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DATE: 1 October 2015

HEALTH AND WELLBEING BOARD INFORMATION BRIEFING

Meeting to be held on Thursday 8 October 2015

QUESTIONS ON THE INFORMATION BRIEFING

1 PHLEBOTOMY REVIEW (Pages 3 - 8)

2 LIVING WELL WITH DEMENTIA CONFERENCE UPDATE (Pages 9 - 12)

3 TB IN LONDON (Pages 13 - 22)

Members and Co-opted Members have been provided with advanced copies of the Part 1 (Public) briefing via email. The Part 1 (Public) briefing is also available on the Council website at the following link:

http://cds.bromley.gov.uk/ieListMeetings.aspx?CId=559&Year=0

Printed copies of the briefing are available upon request by contacting Steve Wood on 020 8313 4316 or by e-mail at stephen.wood@bromley.gov.uk.

Copies of the documents referred to above can be obtained from http://cds.bromley.gov.uk/

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NHS
Bromley
Clinical Commissioning Group

Bromley Clinical Commissioning
Clinical Executive Group
Date: 30 July 2015

ENCLOSURE 10

Title: Phlebotomy Review PID

DIRECTOR RESPONSIBLE: Mark Needham (Director of Commissioning)

CLINICAL LEAD: Dr Jon Doyle

AUTHOR: Alexandra Bigg (Coordination and Delivery Manager)

SUMMARY:
The project mandate was approved on 30 April 2015 to undertake this review. It is anticipated that the review will completed in 3-4 months from the first meeting of the Steering Group. At the end of the review recommendations will be made to the Clinical Executive Group, which may lead to a business case for service change.

Our vision is to commission **swift**, **equitable** and **local** access to a phlebotomy service offering both booked and walk-in appointments. This will also help GPs to make a **timely diagnosis** of a patient's condition.

The **aims** of the review are:
1) To gain a full understanding of current phlebotomy provision (where phlebotomy is offered and when, and what the balance of activity is between hospital, community and GP services) and the extent to which it is meeting the needs of service users.
2) To observe examples of best practice in other boroughs to help inform the options appraisal.
3) To make recommendations for the future of phlebotomy provision.

Key milestones:
August 15 – Draft engagement plan and baseline report on current provision complete
September 15 – First Steering Group
October 15 – Report on other local models of delivery complete
November 15 – Engagement report complete
January 16 (latest) – Options appraisal and recommendations to CEG

KEY ISSUES:

History: The revised 2011 LES for phlebotomy has doubled the phlebotomy activity in GP practices. However, there are still issues with inequity of provision and long waiting times in walk-in clinics. In light of previous work, it is important that:

a) any future changes to phlebotomy provision must be agreed as a result of comprehensive patient and service provider engagement to ensure that they can be implemented successfully
b) any future changes consider current and predicted activity levels carefully so that the phlebotomy service will meet the aims of swift, equitable and local access.

Governance: The review is likely to garner high levels of public and patient interest. The review and the recommendations that follow must therefore be credible. It was agreed by the CEG on 25/6/15 that the CCG would chair the review. A Steering Group will be established and chaired by Dr Jon Doyle (Clinical Lead) and will include a representative from key stakeholders: KCH, BHC, LMC, HWB councillor, Healthwatch and patient representation. The Steering Group will provide an overall steer for the review, analyse the current provision and the outcomes of the engagement, and put together the options appraisal and recommendations paper for CEG.

Engagement: Healthwatch will support the CCG with patient engagement, especially with reaching seldom heard groups. The scope of the review will be presented carefully in order to manage patient expectations. Feedback will be sought from GP practices as requestors of blood tests. Estimated cost £6k.

COMMITTEE INVOLVEMENT:
Planned Care Working Group (review of draft PID)

PUBLIC AND USER INVOLVEMENT:
None as yet

IMPACT ASSESSMENT:
The review itself will have no impact on health inequalities. The vision for phlebotomy is to increase equity in access to services, particularly for vulnerable or frail patients. However, we have considered how we will ensure that the review itself meets the equality impact assessment criteria.

RECOMMENDATIONS:
The Committee is asked to:

1. Approve the PID

ACRONYMS

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Project Initiation Document - Phlebotomy review

Project Lead	Date	Clinical Lead
Alexandra Bigg	23/07/2015	**Dr Jon Doyle**

Project Information	
Project Description	This review of the phlebotomy service is focused on **patient access** to having a blood sample taken when requested by a GP. The testing of the sample and returning the results to the referrer has already been reviewed and is in undergoing service improvement as part of the Direct Access Diagnostics initiative led by Richard Dolby. The project mandate was approved on 30 April 2015 to undertake this review. It is anticipated that the review will completed in 3-4 months from the first meeting of the Steering Group. At the end of the review recommendations will be made to the Clinical Executive Group, which may lead to a business case for service change. **Governance:** The review is likely to garner high levels of public and patient interest. Almost all people require a blood test on at least one occasion and expectations will need to be managed carefully given historical issues with the service. The review and the recommendations that follow must therefore be credible. It was agreed by the CEG on 25/6/15 that the CCG would chair the review. A Steering Group will be established and chaired by Dr Jon Doyle (Clinical Lead) and will include a representative from key stakeholders: KCH, BHC, LMC, HWB councillor, Healthwatch and patient representation. The Steering Group will provide an overall steer for the review, analyse the current provision and the outcomes of the engagement, and put together the options appraisal and recommendations paper for CEG. **Draft engagement plan**: - It is anticipated that the engagement work will take 2-3 months to complete, including write-up. The engagement plan will be agreed by the Steering Group. - **Patients (and wider public):** Distribution of a standard survey asking for feedback on the experience of accessing the phlebotomy service via CCG and partner websites and having hard copies at practices and phlebotomy clinics (support from Healthwatch); an event for the PAG and key voluntary sector organisations; events to reach seldom heard groups (support from Healthwatch). - **GP practices** (as requestors of blood tests): Raise awareness of the review through the GP bulletin and cluster meetings; distribution of a standard survey asking for feedback on what works well with current provision and how it could be improved; attendance at HCA and PN forums to gather feedback; possible focus group of GPs to gather feedback
Project Aims	Our vision is to commission **swift, equitable** and **local** access to a phlebotomy service offering both booked and walk-in appointments. This will also help GPs to make a **timely diagnosis** of a patient's condition. The aims of the review are: 1) To gain a full understanding of current phlebotomy provision (where phlebotomy is offered and when, and what the balance of activity is between hospital, community and GP services) and the extent to which it is meeting the needs of service users. 2) To observe examples of best practice in other boroughs to help inform the options appraisal. 3) To make recommendations for the future of phlebotomy provision.
Rationale	Work to improve access to phlebotomy services has been ongoing since 2010: - In March 2011 a **business case was approved to revise the LES for phlebotomy** in order to increase local access and bookable appointments. This resulted in an increase in the number of practices offering phlebotomy (from 10 to 22) and phlebotomy activity in practices has more than doubled since 2010. - However, the review of local enhanced services conducted in 2013-14 found that access and waiting times for phlebotomy were still a problem. It found that access is **not equitable,** with limited local provision offered to patients living near Bromley Town Centre, Penge and Petts Wood. Waiting times at walk-in clinics were still long, with patients sometimes having to **wait over 90 minutes** to have their blood taken. Clinical Exec approved an **improvement plan to address the challenges at KCH i**n September 2014, but the implementation of this has held up due to the nature of the pathology block contract and moves to transfer the pathology service to Viapath. - In March 2015 the Governing Body noted that although phlebotomy services have improved considerably, there are still concerns over the current provision and that an **engagement plan should be developed alongside Healthwatch** to seek feedback from patients. Following this, recommendations would be made for changes. Existing GP contracts for this enhanced service have been re-issued under an NHS standard contract from 1 April 2015 until March 2018 with a 6 month notice period for termination. To date, 25 practices have signed up to the enhanced service for 2015-18. In light of previous work, it is important that: a) Any future changes to phlebotomy provision must be agreed as a result of comprehensive patient and service provider engagement to ensure that they can be implemented successfully. b) Any future changes consider current and predicted activity levels carefully so that the phlebotomy service will meet the aims of a swift, equitable and local access. A diagnostic review is therefore proposed that engages both patients and service providers so that is seen as credible by all stakeholders.

Key Area of Focus	Stakeholder engagement with (a) service users - patients and GPs as referrers and (b) providers - GPs, Bromley Healthcare and KCH. Options appraisal and recommendations.

Project Scope - IN	Project Scope - OUT
GP registered patients (adults and children) in Bromley for whom a blood test has been requested by their GP practice	Patients for whom a blood test has been requested in another healthcare context (e.g. outpatient appointment)

Project Objectives

Statements of Specific, Measureable, Achievable, Relevant, Timely outcomes

Complete diagnostic report on current provision
Write up an options appraisal and recommendations to go Clinical Executive Group

Expected Benefits (of an amended service following the review)

What is the benefit?	*What is the measure/KPI?*	*Type of Benefit*	*Who benefits?*
Improved access across the borough and across age range	Provision is such that no patient has to travel more than X miles to get their bloods taken at a booked appointment within Y timeframe.	Quality	Patients Practices
Shorter waiting times at walk-in clinics	Local performance indicator in service specification - X minutes maximum waiting time	Quality	Patients Practices
Shorter waiting times to get a booked appointment	Local performance indicator in service specification - X days maximum waiting time	Quality	Patients Practices

Key Milestones (stages of the project plan)

Start Date	30/04/2015		

	Decide	Design						Develop (**TBC**)			Deliver (**TBC**)			
	Gate 2 (PID approval)	Draft engagement plan	Baseline report on current provision	First Steering Group	Other models of delivery report	Engagement report	Options appraisal at CEG							
Target Completion Date	30/07/15	31/08/15	31/08/15	17/9/15 (at latest)	31/10/15	30/11/15	07/01/16 (at latest)							

Project Resource Requirements

Project Team:	Role:	Time commitment:
Alexandra Bigg	Project Manager	2-3 days per week
Janet Edmonds	Head of Clinical Programmes - planned care oversight	1 hour per week
Jon Doyle	Clinical Lead	1 hour per week
Sam Burrows	Information Analyst	1 hour per week
Liz Munro	Communications and Engagement	2-3 hours per week
TBC	Project Support Officer	1 day per week
TBC	Finance	Not required as yet

Additional Resource Requirements:

None as yet

Quality Implications (of an amended service following the review)				Risk Score Complete for Negative Impacts		
Area of Quality	Quality Domain	Description of Quality impact	Positive, Negative, Not	Consequence	Likely-hood	Score
Clinical Effectiveness	1. Preventing people from dying prematurely	n/a	No impact			0
	2. Enhancing quality of life for people with long-term conditions	Improved access to phlebotomy services - closer to home and shorter waits so blood test results can be received and analysed more quickly to inform ongoing treatment.	Positive			0
	3. Helping people to recover from episodes of ill health	Improved access to phlebotomy services - closer to home and shorter waits so blood test results can be received and analysed more quickly to inform ongoing treatment.	Positive			0
Patient Experience	4. Ensuring that people have a positive experience of care	Improved access to phlebotomy services - closer to home and shorter waits so that patients are not unnecessarily inconvenienced.	Positive			0
Patient Safety	5. Treating and caring for people in a safe environment and protecting them from avoidable harm	The project is focused on access, not safety. Any changes to phlebotomy service provision that come out of the review would be subject to existing service specification quality and safety requirements.	No impact			0
Workforce		Possible change in distribution/location of staff offering the phlebotomy service - mainly HCAs. E.g. if an increased number of GPs offer phlebotomy and therefore fewer walk-in appts are required. Need to bear in mind the KCH block contract for pathology services and the staff employed through the outpatients budget.	Not yet known			0
Equality		Increase equity in terms of access to services, particularly for vulnerable or frail patients.	Positive			0

ESTIMATED ANNUALISED IMPACT ON TARGET / BUDGET FOR THIS ACTIVITY

(all categories of benefit and cost to be included, and net benefit calculated for financial projects)

Gross BENEFIT / Target Units (e.g.. clients/consultations)						INVESTMENT / DEVELOPMENT COST (£000s)						
Benefit Description and Units	No. of Units / Activity	Cost / Tariff (£000)	Full Year Benefit	Full/ Part Year 2015/16	Full Year 2015/16	Category	No. of Units / Activity	Rate (£000 / Unit)	Full Year Cost	Full/ Part Year 13/14	Full Year 14/15	Full Year 15/16
Not yet known						Engagement	n/a	n/a	6.0			
						NB. £4k of engagement costs will be covered by the Comms and Engagement money already set aside for Healthwatch work						
Gross BENEFIT Totals:			**0.0**	**0.0**	**0.0**	**Investment / Development Costs Totals:**			**6.0**	**0.0**	**0.0**	**0.0**

Activity Target Units			
Activity Description	HRG / ICD10 or other measurable unit of activity	Full/ Part Year 15/16	Full Year 15/16
Not yet known			
Activity Impact Totals:			

NET BENEFIT (£000s)			
	Full/Part Year 2015/16	Full Year 2015/16	Full Year 2016/17
Gross Benefits	0.0	0.0	
Costs	6.0	0.0	
Net Benefits	**-6.0**	**0.0**	

Risk and Issues Log	Confirmed
Stakeholder Plan	In draft - to be confirmed at Steering Group

Gate 2 Title	Sign-off / Recommendation / Decision	Name	Date
Project Lead		Alexandra Bigg	
Clinical Lead		Jon Doyle	
Finance Lead			
Performance Manager			
Quality Director			
Programme Board			
Clinical Executive Group			

Appendix B

INITIAL SCREENING FOR EQUALITY IMPACT ASSESSMENT

At this stage, the following questions need to be considered:

Name of Policy / Strategy / Service redesign etc.			
1	What is the name of the policy, strategy or project? *Phlebotomy review*		
2	Briefly describe the aim of the policy, strategy or project. What needs or duty is it designed to meet? 1*) To gain a full understanding of current phlebotomy provision (where phlebotomy is offered and when, and what the balance of activity is between hospital, community and GP services) and the extent to which it is meeting the needs of service users.* *2) To observe examples of best practice in other boroughs to help inform the options appraisal.* *3) To make recommendations for the future of phlebotomy provision.*		
3	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any group/s?	**Yes**	**No**
4	Is there any evidence or other reason to believe that different groups have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups? *We recognise that frail and vulnerable people, workers, children and those with LTCs have different needs, and therefore the engagement plan looks to gather the views of as many different groups as possible in order to ensure that no group is adversely affected.*	**Yes**	**No**
5	Has prior consultation taken place with organisations or groups which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address? *There was some consultation in the lead up to the revised 2011 LES, but this did not reveal a problem with a particular group. The proposed engagement plan will be a much more comprehensive engagement piece.*	**Yes**	**No**

Signed by the manager undertaking the assessment:	Alexandra Bigg
Date Completed:	24/7/15
Job Title:	Coordination and Delivery Manager

On Completion of Stage 1 – A full impact assessment (Appendix 2) will normally be required if you have answered YES to one or more of questions 3, 4 and 5 above

Health and Wellbeing Board
Report on the Adult Services Stakeholder Conference – Living Well with Dementia – March 2015

1 Summary

This report provides an update on the Adult Services Stakeholder Conference – Living Well with Dementia in Bromley held in March 2015 and the outcomes arising from it. The report also outlines how the second Living Well with Dementia in Bromley Conference, to be held in November 2015, will take forward any outstanding issues and also look at how delegates can help to make Bromley a dementia friendly community.

2 Adult Services Stakeholder Conference – Living Well with Dementia in Bromley – 11 March 2015

The aim of the Conference was to explore how the lives of those impacted by dementia could be improved so that people with dementia can continue to live independently in their own homes. The community, outside of the health and social care sector, has an important role to play in contributing to a dementia friendly community.

Prior to the Conference an engagement exercise was carried out with over 150 people through an online survey, face to face sessions and focus groups which gathered information on: positive and negative aspects of life with dementia in various areas of everyday living; accessibility of information, advice and guidance; the practicalities of living independently at home and support for carers.

The Conference was attended by 64 delegates including those from the health and social care sector as well as those from other businesses and organisations such as intu Bromley, Mytime Active, the Diocese of Rochester, JobCentre Plus, Bromley Police and other parts of Bromley Council.

During the Conference delegates built on the intelligence gathered previously and carried out the following tasks: mapping of existing dementia specific and generic services and activities; identification of gaps in support and activities including how they can be filled and commitments by delegates as individuals or for their organisation to improve the lives of people with dementia and their carers.

3 Outcomes of the Conference

The following outcomes were achieved at the Conference:

- 50 services and activities were mapped
- 7 areas highlighted as gaps or issues:
    - **Information, advice and guidance** – lack of a central information source about services and activities, assistive technology, benefits, Lasting Power of Attorney
    - **Geographical gaps** in areas of the borough as services and activities tend to be clustered and not always easily accessible to all
    - More **activities** that are affordable and open 7 days a week.
    - **Respite and support for carers** that is specific to people with dementia, can provide personal care if necessary and can be accessed at short notice.

    - **Isolation -** people who live alone and are unknown until a crisis occurs or who spend one day at a day centre and otherwise remain at home
    - **Acceptance and understanding** in the community
    - **Inclusion of people from ethnic minorities** – currently there is a low take up in services
- 59 commitments by individuals or organisations to improve the lives of people with dementia

4 Post Conference Outcomes

Since the Conference the following outcomes have been achieved directly as a result of the Conference:

- Creation and continuing development of the dementia section of Bromley MyLife to act as a central source of information for people with dementia, their carers and families and professionals. This includes the services and activities mapped at the Conference. Since it was launched during Dementia Awareness Week in May 1,800 unique individuals have visited the site viewing 3,000 pages.
- So far we are aware of over 10 Dementia Friends Awareness Sessions have been held training approximately 200 people. Others have also taken part in the on-line training. Those who have had the training are currently being contacted to understand the impact that this had had on them in their personal and professional lives.
- Information stand at intu Bromley to promote: services and activities provided in Bromley; the dementia section of Bromley MyLife and the launch of the Bromley Dementia Action Alliance.
- Promotion of dementia awareness and training in all pharmacies in the borough
- Increased awareness of dementia among Public Health's Health Champions
- Information relating to carers of people with dementia has fed into the Bromley Joint Carers Strategy currently being written.

As well as quantifiable outcomes of the Conference, the goodwill and enthusiasm generated among delegates has prompted them to continue to work together with other delegates. This has been manifest in several new organisations planning to join the Dementia Action Alliance and maintaining links between organisations to work more closely together or learn from existing groups as they establish new dementia focused activities.

Although it is not possible to attribute these directly to the Conference new services and activities have been commissioned or established in the borough such as: five new dementia cafes – two incorporating exercise sessions; a dementia unit at one of the older people day centres; Saturday opening of another day centre and work is being undertaken to promote the uptake of services among BME communities.

5 Living Well with Dementia in Bromley – November 2015

Much has been achieved in consequence of the first Living Well with Dementia in Bromley Conference as well as progress through Better Care Funding raising the number of people in Bromley who have been diagnosed and the planned Post Diagnosis Support Services. However, there remain some outstanding issues raised at the first Conference which could be progressed further. Therefore a second Conference is being held in November to take issues such isolation and support for

carers forward through community groups and volunteers working with established services and groups where appropriate.

Additionally further engagement with people with dementia and their carers prior to the Conference aims to monitor how dementia friendly Bromley is at this stage compared to views given at the beginning of the year and establish a baseline for future engagement. By establishing these views in the eight areas highlighted by the BSI Group (formerly the British Standards Institution) delegates to the Conference will then be asked how they, as individuals or organisations, can help Bromley work towards becoming a Dementia Friendly Community.

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TB in Bromley

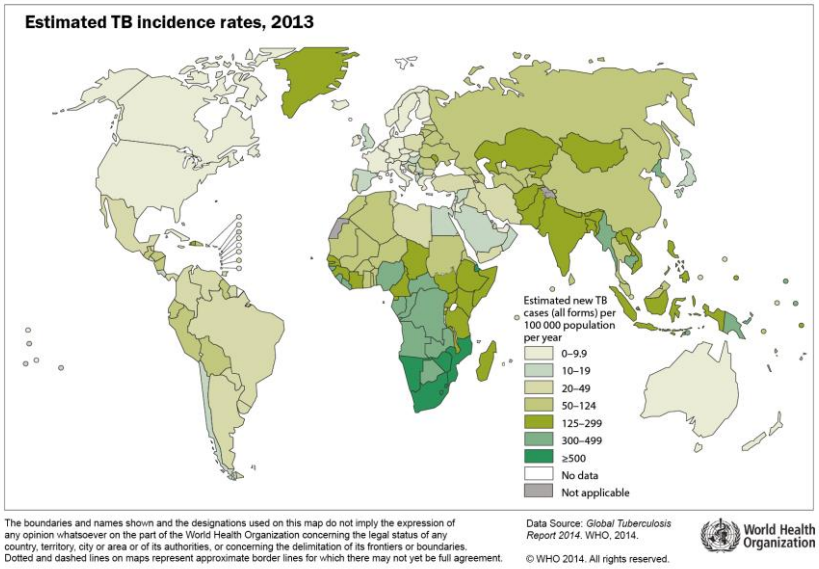
South East London Health Protection Team, Public Health England

Tuberculosis or "TB" is a bacterial infection caused by some of a group of bacteria, the Mycobacterium, i.e. M. tuberculosis, M. africanum or M. bovis. The infection usually affects the lungs but it can affect any other part of the body. It is only individuals with lung (pulmonary) or laryngeal TB who are infectious to others. It usually only spreads after prolonged exposure to a case and so TB most commonly spreads within families who share a household[i,ii].

Unlike many other respiratory infections, TB disease develops slowly and it may take many months for symptoms of infection to occur. Common symptoms include weight loss, loss of appetite, fatigue, fever, cough and shortness of breath.

Following exposure to TB, some individuals may acquire a latent infection i.e. they do not have an active infection but the organism remains dormant in the body. Up to 10% of individuals with latent infection will develop an active infection at some point but this may be years later, often prompted by a weakened immune system.

High rates of TB are seen in many parts of the world, in particular in parts of Africa, Southeast Asia, Russia, China, South America and the Western Pacific region.



http://gamapserver.who.int/mapLibrary/Files/Maps/Global_TBincidence_2013.png

Whilst anyone can catch TB, those most at risk of infection include:

- Those who have spent time in a country with high rates of TB
- Those who are close contacts of a case of pulmonary TB
- Those with a poor immune system, including the very young and very old
- Those with poor health, poor diet and problems such as alcohol or drug misuse
- The homeless
- Those living in crowded conditions.

TB can be treated with antibiotics. A course of several antibiotics is used and treatment usually lasts a minimum of six months. The proportion of cases with a multi-drug resistant TB has remained stable nationally, over the last 3 years, at 1.6%[ii].

TB in Bromley

The incidence of TB in Bromley remains very low (10 per 100,000 population) compared to the average rate in London (36 per 100,000). The table below shows the rate of TB per 100,000 population from 2002 – 2013[iii].

Young males between the ages of 20-39 years of age are most commonly affected. The most common ethnic groups affected are Indian followed by black African and just under 30% of cases in Bromley were UK born. These data should be interpreted with caution as the numbers of infections are very low and small changes cause artificially large percentage changes. However, it is important to monitor trends in the coming years to ascertain if there is a shift in the communities most affected by TB in the borough.

Treatment outcomes in Bromley were below average for London, with 79% completing treatment in 2013, compared to 86% in London. Outcomes are reported on the London TB register 12 months after notification and the target for treatment completion is 85%. Again, as the number of notifications in Bromley is low, caution is required when interpreting these data. Treatment completion may not meet this target due to a patient remaining on initially planned treatment (i.e. treatment extended beyond 12 months); because a patient has died (often not as a result of their TB) or because treatment is stopped when a patient is found subsequently not to have TB.

South East London Health Protection Team continue to case manage TB in liaison with primary care and local TB services. There have not been any recent clusters of TB requiring investigation in the local community but case and contact management and it's continued resourcing is key to TB control across London.

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[i] http://www.nhs.uk/conditions/Tuberculosis/Pages/Introduction.aspx

[ii] https://www.gov.uk/government/collections/tuberculosis-and-other-mycobacterial-diseases-diagnosis-screening-management-and-data

[iii] PHE Bromley TB Profile, unpublished 2014

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Public Health England

PHE London's response to the London Assembly Health Committee investigation into Tuberculosis in London 2015

Please find below a response from PHE London to the key questions posed by the London Assembly Health Committee to support their investigation into Tuberculosis in London.

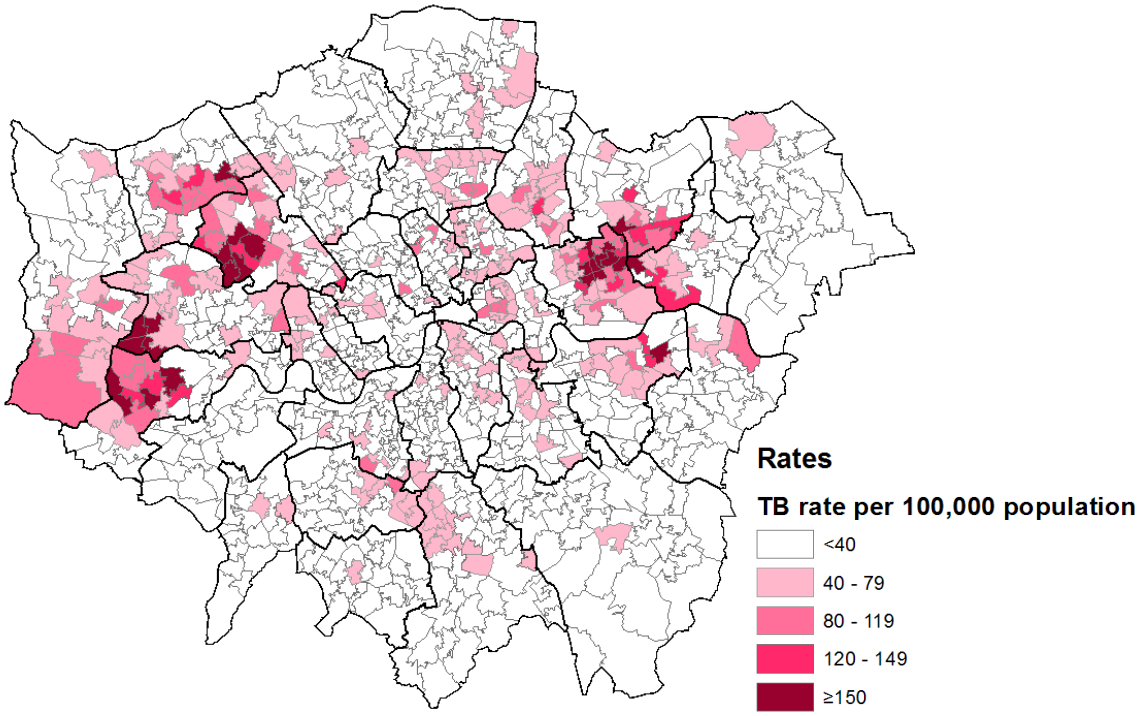
Why is it important to focus on TB in London now?

London has been called the TB capital of Western Europe; the number of TB cases has risen by nearly 50% over the last fifteen years and as a result, London has the highest number of TB cases of any major city in Western Europe. In the last few years TB rates have stabilised and begun to decline, but despite the best efforts of health and social care professionals, the disease remains an urgent public health problem, particularly for migrants and socially deprived and vulnerable groups. This is why Public Health England (PHE) London has made TB one of its priorities.

In 2013, 2985 tuberculosis (TB) cases were reported among London residents, a rate of 36 per 100,000 population. While this was a decrease of more than 10% compared to 2012, London accounts for 38% of the UK TB burden and its numbers and rates remain high compared to the rest of the UK and comparable western European cities.

Rates remain highest in the London boroughs of Newham (335 cases, 107 per 100,000 residents) and Brent (279cases, 89 per 100,000 residents) Rates at local authority level can, however, mask 'hotspots' of very high activity in smaller areas within London (Figure 1).

Figure 1: TB rates by MSOA of residence, London 2013



In 2013, TB rates were highest among males, and also young adults aged 20-39 years old. The majority (83%) were born abroad and rates in this group were approximately 10 times greater than those in the UK born. While the number and rate among non-UK born patients has decreased in recent years, the number of cases among UK born residents has remained stable, at around 500 per year – and more than twice the rate across the rest of the country (10 per 100,000, vs. 4 per 100,000). There were 141 cases in children aged less than 16 years, and 29 aged under 5 years (all of whom apart from one were born in the UK).

The number of cases among individuals who had recently entered the UK (less than two years prior to diagnosis) has decreased, and only accounted for 9% of all TB cases in 2013. Little or no change in case numbers has been seen among other non-UK born populations in London. Many cases have been resident in London for long periods of time prior to their TB diagnosis. Of note, it is estimated that only a third of TB cases in London are due to recent transmission.

The most common country of birth for non-UK born cases was India, although numbers born there fell 17% compared to 2012.

In 2013, 9% of London TB patients had at least one social risk factor (of homelessness, drug or alcohol misuse, imprisonment or mental health issues), and a third of these had multiple risk factors. Social risk factors were more common among TB patients who were UK born, male, white or of black Caribbean ethnicity. Patients with social risk factors had poorer treatment outcomes. TB rates were highest in the most deprived areas of London: 30% of TB patients were resident in the most deprived quintile compared to 6% in the least deprived.

Levels of drug resistance remain high in London, with 9% of TB cases resistant to one or more first line drugs and 2.1% multi-drug resistant. Drug resistance is more common among those with a social risk factor and also those with infectious forms of TB.

In London, 86% of patients with drug sensitive disease not involving the central nervous system completed treatment within 12 months. The most common reason for not completing treatment was being still on treatment. Four per cent were lost to follow up, and while the proportion dying was small (3%), TB caused, or contributed to, almost half of these deaths. Treatment completion was lower among those with disease involving the central nervous system, with 49% completing at 12 months and 37% still on treatment. Outcomes were much worse among those with drug resistant disease (including rifampicin, multi-drug resistant and extensively drug-resistant (XDR) cases): 53% had completed within two years, with one in four still on treatment and 18% lost to follow up.

Despite TB rates decreasing slightly in 2013, TB remains a serious public health problem in London, where rates are substantially higher than New York, other US cities and most European capitals. The decline is likely to be due in part to changes in migration patterns, as it was concentrated in young adults born abroad, who had recently entered the UK predominantly from the Indian sub-continent. The absence of a decline in other groups, particularly the UK born, suggests that further work is needed to address the burden of TB in risk groups in London. In addition, increasing numbers of drug resistant cases present a further challenge.

Public Health England

The London Annual TB Review (using 2013 data) released in Oct. 2014, updated the latest epidemiology of TB in London, describing the areas and populations at increased risk and in addition provides a two page **TB Profile** for each London borough (see links below for further information).

The London report makes recommendations on how to improve TB control in London these include the following:

- Continue excellent case management, including universal HIV testing, adhering to the national Royal College of Nursing guidance on TB case management as best practice.
- Ensure TB is being tackled among hard-to-reach groups with complex social needs:
- Commission and support highly-targeted case finding and prevention activities which focus on high-risk groups
- Implement recommendations from NICE guidance in these groups.
- Continue to tackle TB among other high risk groups, including implementation of NICE recommendations around screening for latent TB.
- Continue and expand cohort review as the tool to improve local TB control, including monitoring of outcomes for patients on longer treatment plans.

What are the main challenges for improving prevention, diagnosis and treatment of TB in London?

There are many challenges to improving the prevention, diagnosis and treatment of TB in London. These include:

1. Improving access to services and ensuring earlier diagnosis
2. Raising awareness of TB among patients and health care professionals
3. Providing universal access to high quality diagnostics
4. Improving treatment and care services
5. Ensuring comprehensive contact tracing
6. Improving BCG vaccination uptake
7. Reducing drug-resistant TB
8. Tackling TB in under-served populations, by improving access to and completion of treatment.
9. Supporting those TB patients who are homeless into accommodation; this has been shown to increase treatment completion and so reduce the chance of developing a drug-resistant form of TB
10. Systematically implementing new entrant latent TB testing and treatment
11. Ensuring fully staffed TB teams and an appropriate workforce to deliver TB control
12. Improving links to third sector organisations particularly those that engage with individuals at risk of TB

13. Social factors have a major role to play in TB infection, transmission and effective therapy. TB may infect and cause disease in people of any race or socioeconomic group. However, a number of factors work together to make certain groups and populations more vulnerable to acquiring TB, becoming unwell and transmitting the infection. All of these factors exist in parts of our capital city and therefore an approach to deal with TB that only focuses on the medical aspects of the illness is unlikely to be successful. Some of these key factors include:
    - Homelessness – increases the likelihood of exposure to TB but also makes managing the care and treatment of patients very difficult. The ‘Find and Treat’

service based at University College Hospital has particular expertise in managing this patient group but cannot reach all patients in London. The problems presented by homeless patients with TB are a strain on the resources of all TB treatment centres across London. A co-ordinated approach between health and social care will really help to address this issue

- Overcrowding/poor housing – is often linked to problems of poverty and homelessness. This is a real issue in some of our boroughs and increases the transmission of infection from active cases of pulmonary TB.
- Poor access to healthcare – some of our most vulnerable and marginalised patient groups are at an increased risk of developing TB but also have historically found it difficult to access consistent health and social care services. This increases the chances of late presentation and diagnosis, harm to the patient and transmission to others. It also increases the risk of treatment failure and/or the development of drug resistance.
- Drug and/or alcohol dependency – drug and alcohol use increases the risks of developing and also of dying from TB. This group requires specific support.
- Poverty – TB disproportionately affects people living in poverty throughout all countries and London is no exception. The impact that TB has on a family can make this significantly worse if the wage earner is unable to work.

There is an urgent need to invest more in services for TB diagnosis, treatment, and prevention, targeted at high-risk and hard-to-reach patients, alongside setting up new entrant latent TB testing and treatment programmes.

How do stigma and lack of awareness affect TB control in London?

Although TB is an infection that can affect absolutely anyone it still provokes a very negative response in many individuals, cultural groups and society in general. In its most extreme manifestation the social stigma of TB has led to individuals being excluded from friends, their community and sometimes even their families. This leads to some people having great difficulty with treatment compliance.

Tackling stigma and raising TB awareness will improve TB control in London in the long term; as these can lead to a delay in diagnosis, which can lead to a patient remaining infectious for longer, and therefore they have the potential to transmit their disease to others, for a greater length of time. Lack of awareness can be both from a patient's point of view and that of the health professional. Both need tackling in London if we are to bring TB under control.

Which agencies and organisations need to be involved in tackling TB in London?

- PHE London
- NHS England and CCGs
- The NHS
- The London Find and Treat Service
- Local Authorities
- TB Alert
- The Mayor and the GLA
- Migrant and refugee communities and community groups
- Schools and educational establishments

How can the Mayor and the GLA support the delivery of the national TB strategy in London?

The Mayor and the GLA could usefully support the delivery of the national TB strategy in London by:

- raising the profile of TB by speaking out about TB and those that it affects, and by so doing reducing the stigma associated with this disease
- through a targeted information campaign so that patients are more aware of the symptoms of TB and seek early testing and treatment. The Mayor could usefully use his TB Ambassador Emma Thompson to front a TB awareness raising campaign
- raising awareness of TB among patients should involve the local authority and community groups as well a direct TB campaign in higher incident boroughs
- ensuring a joined-up approach of active case finding, and testing and treatment for LTBI, by encouraging full involvement of statutory agencies and council departments, such as social care, housing, education and benefits
- encouraging and empowering the voice of people affected by TB. These individuals and groups are an important source of support and role models for others.
- review how third sector organisations could help improve access to services and patient support
- facilitate appropriate access to information and services for under-served populations, such as the homeless. Questions should be raised to determine whether screening, immunisation and treatment services reach out to diverse populations in London and are accessible to deprived or marginalised sections of the population
- supporting the work of the London TB Control Board, a multi-stakeholder group that coordinates a focused, city-wide, multi-agency approach to tackling TB. The London TB Control Board provides strategic oversight and direction to the control, commissioning, quality assurance and performance management of TB services across London

What examples of good practice are there in London (and further afield) in TB control?

Examples of good practice in London and the UK, that support improved TB control, include:

- The London Find and Treat Service – is a specialist outreach team that work alongside over 200 NHS and third sector front-line services to tackle TB among homeless people, drug or alcohol users, vulnerable migrants and people who have been in prison.
- The London TB Extended contact tracing team (LTBeX) is a multidisciplinary team assisting PHE London and NHS TB teams with the public health management of TB incidents and outbreaks
- Olallo TB Project - housing and supporting homeless Eastern Europeans with TB in London
- Regular TB Cohort Review
- Homerton Hospital TB team working in partnership with the London Borough of Hackney housing department have developed a service level agreement to house homeless people with no recourse to public funds

- Newham CCG working with local clinicians and GPs have developed a programmes of primary care based latent TB infection screening
- Screening for latent TB infection in students attending English for Speakers of Other Languages (ESOL) courses in Birmingham
- Citizens advice work with homeless TB cases in the West Midlands
- Refugee Council Screening in the West Midlands
- British Thoracic Society Multi-drug resistant (MDR) TB advisory service – supporting clinicians via a network of experienced clinicians who have treated MDR TB

Examples of good practice from the Netherlands:

- X-Ray van based TB screening which we now have as well in F&T, but we learned a lot from their approach
- Surveillance and systematic treatment of latent TB infection
- Specialist MDR/XDR TB sanatorium compatible with long-term inpatient treatment if required (months to years)
  - State of the art infection control
  - Access to activities of daily living, including kitchen, gym, social & outdoor areas
  - Comprehensive medical, social and psychological support
  - Facilities for enforced detention within the facility if required

Examples of good practice from New York:

- New York City TB Control Board led clear responsibility and accountability for TB control in New York City
- Quarterly Cohort Review for all patients, with findings fed directly back to those with responsibility for programme
- Large workforce of trained lay TB support workers: matched to patients by gender and ethnic group, provide on-going support with treatment completion
- Comprehensive contact tracing, including at least one home visit for every patient to build relationship and improve identification of contacts

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