Scrutiny Review into

Tuberculosis in Kirklees

Kirklees COUNCIL

Governance & Democratic Engagement Service
Crown Court Buildings
Princess Street
Huddersfield
HD1 2TT

Tel: 01484 221000
Email: scrutiny.governance@kirklees.gov.uk

October 2014

CONTENTS	PAGE NO
1. Rationale for the review	**1**
2. Terms of reference and methodology	**1-2**
3. Background	**3-4**
4. Summary of evidence received - Background - Picture in Kirklees - Terms of reference 1 – 4	**5-14**
5. Recommendations	**15**
6. Action Plan	**16-20**

1. RATIONALE FOR THE REVIEW

1.1 In June 2013, Public Health put forward a suggestion that Scrutiny, as part of its work programme development for 2013/14, might want to consider undertaking a piece of work looking at Tuberculosis (TB) in Kirklees. The concern highlighted was that Tuberculosis (TB) remains a major public health issue for Kirklees.

1.2 The Well-Being and Communities Scrutiny Panel, which has the statutory responsibility for scrutinising Health services/partners agreed to consider the issue and requested a more detailed briefing.

1.3 In October 2013, Dr Ebere Orekere, West Yorkshire Health Protection Team (Public Health England) and Jane O'Donnell, Head of Health Protection, provided the Panel with an overview of the history of Tuberculosis and highlighted that since 2004 there had been a steady increase in the incidence of TB in Kirklees.

Following the briefing, the Panel decided to include TB on its 2013/14 work programme and established a Task Group to specifically look into issues relating to Tuberculosis in Kirklees.

2. TERMS OF REFERENCE & METHODOLOGY

2.1 The members of the Task Group were:

- Councillor Elizabeth Smaje
- Cllr Viv Kendrick
- Cllr Judith Hughes
- Peter Mackle (Co-optee)

2.2 The Task Group was supported by officers from the Governance & Democratic Engagement Service.

The agreed terms of reference were:

1. Review the approach and effectiveness of the communication around TB to local communities across Kirklees specifically in those areas with high levels of TB. To include a focus on awareness raising, health promotion and education initiatives.

2. Review the approach being taken to communication, treatment and management of TB by commissioners and providers (Clinicians) and how this compares with national guidance and best practice.

3. To review the role of key services in Kirklees in contributing to the communication, treatment and management of TB across the district. To Include:

- Establishing which services (including the voluntary sector) are currently involved;
- Determining gaps in provision and support: and
- Identifying which other services need to be involved.

4. To explore the approach being taken to TB in other districts, and identify where good practice exists and how this can be replicated in Kirklees.

2.3 The Task Group carried out its work between November 2013 and September 2014 and interviewed the following people:-

DATE	WITNESS
18 November 2013	No witnesses – setting the terms of reference
20 January 2014	Informal meeting of Task Group members
6 February 2014	Dr Ebere Orekere, Regional TB Lead Jane O'Donnell, Head of Health Protection Kirklees Council
26 February 2014	Gillian Laurence, Assistant Director of Clinical Strategy (West Yorkshire) NHS England
17 April 2014	Jane O'Donnell, Head of Health Protection Kirklees Council Julie Oldroyd, Service Development Manager and Transformation Programme Manager NK CCG Kath Greaves, Practice Nurse, Governing Body Member for NK CCG Dr Mike Gent, Consultant in Communicable Disease Control, Leeds Catherine Mullarkey, Senior Specialist Health Visitor TB, Leeds Jackie Henderson, Senior TB Nurse, Locala
16 June 2014	Rachel Spencer-Henshall, Head of Health Improvement Kirklees Council Cliff Dunbavin, Operational Manager, Locala Jackie Henderson Nurse Specialist, Locala Nisar Myet, Operational Manager Locala
3 July 2014	Catherine Riley, Assistant Director Strategic Planning Dr Rehan Naseer, Consultant Respiratory Physician Ellie Sheehan, General Manager Deborah Howgate, Specialist TB Nurse, Locala Jackie Henderson Nurse Specialist, Locala
19 September 2014	Dr David Currie, Lead Respiratory Physician, Mid Yorkshire NHS Hospital Trust

3. BACKGROUND

National Institute of Clinical Excellence (NICE) recommends: ***People at risk of TB from vulnerable groups often have difficulties accessing health services through the usual routes. Working in partnership with the NHS and relevant voluntary community organisation to ensure services are effective and accessible will help people affected by TB to receive early diagnosis and treatment.***

What is Tuberculosis (TB)?

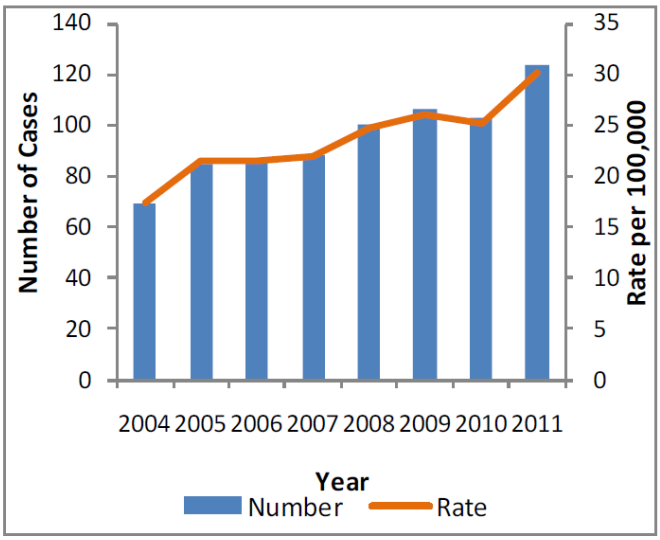
3.1 Tuberculosis (TB) is an illness caused by a bacteria called Mycobacterium Tuberculosis. TB most commonly affects the lungs, but can affect any part of the body. Most cases of TB are curable with a course of antibiotics, usually lasting six months or more.

3.2 TB in the lungs or throat is the only type of TB that can be passed on from person to person. When someone with TB in the lungs or throat coughs or sneezes, TB bacteria can get into the air where they can be breathed in by other people. The spreading of TB from person to person however, requires close prolonged contact, such as is found within households. TB is not spread by spitting or through sharing objects such as cups, plates and cutlery.

3.3 The most common symptoms of TB include a cough that lasts for more than three weeks, fever, night sweats, unexplained weight loss, fatigue and loss of appetite. Control of tuberculosis (TB) requires early diagnosis (before spread occurs) and effective treatment of cases and targeted screening of high risk individuals and groups.

Incidence of TB in Kirklees

3.4 Tuberculosis remains a public health challenge for Kirklees. Since 2004, there has been a steady increase in the incidence of TB in Kirklees (Figure 1), with a three-fold increase in the 25-34 year age group. The incidence of TB in Kirklees is higher than the national and regional averages and is amongst the highest rates in the UK, outside London.



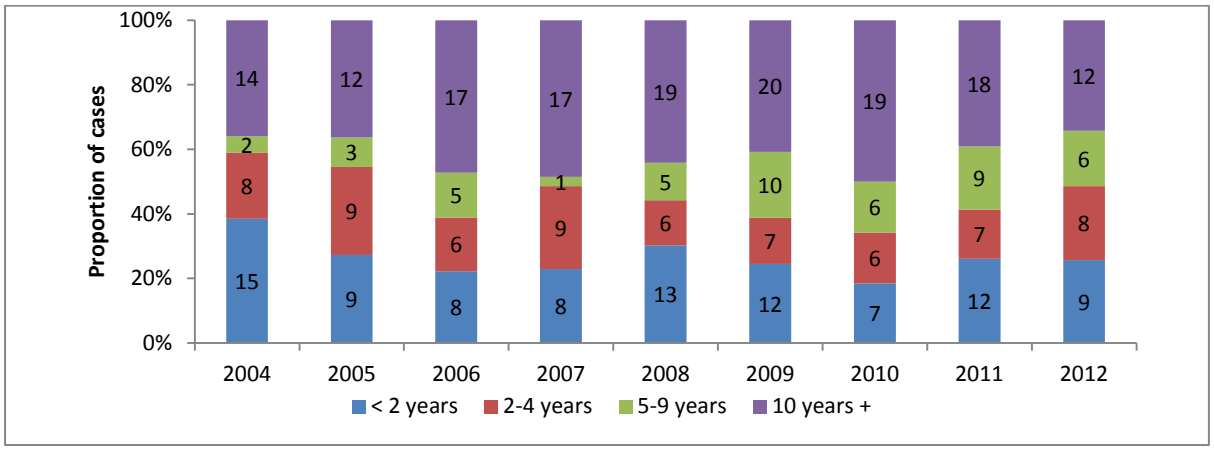
Source: ETS July 2012

Figure 1:

TB in Kirklees 2004 – 2011, no of cases and incidence rate per 100,000 population.

3.5 The district sees approximately 120 cases of TB each year with roughly half of the cases of Pakistani origin. Although the majority of cases are non-UK born, TB infection occurs many years after migration, indicating that there is an opportunity to intervene to prevent disease occurring (Figure 2).

Figure 2: Duration of residence in the UK at time of diagnosis



3.6 On average, over 50% of the TB cases reported in Kirklees each year came from people who were not born in the UK, however, the majority had been living in the UK for over 5 years before developing TB.

3.7 The majority of people with TB in Kirklees live in deprived parts of Huddersfield, Batley and Dewsbury. The association of TB to poverty is well established locally, nationally and globally.

3.8 In North Kirklees incidence of TB tends to be seen in people from South Asian population, whilst in South Kirklees it is seen in those from the homeless community and drug users.

3.9 Alcohol and drug misuse, homelessness and a prison record are the most commonly reported social risk factors for TB.

3.10 Transmission of TB in these so-called 'hard-to-reach groups' has contributed to clusters and outbreaks of TB in Kirklees.

3.11 Implementation of national policy and guidance for the prevention, management and control of TB has stabilised the rate of TB slightly but has failed to reverse the upward trend. Application of national guidance in Kirklees has been inconsistent.

3.12 The current reorganisation of the health and social care services and re-structuring of the Public Health function has highlighted the need for a fresh look at the challenges posed by TB in Kirklees.

4. SUMMARY OF EVIDENCE

Terms of Reference 1

Review the approach and effectiveness of the communication around TB to local communities across Kirklees specifically in those areas with high levels of TB. To include a focus on awareness raising, health promotion and education initiatives.

Communication, awareness raising and Training

4.1 The Task Group learned that Public Health had commissioned a piece of work to look at the increase of cases of TB, based on the fact that the TB nurses had indicated that there was a stigma around TB. The work identified that people were unaware that TB was a current, live disease within the Kirklees area. Findings indicated that whilst people showed no reluctance to visit a GP, they simply did not understand when they were at risk of contracting TB.

4.2 At the initial evidence gathering meetings the Task Group found that in Kirklees there was little or no communication within communities about TB; neither was any evidence presented which pointed to a coordinated approach or communication strategy to raise awareness and understanding of TB.

4.3 The Task Group researched other local authorities to identify the approach taken to raising awareness about TB and identified some areas where leaflets and additional information on TB were readily available.

4.4 No evidence was presented by Kirklees based organisations and services on a similar approach to awareness raising being available in the Kirklees area. The Task Group felt this was a fundamental omission and a coordinated communication strategy should be put in place as soon as possible and rolled out across Kirklees.

4.5 It was felt that the strategy should include how to minimise the risk of contracting the disease, identification of risk behaviours, understanding the risks of contracting TB whilst visiting other countries and bringing the disease back into local communities and recognising the symptoms of the disease. A number of countries were identified as high risk areas, these include, Afghanistan, Bangladesh, Brazil, Cambodia, China, Democratic Republic of Congo, Ethiopia, India, Indonesia and Kenya.

4.6 The strategy should seek to target local employers and schools as well as professionals and frontline staff to ensure that understanding of the condition is spread as widely as possible. There should also be greater awareness

raising within children centres as these were places where many families go for support and advice on a wide range of issues.

4.7 The Task Group subsequently, noted and welcomed the fact that the Council's Public Health was in the process of developing a communications strategy which would be shared with the Task Group at a draft stage.

4.8 The Task Group noted that previously there had been engagement work amongst individuals in Huddersfield that misuse alcohol. The mobile "Find and Treat" van was brought to Kirklees from London and located outside the Methodist Mission in Huddersfield. The mobile van provided x-ray diagnosis and point of care testing. The team had worked with the Methodist Mission to secure a free meal for people who were prepared to be tested. Of the 126 people tested during the day five cases of possible TB were identified. This was a high number, but not unexpected within the target group.

4.9 Public Health England and the Council's Community and Engagement Team had held an engagement event to highlight the risk of TB within local communities. The Engagement Team had received training so they could facilitate discussions to help raise people's awareness and understanding of TB. The team met with a range of people across various age ranges and diverse backgrounds mainly from South Asia and a few from Romania/Hungary.

4.10 The Task Group noted that the engagement event and subsequent study had concentrated on considering high risk communities, however, acknowledged that it was particularly difficult to engage with some of the high risk target groups.

4.11 Dr Ebere Okereke, regional TB lead had provided training to the Midwife Team who were in the position to identify new-born babies at potential risk of contracting TB. The Task Group noted that there was no training available for front line staff within the Council services, for example housing, environmental health, even how to identify TB and all the risks associated with it. The Training and Development Service confirmed that there was no information available for Council staff as part of the corporate training programme.

Task Group views – TOR 1

It was the Task Group's view that there was evidence of a general, cross cutting lack of understanding of the risks of contracting TB in visiting other countries and bringing the disease back into local communities. There was no communication around prevention and ensuring people understood the risks associated with travel and extended stays abroad.

The Task Group felt that engagement work carried out by Public Health England and the Council's Community and Engagement Team was a positive step towards raising awareness about TB. It was however, the Task Group's view that given that Tuberculosis remains a public health challenge for Kirklees, there should be a more concentrated and sustained programme of events to raise awareness about the disease and challenge the myths and stigma associate with the condition.

The Task Group also welcomed the fact that some training with health professionals had been undertaken for example the training provided by Dr Orekere who provided training to the Midwife Team who were in the position to identify new-born babies at potential risk of contracting TB.

The Task group felt that much could be learned from the pilot taking place in London where health professionals from other disciplines such as diabetic nurses, were being trained to identify symptoms of TB. It was the Task Group's view that training should be available in Kirklees and extended to include health professionals engaged in community based work, local authority front line staff and those from the voluntary and community sectors.

Terms of Reference 2

Review the approach being taken to communication, treatment and management of TB by commissioners and providers (Clinicians) and how this compares with national guidance and best practice.

Nice recommends: Local authorities should work with the NHS to support informed commissioning and ensure services reflect the needs of their area, as identified in the Joint Strategic Needs Assessment in areas of high need.

Health Protection Agency, Regional summary of Tuberculosis in Yorkshire and Humberside 2011 – " We need to increase the capacity of our TB specialist services and ensure that they are able to provide a service that is evidence based, efficient and designed around the needs of their patients."

4.12 The Task Group sought to explore the approach taken by the commissioners and providers with regard to the treatment and management of TB services across Kirklees. In addition, the Task Group also considered evidence on the approach taken by Leeds as it is recognised that Leeds has the most expertise in managing TB and deals with some of the more complex cases from across the region.

Contract Commissioning Arrangements

4.13 Following discussions with the Clinical Commissioning Groups the Task Group identified that there was some confusion around who was responsible for the commissioning of TB services.

4.14 Dr Ebere Orekere and Jane O'Donnell informed the Task Group that in Kirklees, all clinical TB services are commissioned by the Clinical Commissioning Groups, except for highly specialised services which are commissioned by NHS England on a national basis. Hospital aspects of TB care in Kirklees are commissioned as part of bulk contracts for respiratory diseases, infectious disease and pathology services. TB community nursing services are commissioned separately under a defined contract

4.15 It was highlighted that there is currently no commissioned service for the social aspects of TB, which was felt to be a significant gap in the provision of TB care in Kirklees. It was also felt that there is an urgent need to engage social care, the housing sector and third sector services in the strategy to improve TB outcomes.

4.16 The Task Group was concerned that with services for TB being subsumed within a much larger Respiratory Contract there was a risk that clinicians would have to focus on other areas to the detriment of the services that were required to treat and prevent TB. Julie Oldroyd, North Kirklees CCG, informed the Task Group that they had identified respiratory as a priority and confirmed that the contract was due to be reviewed next year and that they would be looking at the approach used by Wakefield CCG.

4.17 Dr Okereke highlighted that there were measures that could be put in place to help reduce the cases of TB, these include:-

- Early diagnosis of latent[1] TB
- Reducing time from diagnosis to treatment
- Working with the hard to reach groups
- Ensure the course of treatment has been completed

4.18 The Task Group felt that with the long standing and increasing issues regarding the incidence of TB in the Kirklees district, consideration should be given to separating TB from the broader Respiratory Contract so that it would receive a more focused approach to care with appropriate levels of support. By separating the contract it would enable performance monitoring and the monitoring of the financial costs associated with TB care in the Kirklees district, which is difficult under the current arrangements.

Primary Care

4.19 In considering feedback from the community engagement exercise, the Task Group noted that there was a potential issue about the ability of GPs to diagnose TB. Anecdotal evidence indicated that whilst families provided information that should lead GPs to consider TB, it appeared that GPs were not always aware of the symptoms and therefore not screening at the earliest opportunity.

4.20 Gillian Laurence, Assistant Director of Clinical Strategy (West Yorkshire) NHS England informed the Task Group that under the GP core contract there was an expectation that the GP would not be expected to make the diagnosis but would refer the patient to the appropriate area. This would be the acute Trust who are responsible for diagnosing, treating, monitoring and prescribing medicines for TB.

[1] Is where a person has been infected with the TB bacteria but does not have any symptoms of active disease.

Acute based inpatient and outpatient services

4.21 The Task Group heard evidence which suggested that the way TB services operate in North and South Kirklees had remained separate as this was in part to do with the consultants and hospitals that the TB services worked with. This point was also highlighted by Dr Currie, Consultant MYHT, who stated that currently North and South work to a different policy and going forward it was important that they work to a shared common protocol, so that services for TB are seamless.

4.22 Within Calderdale and Huddersfield Hospital Trust, (CHFT) GPs can refer suspected TB patients directly to the consultants located at Huddersfield Royal infirmary and Dr Naseer was appointed at the beginning of 2014, to run a dedicated TB clinic. The clinic is quick access with referrals being seen within 2/3 weeks with rapid access slots for new referrals. Dr Naseer advised that the clinic is carried out in conjunction with the TB nurses and weekly meetings are held before each clinic to discuss difficult cases or problems the nurses may be encountering.

4.23 At Mid Yorkshire Hospitals Trust (MYHT) there is no specific contract for TB services and issues are dealt with on a bespoke basis, tailored around need. Diagnosis of the disease is often made by the TB nurses or GP and MYHT holds a consultant led clinic each Monday afternoon which is attended by the TB nurse where cases are discussed. Cohort Review has occurred across Calderdale, Kirklees and Wakefield every 4 months since April 2013. The Cohort Review is a systematic review of the management of every case of TB for treatment completion and contact investigation. The cohort is a group of cases that are presented over a specific period of time.

Diagnosis and treatment

4.24 The Task Group was made aware that there is an alternative test to the skin test available for diagnosing TB. This blood test called the IGRA (Interferon Gamma Release Assay) is used in Leeds and Wakefield and costs between £30 and £70 per test. Leicester and Blackburn also use this method and both had seen the number of TB cases decrease. The IGRA test reduces the need for other tests, so could potentially save money and a national study had shown it to be effective. The Task Group learned that Kirklees does not use the IGRA test because of the way in which the service had been commissioned.

4.25 The Task Group recognised that there was an inconsistency in the type of testing used to identify TB across the Kirklees district. There were different

costs associated with the different types of testing and it was down to Commissioner choice and budgets as to which testing approach was adopted. It is difficult to compare data when the same form of testing is not used across the district. Given that the commissioners identify testing mechanisms there is no option available for clinicians to use alternative, potentially better forms of testing.

4.26 The Task Group noted that there was a negative pressure room located at Calderdale Royal Hospital, the room is used to treat very high risk, contagious TB but had only been used on one occasion over the last two years. Pinderfields Hospital is currently being reconfigured to accommodate medical patients from North Kirklees and once the reconfiguration is complete there will be two negative pressure rooms.

4.27 Dr Currie informed the Task Group that negative pressure rooms are important for patients with possible Multi-Drug Resistant TB (MDR-TB), which fortunately is still very rare. If MDR-TB is suspected, the patient would be transferred directly to a negative pressure room. If MDR-TB is confirmed or still considered extremely likely, the patient would be transferred to Leeds Teaching Hospitals, if requiring ongoing inpatient treatment.

4.28 Dr Naseer advised that with Endobronchial Ultrasound (EBUS) and Thoracoscopy, CHFT now has a full complement of investigative tools for the diagnosis and investigation of Mediastinal lymph node, pleural and pulmonary TB.

<u>TB Nurses</u>

4.29 The Task Group noted that Locala was responsible for the employment of TB nurses located in both the North and South of the Kirklees district. The TB nursing services was developed in March 2013 and the nurses have a fundamental role in the communication, management and control of TB.

4.30 TB nurses are responsible for the ongoing care of patients once they have been discharged from inpatient care. Care includes ensuring that the course of medication is completed, which may take up to six months. Failure to complete the course of treatment can lead to reactivation of active disease or development of drug resistant TB. In some cases the TB nurse would be required to provide direct support that could involve visiting the patient 3 times per week.

4.31 The document Tuberculosis Case management and Cohort Review – Guidance for Healthcare Professionals states that one whole time equivalent

(WTE) case manager per 40 notifications of TB annually and one WTE for 20 notifications of TB that require enhanced case management.

4.32 Within Kirklees there were approximately 110 patients per year and 20 complex cases per TB nurse. By the time of the Task Group meeting in April 2014, there were only two FTE nurses working across Kirklees, with neither of those nurses permanently based in North Kirklees. Locala was considering options to build capacity within the team to address the issue of staff shortage.

4.33 The Task Group recognised the tireless efforts of the TB nurses and the critical role they play in supporting patients with TB in communities across Kirklees and commended them for all their work. The Task Group was however concerned that there was insufficient capacity to cover staff shortage and feels that the provider of the TB nurse service should address this as a priority to ensure that staffing levels conform to national guidance and that the service to patients does not diminish.

Task Group views – TOR 2

It was the Task Group's view that:

There should be better information and communication between the CCG and Public Health around where the responsibilities and accountability for TB services lie.

There should be a more coordinated and cohesive approach to the diagnosis and treatment of TB across both North and South Kirklees, with staff working to a common set of protocols based on best clinical practice and national guidance.

It was the Task Groups view that given that TB has a higher incidence in Kirklees, a negative pressure room facility should be available in either North or South Kirklees, as the only facilities that will be available will be based in Halifax and Wakefield.

Terms of Reference 3

To review the role of key services in Kirklees in contributing to the communication, treatment and management of TB across the district. To Include:

- **Establishing which services (including the voluntary sector) are currently involved;**
- **Determining gaps in provision and support: and**
- **Identifying which other services need to be involved**.

4.33 The Task Group did not consider this area in any depth, including discussions around voluntary sector provision, due to the complexity of earlier discussions relating to the commissioning of services. It was felt that these areas took precedence within the Task Group's work and if resolved some of the areas within this terms of reference would take shape.

New entrants to the UK

4.34 The Task Group noted that Health Protection had concerns that there was insufficient data concerning new entrants to the UK from high risk areas. On entry screening at UK airports ceased on the 31 March 2014, following a pilot in 15 countries of pre-entry screening.

4.35 The Task Group learned that there was a risk that new entrants may initially stay at a temporary address before moving to more permanent accommodation potentially in other areas of the UK. At this point they were likely to disappear off authorities systems and potentially increase infection risks in their permanent residence area. The Task Group considered that this issue linked closely to the lack of effective cross district communication concerning TB patients.

4.36 The Task Group was informed of a service being delivered from the University of Huddersfield because the university has many overseas students. Previously the TB service struggled to get them to attend clinics however, the university now has a GP who has worked on improving the service and ensured that the students attend the clinic and there is rigorous follow-up. Over the last 20 years there has only been 3 cases of TB, however there had been more cases of latent TB.

4.37 The Task group was informed that Public Health was running a pilot with 2 GP surgeries in North Kirklees and the pilot would help Public Health understand which approach was best to check new entrants, either via GP surgery or clinic. The pilot ran from 1 May 2014, for a period of 3 months.

Terms of Reference 4

To explore the approach being taken to TB in other districts, and identify where good practice exists and how this can be replicated in Kirklees.

Nice recommends: Local commissioners, and providers of TB services, should ensure multidisciplinary support, including enhanced case management, is available for people with complex social and health issues.

Information sharing/case management

4.38 The Task Group met with representatives from Leeds to discuss their approach to information sharing and case management. The Task Group was informed that the management and treatment of TB was a long term process and Leeds had been working on this initiative for at least a decade. The Task Group was informed that whilst the number of cases in Leeds was falling they were seeing an increase in drug resistant TB that was becoming more complex. Dr Naseer stated that difficult cases identified by CHFT are referred to Leeds TB team for opinion and therefore acts as a regional centre of expertise.

4.39 The Task Group noted that it was good practice to hold multidisciplinary team (MDT) meetings, and the approach taken in Leeds is to hold MDT meetings and involved different services, such as housing. The lead consultant for communicable disease control from Leeds advised the Task Group that he felt the multidisciplinary team would also benefit from the inclusion of a Social Worker to look at the wider issues that could affect some sufferers of TB, such as homelessness. The Leeds Centre had also undertaken a cohort review which looked back at cases of TB and identified the learning points to influence clinical practice.

4.40 The Task Group was impressed by the model of care employed in the Leeds area and noted that MDT meetings do not currently take place in Huddersfield because the physicians did not have commissioned time in their contract as TB was a hidden commission. However, Dr Naseer advised that cross site MDT meetings are held, co-ordinated by the Calderdale TB and attended by TB nurses, clinicians, microbiology and Public Health.

5 RECOMMENDATIONS

1) That the management and treatment of TB should be managed under a separate contract and not form part of the wider Respiratory Contract. Given the long standing and increasing issues regarding the incidence of TB in Kirklees, a separate contract would allow more focus on TB and would also enable financial monitoring to identify costs.

2) That the CCG and Public Health discuss where responsibility for TB services lie and develop clear governance and accountability pathways.

3) That the Communication strategy alluded to at paragraph 4.7 be developed as soon as possible and the programme of engagement and awareness raising aimed at reducing the stigma of TB be strengthened. In addition, those groups considered to be at increased risk of contracting the disease should be specifically targeted through children and community centres, religious establishments, employers and through outreach work.

4) That consideration be given to training Nurses from other disciplines such as diabetic nurses and Health Visitors to recognise the signs and symptoms of TB. This training should also be extended to the Council's front line workers who as part of their work may come into those considered to be at increased risk.

5) That the commissioning and delivery of TB services takes into account the future development and capacity of the service to meet future demand including the prevention of incidence of TB.

6) That the current deficit in staffing levels be addressed in order to ensure staffing ratios meet national guidelines. Adequate staffing levels will ensure that there is support for patients and that cases are followed up so that TB treatment completion rates for active TB and Latent TB infection are increased to reduce the risk of reactivation of disease and the development of drug resistant TB.

7) That there is a consistent approach to the diagnosis and treatment of TB across North and South Kirklees, based on a patient centred model of care, founded on best clinical practice and national guidance.

8) That Kirklees establish a multidisciplinary team approach to case management, as per the approach taken by Leeds. This should include health professionals and partners from the local authority and the voluntary sector.

9) That a West Yorkshire Centre of Excellence for the diagnosis, treatment and management of TB be developed.

SCRUTINY ACTION PLAN

Project: Scrutiny Review into Tuberculosis in Kirklees - Task Group

Lead Governance Officer: Jenny Bryce-Chan

			FOR COMPLETION			
No.	**Recommendation**	**Directorate and Cabinet Member(s) asked to coordinate the response to the recommendation?**	**Do you agree with the recommendations? If no, please explain why.**	**How will this be implemented?**	**Who will be responsible for implementation?**	**What is the estimated timescale for implementation?**
1	That the management and treatment of TB should be managed under a separate contract and not form part of the wider Respiratory Contract. Given the long standing and increasing issues regarding the incidence of TB in Kirklees, a separate contract would allow more focus on TB and would also enable financial monitoring to identify costs.	Directorate for Public Health Cabinet Member CCG	Yes Agree that TB should be performance managed independently but doesn't necessary need a separate contract – this could be a clearly identified service line within a	Within service delivery (Community and Hospital) TB are stand-alone services and so a TB specification will include outcomes and KPIs	This should be taken forward through our local TB Strategy Group and the spec and	To begin implementation October 2015

			contract	to measure performance. This would sit within any over-arching contract. Specification/outcomes/KPI's would be informed by the national work that is ongoing.	KPIs agreed with Public Health colleagues	
2	That the CCG and Public Health discuss where responsibility for TB services lie and develop clear governance and accountability pathways.	Directorate for Public Health Cabinet Member	Yes	Public Health will arrange a meeting with CCGs to discuss these issues.	Public Health and CCGs	Completed by April 2015.
3	That the Communication strategy alluded to at paragraph 4.7 be developed as soon as possible and the programme of engagement and awareness raising aimed at reducing the stigma of TB be strengthened. In addition, those groups considered to be at increased risk of contracting the disease should be specifically targeted through children and community centres, religious establishments, employers and through outreach	Directorate for Public Health Cabinet Member	Yes	Public Health will develop a communication and engagement strategy.	Rachel Spencer-Henshall	May 2015.

4	That consideration be given to training Nurses from other disciplines such as diabetic nurses and Health Visitors to recognise the signs and symptoms of TB. This training should also be extended to the Council's front line workers who as part of their work may come into those considered to be at increased risk.	Directorate for Public Health Cabinet Member CCGs Public Health	Yes Yes	Commissioners need to build training this into the contract. Can be built into the information requirements & training standards – would suggest that providers are responsible for delivering education across other services to ensure seamless care for patients – this would be managed through agreed outcomes and KPIs within the specification. Public Health will identify which frontline services are in touch with those at increased risk and will identify methods to deliver key messages to those staff members.	Contract Managers & Quality Board through local TB Strategy Group Jane O'Donnell	April 2015
5	That the commissioning and delivery of TB services takes into account the future development and capacity of the service to meet future demand including the prevention of incidence of TB.	Directorate for Public Health Cabinet Member	Yes	Public Health will provide support to ensure that the specification is effective in addressing prevention and provide the CCGs with up to date intelligence.	Jane O'Donnell	

		CCGs		Joint work with PH colleagues and providers through new CC2H specification to fully understand local demand and matching capacity accordingly. Local measures to manage activity will be included in agreed KPIs.	All	March 2016
6	That the current deficit in staffing levels be addressed in order to ensure staffing ratios meet national guidelines. Adequate staffing levels will ensure that there is support for patients and that cases are followed up so that TB treatment completion rates for active TB and Latent TB infection are increased to reduce the risk of reactivation of disease and the development of drug resistant TB.	Directorate for Public Health Cabinet Member CCGs	Yes	This would be included in the specification and agreed outcomes KPIs. Commissioners will ensure that demand & is reflected so that providers can demonstrate/evidence their ability to deliver the service, and performance managed.		From March 2016

7	That there is a consistent approach to the diagnosis and treatment of TB across North and South Kirklees, based on a patient centred model of care, founded on best clinical practice and national guidance.	Directorate for Public Health Cabinet Member CCGs	Yes	There needs to be joint commissioning by both CCGs across Kirklees with a common set of protocols. Agree. Would expect providers to agree with commissioners local pathways/protocols. To be reflected within CC2H. Commissioners will agree outcomes and KPIs and performance management arrangements.		To begin implementation October 2015
8	That Kirklees establish a multidisciplinary team approach to case management, as per the approach taken by Leeds. This should include health professionals and partners from the local authority and the voluntary sector	Directorate for Public Health Cabinet Member CCGs	Yes	CCG commissioning needs to include participation in a multi-disciplinary meeting as part of that service. Public Health could support this by ensuring that the right representatives from the Local Authority attend the meeting. This is specified within the CC2H specification to ensure		To begin implementation October 2015

				full integration.		
9	That a West Yorkshire Centre of Excellence for the diagnosis, treatment and management of TB be developed.	Directorate for Public Health Cabinet Member	Yes	Public Health will raise this issue with Public Health England to develop such a centre.	Jane O'Donnell	March 2015