REPORT FOR: **HEALTH AND WELLBEING BOARD**

Date of Meeting:	1 May 2014
Subject:	**INFORMATION ITEM:** Situational Report: Tuberculosis In Harrow
Responsible Officer:	Dr Laura Fabunmi, Public Health Consultant, Harrow council
Exempt:	No
Wards affected:	All
Enclosures:	None

Section 1 – Summary

This report sets out the main findings from a situational report on Tuberculosis in Harrow conducted by the Public Health team. The board is asked to note the report for information.

Section 2 – Report

Introduction
Tuberculosis (TB) is a disease that is preventable and treatable yet it remains a major public health problem in London. Rates of TB in the borough of Harrow are nearly double the London average. The high burden of TB is set against a background of national guidance, policy and recent reorganisation within the healthcare system. The responsibility for the prevention and treatment of TB now lies with several organisations. Information for this report has been obtained from data reports, national guidance and policy and interviews with key stakeholders. The report attempts to analyse the current situation on TB in Harrow and makes recommendations on how the system can work together to reduce the burden of TB in harrow. The recommendations are based on findings from this report, relevant recommendations from NICE guidance and other national policy and interviews with key stakeholders.

Epidemiology
London is considered the Tuberculosis (TB) capital of Western Europe with rates highest in northwest and north east of the capital. Rates of TB in the borough of Harrow are nearly double the London average. In 2013, Harrow had a TB rate of 61.1 per 100,000 population versus 36.3 per 100,000 population London-wide. Between 2010 and 2012, rates in Harrow increased by 21% (figure 1).
Northern London has one of the highest rates of TB in the capital, with Newham leading (108.3 per 100,000) followed by Brent (89.9 per 100,000), Hounslow (63.7 per 100,000), Ealing (62.5 per 100,000) and Harrow (61.1 per 100,000).[1]
Rates of TB vary across the borough. According to data received from Public Health England (PHE), the top four areas in Harrow are: Headstone South, Wealdstone, Rayners Lane, and Marlborough. It is important to note that these rates are based on small numbers: e.g. in Headstone South, the rate of 457.5 per 100,000 population is based on only 9 residents in that area being notified during 2012 (population 1,967 based on 2011 census data).[2]
Therefore, it is expected that these figures will fluctuate year on year and the data should be interpreted with care.

[1] PHE, *London i: Tuberculosis*, Number 2014/02, February 2014. p. 6.
[2] Personal communication, Gail Morgan, TB Coordinator, North West London Health Protection Team, PHE.

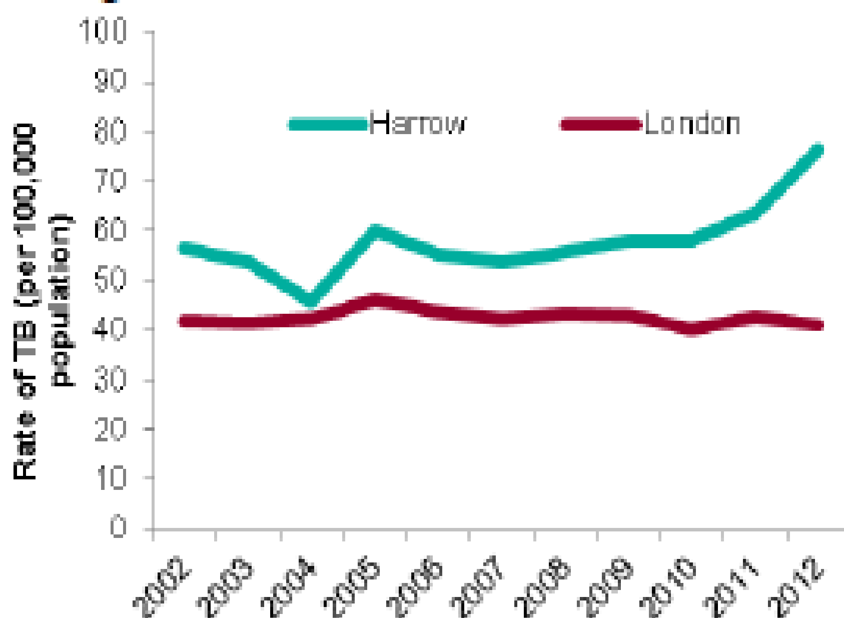

Figure 1: annual TB incidence rate, 2002-2012

The reasons for the increase in rates of TB in Harrow are similar to London, although not definitive. Whilst rates of TB found among the UK-born population living in London are twice that of those living anywhere else in the UK, a high prevalence of TB in London occurs in people born outside the UK who develop active disease several years subsequent to their arrival in London. Almost all of the increase in Harrow can be attributed to people who were born abroad and are from a country of high TB prevalence. 11% had entered the UK within the previous two years (but time since entry was not reported for 31%).[3]

The majority of new cases are in people of Indian ethnicity (mostly born in India, although some from East Africa). Rates are also high among people from Somalia, Sri Lanka and Afghanistan.

The most common age group is 20-39, although seven children aged less than ten were also diagnosed with TB in 2012.

Risk Factors

Five risk factors are collected by the London TB Register: history of drug use, history of homelessness, UK prison history, ability to self-administer treatment affected by alcohol, and mental health concerns. While constituting a small proportion of all patients, the impact of those with risk factors is high as they are more likely to have infectious and drug resistant forms of TB, be part of clusters, and are at risk for not completing treatment. This exposes them to the development of strains of the disease which are more difficult to treat.

According to 2013 data released from PHE, 11.9% of all new TB notifications in London have one or more risk factors (ranging from 0-31% in individual local authorities and in Harrow, 5.4% of new TB notifications have one or more risk factors.[4] Other social risk factors such as living in poverty, unemployment, and lower socioeconomic circumstances which can increase the risk of TB are not currently collected.

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[3] London TB service specification 2013/14. November 2013.

[4] PHE, London i: Tuberculosis, Number 2014/02, February 2014. p. 13.

Table 1: Proportion of new TB notifications with one or more risk factors, 2008 – 2013

	2009	2010	2011	2012	2013
Harrow	15.6%	14.6%	5.9%	0.5%	5.4%
NW London, total	11.9%	12.6%	8.9%	9.1%	11.0%
London, total	12.2%	12.4%	10.3%	11.2%	11.9%

TB transmission and symptoms

TB is spread via an airborne route when an infected person with pulmonary TB coughs or sneezes. Only a few bacteria need to be inhaled by another person to cause infection but the key to transmission is prolonged contact with someone who has active disease.

The symptoms include active persistent cough, sometimes with blood, weight loss, fever and night sweats.

A person with latent TB has been infected with the bacteria that causes the disease but does not show symptoms of it. TB acquired earlier in life can remain dormant for months or years, someone can remain in the latent stage of the disease for a lifetime

Around 80% of people who develop active Tb do so as a result of the reactivation of latent TB.

Prevention

Since TB is spread through airborne route, ensuring adequate ventilation and limiting close contact with people with active disease are key to eliminating the spread of TB to others.[5] Steps must also be taken to identify people with latent TB to ensure that they receive necessary treatment to prevent their latent disease converting to active disease.[6]

The Bacillus Calmette-Guérin (BCG) immunisation increases a person's immunity to TB, providing 70-80% effective prevention against the most severe forms of the disease, such as TB meningitis and disseminated TB in children. It does not prevent primary infection and it does not prevent reactivation of latent pulmonary TB.[7]

[5] National Institute of Allergy and Infectious Diseases. Tuberculosis. http://www.niaid.nih.gov/topics/tuberculosis/understanding/pages/prevention.aspx. Accessed on 17 January 2014.

[6] National Institute of Allergy and Infectious Diseases. Tuberculosis. http://www.niaid.nih.gov/topics/tuberculosis/understanding/pages/prevention.aspx. Accessed on 17 January 2014.

[7] WHO. BCG Vaccine. http://www.who.int/biologicals/areas/vaccines/bcg/en/. Accessed on 23 February 2014.

The recommendations for BCG vaccination are for infants (0 to 12 months of age) living in areas with a high incidence of TB (greater than or equal to 40 cases per 100,000 population).In Harrow, all infants under one year of age are given the vaccine either in the hospital after birth or in the community by the health visitors, immunisation or community nurses.[8]

Unimmunised children aged 1 to 6 years are identified during routine health checks or appointments for other childhood immunisations, school entry health checks and new registrations in primary care. Children in this age group who require BCG vaccination are referred to the relevant BCG clinic in their locality. At risk children aged 6 to 16 years are identified by school nurses as part of school entrance screening and arrangements are made for TST and BCG.[9]

TB and HIV

There is an increased risk of active TB in people suffering from conditions that impair the immune system. People who are co-infected with HIV and TB are 21 to 34 times more likely to develop active disease

According to the London TB Metrics, at least 90% of patients of all ages should be recorded as having been offered an HIV test. In 2013 97% of new TB notifications in London residents were either offered an HIV test or the patient's HIV status was already known. In Northwick Park, there were 321 notifications in 2013. Of this total, 314 patients (97.8%) were offered an HIV test, the HIV status was already known in 5 patients, and 2 patients were not offered the test.[10] Rates of TB-HIV co-infection continue to decrease across England, Wales and Northern Ireland.[11]

Treatment Completion Rates

Successful therapy requires adherence to a complex regimen of medications over a minimum of six months. If treatment is not taken correctly or is stopped, there is an increased risk for complications and/or the development of drug resistant TB. Multi-drug resistant TB (MDR-TB) is associated with a substantial increase in morbidity and mortality as well as being considerably more resource-intensive: it can cost twenty times more than early intervention.[12]

The London TB Metrics state that at least 85% of patients should complete treatment within one year. Of London residents notified during 2012, 85% completed treatment within one year; Harrow was slightly above the London average with 88.6% completing treatment within one year.

Treatment completion rates at Northwick Hospital (which provides care to majority of Harrow's TB population) was 87.8% in 2012.

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[8] Harrow Shadow Health and Wellbeing Board. Harrow Joint Strategic Needs Assessment: 2012-2016. June 2012. 5.15.2, p. 100.

[9] NHS London Health Programmes. *Report on BCG Policy and Provision in London*. February 2013.

[10] PHE. *London i: Tuberculosis*, Number 2014/02, February 2014.

[11] PHE. *Tuberculosis in London: Annual Review (2012 data): Data from 1999 to 2012*. p. 5.

[12] London TB service specification 2013/14. November 2013.

Table 2: Treatment status at one year for new TB notifications, 2012[13]

	Notifications	% completing treatment	% still on treatment	Died	Lost to follow-up	Treatment stopped	Transfer without further info
Northwick Park Hospital	361	87.8%	5.3%	1.1%	1.1%	0.6%	4.2%
Central Middlesex Hospital	98	85.7%	6.1%	2.0%	3.1%	0.0%	3.1%
NW London, total	1188	85.9%	6.0%	2.4%	1.3%	0.3%	4.1%
London, total	3425	85.0%	5.2%	3.0%	1.9%	1.0%	3.1%

Diagnosis and Diagnostic Delay

Information on the onset of symptoms should be interpreted with caution; however in London , a high proportion of patients (34% of all patients and 28% of those with pulmonary TB) had been symptomatic for more than three months before diagnosis. Data is not at borough level.

PHE's Collaborative Tuberculosis Strategy for England,[14] recommends that the goal should be that at least 80% of people with pulmonary TB should start treatment within three months of the onset of symptoms and 100% should start treatment within six months.

Current Policy Guidance

The high burden of TB is set against a background of national guidance, policy and recent reorganisation within the healthcare system. Implementation of some of these measures has contributed to stabilising the rate of TB but has failed to reverse the upward trend. Application of national guidance has been inconsistent in some parts of London and there is no systematic approach to detecting and treating latent TB.[15]

Effective local implementation of detection and treatment strategies can reduce the burden of disease from both a human and economic standpoint, minimising the risk of on-going transmission. Active TB is relatively inexpensive and straightforward to treat and cure when identified early.[16]

[13] N.B. The data in this table include all notifications for the hospital and region. The data are not specific to Harrow residents and include all patients treated at the specific hospital due to sample size.

[14] PHE. Collaborative Tuberculosis Strategy for England, 2014-2019. For consultation. 24 March 2014. p. 10.

[15] London TB service specification 2013/14. November 2013.

[16] London TB service specification 2013/14. November 2013.

The responsibility for the prevention and treatment of TB lies with several organisations and a London TB Control Board has been established to provide strategic oversight with the objective to reduce TB across London by 50% in 5 years.

NICE has developed guidance on Identifying and managing tuberculosis among hard-to-reach groups[17]. It has also produced a local government briefing on this guidance with recommendations to help local authorities make the most efficient use of resources to improve the health of people in their area.[18] These recommendations are referred to later in this report.

PHE released a Collaborative Tuberculosis Strategy for England, 2014 to 2019,[19] on World TB Day, 24 March 2014. The strategy is open for consultation for the next three months. It outlines a set of proposals for the organisation and resourcing of services to tackle TB and is open to views from a range of partners. The goal is to build upon the assets already within the NHS and public health system to support and strengthen local services, provide clarity to the lines of accountability and responsibility and provide national support for local action. The ambition is to bring together best practice in clinical care, social support, and public health to strengthen TB control, leading to a year-on-year decrease in incidence, reduction in health inequalities associated with the disease, and to the ultimate elimination of TB as a public health problem.[20]

Roles and Responsibilities of stakeholders in Prevention and Treatment of TB

Improving and supporting the basic elements of TB control are crucial. Prompt identification of active and latent cases of disease, supporting patients to successfully complete treatment and preventing new cases of disease occurring are critical components of any actions to reduce the spread of this curable disease.[21]

With the changes implemented in England in public health and health and social care since April 2013, there is a real opportunity for PHE, the NHS, CCGs and local authorities to work together to take a new approach to TB control.[22]

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[17] guidance.nice.org.uk/ph37

[18] NICE Local Government Briefing. Tuberculosis in Vulnerable Groups. What NICE says. 25 September 2013. http://publications.nice.org.uk/tuberculosis-in-vulnerable-groups-lgb11/what-nice-says. Accessed 27 March 2014.

[19] PHE. *Collaborative Tuberculosis Strategy for England, 2014-2019*. For consultation. 24 March 2014.

[20] PHE. *Collaborative Tuberculosis Strategy for England, 2014-2019*. For consultation. 24 March 2014. p. 4-5.

[21] PHE. Tuberculosis in London: Annual Review (2012 data): Data from 1999 to 2012. p. 7.

[22] PHE. *Collaborative Tuberculosis Strategy for England, 2014-2019*. For consultation. 24 March 2014. p. 19.

1. Local Authority

Harrow council is a key partner in local efforts to ensure the health of the population. The local authority has a broad remit in its public health role to reduce health inequalities, provide health protection and support service commissioning.

Local authorities can work to reduce TB transmission by addressing some of the contributory social factors that fall within their remit: e.g. overcrowding, poor housing, homelessness, and access to healthcare. Making improvements across these areas will help to reduce inequalities and TB transmission and improve general health outcomes.[23]

They can also provide local leadership in key areas such as housing and care of vulnerable people.

Working alongside clinical TB services (commissioned through NHS England and CCGs), local authorities can help to raise awareness, assist in the identification of new cases and support those affected by TB as they complete treatment. Local authorities can also help to improve a range of health and social outcomes in vulnerable communities through service provision and through the commissioning and management of external service providers.[24]

2. Clinical Commissioning Group

The CCG is responsible and accountable for commissioning high quality TB services. TB does not have its own tariff; commissioning for TB services is part of the normal contract. The recent restructuring of services has caused some disruption. Commissioners need access to clear financial information to understand and develop coordinated, efficient plans for service delivery and tracking the costs of TB services.

Commissioning for TB is challenging due to the different ways of classifying services and accessing information. In the absence of a coordinated London-wide approach, the purchase of TB services remains part of the normal provider contract. Inpatient care can be coded to track the cost for TB care but outpatient services are more complicated. This makes understanding the cost and spend on outpatient resources complicated: if TB services are classified under the infectious disease tariff, as it is in Northwick Park Hospital, services cost twice the amount of TB services classified under the respiratory medicine tariff.[25]

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[23] NICE Local Government Briefing. Tuberculosis in Vulnerable Groups. What Local Authorities can achieve. 25 September 2013. http://publications.nice.org.uk/tuberculosis-in-vulnerable-groups-lgb11/what-can-local-authorities-achieve-by-tackling-tb-in-vulnerable-groups. Accessed 27 March 2014.

[24] NICE Local Government Briefing. Tuberculosis in Vulnerable Groups. Key messages. 25 September 2013. http://publications.nice.org.uk/tuberculosis-in-vulnerable-groups-lgb11/key-messages. Accessed 27 March 2014.

[25] Personal communication, Lynn Altass, NHS England (London), London Strategic Clinical Networks TB Lead.

CCGs pay for TB care through normal tariff support. Based on work done throughout London applied to the situation for Northwick Park Hospital, it has been informally estimated that the income received by the hospital to deliver outpatient TB services to Harrow residents exceeds the amount estimated to be expended on these services.[26] This is based on the fact that according to calculations based on the London TB service specification for 2014/15 and approved by the CCG, Northwick Park should have 9 or 10 nurses and 2 or 3 administrative staff. Currently, however, Northwick Park has 5.6 nurses and 1 administrative staff member.

3. Clinical TB services in Harrow

TB services for Harrow are provided nearly exclusively by Northwick Park Hospital. In 2012, Northwick Park had 156 TB notifications from Harrow residents while Central Middlesex Hospital had 8.

It holds the largest single TB unit in the country, seeing over 100 cases per year, more than any other centre in the UK and it has the highest TB notification rates in Western Europe: 380 new cases were identified in 2013. Additionally, it has a high referral rate for more complicated MDR-TB and XDR-TB cases. TB rates are predicted to rise between 10-15% per annum with approximately 1,000 cases of TB requiring treatment at Northwick Park Hospital (serving a population primarily from Harrow and Brent), alone, by 2019.[27]

The London TB service specification prepared by the London TB Control Board was recently released, and is what CCGs will be commissioning against in 2014/15 and what trust contracts team will be expected to meet in 2014/15. It has been accepted by all CCGs in London. 2014/15 will be used to highlight the successes and gaps in service provision and monitoring performance using cohort review and contact tracing.

a. Cohort review

A systematic appraisal of the way every case of TB has been managed in a given locality in terms of treatment completion rates and contact investigations over a specified time period. It enables whole system review and treatment. Cohort review is organised around the outer NWL TB network. Staffing shortages, at Northwick Park Hospital has resulted in the review of less than 50% of TB notifications at the cohort review, cancellation of cohort review sessions and non-attendance of the service providers at NW London TB cohort review meetings.[28]

b. **Multidisciplinary TB team**.

The service should also include a multidisciplinary TB team. A team of professionals with a mix of skills to meet the needs of someone with TB who also has complex physical and psychosocial issues (that is, someone who is hard-to-reach). The team will meet regularly to plan, implement and evaluate a care pathway. Specific members should be able to meet to deal with urgent issues. Team members will include TB lead physician and nurse, a case manager, a peer supporter/advocate, a social worker, and a psychiatrist.

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[26] Personal communication, Lynn Altass, NHS England (London), London Strategic Clinical Networks TB Lead.

[27] NWLH NHS Trust TB Service, February 2013.

[28] *Personal communication, Lynn Altass, NHS England (London), London Strategic Clinical Networks TB Lead.*

Local authority staff from departments including housing and alcohol and drug services, and also the voluntary sector maybe required to link in with multidisciplinary TB teams.
It is unclear how this is operating in Harrow presently.

c. TB nurse specialist

The TB Nurse Specialist plays a key role in managing patients (adults and children) with active or latent TB in accordance to agreed protocols. The importance of activities such as home visits, directly observed therapy (DOT, given to patients at risk of being non-adherent to their medication regimen), follow-up phone calls, clinic visits, and the availability of walk-in services in achieving compliance and completion of treatment is well understood.

Ensuring the right staffing and skill-mix of nurses needs to be assured: there is significant need for improvement in northwest London.

The Royal College of Nursing (RCN) guidelines for 2012 recommend that nurse to patient ratio should be 1 nurse to 40 patients for general TB and 1 nurse to 20 patients for high risk cases for each whole time equivalent (WTE) nurse. High risk cases are classified as patients who have a history of dual diagnosis: HIV/TB, drug resistant TB, alcoholism, homelessness and mental health problems.

According to calculations based on the London TB service specification for 2014/15 and approved by the CCG , Northwick Park Hospital (the primary source of care for Harrow residents) should have 9 or 10 nurses and 2 or 3 administrative staff. Currently, however, Northwick Park has 5.6 nurses and 1 administrative staff member. This staffing shortage has resulted in the review of less than 50% of TB notifications at cohort review, cancellation of cohort review sessions and non-attendance of the service providers at NW London TB cohort review meetings.

Data compiled by Northwick Park Hospital from the London TB Register 2011 and 2012 show the number of notifications per month per staff member, demonstrating that nurses are working beyond the recommended ratio. It is important to recognise that the data do not provide an opportunity to identify those patients who are at high risk and require more intensive nursing care.

Table 3: 2011 London TB Register Episodes of Care by NPH Nurse Specialist

	Nurse Name	1	2	3	4	5	6	**Total**
	WTE	1	0.8	1	1	0.8	0.67	**5.27**
Caseload	Actual 2011	83	63	63	62	45	42	**358**
	RCN Guidelines per WTE	40	32	40	40	32	29	**213**
	Variance	**+43**	**+31**	**+23**	**+22**	**+13**	**+13**	**+145**

Table 4:Jan - October 2012 London TB Register Episodes of Care by NPH Nurse Specialist

	Nurse Name	1	2	3	4	5	6	**Total**
	WTE	1	0.8	1	1	0.8	0.67	**5.27**
Caseload	Actual 2012	67	55	43	69	59	41	**334**
	RCN Guidelines per WTE	40	32	40	40	32	29	**213**
	Variance	**+27**	**+23**	**+3**	**+29**	**+27**	**+12**	**+121**

Source: NWLH NHS Trust TB Service, February 2013.

The CCG is responsible for ensuring good quality TB services are commissioned and therefore working with service providers to ensure that services are adequately staffed and funded to achieve the necessary standards of care.
NWLH NHS Trust recently submitted a business case and project plan to Harrow CCG highlighting the staffing issues and impact on the control of TB. The proposal includes

- Appropriate shift of care into the community, through
  - Admission avoidance
  - Management of latent TB
  - Management of contacts & tracing
  - Share of workload
  - Population screening & education
- Reduction in cases of active TB
- Primary Care case finding

4. General Practice and Primary Care

NICE guidelines recommend that healthcare professionals (including primary care staff) are responsible for screening new entrants in order to maintain a coordinated programme to detect both active and latent TB, initiate appropriate treatments and provide BCG vaccinations to those in high-risk groups who are not infected and who are unvaccinated. Relevant information should be provided to all new entrants and TB screening should be incorporated within larger health screening programmes for new entrants linked to local services.[29] The London TB Control Board states that at least 60% of new entrants to London from very high incidence countries (countries with rates of >150 per 100,000 population) should be screened for TB and treatment, if indicated, offered by 2015.[30]

The issue of GP prescribing of TB medication is not addressed in national policy guidance or in NICE guidelines. The PHAST report found that across London most GPs have limited experience treating TB and maybe unfamiliar with medication side effects and may not be fully aware of the consequences of non-adherence.[31]

[29] Harrow Joint Strategic Needs Assessment: 2012-2016. June 2012. Chapter 5, p. 97.
[30] PHE & NHS England. London TB Control Board, Terms of Reference. Agreed 10 November 2013.
[31] PHAST report, p. 165.

Recognising the missed opportunities to diagnosis and treat, TB Alert and the Health Protection Agency helped RCGP to develop and launch an online course on TB for which GPs and practice nurses can obtain CPD credit. The course uses case studies to increase knowledge and skills in identifying patients with pulmonary and extra-pulmonary symptoms, highlights risk factors and the importance of screening and contract tracing. Upon completion, the healthcare professional will be able to develop strategies to improve diagnosis and management of TB for patients in general practice.

According to data compiled by RCGP, since the CPD programme was launched in November 2012 through February 2014, a total of 1,169 RCGP members nationwide have completed the course only 46 of whom were from northwest London.[32] The data do not permit any further breakdown to provide borough-specific information.

NHS England is responsible for the commissioning of primary care services and ensuring better outcomes for patients

5. London TB Control Board

PHE and NHS England's London Region are cosponsors of the London TB Control Board. The Board includes all agencies involved in preventing, controlling and treating TB. It ensures the functions of health improvement, health protection and service provision are considered together rather than in isolation.
The board meets quarterly. Their agreed objectives are to:[33]

1. Achieve a 50% reduction in TB rates by 2018.
2. Provide strategic oversight and direction to the control, commissioning, quality assurance and performance management of TB services across London.
3. Promote service specific improvements and a whole systems approach that addresses the incidence of TB.
4. Ensure pan-London resources targeted at TB are commissioned and utilised effectively, provide value for money and improve health outcomes.

The 2014/15 commissioning intentions of the London TB Control Board focus on:

1. Best practice for service delivery by providers through the London TB service specification managed through commissioning intentions for service provider contracts where London CSUs would lead the negotiations.
2. Hold service providers to account via the actions of CCGs and CSUs to enforce contracts and the London TB service specification.
3. CCGs support the goal of reducing the London TB rate by 50% in their five year plans with the London TB Control Board developing robust plans in 2014/15 to implement the London TB Plan in full from 2015/16.

[32] Personal communication, Olivia Spiro, eLearning Project Officer, CPD, RCGP.
[33] PHE & NHS England. London TB Control Board, Terms of Reference. Agreed 10 November 2013.

6. Public Health England

PHE's health protection teams work alongside the NHS, local authorities and emergency services. They provide specialist support in communicable disease, infection control and emergency planning. Health protection staff are based in health protection units providing support and advice on individual TB cases where the patient is a risk to the public or others.[34]
The London Annual TB Report published in October 2013 provides the latest epidemiology of TB in London with two-page profiling for each London Borough. The report makes the following recommendations for improving TB control in London:

1. Improve early diagnosis and successful treatment of cases to minimise onward transmission or disease progression.
2. Conduct highly targeted case finding and prevention activities among high risk groups.
3. Prevent new cases by screening for latent TB infection according to NICE guidelines.
4. Improve case and contact management.
5. Continue and expand use of TB cohort review.
6. Improve service commissioning to address the current system fragmentation by coordinating provision and strengthening the performance management of services.
7. Improve the quality of care and value for money.

7. TB Alert

TB Alert is the only national TB charity. As lead partner with the Department of Health, TB Alert developed "The Truth About TB." The organisation brought local authorities, primary care trusts and third sector organisations together to raise awareness among the most vulnerable people in the community. Funding for this three-year programme from DH ends in March 2014.

TB Alert has created Local TB Partnerships with third sector organisations to provide a mechanism to develop the role of the third sector in local TB care and control as well as provide links between local third sector organisations and communities and statutory agencies. The Local TB Partnerships are "owned" by the local communities, reflect the pattern of TB found in the local community and build TB awareness at the local level in addition to providing support to people undergoing TB treatment.
TB Alert can assist in local TB contact tracing and provide community DOT assistance.

[34] London TB service specification 2013/14. November 2013.

8. Find & Treat

Established in 2005, Find & Treat are a specialist outreach team working alongside over 200 NHS and third sector front-line services to assist in the delivery of TB services among homeless, alcohol and/or drug users, vulnerable migrants and people who have been in prison. The Find & Treat Team are multidisciplinary, include TB nurse specialists, social and outreach workers, radiographers and technicians as well as former TB patients who work as peer advocates. Find & Treat work to identify cases of active TB and support patients to adhere to their treatment.

In addition to case finding, Find & Treat raises awareness of TB among service users and frontline professionals, screening nearly 10,000 high risk people annually using a mobile digital x-ray unit. The screening service covers every borough in London visiting regularly scheduled sites twice annually, more often in some areas where there is a particularly high rate of transience. The organisation provides out-of-hours and weekend screening, helping to meet unmet needs in the community.

Find & Treat works with Groundswell to recruit, train and support former TB patients who have been homeless to serve as peer advocates. Two distinct groups of people are served by the Find & Treat programme: those with advanced disease who have been chronically ill for a long time and people with early, asymptomatic disease who can benefit by immediate treatment.

Once cases have been found, Find & Treat create a treatment service for patients who have not found it easy to be part of the clinic-based system. Additionally, the team helps patients who have housing and /or criminal justice issues as well as drug and/or alcohol addictions

Summary of Key issues identified for TB in Harrow

1. Harrow has persistently high rates of TB and is one of the highest in London
2. Similar to London, prevalence is highest in those people born abroad from a country of high TB prevalence mainly India who have latent disease and develop active disease several years after arrival in the UK.
3. Key to control of TB in Harrow is prompt identification of active and latent cases of disease, supporting patients to successfully complete treatment and preventing new cases of disease occurring
4. Treatment completion rates in Harrow are above the London average but there maybe diagnostic delay (London wide data available only)
5. Management of latent disease is key as approximately 80% of people who develop active TB do so as a result of the reactivation of latent TB rather than through the transmission from someone with active disease.[35]
6. Workload commitments at Northwick park Hospital, has not allowed TB specialist nurses to fully participate in management of latent disease in the community ,DOT therapy and contact management
7. New entrant screening does not appear to be happening consistently in primary care further reducing opportunities to identify latent TB. Furthermore, awareness of diagnosis and treatment of TB is low and opportunities for training are not being utilised.

[35] London TB service specification 2013/14. November 2013.

Recommendations
These are based on findings from this report, relevant recommendations from NICE guidance and other national policy and interviews with key stakeholders.

1. **Local authority**

    a. Informed commissioning

NICE recommends that Local authorities have a role in supporting informed commissioning.

- Harrow council should work with the NHS in ensuring services reflect the needs of their area, as identified by local needs assessment. TB should be included in the joint strategic needs assessment in areas of high need.

  This should include assessment of the number of TB cases in the area, and the size and composition of local at-risk groups.
- Local authority staff from departments including housing and alcohol and drug services, should link with multidisciplinary TB teams, taking part in cohort reviews when appropriate
- Strategic housing leads and relevant services within local authorities should work with multidisciplinary TB teams to set up a process for assessing eligibility for people with TB for housing.
- Local authorities can further support improving services and outcomes in general for local vulnerable groups and communities by identifying and linking with relevant NHS and community services, improving inter-service communication and sharing information, identifying opportunities for joint work and activity, and through multi-agency support for health improvement.

    b. Raising and sustaining awareness of TB

- Harrow council should commission in partnership with the NHS, a proactive programme of awareness raising with population-specific communication campaigns to dispel the myths about TB.

  The communication campaign should also include staff in regular contact with high-risk groups so they can seek medical advice when necessary. Relevant local authority services may also be able to provide links for staff and service users to appropriate NHS services for immunisation, diagnosis and treatment.

  - There is a role for the council to ensure services that support vulnerable groups (commissioned by the LA or voluntary sector) are facilitated to link into multidisciplinary TB team for support and educational materials.

2. **Clinical Commissioning Group**

Harrow CCG needs to ensure that it is commissioning TB services locally against the London TB service specification. Particular areas that need to be addressed with the provider include:

- Multidisciplinary TB teams are set up, ensuring they have the skills and resources to manage those who are from hard-to-reach groups and also those who are not. Also, they are adequately equipped to provide ongoing TB awareness-raising activities for professional, community and voluntary (including advocacy) groups.

- Can provide rapid access TB clinics for hard-to-reach groups
- Addressing current capacity issues in Northwick park to ensure there is adequate case finding, of active and latent TB and provision of DOT,
- Assurance that patients attending these services are not suffering a delay in diagnosis and treatment
- Support providers to use find and treat service for certain TB patients such as those who have become non adherent and lost to follow up
- Participation in cohort reviews

3. NHS England working with Primary Care services

- NHS England should ensure primary care services are fulfilling their obligation to register vulnerable migrants.
- Primary care services should support local, community-based and voluntary organisations that work with vulnerable migrants to ensure they register with a primary care provider and know how to use NHS services
- Reduce diagnostic and treatment delay by ensuring screening of all new entrants for active and latent TB in line with NICE guidance on tuberculosis for new entrants. The London TB Control Board[36] has set a target that at least 60% of new entrants to London from very high incidence countries (countries with rates of ≥150 per 100,000 population) should be screened for TB and treatment, if indicated, is offered by 2015.
- NHS England should work with GPs in Harrow to improve their knowledge of TB and encourage them to take the free online CPD course offered on the RCGP website

4. Other

- Agencies should consider working with TB Alert who have the knowledge and experience to be a valuable partner in contract tracing and to provide assistance in the delivery of community-based DOT services

Section 3 – Further Information

Full report is available on request.

Section 4 – Financial Implications

Proposed communication plan to be funded from the PH budget

Section 5 - Equalities implications

No

[36] PHE & NHS England. London TB Control Board, Terms of Reference. Agreed 10 November 2013.

Section 6 – Corporate Priorities

If a Council or Joint report - Please identify which corporate priority the report incorporates and how:

- Supporting and protecting people who are most in need.

STATUTORY OFFICER CLEARANCE (Council and Joint Reports

Name: Simon George	x	on behalf of the Chief Financial Officer
Date: 4 April 2014		

Ward Councillors notified:	**NO**

Section 7 - Contact Details and Background Papers

Contact: Dr Laura Fabunmi, Consultant Public Health, Shared Barnet and Harrow Public Health team, laura.fabunmi@harrow.gov.uk

Background Papers:

None