BIRMINGHAM CITY COUNCIL

LOCAL COVID OUTBREAK ENGAGEMENT BOARD WEDNESDAY, 23 FEBRUARY 2022

MINUTES OF A MEETING OF THE LOCAL COVID OUTBREAK ENGAGEMENT BOARD HELD ON WEDNESDAY 23 FEBRUARY 2022 AT 1400 HOURS ON-LINE

PRESENT: -

Andy Cave, Chief Executive, Healthwatch Birmingham
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
Councillor Ian Ward, Leader of Birmingham City Council and Chairman for the LCOEB

ALSO PRESENT:-

Damilola Akinsulire, Consultant in Public Health
Toyin Amusan
Richard Burden, Chair, Healthwatch Birmingham
Jaswinder Didially, Head of Service, Education Infrastructure
Dr Julia Duke-Macrae, Consultant in Public Health
Ayan Mohamoud
Remi Omotoye, Public Health Service Lead
Dr Iheadi Onwukwe, Consultant in Public Health (Business & Strategy), Test & Trace Team
Simon Robinson, Senior Officer, Test and Trace Team, Public Health
Chief Superintendent Mat Shaer, West Midlands Police
Errol Wilson, Committee Services

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WELCOME AND INTRODUCTIONS

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

NOTICE OF RECORDING/WEBCAST

289 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

290 Apologies for absences were submitted on behalf of, Dr Manir Aslam, GP Director, Black Country and West Birmingham CCG Chair, West Birmingham, Councillor Matt Bennett, Opposition Spokesperson on Health and Social Care, Councillor Paulette Hamilton, Cabinet Member for Health and Social Care and Deputy Chair of the LCOEB
Paul Sherriff, NHS Birmingham and Solihull CCG

DECLARATIONS OF INTERESTS

291 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

292 **RESOLVED:-**

The Minutes of the meeting held on 26 January 2022, having been previously circulated, were confirmed by the Chair.

COVID-19 SITUATION UPDATE

293 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. 1)

The Chair enquired the fact that the vaccine wears off over a period of time – all of that data Dr Varney was giving about lessening the impact of going to hospital, lessening the risk of death and the fact that people were less likely to have some severe side effects if you were vaccinated as opposed to catching the virus itself. The Chair enquired what the thinking was going forward when we get to next autumn, whether there will be a need for a further booster vaccine.

At this juncture Dr Varney shared another set of slides which was not included in the main set.
(See document No. 2).

Dr Varney then made the following statements
statements:-

- In terms of the impact of the vaccine and how it changes over time, it was seen that over time the volume of antibodies those special attack forces we have particularly focussed on the Covid virus itself started to reduce.
- We retain the most important bit of the defence against severe illness, hospitalisation and death.
- The UKHSA continues to monitor that but what we were seeing was the bottom part of the table was Omicron which was more recent as we only had data from December 2021 onwards.
- About 4-6 months after the booster you were reducing your risk of catching Covid and having symptomatic disease by about 50% as opposed to 60% - 65% when you had the first jab/first protection.
- The protection against hospitalisation after the booster immediately was about 80% - 95%. Four to six months later it as still 75% - 85%.
- We still have insufficient data on death, but what we were seeing so far was that it was a similarly high level of protection against death.
- It would be very odd for someone to be protected against severe disease and not be protected against death as it was the same mechanism protection.
- This was the reason the government had announced the fourth dose of the vaccine for people who had severe immunosuppression - their immune system did not work effectively to those over 75 as we wanted to boost up after six months this defence from 75% to 85% back up to an 80% - 95%.
- The reason the fourth dose was more focussed on the elderly age group was that when the risk of hospitalisation and death was looked at between vaccinated and unvaccinated, it was noted that in the elderly population, their risk of hospitalisation as was seen in the slide presentation, 221 out of every 100,000 hospitalised following a Covid test in those that were unvaccinated and only 83 in people who were vaccinated.
- When we looked at death, the difference in death rate in the over 80s 297 in the unvaccinated 86 in the vaccinated.
- These were huge differences and that was the reason boosting up that defence in the over 75s (unfortunately the age bracket did not quite matched) but it gave that understanding as to why it was so important to do it.
- Even when we looked at younger age groups the risks of death between the vaccinated and the unvaccinated death was much clearer linked to Covid in the 18 – 29-year olds, but the risk o death was halved by being vaccinated. This was more than a fifth in the 30 -39-year olds.
- When we looked at the risk of those ending up in hospital, again, this was almost halved by having the vaccine. There were big differences here and this was the reason the booster programme of that fourth dose was important.
- The risk of a severe clot with the AstraZeneca vaccine similar to Pfizer was about 4 cases of severe blood clot in every million people who had the vaccine.
- The risk of having the same type of severe blood clot in every million people who had Covid 165,000 people had that kind of blood clot. With

the vaccine you had a risk of 4 in a million. Catching Covid your risk was 165,000 in a million. You were definitely *quids* in with the vaccine.

- When we looked at myocarditis – where the heart muscle became inflamed – this was something that happened every year in the population.
- Looking at additional cases, what we found was that there were 40 additional cases due to people catching Covid.
- In comparison for the Pfizer vaccine there was only one additional case and for the AstraZeneca vaccine there were only two.
- For the Moderna vaccine which was less commonly used in the UK there were 16 additional cases, but it was still much less common than the number of additional cases linked to Covid itself.
- There were risk with the vaccine but your risk from catching Covid was much more significant. Whatever age you were the risk from the vaccine was less than the risk from Covid itself when it comes to adults.
- The rationale as to why we were doing the fourth dose was to boost the immune system of the people who were at the highest risk of dying, but it was really about topping up.
- Whether this became an annual programme or not was it was not certain as there was still a lot of work being done around new variants.
- It was suspected it will but at this stage it was for those people over 75 years old who were six months after their booster and those who were in particular clinical groups will have received a letter or text message from the NHS inviting them to attend for a fourth dose.

The Chair commented that this was useful information.

The Board noted the presentation.

VACCINATION ROLLOUT AND UPTAKE UPDATE

294 The Chair advised that as Mr Paul Sherriff, NHS Birmingham and Solihull CCG had a clash of meeting this item would be deferred to the next meeting.

LIVING WITH COVID STRATEGY

295 Dr Justin Varney, Director of Public Health introduced the item and commented that as colleagues would be aware the Prime Minister, Boris Johnson announced on Monday a change in direction in terms of moving forward in living with Covid. We have pulled together for the Board a summary and what our plans were moving forward particularly given the specialist public health function.

Dr Justin Varney then drew the attention of the Board to the information contained in the slide presentation highlighting the main points

(See document No. 3)

Richard Burden, Chair, Healthwatch Birmingham enquired about the issue of surveillance both within the national principles which was an ongoing priority.

The question was how we could have effective surveillance if we have not got testing as a result of the winding down of free testing. A further question was how surveillance could be maintained and how could we get an early warning of a new variant and the particular problems with a new variant.

Dr Varney made the following statements:-

a. This was a challenge in the sense that we moved from population testing to testing, which was triggered by outbreaks or by symptoms, but we were still not clear on what the actual testing policy was going to be.
b. There were two ways we might maintain surveillance. We already have a national network of what was called surveillance practices. This was how we monitored what was going on with flu.
c. These were GP practices where there was a random sampling and surveillance of how many people had presented with respiratory conditions.
d. This was the way we picked up new variants of flu and was the way we could keep an eye on what was happening, and those sentinel practices were positioned to allow getting a good coverage of the country and also took into account differences in variation of population. That was the first level that we had.
e. The second was we continue to monitor wastewater as detailed in the overview pack earlier. This was a new method of monitoring the surveillance that came into effect December 2020.
f. The wastewater surveillance as Public Health understand it, they were planning to continue that as this was helpful over the last year in allowing us to benchmark how much and what people flushed down the toilet matches what we saw from testing. They had matched closely through the pandemic which allows us to see that wastewater was a useful proxy if we were not doing population testing.
g. Another important thing to mention was that the wastewater testing had also picked up variants.
h. One of the things we were able to see which was particularly helpful when Delta appeared as at that time most of us were doing lateral flow test and not everyone were doing PCR testing if they tested positive.
i. It was difficult to understand where Delta was emerging, but with the wastewater sampling we could find it from that. The wastewater was our second line of surveillance defence.
j. We will probably see a third line which was around focussed testing in outbreaks and how we looked at variants in sampling, but this was still on the to do list.
k. It would be a different type of surveillance and would be more akin to what we do to seasonal flu and the hope was that we maintain wastewater, but we were still waiting for some of this to come through. The hope was that within the next 3-4 weeks we would get more clarity.

The Board noted the position and agreed the proposed way forward

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COMMUNICATIONS AND ENGAGEMENT FORWARD PLAN

294 Damilola Akinsulire, Consultant in Public Health and 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.

(See document No. 4)

The Chair commented that communications has been excellent throughout the last two years of the pandemic to the Credit of Dr Varney and the Public Health team that had delivered this. The Chair requested that his congratulations be passed on to everyone involved as it was a superb effort.

The Board noted the presentation.

At this juncture, the Chair welcomed Chief Superintendent Mat Shaer, West Midlands Police to the Board and advised that Chief Superintendent Shaer was replacing Chief Superintendent Steve Graham.

SCHOOLS UPDATE

295 Jaswinder Didially, Head of Service, Education Infrastructure introduced the item and drew the Board's attention to the information contained in the slide presentation.

(See document No. 5)

The Board noted the update on schools.

PUBLIC QUESTIONS SUBMITTED IN ADVANCE

296 The Chair advised that there were no public questions submitted for this meeting.

TEST AND TRACE BUDGET OVERVIEW

Dr Justin Varney, Director of Public Health introduced the item and drew the attention of the Board to the information contained in the report.

(See document No. 6)

Dr Varney made the following statements: -

1. The report gives an update on budget planning and there were no significant variations from where we had been previously.
2. We continue to monitor and profile the budget across the financial years to take us through to the end of September 2022.
3. We knew that there were ongoing national discussion about the additional financial resource and pressures for local government around

the ongoing response to living safely with Covid, but we were positioned well as a local authority because of the way we had profiled this budget to see us through at least the immediate period of the Commonwealth Games and to allow those national discussions and negotiations to play through.

297 **RESOLVED: -**

That the Board noted the report.

OTHER URGENT BUSINESS

298 No items of urgent business were raised.

DATE AND TIME OF NEXT MEETING

299 It was noted that the next Local Covid Outbreak Engagement Board meeting was scheduled for Wednesday 23 March 2022 at 1400 hours as an online meeting.

EXCLUSION OF THE PUBLIC

300 **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.