Public Health England

PHE Board Paper

Title of meeting	PHE Board
Date	23 May 2014
Sponsor	Paul Cosford, Director for Health Protection and Medical Director
Presenter	Ibrahim Abubakar, Head of Tuberculosis Section
Title of paper	Tuberculosis – a public health threat

1. Purpose of the paper

1.1 The purpose of the paper is to brief the PHE Board on why tuberculosis (TB) is a public health priority for England, one of a handful of areas for special focus by PHE in 2014/15, and to discuss PHE's proposed approach assisted by an external panel of experts.

2. Recommendation

2.1 The Board is asked to:

a) **NOTE** the public health burden of TB in England and the successful launch of the Collaborative Tuberculosis Strategy for England 2014-2019 in March 2014;

b) **COMMENT** on the strategy (independently of the strategy consultation process) and the proposals PHE has identified about how it should organise and resource its services to tackle TB.

3. Introduction

3.1 TB incidence in England increased from the late 1980s to 2005, and has remained at high levels ever since. England now has the second highest rate of TB in western Europe, with over 8,000 cases diagnosed each year. Trends in England are in marked contrast to some comparable countries that have achieved consistent reductions by concerted approaches to TB treatment and control. If current trends continue, the total number of cases in England will exceed those in the whole of the United States within four years (Figure 1).

3.2 The rise in TB in England has predominantly affected deprived groups, especially migrants from high burden countries, and those with social risk factors such as homelessness, a history of imprisonment or misuse of drugs or alcohol. Action to tackle TB would therefore have an important impact on health inequalities.

3.3 TB is largely concentrated in a small number of high incidence urban areas, although complex multi-drug resistant cases can occur anywhere in the country.

3.4 Some areas have had notable achievements in strengthening TB services and

there is great commitment from those involved in delivering and organising services. However, despite that commitment, and despite the fact that there is good evidence of what works in TB control, overall rates are not reducing.

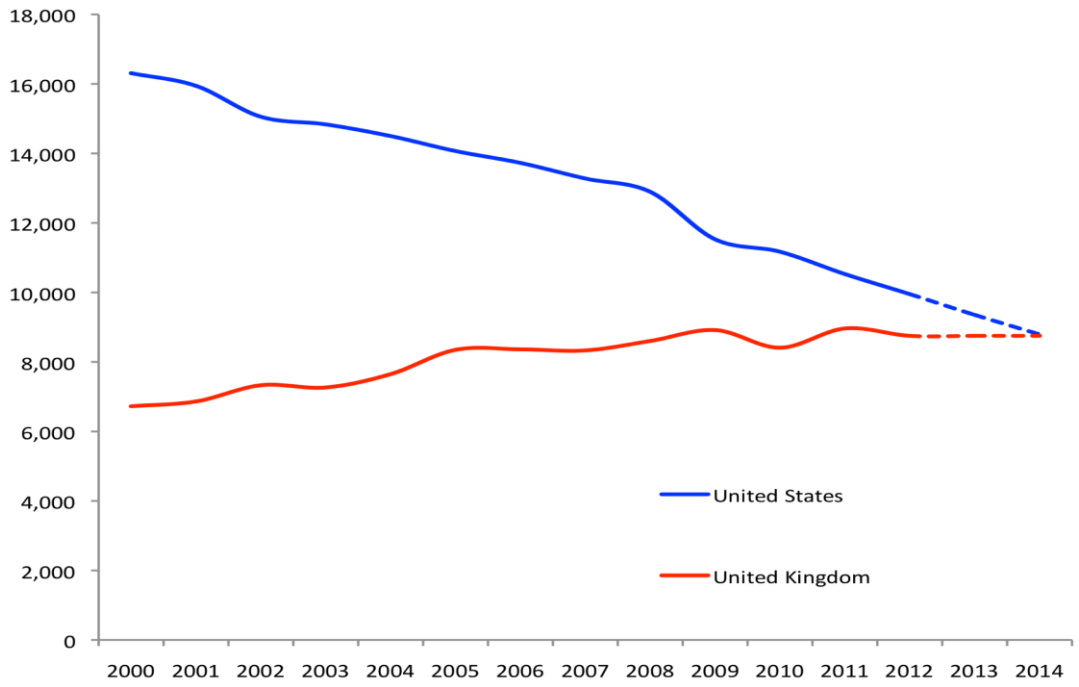

Figure 1 - Trends in the annual number of cases of tuberculosis in the UK compared with the USA. Dotted lines show projected numbers, assuming present annual percentage change continues for 2 more years. Prepared by and based on data from Public Health England's Centre for Infectious Disease Surveillance and Control (UK) and the Centers for Disease Control and Prevention (USA). (Zenner et al 2013)

4. The collaborative TB strategy for consultation

4.1 On World TB day, 24 March 2014, PHE launched a collaborative TB strategy for consultation (available publicly see Note 1) at a parliamentary event attended by the Public Health Minister and NHS England. The consultation period will end on 24 June 2014. The strategy aims 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, a reduction in health inequalities associated with the disease, and ultimately to the elimination of TB as a public health problem.

4.2 The strategy proposes a five point plan to achieve this aim:

a) **Develop TB accountability arrangements at an appropriate geographical level,** through the establishment of formal TB control boards with responsibility to plan, oversee, support and monitor all aspects of local TB control.

b) **Develop a clear evidence-based model service specification of the clinical and public health actions required to control TB,** based around 9 key areas of activity.

c) **Assess local services against the service specification and develop plans to secure improvements.** Local TB control boards will review the commissioning and provision within their area against the evidence based service specification, and ensure that commissioning arrangements are in place to secure both the clinical and public health aspects of these services.

d) **Develop the business case for establishing additional services to address specific gaps in current TB control arrangements.** In addition to addressing gaps in local services, explicit funding should be sought to establish an outreach service for under-served populations such as the "Find and Treat" service in London and to establish testing for, and treatment of, latent TB in new entrants from countries of high TB incidence.

e) **Strengthen national support for local TB control,** including nationally co-ordinated functions, such as reference microbiology services, surveillance and monitoring activities, research and development, workforce development and international measures, such as a quality assured pre-entry screening programme and contribution to global TB control efforts.

4.3 Progress on delivery of the strategy will be monitored through a suite of monitoring indicators produced by PHE, including measures of TB incidence, diagnostic delay, treatment completion, BCG uptake and contact tracing.

5. Challenges and opportunities

5.1 Overall accountability for TB control is currently unclear at both local and national levels, with responsibilities shared between a number of different organisations. Given the important public health consequences of under-investment in TB services, the opportunities and levers available in the new system to influence CCGs and local government to prioritise TB services should be utilised more effectively.

5.2 The development of local TB control boards will introduce improved accountability for TB control. However, it is important to recognise that achieving improved investment in local TB services may be challenging in the current climate. A proposal is being developed by NHS England to adopt some TB services as a specialised commissioned service, which if successful would help to ensure that funding for several elements of TB control is secured.

5.3 Commissioning and funding arrangements for several interventions proposed in the strategy, including active case finding in underserved populations and latent TB screening, needs to be secured. Additional resources will also be required within PHE to provide the proposed strengthened TB control functions at local and national level.

5.4 PHE and NHS England are currently scoping the costs of these proposed interventions, completion of which would allow NHS England to co-sponsor the strategy. Full costing of the strategy and clear agreements about the different organisational responsibilities will be required to achieve full co-ownership.

6. Next steps

6.1 a) Complete the strategy consultation process, including supporting PHE Centre Directors lead engagement with local stakeholders.

b) Work with NHS England to cost the different elements of the strategy, including those that will be delivered by PHE and those that will be delivered by NHS England.

c) Support NHE England to develop the proposal for the specialised commissioning of TB services.

d) Work with partners to finalise the collaborative TB strategy and implementation plan. This will be published in Autumn 2014.

Notes

(1) The *Collaborative Tuberculosis Strategy for England 2014-2019* and related consultation material is available on the PHE website:

http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317140970182

http://www.hpa.org.uk/Publications/InfectiousDiseases/Tuberculosis/1403TBstrategyconsultation2014/

(2) Other useful information may be found in the *TB in the UK: 2013 Report :*

http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317139689583