Tackling tuberculosis in England: the PCT response to the challenge

Second National Tuberculosis Survey of English Primary Care Trusts

December 2009

Commissioning organisations and authors

The All-Party Parliamentary Group (APPG) on Global TB was established in 2006 by Andrew George MP (Liberal Democrat – St Ives and Isles of Scilly), Nick Herbert MP (Conservative – Arundel and South Downs) and Julie Morgan MP (Labour – Cardiff North) who jointly chair the Group.

The overall purpose of the APPG is to raise the profile of the global tuberculosis epidemic (which includes the growing incidence of TB in the UK) and to help accelerate efforts to meet international TB control targets. For more information please contact the APPG Co-ordinator: (Debbie@results-uk.org) or visit the website: www.appg-tb.org.uk

The British Thoracic Society (BTS), formed in 1982, is a registered charity and a company limited by guarantee. Members include doctors, nurses, respiratory physiotherapists, scientists and other professionals with an interest in respiratory disease. All join because they share an interest in the Society's main charitable objective, which is to improve the care of people with respiratory and associated disorders. The BTS does this by promoting optimum standards of care, advancing knowledge and disseminating research. For more information, please contact tb@brit-thoracic.org.uk or visit www.brit-thoracic.org.uk

TB Alert, founded on World TB Day 1999, is the only TB-specific charity working in the UK. It was set up by people who felt that with its long tradition of TB work, there should be a greater response in Britain as well as overseas to the resurgent threat of tuberculosis. The vision of TB Alert is the control and ultimate eradication of TB, and its mission is to increase access to effective treatment for all. The charity's objectives are: to increase access to treatment, improve the effectiveness of treatment, and ensure that the most structurally and socially disadvantaged people are not missed out of TB programmes. For more information, please contact info@tbalert.org or visit www.tbalert.org

The Royal College of Nursing (RCN) represents nurses and nursing, promotes excellence in practice and shapes health policies. Forums exist in key areas with elected members from the UK to act as experts in their particular field to inform and lead activities of the forums.

The current committee consists of a Chair and 6 RCN members representing England (London, Birmingham, Sheffield and Manchester), Scotland and Wales. The Tuberculosis nursing forum has approximately 800 members. For more information please contact the Forum Chair: (malcolm.cocksedge@bartsandthelondon.nhs.uk)

Report published December 2009

Report written by Debbie Laycock, Marc Lipman, Sheila Edwards, Mike Mandelbaum, Elias Phiri, Malcolm Cocksedge, and Ed Gyde

Foreword

At the age of seven I had clinical tuberculosis, and my decision to become a doctor was made there and then. I clearly remember three months of streptomycin injections into not much buttock - and taking various anti-TB drugs for over a year. The overall experience gave me a real fascination for medical progress in this area, empathy with TB patients, and also an awareness of the stigma sometimes still associated with TB. I counter this by being explicit about my own history and experience. So, as a former TB sufferer and a current consultant with an interest in the disease, I am grateful to be asked to write this foreword.

Firstly, I'd like to pay tribute to the pioneering work of Sir John Crofton, who sadly passed away in November. His professional and public battle to combat TB, lung disease and smoking, as a scientist, clinician, teacher, academic and global campaigner was an inspiration to us all.

TB, however, has re-emerged from the history books, with nearly 8,000 cases reported in England in 2008. Some of our major cities, including Manchester, London, Leeds and Leicester, are really on the front-line showing major rises in TB, and needing to tackle extremely challenging issues such as multi-drug resistance, and hard-to-reach groups.

I know that the Departments of Health across the UK take the issue seriously – and the last five years have seen a wealth of robust national evidence, guidance and policy from the Chief Medical Officer, National Institute for Health and Clinical Excellence, the British Thoracic Society and others. Ultimately, however, our fight against TB will be won or lost at a local and grass roots level. A well funded, co-ordinated and innovative operational response, involving many partners across the NHS and voluntary sector at local level, is needed to convert strategy into action on the ground.

I wholeheartedly support this report which includes the results of a follow-up survey of primary care trusts in England. It is imperative we evaluate the delivery of local TB services over time, and the survey demonstrates real progress: with increased funding, accountability, and awareness raising activities.

The battle, though, is far from won. The report also highlights that an urgent and increased focus is needed on the delivery of local TB strategies, screening high risk groups, needs assessment, and better partnership working.

I applaud the efforts of the British Thoracic Society, Royal College of Nursing and TB Alert in compiling and analysing this data - and also the All-Party Parliamentary Group on Global TB for keeping the issue high on the political agenda, stressing the importance of a strong holistic approach in our communities.

We ***are*** making headway, but there's some way to go. It's imperative that we all redouble our efforts, and work across sectors and disciplines, to turn the tide against TB.

Professor Peter Ormerod

Consultant Respiratory Physician
Royal Blackburn Hospital
President British Thoracic Society 2008/9

Abbreviations

APPG	**All-Party Parliamentary Group**
BME	**Black, Ethnic Minority**
BTS	**British Thoracic Society**
CMO	**Chief Medical Officer**
DPH	**Director of Public Health**
FOI	**Freedom of Information**
GP	**General Practitioner**
HPA	**Health Protection Agency**
HPU	**Health Protection Unit**
LA	**Local Authority**
LiNKS	**Local Involvement Networks**
MDT	**Multi-Disciplinary Team**
MXU	**Mobile X-Ray Unit**
NHS	**National Health Service**
NICE	**National Institute for Health and Clinical Excellence**
PALS	**Patient Advice and Liaison Service**
PCT	**Primary Care Trust**
RCN	**Royal College of Nursing**
SHA	**Strategic Health Authority**
SLA	**Service Level Agreement**
TB	**Tuberculosis**

Message of Thanks

The authors would like to thank all of the Primary Care Trusts (PCTs) who responded to the survey. With the issues of swine flu and postal strikes we understand that PCTs were already incredibly busy and so appreciate the time taken to complete the survey. We would also like to thank the Strategic Health Authorities who supported their PCTs in replying to the survey.

Special thanks goes to Ann Dennis and Sharon Haggerty for assisting in the design of the survey.

Executive Summary

The number of TB cases is still high in England – and Primary Care Trusts have the lead role in combating the disease locally.

Tuberculosis (TB) in England has been increasing since the late 1980s. The Health Protection Agency provisionally reported that there were 7,998 cases in 2008 – a rise of 2% on the previous year. All parts of the country and most Primary Care Trusts (PCT) report active cases every year. Very different issues face high and low TB incidence areas, but all need to be prepared to treat TB patients and effectively manage any associated infection control and public health issues. TB is not only a medically complex disease but also one that requires flexible and reactive commissioning which encompasses primary, secondary and tertiary care services. PCTs have responsibility for commissioning health services for the local population that they serve. The PCT should be the local leader on health, and to commission locally appropriate, fully staffed TB services.

National TB policy and guidance exists – but local NHS delivery has been audited by specialist bodies and charities, not Government

A Government Action Plan and Commissioning Toolkit exist to provide guidance to PCTs on commissioning local TB services. In addition, an abundant resource exists for PCTs in the shape of colleagues working in other PCTs. There are no national standards for TB against which PCTs are assessed. Furthermore, there has been no national evaluation of the Chief Medical Officer's Action Plan or Commissioning Toolkit to assess the degree to which they have been implemented locally. It therefore falls to TB organisations to audit PCTs.

The first national TB audit of PCTs was carried out in autumn 2007 by the British Thoracic Society and All-Party Parliamentary Group on Global Tuberculosis*. This second national TB audit therefore seeks to determine if progress has been made at PCT level in ensuring TB is made a priority and national guidelines implemented. The second national TB audit was carried out by the British Thoracic Society, Royal College of Nursing, All-Party Parliamentary Group on Global TB and TB Alert.

The second national audit of PCTs benchmarks progress

The second national TB audit, reported in detail here, seeks to determine if progress has been made at the PCT level to ensure that TB is a priority and national guidance implemented. It was carried out by the All-Party Parliamentary Group on Global TB, the British Thoracic Society, Royal College of Nursing and TB Alert.

Methodology - number of PCTs taking part has increased from 2007

To allow comparison with the 2007 PCT audit, the 2007 survey, with some modifications, was used as a basis for the 2009 audit. The survey was sent by post (along with a cover letter explaining its purpose) to PCTs on the 6th August 2009, with a follow up letter sent to non-respondents.

The results of the survey were collated into an Excel database and the data 'cleaned' to ensure no duplicates. All responses were completed adequately and no duplicates submitted. Therefore all 112 responses were included in the final analysis. In comparison to the 2007 PCT survey, the response rate increased from 66.4% to 73.7%.

* http://www.appg-tb.org.uk/documents/PuttingTuberculosisontheLocalAgendaFINAL.pdf

The results of the 2009 audit:

The majority of PCTs lacked a current strategy to tackle TB

Only 40% of PCTs had a strategy in place for TB. Worryingly, about a fifth of PCTs with a high TB burden (> 40 new cases per 100,000 population) had no TB strategy whatsoever. This shows limited progress since the 2007 survey - overall one fifth less PCTs are now either developing, or have completed, their TB strategy compared with two years ago.

Demographic changes may result in a rise in TB cases

Just over 50% of PCT respondents stated that they forecast potential changes in local demography which will impact on TB. Ninety seven percent indicated that this will likely result in a rise in the number of TB cases.

A range of NHS professionals were consulted in developing local strategies – but little or no input was sought from commissioning specialists and people with TB.

Of those PCTs with a written strategy, most consulted a range of health care professionals including TB consultants, specialist nurses and public health specialists. However, only 11% had involved commissioning specialists when producing their strategy. Of more concern; no PCT consulted service users or affected communities.

Nearly three quarters of PCTs included TB in public health report

Despite poor results for the numbers of PCTs having a local strategy, 73% of PCTs included TB in their annual public health report.

Significant increase in designated TB 'leads' spearheading local plans

Ninety three percent of PCTs now have a designated lead for TB. This is a large increase from that seen in the 2007 PCT audit where only 50% had a lead. Encouragingly, the PCT TB lead was also now much more frequently a senior public health member of the PCT than in 2007.

Seventy seven percent of PCTs stated that there was someone within the PCT with designated responsibility for TB commissioning. In over a quarter of cases, the PCT TB lead was the same person as the individual with responsibility for commissioning TB services. More than half of PCTs with a TB lead meet with the service provider lead for TB on a quarterly basis. 26% meet more regularly than this, though 4% have never met the service provider lead for TB.

Major variations in the existence of TB 'service level agreements' - 18% of local areas with high TB rates didn't have one at all

It was evident that large variations existed between neighbouring PCTs in regards to the services commissioned for TB.

Twenty nine percent of PCTs stated that they had a service level agreement (SLA) in place for TB services. An additional 8% indicated that they had an SLA for TB services in the community only. 22% also reported that they were in the process of actively preparing the SLA. Eighteen percent of PCTs in high TB burden areas had no TB SLA. This is particularly dismaying as it is little changed from that in 2007, where 32% of PCTs stated that an SLA was in place and 24% were preparing an SLA.

A large variety of stakeholders were involved in writing the SLAs. This included clinical TB specialists (93%), public health specialists (78%), primary care specialists (37%), TB service users and affected communities (22%).

TB services varied substantially across England

An area of concern is the apparent low number of specific activities contained within SLAs. For example, of the list of activities required within a comprehensive TB service described within the TB Toolkit[†], 66% of SLAs included provision for multidisciplinary TB clinics and 61% access to social care and support, 44% specific arrangements for the management of patients with complex social needs and 61% active case finding in high-risk groups. Only 39% included provision and management of long-term isolation facilities for TB patients.

Many PCTs have allocated increased funding to TB services

Sixty percent of PCTs highlighted that funding had increased for TB services over the past three years. This was related to TB incidence, in that 91% of PCTs in areas of over 40 new cases per 100,000 population reported a rise, compared to only 51% in areas with a TB incidence of less than 10 per 100,000.

TB awareness initiatives have increased, but vary in scope and depth

Seventy four percent of PCTs stated that they carried out health promotion/awareness raising activities for TB. These activities were varied and included promoting TB around World TB Day, raising awareness among GPs, other healthcare staff and educational institutions.

When asked to identify the target of the health promotion/awareness activities, 21% of PCTs stated ethnic minority groups, 20% organisations working with complex needs patients (or with the patients directly), 16% with refugees/new entrants and 10% with NHS colleagues. Only 7% targeted GPs specifically.

Only 50% of PCTs actively encourage service user input into health promotion and awareness activities and ensure that service users are encouraged to feedback on TB services received. Of this 50%, half rely on patient satisfaction surveys.

TB screening for 'new entrants' has increased – but there is no uniform standard

Seventy percent of PCT respondents have a system in place for TB screening of new entrants. However, there appears to be no unified national standard in place as a variety of information sources are used to identify new entrants. In the 2007 PCT audit 55% of PCTs stated that they had a new entrant screening plan in place and an additional 26% were actively preparing the plan.

The number of PCTs screening 'high risk groups' has dropped by 10% since 2007

Only 57% of PCTs carry out routine active TB screening for high risk populations. This is associated with local TB incidence: as 91% of PCTs in high burden areas (>40 per 100,000 population) carried out screening compared with 43% in areas with TB incidence less than 10 per 100,000. In the 2007 audit 67% of PCTs routinely screened high-risk groups.

Many of the PCTs in London highlighted the Mobile X-Ray Unit (MXU) as their main source of active screening in groups. With the future of the MXU uncertain due to a lack of financial input by PCTs, this area is at risk of being neglected in future years.

[†] Ref: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_075638.pdf Pg 15

Over a third of PCTs lack an 'agreed pathway' to deal with TB outbreaks

Only 61% of PCTs have an agreed pathway in place in the event of a TB incident or outbreak. An additional 21% were actively preparing a pathway.

Wider partnership working increases marginally, but 8 in 10 PCTs are now part of multi-disciplinary clinical networks

Only 47% of PCTs work in collaboration with local partners including local authorities and the not-for-profit sector. This is only a small increase since the 2007 PCT audit, where 44% of PCTs had developed working relationships with local partners.

Eighty percent of local PCT service providers are, however, part of a TB specific multi-disciplinary clinical network. This is a strong improvement on the 2007 PCT survey where only 67% were part of a local TB clinical network.

List of Recommendations

Recommendation 1: All PCTs (especially those in high burden areas) should have a coherent, locally relevant strategy in place to control and prevent TB through consultation with a wide variety of stakeholders including the local authority, commissioners and service users/affected communities.

Recommendation 2: All PCTs (especially those in high burden areas) should have an SLA in place with local service providers for TB services. This should be in line with the CMO's Action Plan, NICE Guidance and the TB Toolkit.

Recommendation 3: All PCTs should encourage meaningful service user/patient advocate input into TB service planning, provision and evaluation.

Recommendation 4: PCTs and Local Authorities should ensure that TB is included in Local Area Agreements, Joint Strategic Needs Assessments and local health implementation plans.

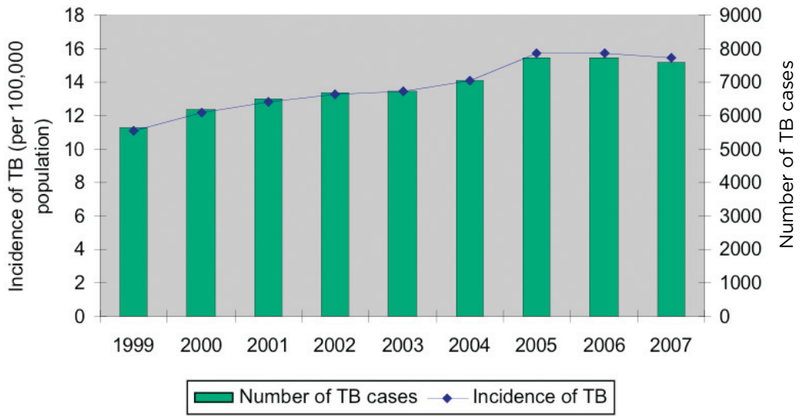
Recommendation 5: The UK Government should carry out an evaluation of the TB new entrant screening system in the UK, make a decision on whether it should continue in its current structure and provide guidance on sustainable ongoing screening programmes for settled migrants.

Contents page

1.0 Introduction

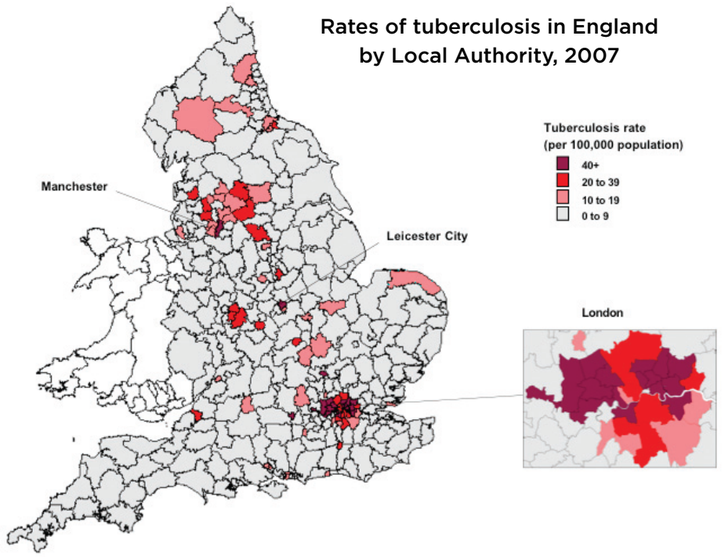
Tuberculosis (TB) in England has been increasing since the late 1980s. Whilst London sees 43% of the country's TB cases, the remaining 57% of cases are mainly (but not solely) concentrated in other urban areas e.g. Birmingham, Manchester, Bradford and Leicester. However, active TB is seen in all parts of the country and most Primary Care Trusts (PCTs) will have at least one case annually. Provisional data shows that TB rose again in 2008 - to nearly 8,000 cases in England.

Number and incidence of TB cases in England (1999-2007)



Source: http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1226565422987

Rates of tuberculosis in England by Local Authority, 2007



Source: Tuberculosis in the UK: Annual report on tuberculosis surveillance in the UK 2008 (Health Protection Agency Centre for Infections)

Very different issues face high and low TB incidence areas, but all need to be prepared to treat TB patients and effectively manage any associated infection control and public health issues. A failure to do so could lead to an outbreak of the disease or drug resistance, which financially burdens NHS Trusts and puts patients' lives at risk. For example, a case of drug resistant TB in the UK is estimated to cost 50 to 70 times more to treat than a patient with drug susceptible disease[‡].

TB is a public health issue

In order to reduce onward transmission, early diagnosis and treatment of TB is required. As many patients initially present to General Practitioners, it is vital that there are close working relationships between primary and secondary care organisations with respect to TB. In addition, to ensure that individuals at high risk of TB are able to recognise the symptoms and understand the urgency of seeking care when symptoms manifest, health promotion and awareness is essential in highly affected and at risk communities.

Commissioning TB Services

The result is that TB is not only a medically complex disease but also one that requires flexible and reactive commissioning which encompasses primary, secondary and tertiary care services. Historically, however, these have been usually commissioned separately; with most Acute Trusts not being paid for community work under Payment by Results (an issue where hospital based nursing staff need to do community visits). Equally, if a TB service is based wholly in the community there is the need for rapid diagnostic facilities to be locally available, as well as access to paediatric and HIV specialists when treating children or those co-infected with HIV/AIDS.

Primary Care Trusts have responsibility for commissioning health services for the local population that they serve. Therefore, it is the responsibility of PCTs to become the local leader on health; commissioning locally appropriate, fully staffed TB services. This requires an evidence-based understanding of the health needs of their local population.

What Government policies exist on TB? And what guidance is available to aid PCTs in commissioning TB services?

In 2004, the English Chief Medical Officer (CMO) published his TB Action Plan[§]. This document highlighted the TB problem in England and set out actions that should be undertaken in order to reduce rates of TB, including increased awareness and improved TB surveillance. The TB services that all PCTs provide should be working towards this National Action Plan; and PCTs should assess themselves against the measures of success highlighted by the CMO.

Clinical guidance on the diagnosis, treatment, prevention and control of TB was published by NICE in March 2006**.

Though the CMO's Action Plan stated what should be done, the change in the NHS health economy resulted in guidance being needed on how to implement the strategy locally and provide appropriate TB services. This came in the form of the TB Toolkit – a guide for PCTs and Acute Trusts on how to plan, commission and deliver TB services, published by the NHS in June 2007[††] .

‡ Reference: Page 6
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_075638.pdf
§ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4100860.pdf
** http://www.nice.org.uk/nicemedia/pdf/CG033FullGuideline.pdf
†† http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_075638.pdf

In addition to official guidance, another abundant resource for PCTs is their colleagues working in other PCTs. Many PCTs already provide high quality TB services and have formed well functioning clinical networks and multi-disciplinary teams. PCTs can learn from their neighbours or other regions with similar disease burdens.

Why carry out a national TB audit of PCTs?

There are no national standards for TB against which PCTs are assessed. Furthermore, there has been no national evaluation of the CMO's Action Plan or Commissioning Toolkit to assess the degree to which they have been implemented locally. It is not mandatory for PCTs (or Strategic Health Authorities) to publish local standards or evaluate services for TB. There is therefore no official in-depth national audit of the services provided locally for TB.

It therefore fell to TB organisations to audit PCTs. The first national TB audit of PCTs was carried out in autumn 2007 by the British Thoracic Society and the All-Party Parliamentary Group on Global Tuberculosis[‡‡]. The survey was sent to all English PCTs and 101 responses were received resulting in a response rate of 66%.

The major results of the survey included:

- 68% of respondents thought that local demography changes would lead to a rise in the local incidence of TB. No respondents were expecting a fall in TB rates in their local area
- Only 50% of PCT respondents had a designated PCT TB lead
- Only 30% of PCTs had a specific service level agreement in place for TB
- 41% of PCTs were not carrying out awareness raising activities for TB

The recommendations highlighted from the first national TB audit were:

- There should be a properly funded national TB awareness campaign, tailored to local circumstances, aimed at healthcare professionals as well as the general public
- PCTs must ensure that there is a clearly identified individual within their organisation who is charged with developing strategies for service provision for TB and ensuring that provision of such services meets, at the minimum, the TB guidelines of NICE
- PCTs should specifically identify and commission TB services in accordance with the guidance set out in the TB Commissioning Toolkit

‡‡ http://www.appg-tb.org.uk/documents/PuttingTuberculosisontheLocalAgendaFINAL.pdf

Progress has been made since this time

Following the first TB audit, the English Department of Health provided funding to TB Alert to develop culturally and contextually appropriate ways of raising awareness of TB, specifically among TB high risk groups. TB Alert works with PCTs, local authorities and third sector organisations to promote a model of working where social determinants of health are addressed more effectively. The charity encourages and supports the development of cross sector partnerships that take innovative approaches to raising awareness of TB, and that involve affected communities in local TB policy and programme development and delivery.

Other activities within TB Alert's UK awareness programme include: providing information to members of the public, patients and health professionals concerned about TB; public awareness campaigns, especially focused around World TB Day; undertaking research to support UK advocacy; and facilitating the TB Action Group (TBAG). TBAG is a network for people who are, or have been, affected by TB in the UK. The group aims to provide a patient voice within the TB sector and to raise awareness of the patient experience amongst health professionals. They work to increase the public profile of TB, to provide peer support to patients going through treatment and to help improve TB services in the UK, based upon their personal experiences.

The British Thoracic Society (BTS) has an active specialist advisory group (TB SAG) which fosters constructive links with other organisations working in TB to improve the care of those affected by the disease. The group is mid-way through supporting a project funded by the Department of Health encouraging greater collaboration between colleagues managing TB. The project aims to understand how current local groups are working within high and low TB incidence areas, and use this knowledge to develop resources to help new and established groups operate effectively. The work has provided the impetus to create a TB information library and also an online network for health professionals to share best practice and seek advice. In addition, BTS, in conjunction with General Practice In Airways Group (GPIAG), is in the process of producing a guide to commissioning TB services under their joint initiative IMPRESS.

However, despite this cross sector work, a survey of frontline staff carried out earlier this year by the BTS, RCN and APPG on Global TB found that only 17% thought that the TB Commissioning Toolkit had been fully implemented in their area. Only 45% said that TB services in their area were specifically commissioned by their local PCT. In addition, around a quarter of respondents regarded the priority given to TB by their local PCT as inadequate.

Objective and delivery of this second PCT audit

This second national TB audit therefore seeks to determine if progress has been made at the PCT level in ensuring TB is made a priority and national guidelines are implemented.

The second national TB audit was carried out by the All-Party Parliamentary Group on Global TB, the British Thoracic Society, Royal College of Nursing, and TB Alert; hereafter referred to as 'we' or 'the authors'.

2.0 Methodology

Writing of the survey

In order to allow comparisons with the 2007 PCT audit, the 2007 survey structure was used as a basis for the 2009 audit. However, ongoing feedback and ambiguous responses from the 2007 survey highlighted that a number of questions were unclear and needed to be modified. There were also a number of questions in the 2007 survey that needed to be expanded as additional information would be beneficial. In addition, there were some themes e.g. service user input, that were new to the 2009 survey. Some questions were written to elicit binary answers, whilst others were qualitative in nature, encouraging answers that would add depth and a greater understanding to current practices and services for TB.

The 2009 survey was written by personnel from the Royal College of Nursing TB Forum, British Thoracic Society, APPG on Global TB and TB Alert. In addition, service user and PCT input was sought to ensure questions were appropriate and accurate. The 2009 survey can be found in Appendix 2.

Dissemination of the survey

The survey was sent by post (along with a cover letter explaining the purpose of the survey) to PCTs on the 6th August 2009. Surveys were addressed to the Chief Executive of the PCT and sent to all 152 PCTs in England. The initial deadline for responses was set for 14th September 2009. In addition, a letter and copy of the survey was sent to each SHA requesting that they encourage their PCTs to respond.

A reminder letter was sent to non-respondent PCTs on 9th September 2009 and the deadline extended to 12th October 2009. A follow-up letter was also sent to SHAs on 21st September 2009 highlighting the PCTs in their regions who had not responded to the survey by that date.

We were contacted by a large number of PCTs before 12th October 2009 informing us that they would like to respond to the survey but needed more time owing to staff shortages due to the swine flu outbreak. In addition, a number of surveys were delayed due to the multiple London postal strikes. Therefore, a small number of responses were submitted after the second deadline date.

Analysis of results of the survey

The results of the survey were collated into an Excel database and the data was 'cleaned' to ensure there were no duplicates. The data was analysed using Excel. All responses were completed adequately and no duplicates submitted. Therefore all 112 responses were included in the final analysis.

3.0 Results

3.1 Responses

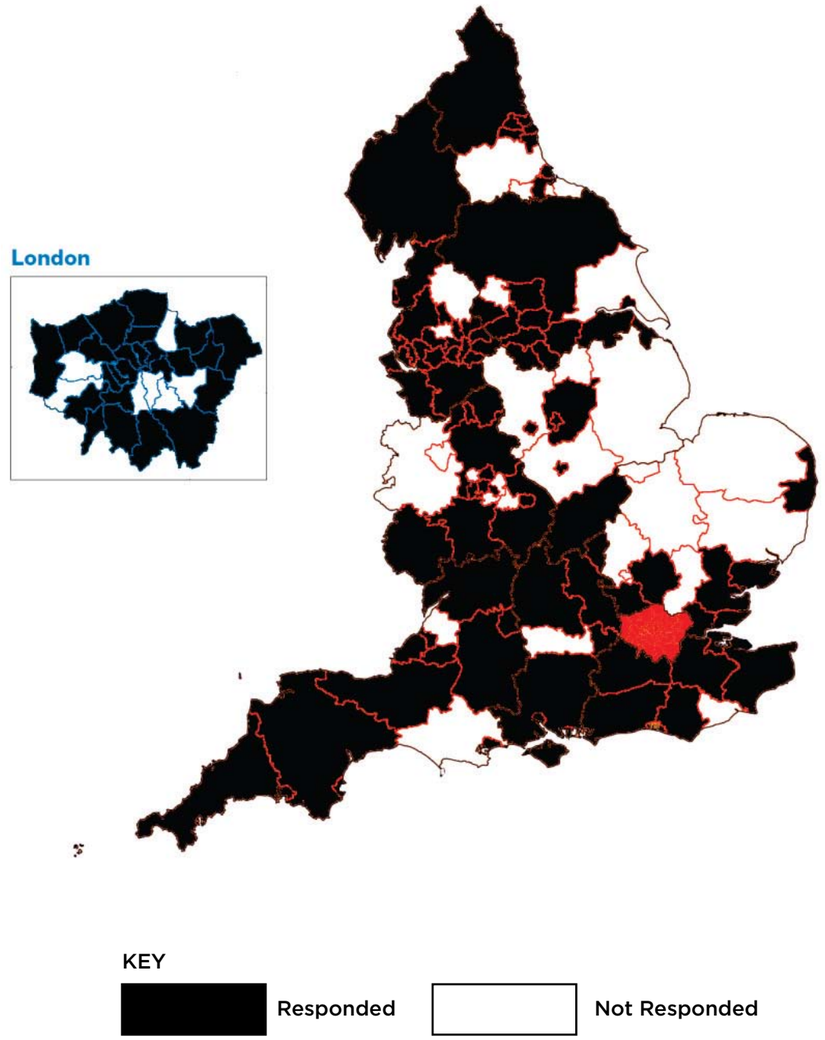
A list of the PCTs that responded to the survey can be found in Appendix 1.

Response rate

No. PCTs survey sent to = 152 No. Responses = 112

Response rate = 73.7% No. responses used in final analysis = 112

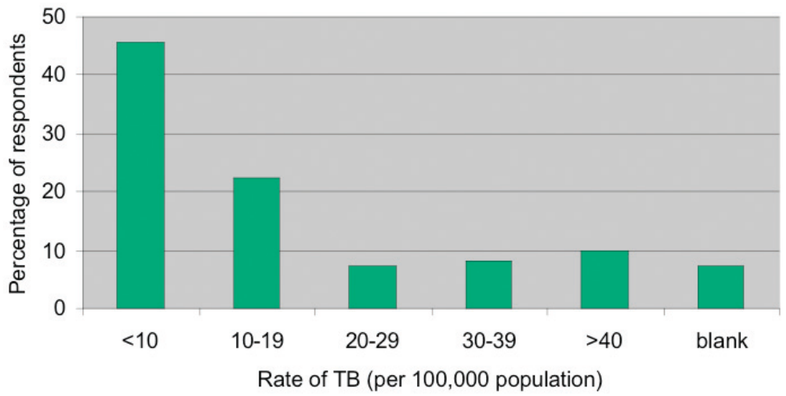
Location of respondents



Response rate by Strategic Health Authority

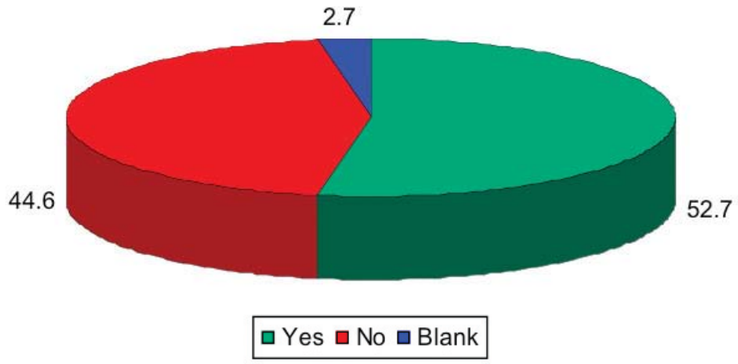
Strategic Health Authority	Response rate of PCTs within SHA Area (%)
South Central	88.9
South East Coast	87.5
South West	85.7
Yorkshire and the Humber	85.7
North West	83.3
London	77.5
West Midlands	68.8
North East	66.7
East Midlands	55.6
East of England	40.0

Local TB incidence of respondent PCTs (n=112)

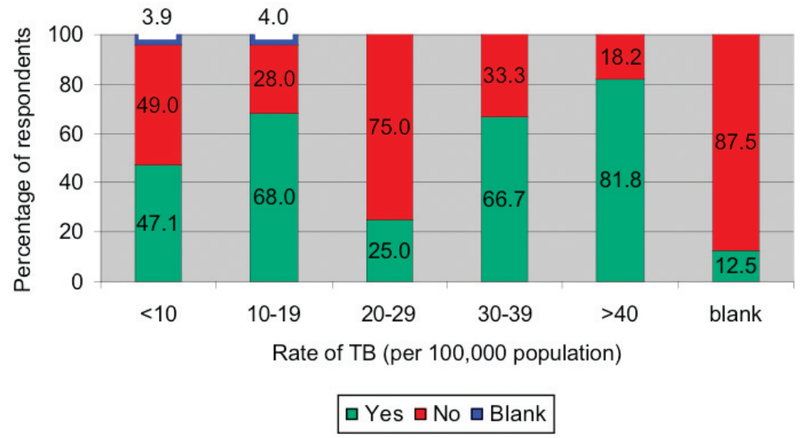


3.2 Future changes in TB incidence

Has your PCT forecast potential changes to its population demography that would affect TB incidence? (n=112) (%)



Breakdown by TB incidence (n=112)

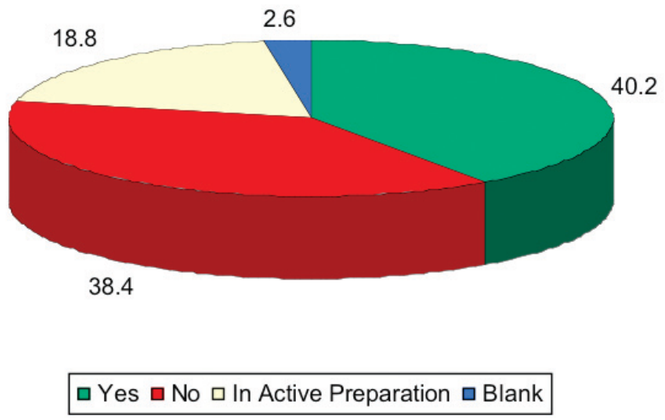


The likely result of these demographic changes (n=59)

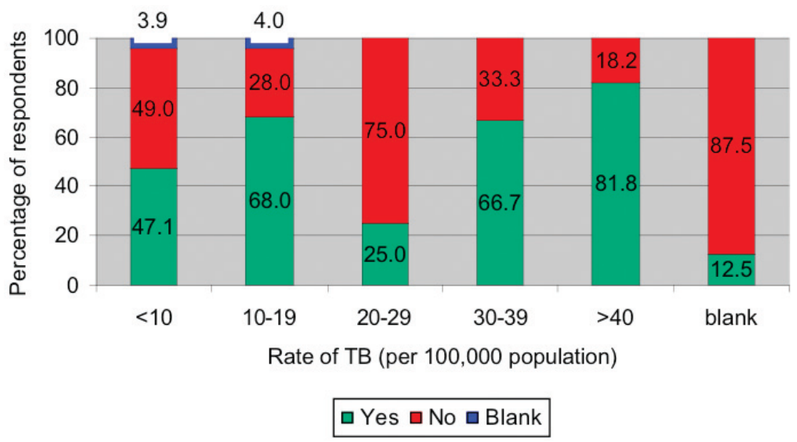
Likely change	No. respondents	% respondents
A small rise in the number of cases of TB	52	88.1
A significant rise in the number of cases of TB	5	8.5
A small fall in the number of cases of TB	1	1.7
Blank	1	1.7
A significant fall in the number of TB cases	0	0.0
TOTAL	59	100

3.3 TB strategy

Does your PCT have an agreed TB strategy? (n=112) (%)



Breakdown by TB incidence (n=112)

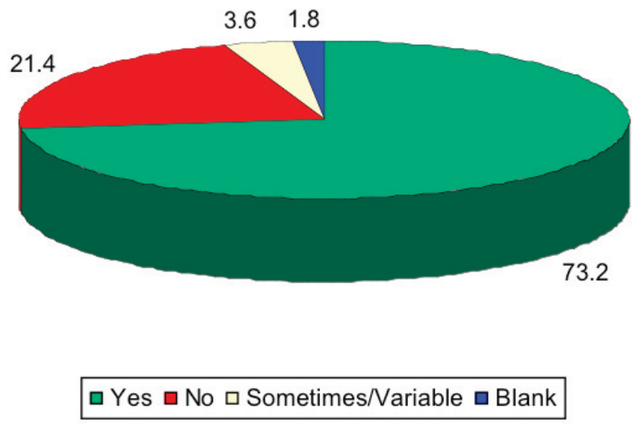


Who was involved in writing the TB strategy?§§ (n=45)

	Percentage of respondents		Percentage of respondents
Member PCT public health team	48.9	HIV specialist	4.4
Health Protection Agency	40.0	Housing and social services	4.4
TB specialist nurse	33.3	Pharmacist	4.4
Clinical TB Network	33.3	Voluntary Sector	4.4
TB consultant	17.8	Blank	4.4
Respiratory consultant	15.6	Occupational health	2.2
Commissioning/Development team	11.1	Immunisation team	2.2
Prison health	8.9	Infection control team	2.2
Primary care specialist	6.7	Local authority	2.2
Microbiology team	6.7	Asylum seekers team	2.2
GP	6.7	Mental health specialist	2.2
Child health/Paediatrician	6.7	Health visitor	2.2
Respiratory nurse	4.4	Service user/ Affected community	0.0

3.4 Priority of TB

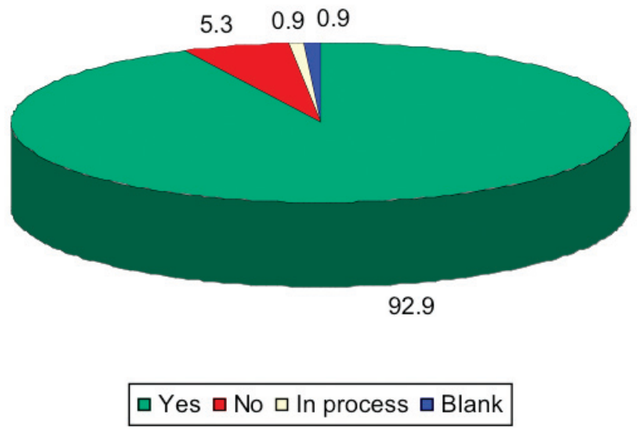
Does your PCT include TB in its annual public health report? (n=112) (%)



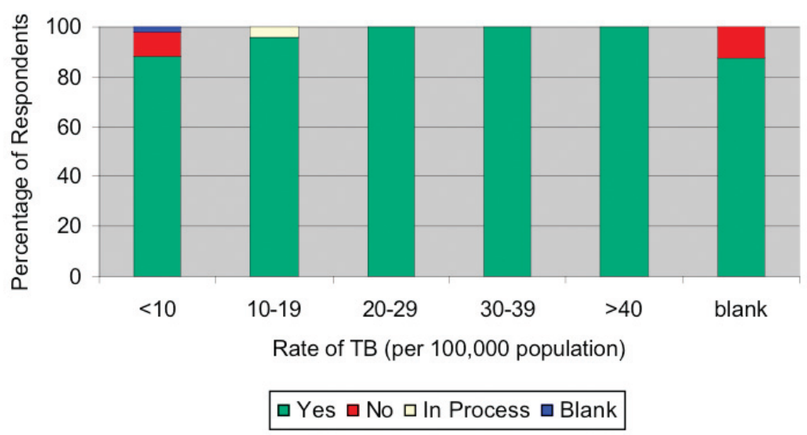
§§ Please note, respondents can give more than one answer to this question

3.5 PCT TB lead

Within your PCT is there a designated lead for TB? (n=112) (%)



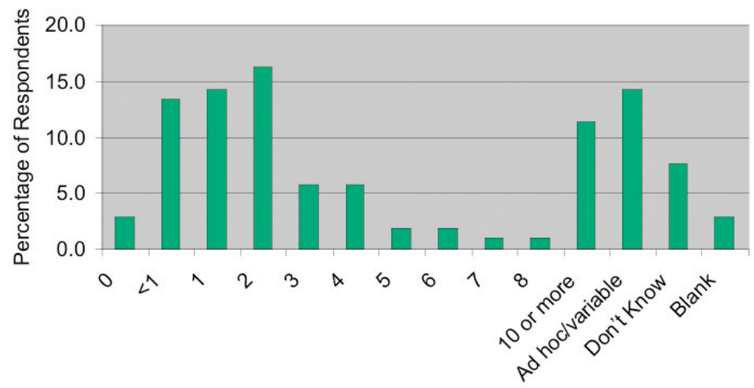
Breakdown by TB incidence (n=112)



Job title of the TB lead (n=104)

Job Title	Percentage	Job Title	Percentage
Consultant in Public Health	45.2	Public Health Lead	1.9
Director of Public Health (DPH)	12.5	Head of Health Protection	1.9
Infection control/ TB specialist nurse	7.7	Specialist Registrar in Public Health	1.9
Associate DPH	4.8	Head of Infection Control	1.0
TB Network Manager	3.8	Acting Associate DPH	1.0
Deputy DPH	2.9	Principal in Health Protection	1.0
Advanced Health Improvement Specialist	1.9	Senior Public Health Strategist	1.0
Assistant DPH	1.0	Project Lead - Health Protection	1.0
Director of Health Protection	1.0	Acting DPH	1.0
Director of Care	1.0	Senior Public Health Commissioning Manager	1.0
Director of Operations	1.0	Senior Nurse in Public Health	1.0
Head of Commissioning for Long Term Conditions	1.0	Blank	1.9
Head of Health Improvement	1.0	TOTAL	100.0

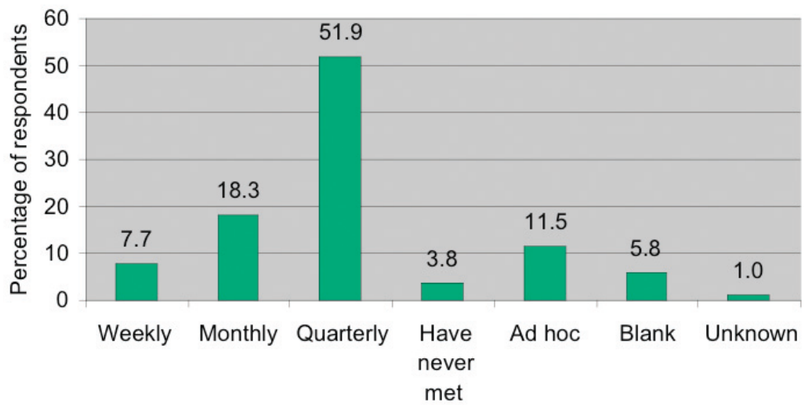
Hours per week spent on TB by PCT TB Lead (n=104)



Areas of responsibility of TB lead (n=104) (%)

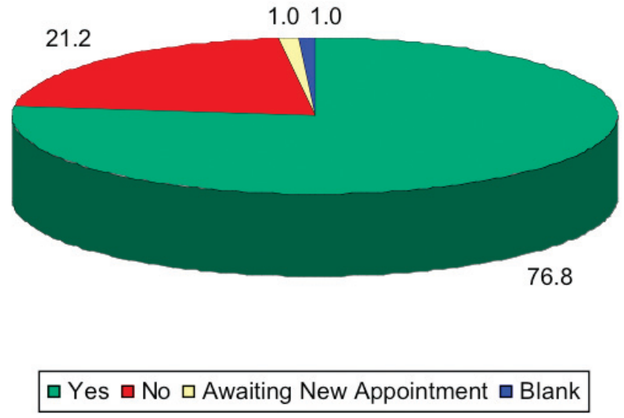
Responsibility	Yes	No	Blank	TOTAL
Liaising and co-operating with the local Health Protection Unit	89.4	8.7	1.9	100.0
Developing partnerships with other organisations in relation to TB	86.5	11.5	1.9	100.0
Maintaining vigilance regarding potential outbreaks or rises in prevalence	84.6	13.5	1.9	100.0
Evaluating which elements of TB services need to be in place	81.7	16.3	1.9	100.0
Coordinating development of the local strategy for TB prevention and control	78.8	19.2	1.9	100.0
Other - Advising commissioners/direct commissioning	16.3	0.0	83.7	100.0
Other - Contribute to the development of a TB protocol/strategy/funding proposals/ care pathways	4.8	0.0	95.2	100.0
Other - Chair of local TB strategy board/MDT	3.8	0.0	96.2	100.0
Other - Liaising and coordinating others e.g. community nursing teams, GPs, microbiology	2.9	0.0	97.1	100.0
Other - FOI requests/answering queries from health scrutiny and the public/media work during outbreaks	1.9	0.0	98.1	100.0
Other - Monitoring performance against TB standards/ audits	1.9	0.0	98.1	100.0
Other - Broader health protection agenda	1.0	0.0	99.0	100.0

Frequency that PCT TB lead meets with local Service Provider TB Lead (n=104)

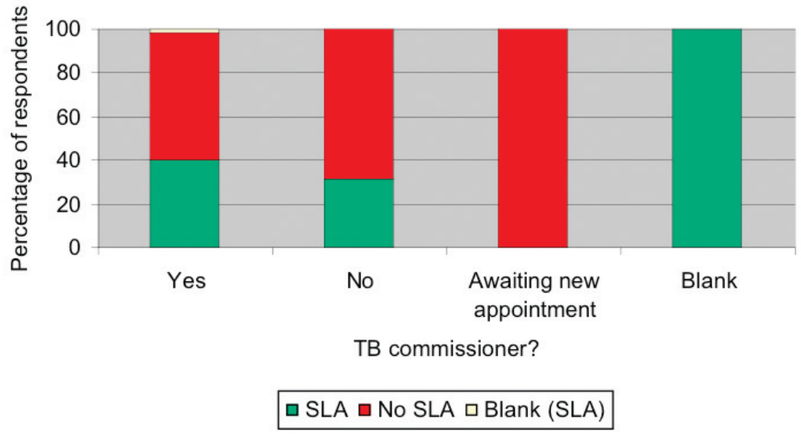


3.6 Commissioning of TB Services

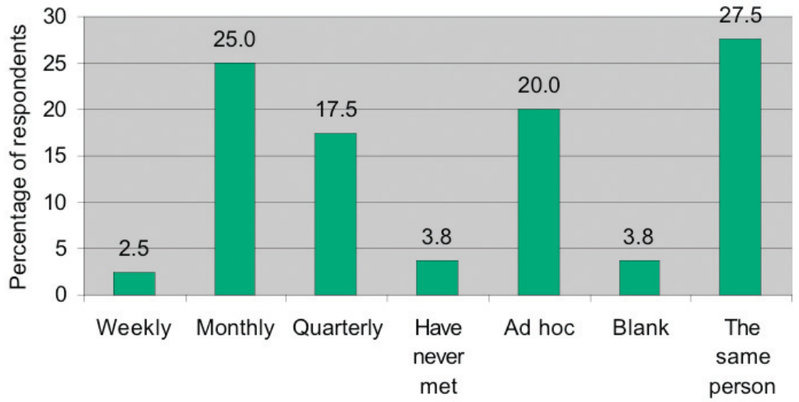
Is there a named individual within your PCT with designated responsibility for TB commissioning? (n=104) (%)



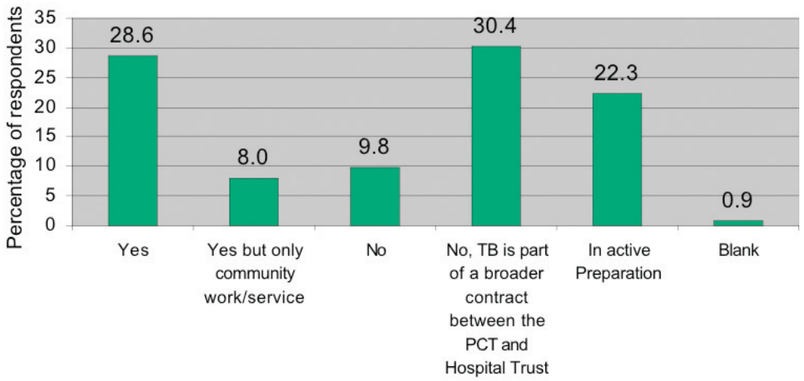
Breakdown by whether TB SLA in place (n=104)



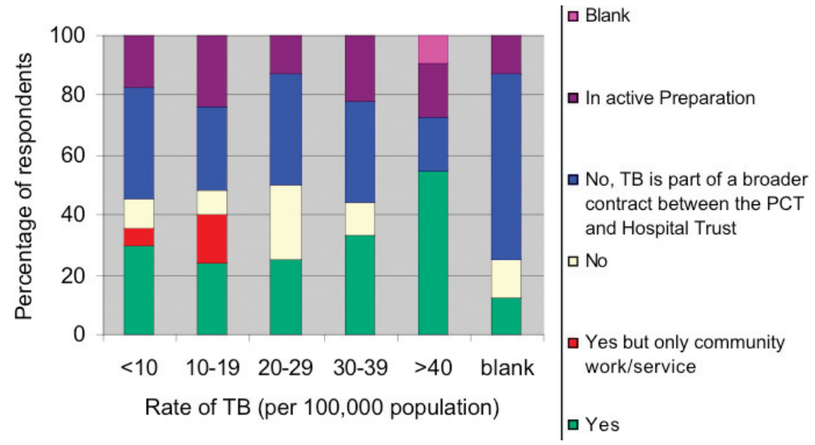
Frequency that PCT TB lead meets with PCT commissioner with responsibility for TB (n=80)



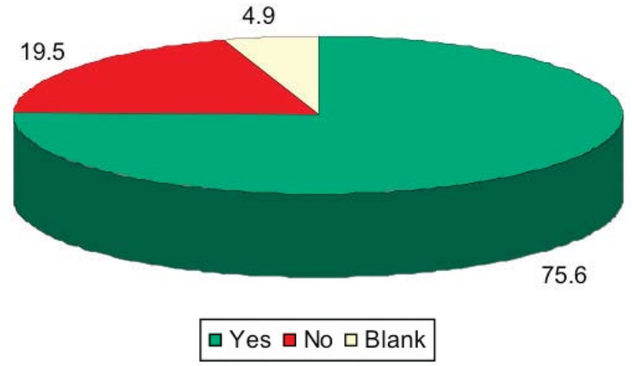
Do you have a specific SLA in place for TB Services provided in your PCT area?



Breakdown by TB incidence



Was a needs assessment carried out before the TB specific SLA was written? (n=41)%



People consulted/involved in drafting the TB specific SLA (n=41)***

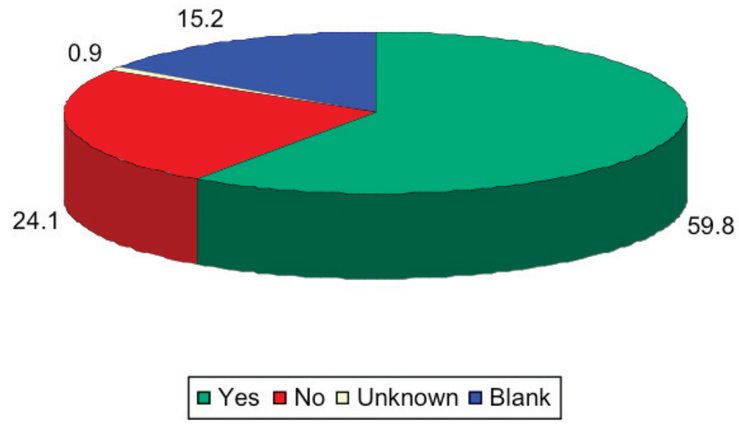
	Percentage		Percentage
Clinical TB Specialists	92.7	Other – Acute Service Provider	4.9
Public Health Specialists	78.0	Other – Nurses	4.9
Health Protection Specialists	78.0	Other – Infection Control Team	2.4
Microbiology/Laboratory Specialists	43.9	Other – GPs	2.4
Primary Care Specialists	36.6	Other - Medicines management team	2.4
TB service users or affected communities	22.0	Other – Care group manager	2.4
Other – Commissioners	14.6	Unknown	2.4

*** Please note, respondents can give more than one answer to this question

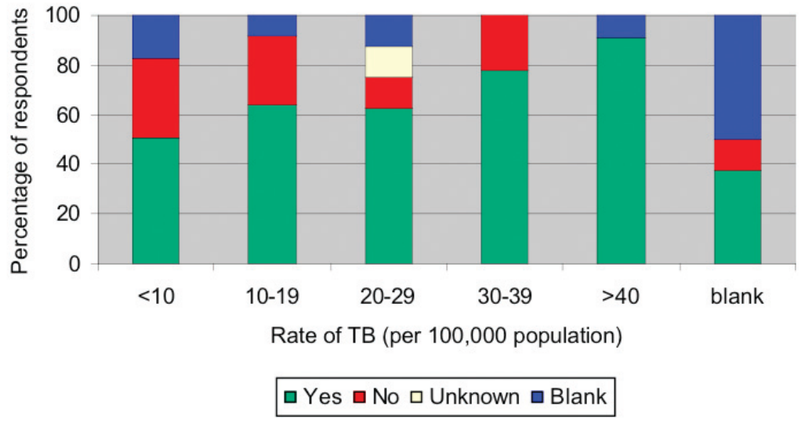
Services included as part of the TB specific SLA (n=41)

Service	Percentage of respondents
Contact tracing of individuals exposed to TB	92.7
Case management of TB patients	85.4
Community home visiting	85.4
Reactive outbreak case detection/monitoring	85.4
Rapid access to specialist services if GPs suspect TB	80.5
Ward visits to TB patients	80.5
Directly Observed Therapy	80.5
Locally targeted health promotion and awareness raising	73.2
New entrant services	70.7
TB diagnostic services in hospitals	68.3
Neonatal BCG vaccination service	68.3
Quality assured and timely TB microbiology services	65.9
Multidisciplinary TB clinics	65.9
Tuberculin Skin Testing for ward patients	63.4
Outreach work through dedicated community-based workers	63.4
In-patient beds for TB patients requiring hospitalisation	61.0
Access to social care and support	61.0
Active case finding in high risk groups	61.0
Community infection control services	58.5
In-patient infection control services	51.2
Negative pressure facilities	48.8
Occupational Health assessment of TB risk among healthcare workers	48.8
Specific arrangements for the management of patients with complex social needs	43.9
Provision and management of long term isolation facilities	39.0
Coherent service provision with the prison and custody sector	31.7

Has funding increased for TB services over the past three years? (n=112) (%)

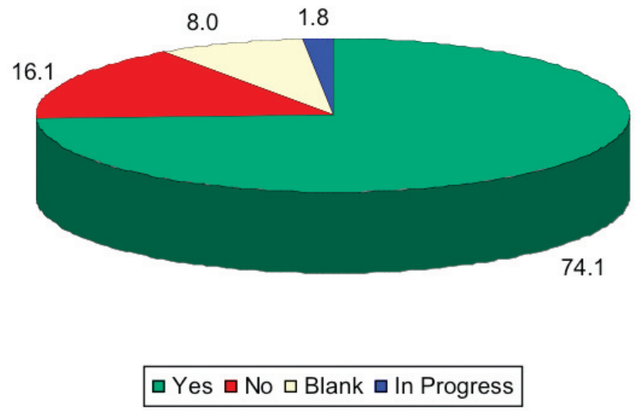


Breakdown by TB incidence (n=112)



3.7 Health Promotion and Awareness

Are health promotion/awareness raising activities carried out by the PCT? (n=112) %



Spotlight on...Examples of health promotion/awareness activities

- **NHS Wandsworth is undertaking research on stigma experienced by TB patients. This will inform local awareness raising activities – the goal being to reduce stigma. The research is being carried out jointly between South West London (SWL) HPU and NHS Wandsworth public health team. Another programme being co-ordinated and put in place aims to raise awareness among the Somali population, in collaboration between the HIV/sexual health team (public health), the SWL HPU and SWL TB service development manager.**
- **Southampton City PCT engaged the local Consultant in Public Health to work with health trainers to raise awareness around TB. The consultant also appeared on a phone-in show on a local radio station popular with minority residents.**
- **NHS Bristol has recently established an awareness group with representation from the specialist nurse service, public health, health promotion, the HPA, asylum seekers' service and the voluntary sector. An action plan is being finalised. Its main objectives will include identifying and targeting at risk groups as well as to identify and address development needs among key workers.**

Target of health promotion/awareness raising activities (n=98)

Target	Percentage of Respondents	Target	Percentage of Respondents
Minority groups (BME) - based on TB prevalence data	20.4	Patients with long-term conditions	1.0
Organisations working with complex needs patients/the patients directly	19.4	Pharmacists	1.0
Refugees/migrants/new entrants - directly, through their communities or through targeted organisations	16.3	No-one in particular	1.0
NHS Colleagues	10.2	Pubs	1.0
Prisoners or prison staff	9.2	Schools	1.0
GPs	7.1	Lower income groups	1.0
Local College with high numbers of international students	5.1	Older population	1.0
General population	3.1	Children	1.0
New parents	1.0		

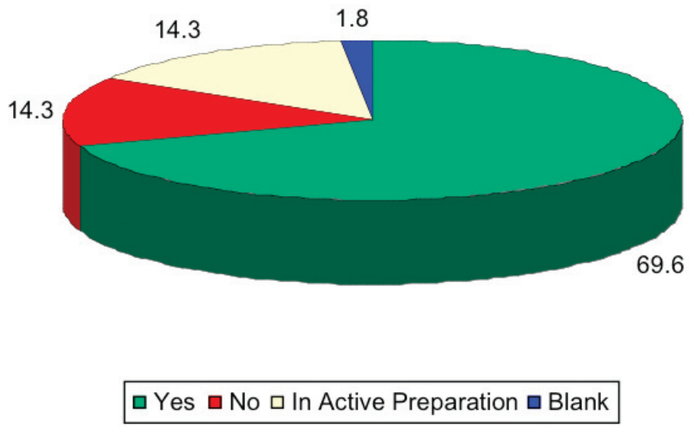
How does the PCT actively encourage service user input into health promotion and awareness and ensure that service users/advocates are encouraged to feedback on the TB services received? (n=112)†††

Method	%
Blank	38.4
Through patient satisfaction surveys	25.0
Do not do this	11.6
Under development	8.9
LINKs/PALS	6.3
Participation in TB meetings/policy development	6.3
Focus groups	4.5
Via TB nurse/community teams	1.8
Targeted outreach	1.8
TB Alert	1.8
Social marketing initiative	1.8
Through phone calls from the public and comments/complaints made to community TB nurse	1.8
Via Community staff engagement	0.9
Work with non statutory organisations for homeless	0.9
By involving the lead who has responsibility for patient and public involvement	0.9
Professional consultation	0.9
Public Consultation	0.9
Care Pledge	0.9

††† Please note, respondents can give more than one answer to this question

3.8 New Entrant Screening

Does the PCT currently have a system in place for screening TB in new entrants? (n=112) (%)



What information sources does the PCT use to identify new entrants for TB screening?‡‡‡ (n=89)

Method	Percentage of Respondents
Port of Entry Forms	48.3
New GP Registrations	32.6
HPA	18.0
Blank	9.0
Asylum Seekers Team	6.7
Educational Settings	6.7
Health Visiting Service	6.7
Social Services	3.4
Occupational Health	2.2
Direct contact from Port Health Control Units	1.1
Via Community Groups	1.1

‡‡‡ Please note, respondents can give more than one answer to this question

How does the PCT seek to ensure maximum attendance at new entrant screening clinics? ** (n=89)**

Method	Percentage of Respondents
Follow up non-attendees	23.6
Accessible location for clinic	10.1
Multiple appointments given	5.6
Flexible clinic hours	3.4
Phone/Text appointment reminder	3.4
Help of health visitors/outreach workers	3.4
Interpreting services made available	2.2
Simple written invitation	2.2
Accompany patient to clinic	1.1
Engaging with local leaders	1.1
Language leaflets	1.1
TB information card sent with appointment (visual rather than in written text)	1.1
Multi-lingual leaflets/appointment cards	1.1
Maps provided to each community centre where screening takes place	1.1
Accompanying letter explaining process and need	1.1

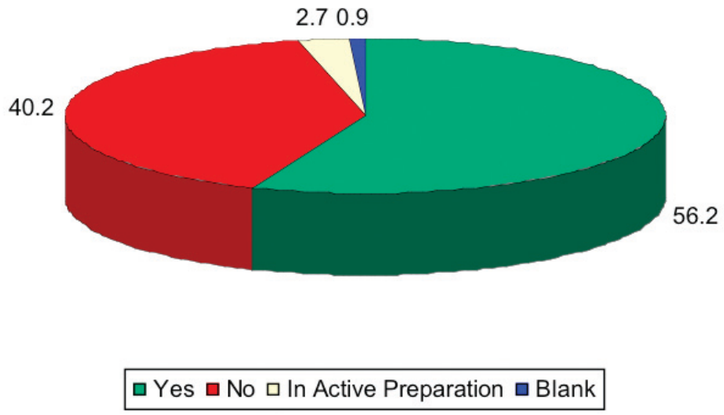
Spotlight on... Example of new entrant screening attendance methods

- **NHS Brighton and Hove strive to reduce stigma around TB through community engagement, explaining the importance of TB screening and clarifying that treatment is available. They also ensure notifications/ appointments are sent out with clear indication of TB treatment centres.**
- **Hull PCT produces multi-lingual leaflets/appointment cards, offer multiple appointments, provide maps to each community centre where screening takes place and allows flexibility with regards to appointment times. They also inform local GPs if new entrants do not attend screening.**
- **NHS Central Lancashire sends a TB information card with appointment details displayed visually, rather than in written text, to try and reach non-English speakers.**

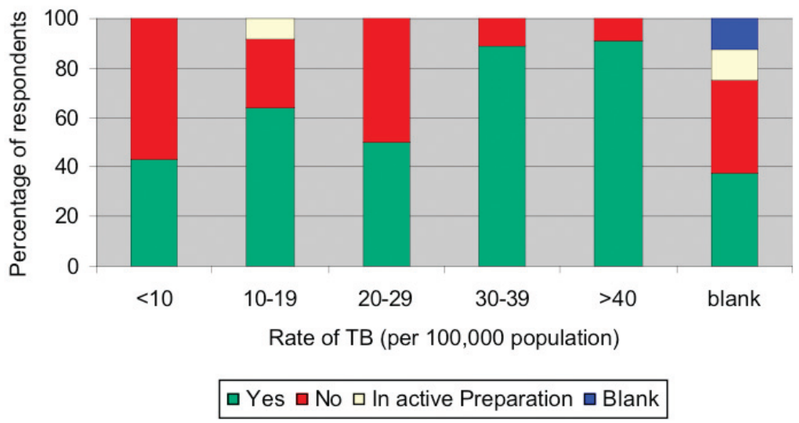
**** Please note, respondents can give more than one answer to this question

3.9 Active Screening

Does the PCT commission or provide routine active TB screening for high risk populations in its area? (n=112) (%)



Breakdown by TB incidence

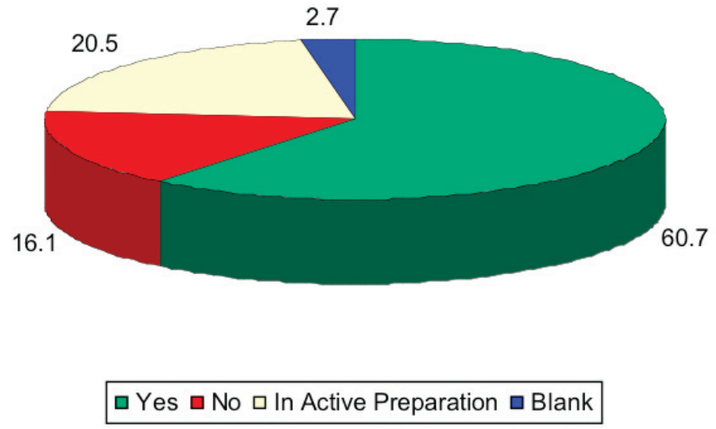


Spotlight on...example of active screening

- The Mobile X-Ray Unit is used to screen hard to reach and treat patients in accessible institutions e.g. homeless hostels and prisons. It has a dedicated team of professionals with experience of working with specific client groups. They provide a service across London.

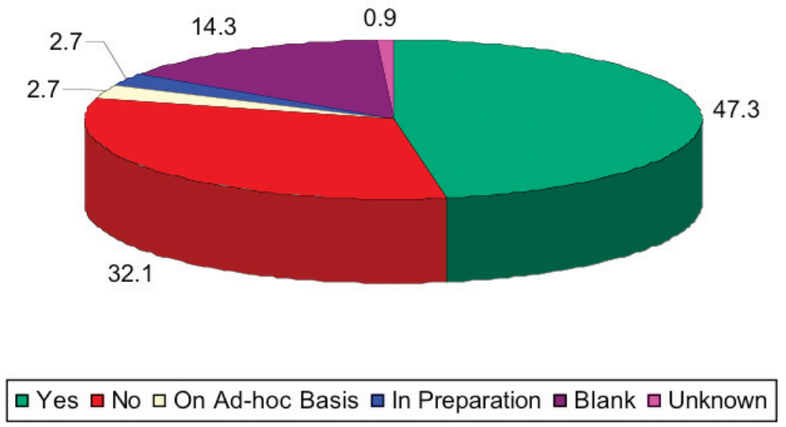
3.10 Outbreak Control

Does the PCT have a written pathway agreed with the HPU and TB Service Provider defining actions and responsibilities in the event of TB incidents or outbreaks? (n=112) (%)

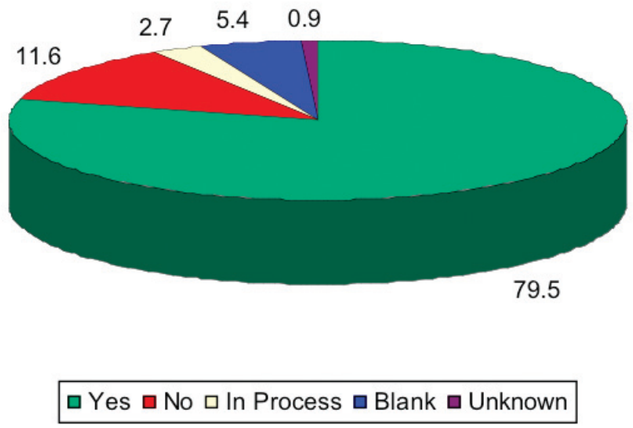


3.11 Collaborative Working

Does the PCT work with partners in the local authority, not-for-profit sector or voluntary organisations to help manage TB care and control? (n=112) (%)



Are the Acute Trusts with whom you work part of a specific TB multi-disciplinary clinical network? (n=112) (%)



4.0 Discussion

Response Rate: In comparison to the first PCT survey in 2007, the response rate has increased from 66.4% to 73.7%. It was evident that large variations existed between neighbouring PCTs in regards to the services commissioned for TB and whether or not the PCTs actually responded to the survey.

Future changes in TB incidence

Just over 50% of PCT respondents stated that they have forecast potential changes in local demography which will have an impact on TB. Of those who predict a change, 97% indicate that this will likely result in a rise in the number of TB cases. In the 2007 TB audit, 86% of PCTs forecast potential changes in demography and 68% of these respondents thought that this would lead to a rise in TB.

Local TB strategy

Only 40% of PCTs had a strategy in place for TB. An additional 19% were in the process of actively preparing a strategy. Worryingly, 18% of PCTs with a high TB burden (> 40 cases per 100,000) do not have a TB strategy in place. The 2007 TB audit asked whether the PCT had a local TB-related plan in place. Only 20% of PCTs confirmed that they did with a further 48% stating that the plan was in active preparation. The 2009 audit therefore shows that some of the plans in active preparation two years ago are now in place, but it also suggests that half of these are still in the process of being written two years on. Of great concern, the current survey suggests that overall one fifth fewer PCTs are now either developing, or have completed, their TB strategy when compared to our findings in 2007.

Of those PCTs that have a written strategy, most consulted with a good range of health care professionals including TB consultants, specialist nurses and health protection specialists. However, only 11% consulted commissioning specialists and of more concern, no PCT consulted service users or affected communities in writing the strategy.

Recommendation 1

All PCTs (especially those in high burden areas) should have a coherent, locally relevant strategy in place to control and prevent TB through consultation with a wide variety of stakeholders including their local authority, commissioners and service users/affected communities.

Priority of TB

Encouragingly, 73% of PCTs include TB in their annual public health report. Though, without a TB strategy in many of these PCTs, it is difficult to know what sort of impact or relevance this might have had.

PCT TB Lead

Ninety three percent of PCTs have a designated lead for TB. This is a large increase from that seen in the 2007 PCT audit where only 50% had a lead. The rationale behind the lead is that it should be an individual with the authority to take major strategic decisions on TB and influence commissioning arrangements at PCT board level. It is encouraging that a large proportion of TB leads hold a position of Deputy Director or above. 45% are Consultants in Public Health. This is appropriate and of value, provided that there is also a route by which changes can be enacted within the PCT. Some PCTs still provide TB services as well as commission them. In these instances, the TB lead should be someone within Public Health (or an affiliated team) and not a TB specialist, nurse or consultant who is also providing the service. In the 2007 PCT audit, 30% of those PCTs with a TB lead identified that person as a TB nurse specialist. By 2009, this number had decreased. But given that 8% of TB leads were still infection control or TB nurses and 2% were specialist registrars, we would be interested to know what level of support they received, and how much influence they had, in carrying out their duties within the PCT.

Seventy seven percent of PCTs stated that there was someone within the PCT with designated responsibility for TB commissioning. In 28% of cases, the PCT TB lead was the same person as the individual with responsibility for commissioning TB services. When the positions were taken by different people, meetings most commonly took place between them monthly (25%), quarterly (18%) or on an ad-hoc basis (20%).

Fifty two percent of PCTs with a TB lead met with the service provider lead for TB quarterly. Twenty six percent met more regularly than this whilst 4% have never met the service provider lead for TB.

Commissioning of TB Services

Twenty nine percent of PCTs stated that they had an SLA in place for TB services. An additional 8% stated that they had an SLA for TB services in the community only. 22% also stated that they were in the process of actively preparing the SLA. 18% of PCTs in high TB burden areas (over 40 cases per 100,000) did not have a TB SLA in place. In the 2007 PCT audit, 32% of PCTs stated that an SLA was in place and 24% were preparing an SLA. There has therefore been no progress in PCTs implementing the TB Toolkit action of ensuring a TB SLA is formulated.

Recommendation 2

All PCTs (especially those in high burden areas) should have an SLA in place with local service providers for TB services. This should be in line with the CMO's Action Plan, NICE Guidance and the TB Toolkit.

For an SLA to be constructed, a needs assessment or situational analysis should be carried out. This would enable commissioners to determine the TB services required locally. 76% of PCTs had carried out a needs assessment. However, 20% of PCTs hadn't. We would be interested, in these cases, to know how decisions were made regarding which local services were included in the SLA.

A large variety of stakeholders were involved in writing the SLAs. This included clinical TB specialists (93%), public health specialists (78%), primary care specialists (37%), TB service users and affected communities (22%).

An area of concern is the apparent low number of specific activities contained with SLAs. For example, of the list of activities required within a comprehensive TB service described within the TB Toolkit[§§§] , only 39% of SLAs included provision and management of long term isolation facilities for TB patients. Furthermore, 66% included provision for multi-disciplinary TB clinics, 61% access to social care and support, 44% specific arrangements for the management of patients with complex social needs and 61% active case finding in high risk groups.

Sixty percent of PCTs highlighted that funding had increased for TB services over the past three years. This was related to TB incidence, as 91% of PCTs in areas of over 40 new cases per 100,000 population reported a rise, compared to only 51% in areas with a TB incidence of less than 10 per 100,000.

Health Promotion and Awareness

Seventy four percent of PCTs stated that they carried out health promotion/awareness raising activities for TB. These activities were varied and included promoting TB around World TB Day, raising awareness among GPs, educational institutions and other healthcare staff.

When asked to identify the target of the health promotion/awareness activities, 21% of PCTs stated ethnic minority groups, 20% organisations working with complex needs patients (or with the patients directly), 16% with refugees/new entrants and 10% with NHS colleagues. Only 7% targeted GPs specifically.

In the 2007 PCT audit, 59% of PCTs stated that they carried out health promotion. Of these 16% provided information on BCG vaccinations, 40% raised awareness in high risk groups through working with local organisations, 31% raised awareness among healthcare staff and 22% carried out awareness activity for World TB Day.

Only 50% of PCTs actively encourage service user input into health promotion and awareness activities and ensure that service users are encouraged to feedback on TB services received. Of this 50%, half rely on patient satisfaction surveys. Surveys of this kind only work where the information gathered is acted upon, and subsequent changes to TB services fed back to survey participants. We would like more information on how these patient satisfaction surveys are used.

Recommendation 3

All PCTs should encourage meaningful service user/patient advocate input into TB service planning, provision and evaluation.

New entrant screening

Seventy percent of PCT respondents have a system in place for TB screening in new entrants. However, there does not seem to be a unified national system in place as a variety of information sources are used to identify new entrants. With epidemiological data showing that the vast majority of new entrants developing TB do so after living in the UK for two or more years, more information is needed on how PCTs commission continued TB screening and care for these settled migrants.

In the 2007 PCT audit 55% of PCTs stated that they had a new entrant screening plan in place and an additional 26% were actively preparing the plan. Most PCTs used port health or GP registrations as sources of new entrant information.

§§§ Ref: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_075638.pdf Pg 15

Recommendation 4

PCTs and Local Authorities should ensure that TB is included in their local area agreements, joint strategic needs assessments and local health implementation plans.

Recommendation 5

The UK Government should carry out an evaluation of the TB new entrant screening system in the UK, make a decision on whether it should continue in its current structure and provide guidance on sustainable ongoing screening programmes for settled migrants.

Active screening

Only 57% of PCTs carry out routine active TB screening for high risk populations. This is associated with local TB incidence, as 91% of PCTs in high burden areas (>40 cases per 100,000 population) compared to 43% in areas with an incidence of less than 10 per 100,000. In the 2007 audit 67% of PCTs routinely screened high risk groups.

Many of the PCTs in London highlighted the Mobile X-Ray Unit as their main source of active screening in high risk groups. With the future of the MXU uncertain due to a lack of financial input by PCTs, this area will be at risk of being neglected in future years.

Outbreak control

Only 61% of PCTs have an agreed pathway in place in the event of a TB incident or outbreak. An additional 21% are actively preparing a pathway.

Collaborative Working

Only 47% of PCTs work in collaboration with local partners including local authorities and the not-for-profit sector. This is only a small increase since the 2007 PCT audit, where 44% of PCTs had developed working relationships with local partners. It is important that these relationships are formed, especially where TB services see complex and hard to reach patients with housing and social care needs.

Eighty percent of local PCT service providers are part of a TB specific multi-disciplinary clinical network. This is a vast improvement on the 2007 PCT survey where only 67% were part of a local TB clinical network.

Appendix 1 List of PCTs that responded to Survey

Barking and Dagenham PCT
Bath and North East Somerset
Berkshire East PCT
Bexley Care Trust
Blackburn with Darwen PCT
Blackpool PCT
Bournemouth and Poole PCT
Brighton and Hove PCT
Bromley PCT
Buckinghamshire PCT
Bury PCT
Calderdale PCT
Central and Eastern Cheshire PCT
City and Hackney PCT
Coventry PCT
Cumbria PCT
Derby City NHS PCT
Devon PCT
Doncaster PCT
Dudley PCT
East Sussex Downs and Weald PCT
Gateshead PCT
Gloucestershire PCT
Halton and St Helens PCT
Hampshire PCT
Havering PCT
Heart of Birmingham PCT
Herefordshire PCT
Hilingdon PCT
Hull PCT
Isle of Wight PCT
Kensington and Chelsea PCT
Knowsley PCT
Leeds PCT
Leicester City PCT
Liverpool PCT
Manchester PCT
Milton Keynes PCT
Newcastle PCT
NHS Ashton, Leigh and Wigan
NHS Barnet
NHS Barnsley
NHS Brent
NHS Bristol
NHS Camden
NHS Central Lancashire
NHS Cornwall and Isles of Scilly
NHS Croydon PCT
NHS Eastern and Coastal Kent
NHS Enfield
NHS Great Yarmouth and Waveney
NHS Hammersmith and Fulham
NHS Haringey
NHS Harrow
NHS Hartlepool
NHS Islington
NHS Kingston
NHS Kirklees
NHS Medway
NHS Mid Essex
NHS Newham
NHS North East Essex
NHS North Somerset
NHS Nottingham City
NHS Nottinghamshire County
NHS Oldham
NHS Plymouth
NHS Richmond
NHS Sefton
NHS Sheffield
NHS Somerset
NHS South West Essex
NHS Stockton-on-Tees
NHS Tameside and Glossop
NHS Wakefield District
NHS Walsall
NHS Wandsworth
NHS Warwickshire
NHS West Kent
NHS Western Cheshire
NHS Westminster
NHS Wiltshire
North East Lincolnshire Care Trust
North Lancs PCT
North Lincolnshire PT
North Staffordshire PCT
North Tyneside PCT
North Yorkshire and York PCT
Northamptonshire PCT
Northumberland Care Trust
Oxfordshire PCT
Portsmouth PCT
Redbridge PCT
Rotherham PCT
Salford PCT
Sandwell PCT
South Staffordshire PCT
South Tyneside PCT
Southampton City PCT
Stockport PCT
Stoke on Trent PCT
Sunderland PCT
Surrey PCT
Sutton and Merton PCT
Swindon PCT
Torbay Care Trust
Tower Hamlets PCT
Trafford PCT
Warrington PCT
West Sussex PCT
Wirral PCT
Worcestershire PCT

Appendix 2 Copy of Survey sent to PCTs

All Party Parliamentary Group On Global Tuberculosis

Royal College of Nursing

TB ALERT

PCT Tuberculosis Survey 2009

Please note: Please go directly to the next question in the sequence unless directed otherwise. If you require further space for answers please use a separate sheet of paper but clearly indicate the question being answered. We would be grateful if you could complete and return the questionnaire by 14th September 2009.

1. Local population and TB Caseload

TB Commissioning Toolkit (page 7) "To secure high-quality services, commissioners need to consider their local TB incidence and population demography, and potential changes to that demography, for example new demands as a result of population migration."

a. What is the name and the population of your PCT area?
Name .....
Population .....

b. How many TB cases have been notified in the last year in your PCT?
Number of cases.....
Incidence (per 100,000 population):.....

c. i. Has your PCT forecast potential changes to its population demography that would affect TB incidence?

Yes..... ☐ No ..... ☐

ii. If yes, please summarise the forecasted demographic changes

d. Are these changes likely to result in:
A small rise in the number of cases of TB ☐ A significant rise in the number of cases of TB ☐
A small fall in the number of cases of TB ☐ A significant fall in the number of cases of TB ☐

e. i. Does your PCT currently have an agreed TB strategy (including ways of coping with projected change)?

Yes .....

No (if no – please go to section 2 of the survey).....

In active preparation.....

ii. Who was involved in writing this TB strategy?

iii. Please give a brief outline of this strategy. Alternatively, please attach a copy with your survey response

2. Priority of TB

Chief Medical Officers Action Plan for TB (pg 13) "...chief executives and boards of primary care trusts to give appropriate priority to TB".

a. Does your PCT include TB in its annual public health report?

Yes..... ☐ No ..... ☐

b. Please state how many times in 2008 TB was on the agenda of the PCT Professional Executive board meeting?

Number of occasions.....

3. PCT TB Lead

TB Commissioning Toolkit recommends (pg 14) "that every PCT appoint a named TB lead...who could be a public health doctor or specialist or manager. Most importantly, the TB lead would need to work closely with those commissioning TB services and would need to have the authority and influence to ensure services are commissioned against the local plan."

a. Within your PCT is there a designated lead for TB?

Yes..... ☐ No ..... ☐

b. Please provide the job title of the TB PCT lead:

c. How many hours per week does the TB lead typically spend specifically on TB issues?

d. Is the TB lead shared with other PCTs?

Yes..... ☐ No ..... ☐

If yes, names of PCTs.....

(If the PCT does not have a TB lead please identify who, if anyone, undertakes the responsibilities outlined below)

.....

e. Please tick which of the following areas the TB lead is responsible for.
Coordinating development of the local strategy for TB prevention and control..... ☐
Evaluating which elements of TB services need to be in place..... ☐
Developing partnerships with other organisations in relation to TB..... ☐
Maintaining vigilance regarding potential outbreaks or rises in prevalence..... ☐
Liaising and co-operating with the local Health Protection Unit..... ☐
Please specify any additional roles the TB lead is responsible for .....
.....

f. How often does the PCT TB lead meet with the local Service Provider TB lead (s)?

Have never met..... ☐ Weekly..... ☐

Monthly..... ☐ Quarterly..... ☐

Other .....

g. Is there a named individual within the PCT with designated responsibility for TB commissioning?

Yes..... ☐ No ..... ☐

If yes, job title of the commissioner:

h How often does the PCT TB lead meet with the PCT commissioner with responsibility for TB?

Have never met..... ☐ Weekly..... ☐

Monthly..... ☐ Quarterly..... ☐

Other .....

4. Commissioning of TB Services

TB Commissioning Toolkit (pg 11) "an SLA should identify the requirements of the commissioner as regards the delivery of services". In addition it advises (pg 11) "that if the number of active cases is likely to be low, commissioning TB services on a shared or amalgamated basis is a route to provide high-quality services".

a. Do you have a specific Service Level Agreement (SLA) in place for TB Services provided in your PCT area?

Yes..... ☐ No ..... ☐

No, but in active preparation..... ☐

No, TB is part of a broader contract between the PCT and Hospital Trust
e.g. acute medicine..... ☐

b. Was a local needs assessment for TB carried out before the TB specific SLA was written?

Yes..... ☐ No ..... ☐

c. Who was consulted / involved in drafting the TB specific SLA?

Public Health Specialists..... ☐ Clinical TB specialists..... ☐

Microbiology/laboratory specialists..... ☐ Health Protection specialists..... ☐

Primary Care specialists..... ☐ TB service users or affected communities..... ☐

Other .....

d. If you have an SLA, please indicate which services are included as part of the TB specific SLA:

Rapid access to specialist services if GPs suspect TB	
TB diagnostic services in hospitals	
Case management of TB patients	
Ward visits to TB patients	
Tuberculin Skin Testing for ward patients	
Contact tracing of individuals exposed to TB	
In-patient beds for TB patients requiring hospitalisation	
Negative pressure facilities	
Quality assured and timely TB microbiology services	
In-patient infection control services	
Provision and management of long-term isolation facilities	
Multidisciplinary TB clinics	
Occupational Health assessment of TB risk among healthcare workers	
Community infection control services	
Community home visiting	
Access to social care and support	
Active case finding in high-risk groups	
Outreach work through dedicated community-based workers	
Directly Observed Therapy	
New entrant services	
Locally targeted health promotion and awareness raising	
Reactive outbreak case detection/monitoring	
Coherent service provision with the prison and custody sector	
Neonatal BCG vaccination service	
Specific arrangements for the management of patients with complex social needs	

e. How many TB specialist nurses does the PCT provide funding for? .....W.T.E

f. Does the PCT have any shared or amalgamated formal agreements in place with other PCTs to manage TB care?

No agreement .....

Formal agreement with nearby PCT (s) (please state which PCT (s)) .....

g. If you do have agreements with other PCTs, please very briefly explain the nature of, and reason for, the agreements

h. What funding has been allocated for TB specifically in the last financial year?

No specific funding .....

If funding has been allocated please indicate how much:

i. Has funding increased for TB services over the past three years?

Yes..... ☐ No ..... ☐

5. TB Services

TB Commissioning Toolkit (pg 15) "Commissioning TB services needs to go beyond simply the treatment of active TB cases, as referenced by full NICE guidelines and the TB action plan."

a. Health Promotion and awareness:

i. Please outline locally targeted TB health promotion/awareness-raising activities that the PCT has undertaken, and explain who was involved in delivering them

ii. At which communities or groups were the promotional/awareness activities targeted, and how was the decision made about which communities or groups to target?

iii. How does the PCT actively encourage service user input into health promotion and awareness and ensure that service users / advocates are encouraged to feedback on the TB services received?

b. New Entrant Screening:

i. Does the PCT currently have a system in place for screening TB in new entrants?

Yes..... ☐ No ..... ☐

In active preparation..... ☐

If no, please go to question 5c

ii. What information sources does the PCT use to identify new entrants for TB screening?

iii. How does the PCT seek to ensure maximum attendance at new entrant screening clinics?

c Active screening in high risk groups: Does the PCT commission or provide routine active TB screening for high risk populations in its area? (High risk defined as: drug/alcohol use/ homelessness/hostel use/asylum seeker/prison population)

Yes..... ☐ No ..... ☐

Details:

d. Outbreak control: Does the PCT have a written pathway agreed with the local HPU and TB Service Provider defining actions and responsibilities in the event of TB incidents or outbreaks?

Yes..... ☐ No ..... ☐

In active preparation..... ☐

6. Collaborative working

TB Commissoning Toolkit (pg 11) "Commissioners will also want to consider how to develop sophisticated working relationships with partners in local authority, the not-for-profit sector and voluntary organisations."

a. Does the PCT work with partners in the local authority e.g. the not-for-profit sector and voluntary organisations to help manage TB care and control? (Please give details)

b. Clinical Networks:

i. Are the Acute Trusts with whom you work part of a specific TB multi-disciplinary clinical network?
Please provide details.....

ii. How many times has the TB Clinical Network met in the last two years?

Has not met..... ☐

Yes, has met ..... times in the last 2 years

Thank you for taking the time to complete this questionnaire. Please return your reply in the enclosed pre-paid envelope. Please provide your contact details below if you would like to receive a copy of the final report. Yes, I would like to receive a copy of the final report..... ☐

Name..... PCT.....
Address.....

If you would prefer to receive the report by email please provide your email address:
.....