Situational Report on TB in Barnet

Summary

Tuberculosis (TB) is a disease that is preventable and treatable yet it remains a major public health problem in London. Although, not one of the highest rates in London, rates of TB in Barnet have remained around 30 per 100,000. In response to concerns, a new national TB strategy has been launched, a London TB board has been set up and there is NICE guidance on management of TB including measure for its prevention and control. This report considers the implications for Barnet and makes recommendations for the different organisations so they can work together and take a new approach to TB control.

Introduction

Tuberculosis (TB) is a disease that is preventable and treatable yet it remains a major public health problem in London. After two decades of increase, TB rates in London have stabilised since 2005 at around 40 per 100,000; but remain considerably higher compared to other parts of the UK. Rates of TB in the borough of Barnet have remained consistently around 30 per 100,000 which although twice the England average is lower than the London average which has been around 40 per 100,000. However, it should be noted that the overall borough rate masks smaller areas of very high incidence.

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 as well as interviews with key stakeholders. The report attempts to analyse the current situation on TB in Barnet and makes recommendations on how the system can work together to reduce the burden of this disease. The recommendations are based on findings from this report, relevant recommendations from NICE guidance, national policy and interviews with key stakeholders.

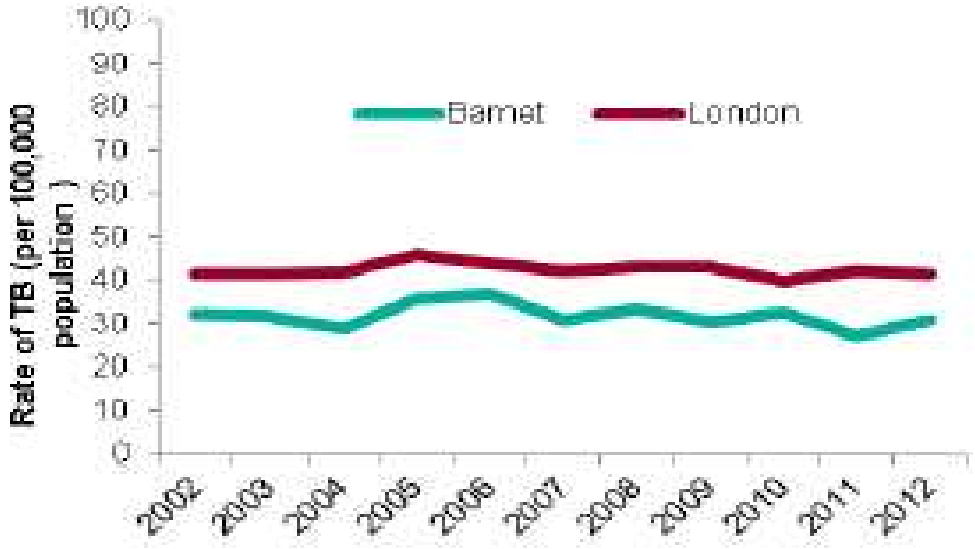
Epidemiology

London is considered the Tuberculosis (TB) capital of Western Europe with rates highest in the northwest and northeast areas of the capital. Rates of TB in the borough of Barnet have remained around 30 per 100,000 since the early 2000s. According to provisional data released in February 2014, the TB rate for Barnet in 2013 dropped to 20.9 per 100,000 from 30.5 per 100,000 in 2012.[1] The overall TB rate for London dropped in 2013 from 41 per 100,000 population in 2012 to 36.3 per 100,000 population.[2] PHE advises that the drop in rates seen between 2012 and 2013 should be interpreted with caution;

[1] PHE. London i: Tuberculosis, Number 2014/02, February 2014. p. 6.
[2] PHE, London i: Tuberculosis, Number 2014/02, February 2014. p. 4.

fluctuations from one year to the next are common in small areas and should always be interpreted with care.[3]

Figure 1: Annual TB Incidence Rate, 2002 – 2012



Source: PHE, Local Authority TB Profiles, Barnet, p. 4.

TB rates remain highest in northwest and northeast London.[4] North 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).[5]

Table 1: Number of new TB notifications and rate per 100,000, 2008 – 2013

	2009		2010		2011		2012		2013	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Barnet	105	30.4	116	33.0	101	28.2	111	30.5	76	20.9
North Central London, total	545	41.7	444	33.5	463	34.2	424	30.8	343	24.9
London, total	3418	43.0	3256	40.4	3520	42.9	3425	41.2	3020	36.3

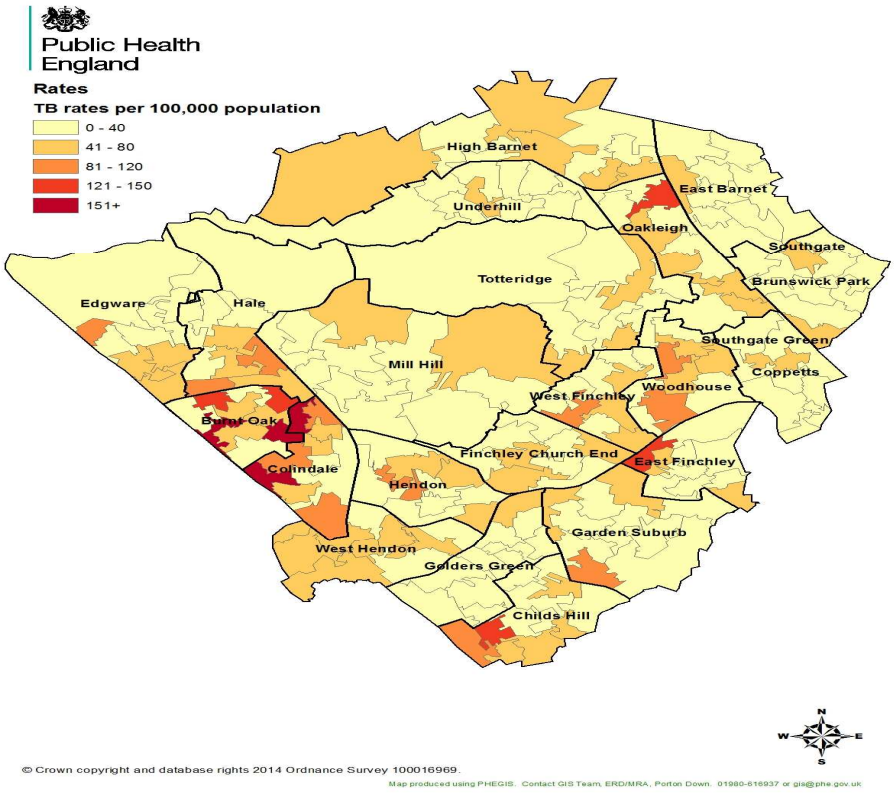
Source: PHE, *London i: Tuberculosis*, Number 2014/02, February 2014.

[3] The TB rates published in the London i for 2013 are calculated using 2012 population figures and may change once 2013 population levels have been incorporated.

[4] London TB service specification 2013/14. November 2013.
[5] PHE, London i: Tuberculosis, Number 2014/02, February 2014. p. 6.

LA overall rates can mask smaller areas of very high incidence. Rates of TB vary across the borough of Barnet. According to data received from PHE, the top three areas in Barnet are: Colindale, Burnt Oak and Oakleigh. It is important to note that these rates are based on small numbers.[6] Therefore, it is expected that specific figures for these areas within the borough will fluctuate year on year and area-specific data should be interpreted with care.

Map 1: London Borough of Barnet TB Incidence Rate by LSOA, 2012



Source: PHE, Local Authority TB Profiles, Barnet, p. 4.

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.[7] TB rates were highest and continue to increase in those born in India with those born in Pakistan and Somalia following in frequency. Rates in black Africans is declining but still makes up 21% of cases identified in 2012.

The reasons for the intractability of TB rates in Barnet are similar to the reasons for the increase in rates London-wide, although not definitive. The majority of people diagnosed with TB in Barnet were born abroad and are from a country of high TB prevalence, 14% entered the UK within the previous

[6] Personal communication, Gail Morgan, TB Coordinator, North West London Health Protection Team, PHE.
[7] London TB service specification 2013/14. November 2013.

two years and 30% had been in the UK for more than a decade prior to diagnosis (time since entry was not reported for 6% of the cases). Many of the cases in Barnet as in London are in people who have resided in the UK for long periods prior to being diagnosed with TB. The majority of new cases were in people of Indian ethnicity (30%) and mixed/other ethnicity was the next most common and reflects people with a range of backgrounds (26%).[8] The age/sex profile of cases shows that females aged 20-29 made up a larger than usual proportion, although patients were more often male across other age groups.

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. 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.

According to provisional 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). North Central London (NCL) has consistently had a higher percentage of new TB notifications with social risk factors than the London average, 16% in 2013. Since 2011, Barnet has routinely been below the London average with 3.9% in 2013, down from 15.5% in 2010.[9] It is important to note that these percentages are based on small numbers.[10]

Table 2: Proportion of new TB notifications with one or more risk factors, 2008 – 2013

	2009	2010	2011	2012	2013
Barnet	14.3%	15.5%	7.9%	6.3%	3.9%
North Central London, total	18.7%	19.6%	16.0%	16.3%	16.0%
London, total	12.2%	12.4%	10.3%	11.2%	11.9%

Source: PHE, *London i: Tuberculosis*, Number 2014/02, February 2014. p. 13.

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

[8] PHE. Local Authority TB Profiles, Barnet. October 2013. p. 4.
[9] PHE, London i: Tuberculosis, Number 2014/02, February 2014. p. 13.
[10] Personal communication, Gail Morgan, TB Coordinator, North West London Health Protection Team, PHE.

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.

In London it has been estimated that between 75 - 80% of people who develop active TB do so as a result of the reactivation of latent TB.

Prevention

Since TB is spread through an airborne route, ensuring adequate ventilation and limiting close contact with people with active disease are key to eliminating the spread of TB to others.[11] 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.[12]

In NICE TB clinical guideline 117, new recommendations have been added for diagnosing latent TB which includes using a blood test – Interferon Gamma which is more specific than the tuberculin skin testing.

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.[13]

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).

The Green Book recommends that all infants (0 - 12 months old) living in an area where the incidence of TB is greater than 40/100,000 should be offered BCG immunisation. Currently, a selective policy for neonatal BCG vaccination is operating in Barnet for high risk infants. The most recent coverage report available for neonatal BCG is 2011/12, showing 93% coverage of infants identified as high risk in Barnet. 50% of all neonates born in Barnet are vaccinated with BCG.

The London Immunisation Board has now agreed that London should be seen as one geographical area and all Local Authorities/CCGs will be expected to

[11] National Institute of Allergy and Infectious Diseases. Tuberculosis. http://www.niaid.nih.gov/topics/tuberculosis/understanding/pages/prevention.aspx. Accessed on 17 January 2014.
[12] National Institute of Allergy and Infectious Diseases. Tuberculosis. http://www.niaid.nih.gov/topics/tuberculosis/understanding/pages/prevention.aspx. Accessed on 17 January 2014.
[13] WHO. BCG Vaccine. http://www.who.int/biologicals/areas/vaccines/bcg/en/. Accessed on 23 February 2014.

commission universal neonatal BCG in 2015/16 as per the London TB Model of Care recommendations.[14]

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. Rates of TB-HIV co-infection continue to decrease across England, Wales and Northern Ireland.[15]

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 the Edgware TB Clinic, there were 46 notifications in 2013. Of this total, 43 patients (95.7%) were offered an HIV test, one patient was offered the test but it was not done, the test was not offered to one patient and there was no information for one patient.[16]

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.[17]

The London TB Metrics state that at least 85% of patients should complete treatment within one year. Of residents London-wide notified during 2012, 85% completed treatment within one year; Barnet was above the London average with 91.0% completing treatment within one year.

The treatment completion rate at the Edgware TB Clinic (which provides care to a majority of Barnet's TB population) was 91.4% in 2012. The treatment completion rate at the Royal Free Hospital (second most frequently used site for Barnet residents) in 2012 was 85.7%, meeting the London-wide average but below the Edgware TB Clinic and North Central London (NCL) rates.[18]

[14] Personal communication, Lynn Altass, NHS England (London), London Strategic Clinical Networks TB Lead.
[15] PHE. *Tuberculosis in London: Annual Review (2012 data): Data from 1999 to 2012*. p. 5.
[16] PHE. *London i: Tuberculosis*, Number 2014/02, February 2014. p. 11.
[17] London TB service specification 2013/14. November 2013.
[18] PHE, *London i: Tuberculosis*, Number 2014/02, February 2014. p. 9.

Table 3: Treatment status at one year for new TB notifications, 2012[19]

	Notifications	% completing treatment	% still on treatment	Died	Lost to follow-up	Treatment stopped	Transfer without further info
Edgware TB Clinic	81	91.4%	2.5%	1.2%	1.2%	0.6%	2.5%
Royal Free Hospital	70	85.7%	2.9%	4.3%	0.0%	5.7%	1.4%
North Central London, total	479	87.5%	3.3%	3.3%	0.8%	2.7%	2.1%
London, total	3425	85.0%	5.2%	3.0%	1.9%	1.0%	3.1%

Source: PHE*, London i: Tuberculosis,* Number 2014/02, February 2014. p. 9.

Diagnosis and Diagnostic Delay

Delay to diagnosis is the time between reported symptom onset and date of diagnosis. Information on the onset of symptoms should however be interpreted with caution. In Barnet, 33% of patients with pulmonary disease had been symptomatic for more than three months before diagnosis which is higher than London average of 28%. For all patients with TB, 36% of patients had been symptomatic for more than three months before diagnosis compared to 34% in London.
PHE's proposed Collaborative Tuberculosis Strategy for England[20] recommends that at least 80% of people with pulmonary TB 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, regional and sector strategy 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.[21]

Effective local implementation of detection and treatment strategies can reduce the burden of disease from both a human and economic standpoint,

[19] N.B. The data in this table include all notifications for the hospital and region. The data are not specific to Barnet residents and include all patients treated at the specific hospital due to sample size.
[20] PHE. Collaborative Tuberculosis Strategy for England, 2014-2019. For consultation. 24 March 2014. p. 10.
[21] London TB service specification 2013/14. November 2013.

minimising the risk of on-going transmission. Active TB is relatively inexpensive and straightforward to treat and cure when identified early.[22]

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% by 2018.

NICE has developed guidance on Identifying and managing tuberculosis among hard-to-reach groups.[23] 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.[24] These recommendations are referred to later in this report.

PHE released a proposed Collaborative Tuberculosis Strategy for England, 2014 to 2019,[25] on World TB Day, 24 March 2014. The strategy is open for consultation until June. 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 on 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.[26]

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.[27]

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,

[22] London TB service specification 2013/14. November 2013.
[23] guidance.nice.org.uk/ph37
[24] 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.
[25] PHE. *Collaborative Tuberculosis Strategy for England, 2014-2019*. For consultation. 24 March 2014.

[26] PHE. *Collaborative Tuberculosis Strategy for England, 2014-2019*. For consultation. 24 March 2014. p. 4-5.
[27] PHE. Tuberculosis in London: Annual Review (2012 data): Data from 1999 to 2012. p. 7.

CCGs and local authorities to work together to take a new approach to TB control.[28]

1. Local Authority

Barnet 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 in addition to improving general health outcomes.[29] The Council 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.[30]

2. Clinical Commissioning Group

Prior to April 2013, commissioning of TB services was done collaboratively across NCL by the NCL TB network on behalf of the 5 PCT's. This was handed over to the CCG's , with Islington as the lead CCG. Discussions are on going to ensure this approach of a managed TB network of services across NCL is sustained. The CCG's are therefore now responsible and accountable for commissioning high quality TB services.
Commissioning for TB is challenging due to the different ways of classifying services and accessing information. TB does not have its own tariff; it is part of the normal 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

[28] PHE. *Collaborative Tuberculosis Strategy for England, 2014-2019*. For consultation. 24 March 2014. p. 19.
[29] 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.
[30] 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.

services are classified under the infectious disease tariff, services cost twice as much than if classified under the respiratory medicine tariff.[31]

3. Clinical TB services in Barnet

TB services for Barnet residents are provided nearly exclusively by the Edgware TB Clinic followed by the Royal Free Hospital. In 2012, the Edgware TB Clinic had 59 notifications while the Royal Free Hospital had 30.[32]

Edgware TB Clinic is a multidisciplinary clinic staffed by a physician, nurses, social worker and DOT team based at Edgware Community Hospital

The London TB Service Specification prepared for the London TB Control Board by the London TB Clinical Leadership Group was recently released, and is what CCGs will be commissioning against in 2014/15 and what the 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

Cohort review is 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. The introduction of cohort review in the NCL TB Service led to improved patient and contact outcomes and is a valued tool in ensuring accountability for patient care due to better quality data being recorded and communicated.[33] According to the 2014/15 contract, the quarterly cohort reviews in NCL are being done as per the London TB Service Specification and Key Performance Indicators.

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 people with TB especially those who have complex physical and psychosocial issues (i.e., 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 the TB lead physician and nurse and, as necessary, include a peer supporter/advocate, a social worker, and a psychiatrist. Local authority staff from housing, alcohol and drug services, and the voluntary sector maybe required to link in with multidisciplinary TB teams.

There is a multidisciplinary team based at Edgware Hospital.

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

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

[33] *Anderson C et al. "Evaluation of the implementation of cohort review by North Central London TB Service." May 2010.*

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.

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.

Table 4: Nursing Requirements for Edgware TB Clinic and Royal Free Hospital

	1:40 Nursing Staff	1:20 Nursing Staff	Total Nursing Staff Required
Edgware TB Clinic	1.7	0.2	1.9
Royal Free Hospital	1.7	0.5	2.2
North Central London, total	10.0	3.6	13.6

Source: L. Altass, NHS England, May 2014.

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.

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. 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.[34]

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

Indications are that new entrant screening in primary care is not happening consistently. Through the Office of London's CCGs, Public Health England and NHS England (London Region) are working with CCGs to develop robust plans to implement latent TB case finding in 2015/16 to reduce TB rates in London.[35]

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 51 of whom were from northeast London (there have been a total of 159 course completions London-wide).[36] The data gathered by RCGP do not permit any further breakdown to provide data specifically for NCL or borough-specific information.

NHS England is responsible for the commissioning of primary care services and ensuring better outcomes for patients. NHS England's London Region is currently preparing a map of TB cases in Barnet to identify and illustrate GP practices with the greatest workload related to TB.[37]

5. London TB Control Board

PHE and NHS England's London Region are co-sponsors 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:[38]

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.

[35] Personal communication, Lynn Altass, NHS England (London), London Strategic Clinical Networks TB Lead.
[36] Personal communication, Olivia Spiro, eLearning Project Officer, CPD, RCGP.
[37] Personal communication, Lynn Altass, NHS England (London), London Strategic Clinical Networks TB Lead.
[38] PHE & NHS England. London TB Control Board, Terms of Reference. Agreed 10 November 2013.

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.

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.[39]

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.

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

There is a national recognition of the need to identify latent TB infection at an earlier stage. Public Health England are currently in the process of developing a policy proposal to the UK National Screening Committee for the development of a screening programme among new entrants to the UK aged 16-35 from areas of very high TB incidence (>150 per 100,000).

7. TB Alert

TB Alert is the main 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 communities with the highest rates of TB and the most vulnerable people. Funding for this three-year programme from DH ended 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, 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.

TB Alert worked with London Health Programmes in 2012/13 to develop and print information leaflets that are more relevant to London residents.

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 provide active outreach to identify cases of active TB and support patients to adhere to their treatment.

In addition to case finding, Find & Treat raise awareness of TB among service users and frontline professionals and screen 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 hard to reach community.

Find & Treat work 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 from 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 help 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 Barnet

1. Whilst rates of TB in Barnet are below London-wide rates, the borough's rates have remained consistently around 30 per 100,000 since the early 2000s, above the level targeted for London by 2018 (20 per 100,000).

2. Similar to London, prevalence of TB in Barnet 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 the control of TB in Barnet is prompt identification of active and latent cases of disease; supporting patients to successfully complete treatment and preventing new cases of disease.

4. Treatment completion rates in Barnet are above the London average.

5. A third of patients with pulmonary disease had a delay of more than three months before diagnosis, which is above the London average and exceeds the national TB strategy guidance recommendation.

6. 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 transmission from someone with active disease.[40]

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 needs to be better understood and opportunities for training encouraged.

Recommendations

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

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

1. Local authority

a. Informed commissioning

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

- Barnet Council should work with the NHS to ensure services reflect the needs in 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 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 housing eligibility for people with TB.

- 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

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

  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 local authority or voluntary sector) are facilitated to link into the multidisciplinary TB team for support and educational materials.

2. Clinical Commissioning Group

Barnet 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:

- Ensuring that the multidisciplinary TB teams have the right of the skill and resource mix necessary to manage those who are from hard-to-reach groups and also those who are not. Also, the teams are adequately equipped to provide ongoing TB awareness-raising activities for professional, community and voluntary (including advocacy) groups.
- Rapid access TB clinics for hard-to-reach groups.
- Assurance that services are adequately staffed to support adequate case finding of active and latent TB and provision of DOT
- Support providers to use the services of Find & Treat for TB patients who have become non-adherent and lost to follow up.
- Continuing participation in cohort reviews.

3. NHS England working with Primary Care Services

- Reduce diagnostic and treatment delay by ensuring all new entrants are screened for active and latent TB in line with NICE guidance on TB for new entrants. The London TB Control Board[41] 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) are screened for TB and treatment, if indicated, is offered by 2015.

- NHS England should ensure that 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.

- NHS England should work with GPs in Barnet 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

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

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