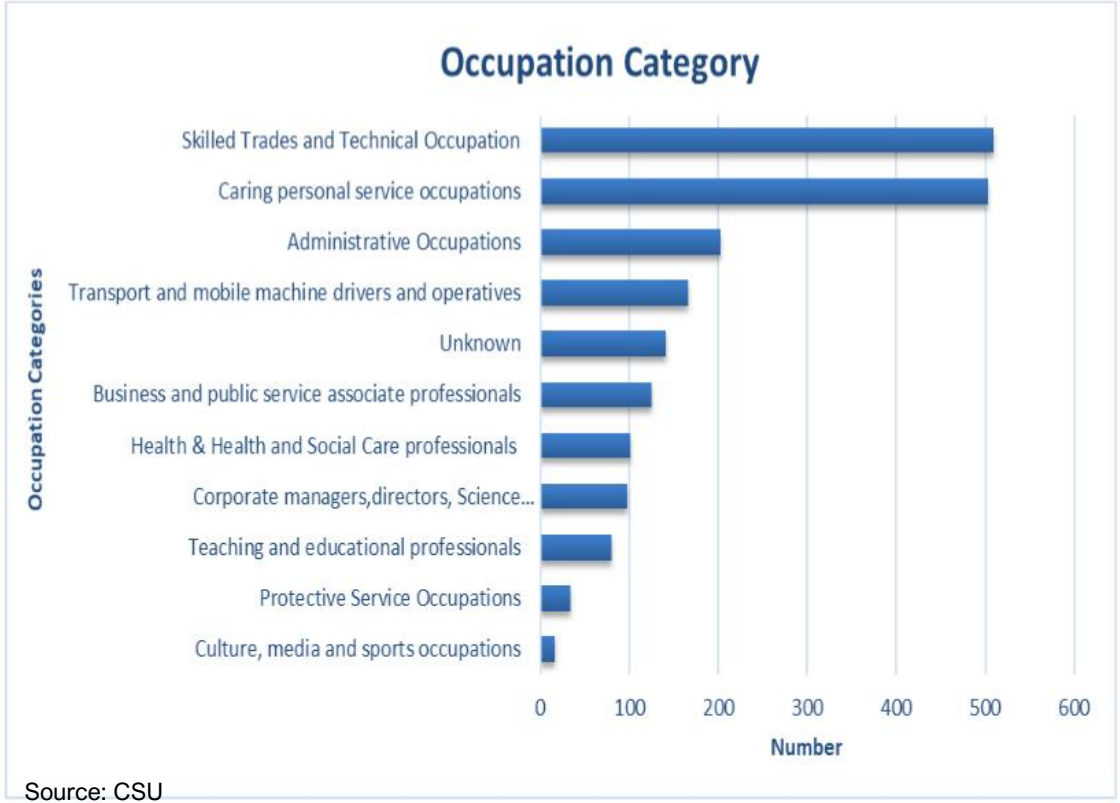
- The majority of those who died from Covid-19 (78%) had other underlying conditions.

Co-morbidities Associated with Covid-19 Deaths

Co-morbidities (Top 7)	%
Pneumonia	71.9
Essential Hypertension	31.4
Other Specified General Symptoms & Signs	26.0
Non-Insulin Diabetes Mellitus without complication	25.8
Chronic Ischaemic Heart Disease	19.8
Unspecified Diabetes Mellitus	14.0
Dementia	12.2

- The top three co-morbidities were:
  - Pneumonia
  - Diabetes Mellitus (all types)
  - Hypertension

Occupation Categories of all Covid-19 Deaths

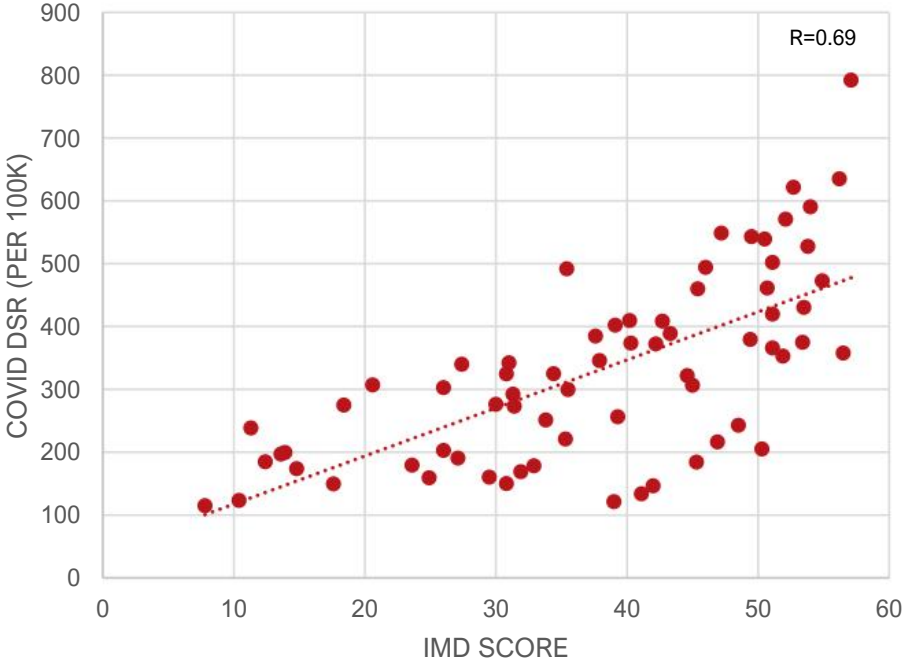


Occupation Categories Top 2	Examples	Number (%)
Skilled Trades & Technical Occupations	Warehouse operative, Machinist, Factory worker, car production worker, Electrician, welder, foundry worker, carpenter, seamstress, painter and decorator, labourer, plumber, mechanic, maintenance engineer, computer programmer, builder, assembly worker, gardener, florist	509 (20%)
Caring personal service occupations	Housewife, care assistant, cleaner, home help	503 (20%)

Source: CSU

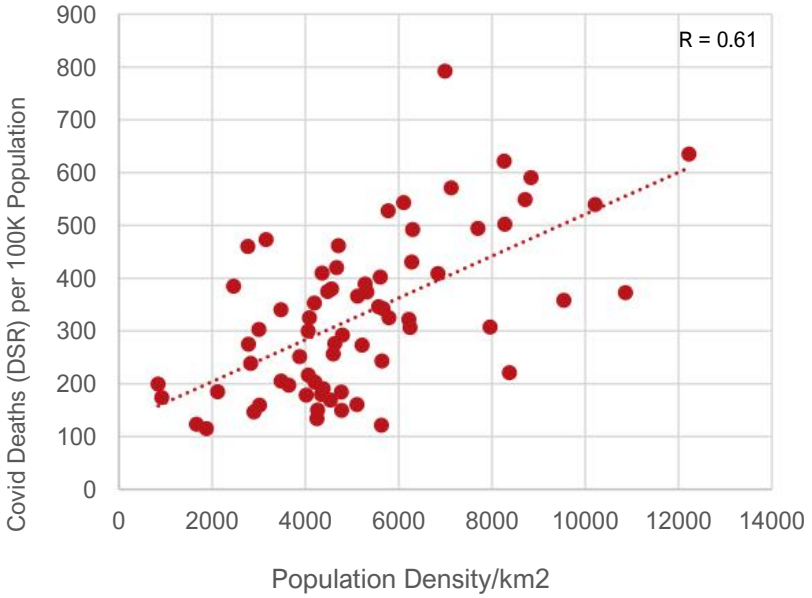
370 (73.6%) of the 503 in the caring personal service occupations were housewives

Relationship between Ward Deprivation and Covid-19 Death Rates.



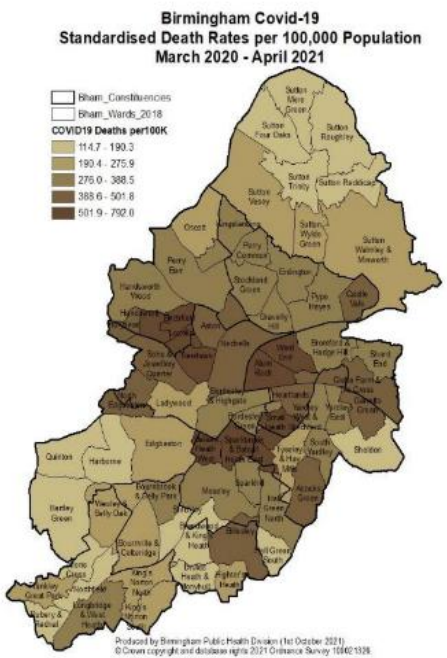
- There is a strong positive correlation between Covid-19 deaths and ward deprivation.
- The age adjusted death rate due to Covid-19 increases with increase in ward deprivation.

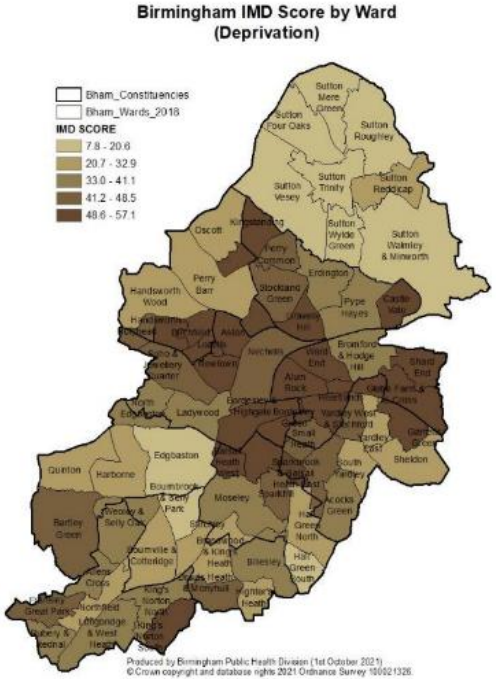
Relationship between Population Density of Wards and Covid-19 Death Rates.

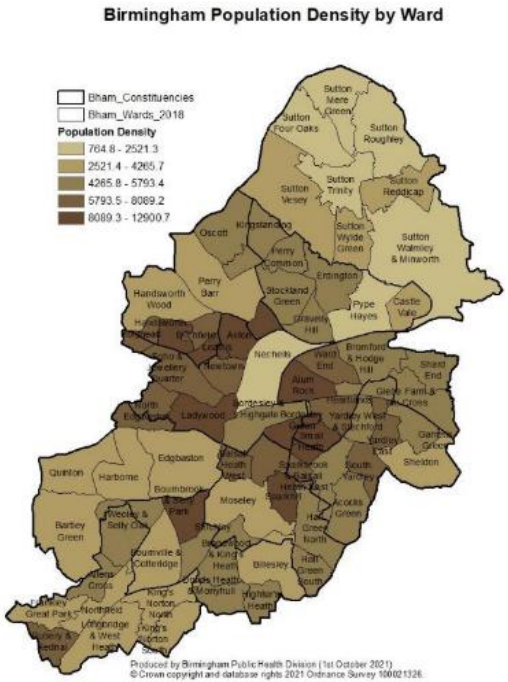


- The close proximity of populations is important in the spread of infectious diseases like Covid-19.
- Birmingham population density ranges between 2 to 28 times that for England (432 person/km2).
- The age adjusted death rates from Covid-19 increases with increase in population density.

Map of Birmingham illustrating Covid-19 Death Rates, Deprivation and Population Density

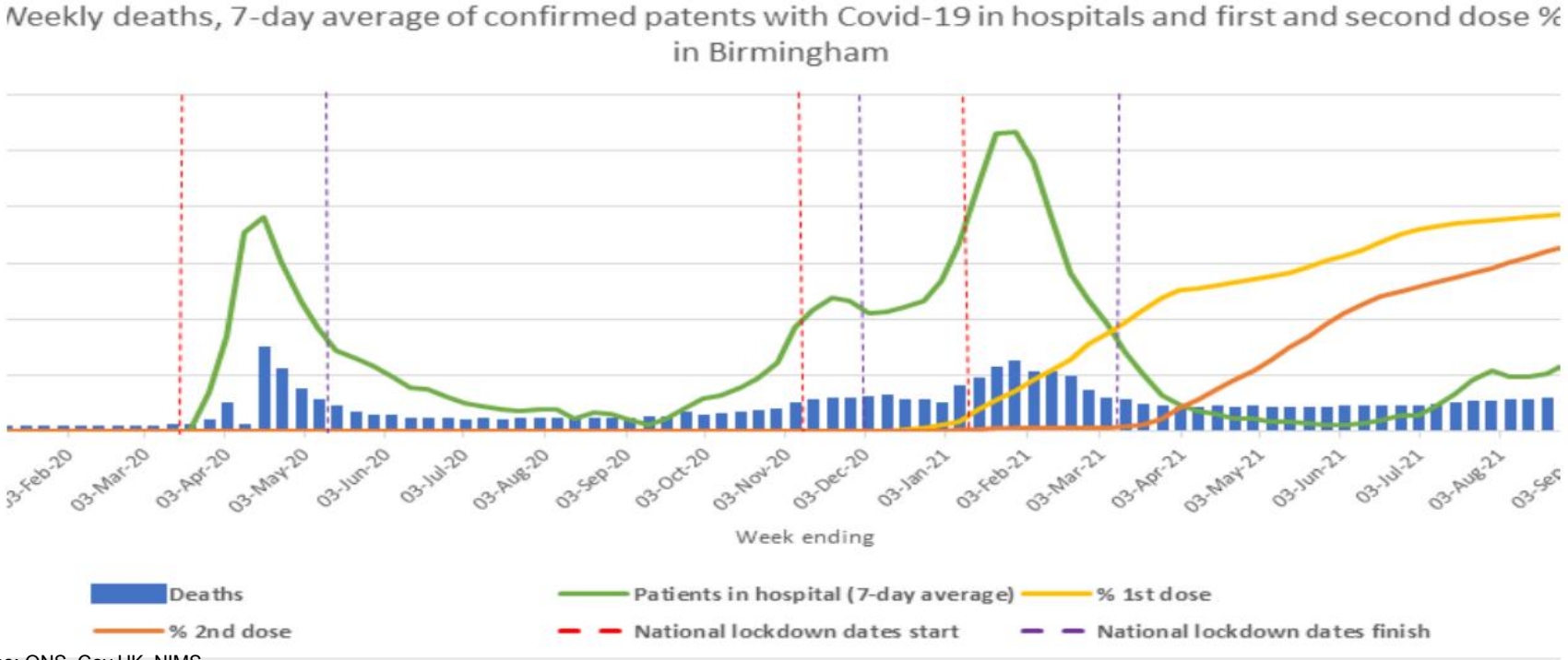






The maps almost mirror one another highlighting the link between the three parameters.

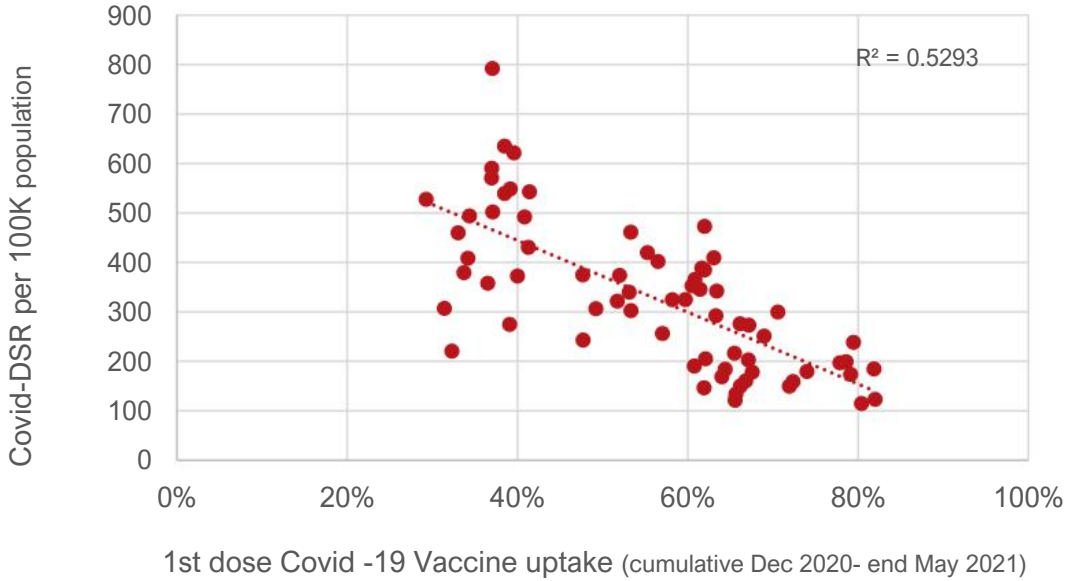
Health Interventions and Impact on Hospital Admissions and Deaths in Birmingham



Source: ONS, Gov.UK, NIMS

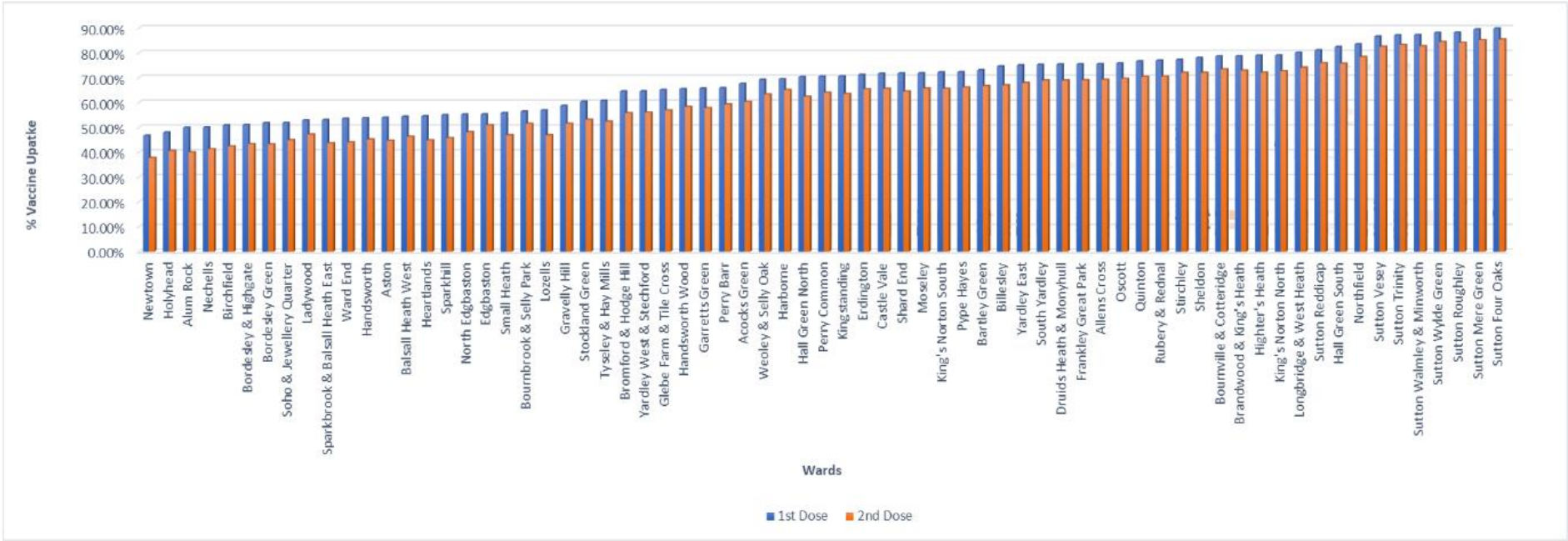
Health interventions such as lockdowns, social distancing, face mask, hand washing and vaccines have all played a key role in reducing hospital admissions and deaths.

Uptake of Covid-19 Health interventions and Covid-19 Death Rates.



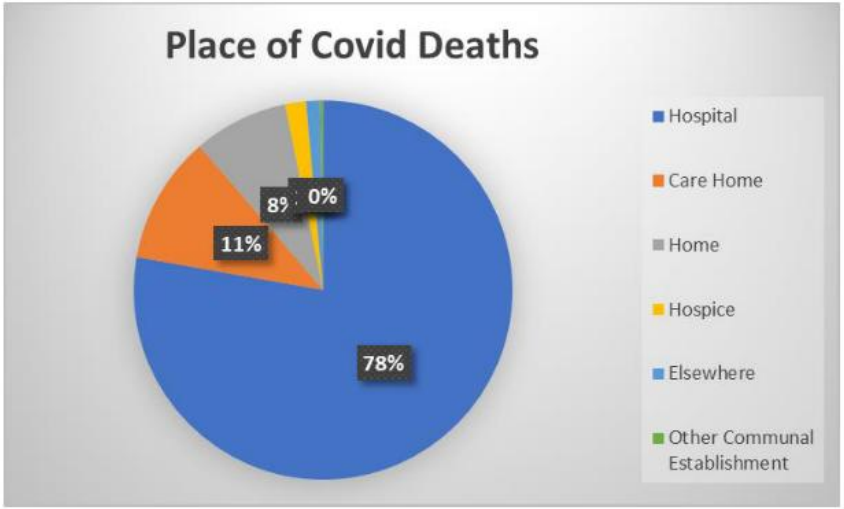
- Health interventions have played a key role in reducing hospital admissions and deaths.
- This chart illustrates the use of Covid-19 vaccine uptake as a proxy measure for compliance with the uptake of health interventions against Covid-19.
- The age adjusted death rates from Covid-19 decreases with increase in the uptake of 1st dose vaccine, suggesting an association between the uptake of interventions and death rates at ward level.

Covid-19 Vaccine Uptake 1st and 2nd Dose by Wards



Wide variation in vaccine uptake across the wards.1st dose 46.6% -89.7%, 2nd dose 37.7% – 85.3%.

Place of Covid -19 Deaths



Place of Deaths	Number (%)
Hospital	2314 (78%)
Care Home	325 (11%)
Home	240 (8%)
Hospice	53 (2%)
Elsewhere	35 (1%)
Other Communal Establishment	8 (<1%)

- The Majority (91%) of deaths occurred in a health institution, suggesting that most severely ill patients had access to a health facility at some stage in their illness.

Summary

- There was an increase in mortality across all the wards, with an average increase of 35%.
- On average Covid-19 deaths contributed 23.5% to all registered deaths.
- Factors associated with increase in Covid-19 deaths include:

  -Personal (age >65 years, male gender, BME ethnic groups, co-morbidities, skilled trades & caring personal service occupations).

  - Socio-economic (deprivation and population density).
- Health interventions such as lockdowns, social distancing, face masks, hand hygiene and vaccines were associated with a decrease in hospital admissions and deaths.
- Compliance with uptake of health interventions appears to vary across wards using vaccine uptake as a proxy measure.
- There is a wide variation in vaccine uptake across the wards.

Recommendations

- There is need to continue with the improvement of the uptake of the Covid-19 vaccines and compliance with other non pharmaceutical interventions whenever these are introduced to break the chain of Covid-19 transmission.

- Continued engagement with at-risk groups in the uptake of health interventions. These include the BME group, people with underlying health conditions and those in the skilled trades and caring personal service occupations.

Acknowledgements

PH Intelligence and Governance Team:

- Remi Omotoye
- Rebecca Fellows
- Simon Robinson
- Colette Duignan
- Gurdeap Kaur
- Ben Murphy
- Shazia Ahmed
- Jeanette Davis

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	Agenda Item: 11
Report to:	**Local Covid Outbreak Engagement Board**
Date:	**6th October 2021**
TITLE:	**TEST AND TRACE BUDGET OVERVIEW**
Organisation:	**Birmingham City Council**
Presenting Officer:	**Justin Varney**

Report Type:	**For discussion**

1.	**Purpose:**
1.1	To inform the Board of the planned spend of the allocated test and trace budget

2.	**Recommendation:**
2.1	The Board is asked to note for discussion at the meeting.

3. Report Body:

3.1

The table below shows the actual spend for the first 5 periods of the current financial Year (April to Aug). This table includes all spend items that are reported to and paid from the Contain Outbreak Management Fund (COMF)

Spend item	Spend to date 2021/22 £'000	Budget 2021/22£'000	Budget to Sept 2022 £'000
Staffing	1,154	3,263	1,632
Training	0	10	5
Translation services	18	60	30
Equipment	21	47	24
Communications	20	961	481
Community swabbing and support	127	662	331
Test & Trace system - Software licence, implementation & support	0	165	83
Health and wellbeing support	43	546	273
Whistleblowing	0	77	39
Enforcement support incl Covid Marshalls	566	2,826	1,413
Local contact tracing	0	865	433
Testing Facilities	0	145	73
Isolation Support	0	500	250

Asymptomatic Testing Contingency	292		1,113		557
Supporting compliance	0		1,867		934
Contingency	0		2,574		1,295
Wave 3 response	0		3,500		
Total	**2,241**		**19,181**		**7,848**

3.2 Spend funded from other sources

The following table shows expenditure from different funding sources

Spend item	**Spend to date 2020/21 £'000**	**Budget for 2021/22 £000s**
Asymptomatic Testing *	1,498	} Reimbursed via
Operation Eagle *	71	} grant
Community Champions Fund **	97	440
Total	**1,738**	

* Department of Health & Social Care, ** Ministry of Housing, Communities & Local Government

4. Risk Analysis:

Risk

Identified	**Likelihood**	**Impact**	**Actions taken**
Inadequate funding to provide robust response to local outbreaks	Medium	Medium	Significant contingency has been included in the planning for 2021/22 to September 2022.
Asymptomatic testing will not be fully funded by the Community Testing grant due to changes in the administration of that fund	High	Medium	This was anticipated and a budget of 1.6m allowed for from the COMF funding to absorb the excess costs

The following people have been involved in the preparation of this board paper:

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Iheadi Onwukwe, Consultant in Public Health (Test & Trace)