Public Health England

NHS England

Collaborative Tuberculosis Strategy: Commissioning Guidance

Collaborative Tuberculosis Strategy; Commissioning Guidance

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1 Introduction

The *Collaborative Tuberculosis Strategy for England: 2015 to 2020*[1] (referred to below as 'the Strategy') set out approaches to be taken to support TB prevention, treatment and control. This commissioning guidance should be read in conjunction with the Strategy and also with the Latent TB Testing and Treatment for Migrants guidance developed by Public Health England (PHE) and NHS England[2].

This commissioning guidance recommends what the roles of CCGs and NHS England teams should be in the implementation of the strategy and the actions that should be taken.

The incidence of TB in England is higher than in most other European countries and four times as high as in the United States.

TB is concentrated in large urban centres, with rates in London, Leicester, Birmingham, Luton, Manchester and Coventry more than three times the national average. Other areas with high caseloads include: Bradford, Leeds, Kirklees, Slough and Reading (see maps overleaf). However, as the maps show, there are also pockets of TB cases in other localities. Nearly three quarters of all TB cases occur in those born abroad, mainly from high TB burden countries, and the vast majority of these cases (85%) occur among settled migrants who have been in the country for more than two years, rather than in those who have arrived more recently. There is a strong association between TB and social deprivation, with 70% of cases occurring in areas with the two most deprived quintiles in the country, and 9% of all TB cases having at least one social risk factor (a history of alcohol or drug misuse, homelessness or imprisonment).

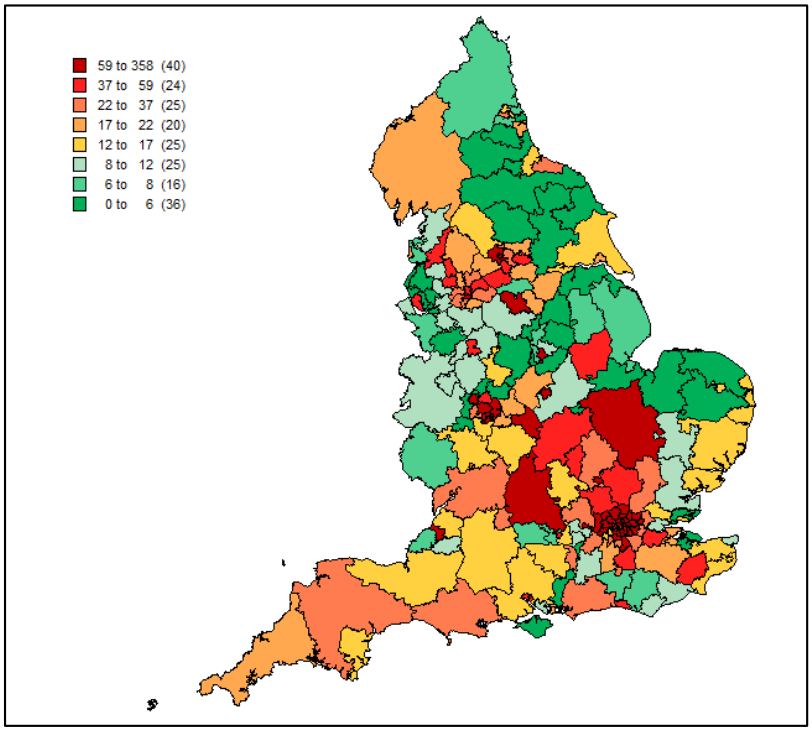
It is likely that the majority of TB cases in the UK are the result of 'reactivation' of latent TB infection (LTBI), an asymptomatic phase of TB which can last for years. LTBI can be diagnosed by a single, validated blood test and treated effectively with antibiotics, preventing TB disease in the future.

NHS England has identified £10 million in 2015/16 for the development of LTBI testing and treatment services which is planned to be distributed to local communities via lead CCGs on the basis of a locally developed TB strategy signed off by the local TB Control Board and approved by the national NHS England/Public Health England TB programme team (referred to below as 'the national programme team'). Any additional funding in future years will be subject to the outcome of the Spending Review by HM Government and prioritisation processes for the use of resources.

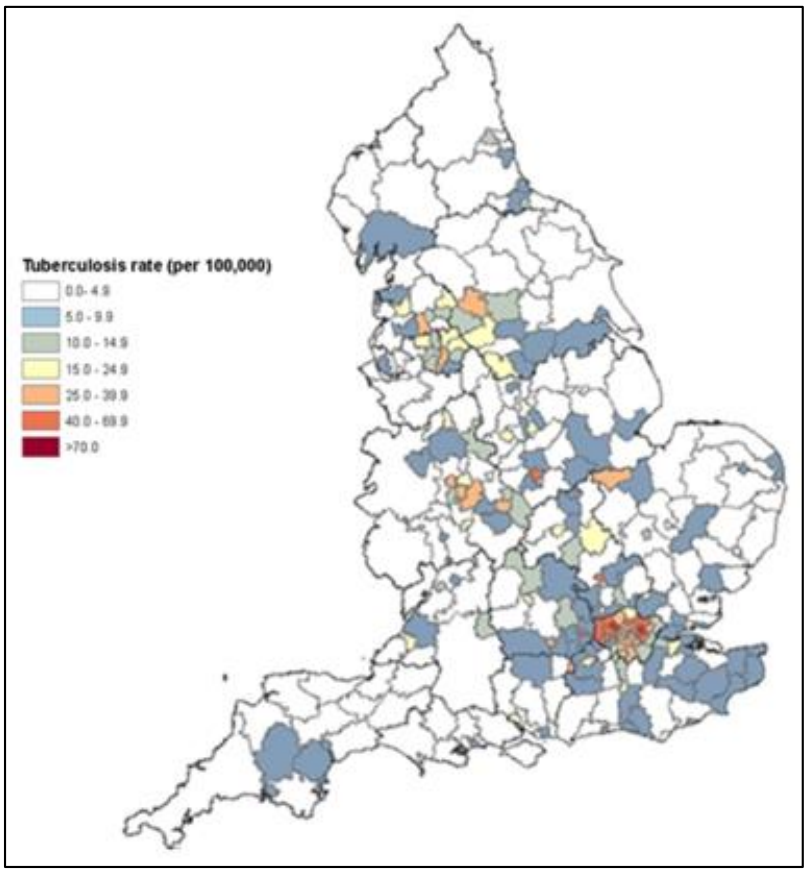
[1] https://www.gov.uk/government/publications/collaborative-tuberculosis-strategy-for-england

[2] Latent TB testing and treatment for migrants: A practical guide for commissioners and practitioners

Map 1 - Average number of TB cases in England by CCG: 2011-2013



Map 2 - Average TB rates in England by CCG: 2011-2013



A table showing TB rates and numbers by CCG is at annex A.

2 Aims of the Strategy

The Strategy sets out, that in order to achieve its ambitions and make significant advances in TB control, action should be focussed in the following key areas:

1. **Improve access to services and ensure early diagnosis**
2. **Provide universal access to high quality diagnostics**
3. **Improve treatment and care services**
4. **Ensure comprehensive contact tracing**
5. **Improve BCG vaccination uptake**
6. **Reduce drug-resistant TB**
7. **Tackle TB in under-served populations**
8. **Systematically implement new entrant latent TB screening**
9. **Strengthen surveillance and monitoring**
10. **Ensure an appropriate workforce to deliver TB control**

Full details of the specific evidence-based areas for actions in relation to the above are set out in **Annex A** of the Strategy.

3 TB Control Boards

The Strategy advises that nine TB Control Boards (referred to below as 'Control Boards') will be set up, based on PHE centre boundaries. These Control Boards are central to the strategy and we anticipate that they will play a key role in bringing together local partners, signing off the local TB strategy, overseeing distribution of national resources to local partner organisations, and monitoring progress. The Control Boards should include representatives from:

- CCGs
- NHS England
- Public Health England
- Local authority directors of social care and public health
- Local TB service providers
- Senior TB secondary care clinicians, (adults and children)
- TB nursing services
- GPs[3]
- Service users and/or advocacy organisations and relevant third sector organisations

Control Boards should also consider whether there are other partners who should be members of the Board.

The Strategy sets out the responsibilities of the Control Boards will include:

[3] GP representatives, CCGs and Control Boards should be mindful of the Managing Conflicts of Interest Guidance at: http://www.england.nhs.uk/commissioning/pc-co-comms/

- To plan, oversee, support and monitor all aspects of local TB control, including clinical and public health services and workforce planning
- To work closely with local clinical and TB networks and engage with other key stakeholders such as local government and the third sector
- To develop a local TB control plan based on the national strategy, local services, local need and evidence-based models
- To agree and ensure the appropriate commissioning of TB services, and through collaborative working and the use of existing accountability arrangements, hold providers and commissioners of clinical care and public services to account
- To ensure TB cohort review is undertaken regularly (every 3–4 months) and fed back to the Control Board, commissioners, TB service provider management and the local directors of public health; and that appropriate action is taken as a result of cohort review
- To ensure full and consistent use of current national guidelines in particular those of the National Institute for Health and Care Excellence (NICE)
- To ensure an appropriate workforce strategy is developed and implemented
- To ensure the needs of under-served populations are addressed and health inequalities are reduced
- To involve under-served populations in designing and shaping services so that they are responsive to the specific needs of these groups
- To ensure the delivery of a quality-assured local programme of new entrant LTBI testing and treatment focused on areas of high TB incidence
- To consider commissioning a team to undertake extended community contact tracing of incidents and outbreaks
- To ensure appropriate TB awareness-raising in collaboration with the third sector, local authorities and other organisations who provide this

PHE are making funding arrangements with the nine new PHE Centres for the establishment of the Control Boards and their support. Each include a dedicated clinical/public health lead (TB Control Board Director), TB programme manager, administrative support and input from clinicians, GPs and TB nursing services.

The Strategy advises that the precise arrangements for TB Control Boards and TB networks will be determined by local NHS organisations, CCGs, PHE Centres, local authorities and other key stakeholders to allow flexibility in the local delivery of improved TB control. The directors of the TB Control Boards will be responsible to their local PHE Centre Director for the operation of the Control Board and in addition there will be a formal relationship with the National TB Programme Director.

4 CCG and NHS England Roles

As set out above, the incidence and case load of TB is not evenly distributed across England. Within individual TB Control Board areas incidence is likely to be concentrated within specific CCGs. It is recommended therefore that CCGs should work with their TB Control Board and NHS England to agree lead CCGs for implementation of the Strategy. The rationale for preferring to have lead CCGs is to

enable NHS England and the TB Control Board to have a single co-ordinating point for the purposes of distributing national resources to support delivery of the Strategy.

It is preferable for there to be one lead CCG within a TB Control Board area. However, exceptionally, there may be circumstances where a Control Board considers that more than one lead CCG is appropriate. For example, if a CCG with a significant level of TB incidence is geographically distant from other CCGs with significant TB incidence and is served by different providers a Control Board may consider it appropriate for separate lead arrangements to be agreed with them.

5 Responsibilities of Lead CCGs

Responsibilities of lead CCGs will include:

- Entering into an appropriate agreement with NHS England regarding use of the additional resources made available for the TB Strategy
- Developing appropriate arrangements with other local CCGs to reflect how mutual responsibilities will operate and resources distributed, within the framework of the lead role
- Representing local CCGs on the Control Board
- Working with the Control Board and with other local CCGs and partners to agree the commissioning actions required to support implementation of the Strategy, the local TB control plan and its associated LTBI plan
- Working with relevant partners to develop and submit the local LTBI plan (details below)
- Ensuring that there is clarity on the commissioning responsibilities of the lead CCG and other CCGs in relation to TB services
- Working with other CCGs and local GPs to put arrangements in place for primary care based LTBI identification, testing and treatment. (Further details are set out below). Where NHS England holds primary care commissioning responsibilities within a CCG area the CCG should also work with it to agree such arrangements
- Working with NHS England to agree appropriate arrangements for the commissioning of additional capacity for the laboratory analysis and reporting of the LTBI test (Further details below and within the '*Latent TB testing and treatment for migrants'* guide)
- Working with relevant providers to ensure clear pathways and sufficient capacity for latent and active TB treatment services
- Working with local partners on actions agreed with the relevant Control Board in support of the wider implementation of the Strategy

6 Service Developments

There are three defined areas for which, prior to the issuing of the Strategy, there was no systematic commissioning or provision and which have the potential to lead to significant improvement in TB control. These are:

1. The establishment of nine TB Control Boards, as set out above.
2. An outreach service, similar to the 'Find and Treat' service in London, for other areas of high TB incidence in the rest of England.
3. Testing for, and treatment of, latent TB in new entrants from countries of high TB incidence. Full details of the testing and treatment service developments are set out in the '*Latent TB Testing and Treatment for Migrants*' guidance. In summary they are:
   i) Having processes in place for the identification of new entrants to the UK from countries with a TB incidence of ≥150/100,000 population. This involves both initially identifying new patients when they register with a GP practice and then in due course moving on to retrospective identification of relevant patients who have entered the UK in the past five years.
   ii) Offering testing for LTBI. The optimum setting for this to take place is in primary care and, with regard to new patients, has often been done as part of new patient health checks where these are offered. Other models such as education or community settings have also been used.
   iii) Where patients' test results show that they are LTBI positive, offering appropriate treatment via referral to an appropriate secondary care TB service.

7 Planning and Funding

Control Boards, with the organisations that are represented on them, should oversee development of an overall plan, with timescales, for the delivery of the Strategy within their area. The Strategy sets out that many of the actions it advises can be implemented through services and funding already in place, in addition to the new funding for specific developments set out above.

Within the context of the overall local TB Strategy plan, there should be specific plans drawn up for LTBI testing and treatment – the existence of a plan for introducing LTBI testing and treatment is a prerequisite for accessing any central funding. This plan should set out how local organisations will utilise both existing resources and the proposed new TB funding to implement LTBI identification, testing and treatment. The development of a plan for identifying LTBI should be co-ordinated by the lead CCG, working with other CCGs, together with GPs and local secondary care TB services.

The additional funding that NHS England is making available in 2015/16 is principally to support the costs of the service requirements in section 6 above, including:

- ***Identifying and testing new and recently arrived migrants*.** In order to access the additional funding in 2015/16, we would expect CCGs, with Control Boards, to develop appropriate local arrangements with primary and secondary care services (and other local service providers where appropriate) for these additional responsibilities, and for these to be set out in a local LTBI testing and treatment implementation plan. For example, with respect to primary care, a number of local areas have developed local incentive schemes for this purpose, such as offering GPs a small payment (for example, £5) for each patient identified as falling within the risk group and

who is tested for LTBI, together with a larger payment for those identified as having LTBI or active TB (for example, approximately £20 and £100, respectively in current local schemes). Arrangements are also being developed for the recording and submission of data in relation to patients identified and/or tested and the schemes developed locally should include participation in this data collection as part of the requirements for receipt of the funding. The specific local arrangements will require agreement with local GPs. CCGs should liaise with NHS England, as appropriate to the local primary care co-commissioning position, in developing local primary care arrangements.

- ***The LTBI test and analysis*** **(further details within the *'Latent TB testing and treatment for migrants*' guide)**. Consideration is being given to the procurement of additional testing capacity, potentially through a nationally co-ordinated framework for use by lead CCGs. However these arrangements are not likely to be in place until later in 2015/16. CCGs should therefore ensure sufficient capacity within existing testing arrangements in the interim period.
- ***Management and treatment of LTBI***, including further investigations where necessary. Treatment services are likely to form a significant proportion of the service costs supported by the additional funding. CCGs should work with the Control Board and with TB service providers to understand the potential caseloads arising from positive LTBI tests and consider appropriate arrangements.

The funding will be notionally allocated using an approach that takes into account the TB rates and case load within each CCG, although the actual allocations will be made on the basis of Control Board areas (which each include a number of CCGs). These plans (which should be signed off by Control Boards, NHS England and Public Health England) may set out deployment of these additional resources across the relevant local area in the manner they consider most effective to support reduced incidence of LTBI. The allocations will be held by the lead CCG(s) within a Control Board area.

Annex B sets out the notional allocations per Control Board for 2015/16 in terms of:

a) Identifying and testing new and recently arrived migrants and
b) Management and treatment of LTBI,

The actual amounts made available within these allocations will be dependent upon the nature and quality of local LTBI plans and their implementation timescales and progress. Further details are set out below.

- **Annex B** also sets out details of resources for the LTBI test and analysis. This funding will also be made available to CCGs in addition to the above, with the notional allocations to be confirmed when the above procurement arrangements are in place. CCGs should set out the funding sought for interim arrangements as part of their LTBI plans.

- Lead CCGs should have appropriate arrangements with other local CCGs to ensure that they are supportive of plans and can input into their development, particularly where the plans will result in other CCGs needing to take commissioning actions.

- The commissioning of relevant additional or redesigned services should be carried out by the relevant bodies with commissioning responsibility for that service, within the context of the plans agreed by the Control Board. For example, local incentive schemes for the identification and testing of patients should be agreed with local GPs by the relevant CCG as part of their wider responsibilities for local incentives schemes. Similarly, developments within secondary care services should be via the relevant CCGs within the context of their wider commissioning of TB services.

Factors which should be taken into account in the development of plans to tackle LTBI may include:

- The CCGs with high LTBI incidence within the Control Board area
- Whether these are geographically adjacent
- Whether the proposed approaches in adjacent areas (such as with regard to GP incentive schemes) are similar
- The footprint of existing local TB provider services

Plans should set out details of the additional funding required on a month by month basis during 2015/16, linked to implementation, actions and timescales and should include details of:

- How existing and additional funding will be effectively used for LTBI testing and treatment, having regard to the number of individuals planned to be identified and tested
- Confirmation that the plans have the support of all relevant partners set out in the template
- That the plans are deliverable in 2015/16, having regard to the key issues and risks identified
- That there is local clarity of responsibilities between CCGs, Control Boards and NHS England. Plans should include details of the arrangements between CCGs, their Control Board and NHS England with regard to the respective roles of the assurance process and of Control Boards in the implementation of the TB Strategy and how this will be managed on an ongoing basis

The template at **Annex C** has been developed for use by local organisations and TB Control Boards to support the development of plans for LTBI testing and treatment.

The prime responsibility for agreeing the plans rests with the Control Board and its members. In order to finalise an agreement in respect of the additional TB funding the national programme team would expect to see evidence that the local Control Board is content with the proposed local strategy and that there are specific plans in place in respect of latent TB testing and treatment broadly covering the issues set out in the proforma at **Annex C**.

In overseeing the development of local plans we recommend that Control Boards consider whether:

a) the plan sets out effective arrangements for LTBI testing and treatment, including monitoring
b) the plan sets out how it fits within the wider plans of the Control Board to address the aims of the Strategy

c) all appropriate partners have been engaged in the development of the LTBI plan and are supportive of it
d) the plan has appropriate senior approval, as set out in the template
e) the proposed use of existing resources and the additional resources requested are appropriate and represent value for money, having regard to the overall resources that may be required across all local LTBI plans that are to be submitted to the Control Board

When a plan has been finalised it should be submitted to england.reducingprematuremortality@nhs.net and at tbstrategy@phe.gov.uk , enclosing a copy of the supported plan, including any amendments that were made during the approval process and evidence of approval by the Control Board. Upon receipt, the national programme team will review the supported plan with regard to whether:

a) the plan covers all issues set out in the template
b) the proposed use of the additional resources requested are appropriate and represent value for money, having regard to the overall resources that may be required across all local LTBI plans and implementation of the Strategy.

Provided the above criteria are satisfied, agreement to release the relevant funding will be given. It is planned that the funding will be released on a quarterly basis with the initial quarter's funding released upon confirmation of agreement to the plan by the national programme team. Funding for subsequent quarters will be dependent upon ongoing confirmation by the Control Board to the national programme team that satisfactory progress is being made.

Annex A - CCGs by TB rates and numbers

Allocations to Control Boards have been calculated on the basis of CCGs within their area which have:

- TB rates ≥20/100,000 and TB numbers that represent ≥0.5% of total England TB numbers
- TB rates ≥20/100,000 but TB numbers that represent <0.5% total England numbers
- TB numbers ≥0.5% total England TB numbers but TB rates that represent <20/100,000

Each of these categories is identified separately in the table below. However, all three categories are equal priorities for use of the allocations.

Key	CCGs with TB rates ≥20/100,000 and TB numbers ≥0.5% total England TB numbers	CCGs with TB rates ≥20/100,000 but TB numbers <0.5% total England numbers	CCGs with TB numbers ≥0.5% total England TB numbers but TB rates <20/100,000

TB Control Board/PHE Centre	**CCG**	**TB numbers, average 2011 - 2013**	**TB rates, average 2011 - 2013**	**% total TB numbers England**
East Midlands	Corby	5.0	7.9	0.06
	East Leicestershire and Rutland	19.0	5.9	0.24
	Erewash	4.3	4.2	0.06
	Hardwick	3.0	2.8	0.04
	Leicester City	175.0	53.1	2.22
	Lincolnshire East	8.0	3.5	0.10
	Lincolnshire West	8.0	3.5	0.10
	Mansfield and Ashfield	6.3	3.1	0.08
	Nene	57.7	9.3	0.73
	Newark and Sherwood	1.7	1.7	0.02
	North Derbyshire	11.0	4.0	0.14
	Nottingham City	62.0	20.1	0.79
	Nottingham North and East	9.3	6.1	0.12
	Nottingham West	6.7	6.3	0.08
	Rushcliffe	4.7	4.5	0.06
	South Lincolnshire	5.7	4.2	0.07
	South West Lincolnshire	5.0	4.1	0.06
	Southern Derbyshire	50.7	9.9	0.64
	West Leicestershire	18.0	4.8	0.23
East Midlands total		461.0		5.85
East of England	Aylesbury Vale	14.3	7.1	0.18
	Basildon and Brentwood	14.0	5.6	0.18

TB Control Board/PHE Centre	CCG	TB numbers, average 2011 - 2013	TB rates, average 2011 - 2013	% total TB numbers England
	Bedfordshire	34.0	8.1	0.43
	Cambridgeshire and Peterborough	98.0	11.6	1.24
	Castle Point, Rayleigh and Rochford	4.3	2.3	0.06
	East and North Hertfordshire	38.0	7.0	0.48
	Great Yarmouth and Waveney	14.0	6.6	0.18
	Herts Valleys	48.3	8.6	0.61
	Ipswich and East Suffolk	14.7	3.8	0.19
	Luton	86.0	41.8	1.09
	Mid Essex	11.3	2.9	0.14
	Milton Keynes	37.3	14.3	0.47
	North East Essex	13.0	4.1	0.17
	North Norfolk	4.7	3.0	0.06
	Norwich	14.0	7.2	0.18
	South Norfolk	5.0	2.1	0.06
	Southend	16.7	9.7	0.21
	Thurrock	11.3	6.9	0.14
	West Essex	30.3	10.3	0.39
	West Norfolk	4.3	2.3	0.06
	West Suffolk	9.0	4.1	0.11
East of England total		522.7		6.64
London	Barking and Dagenham	67.0	35.1	0.85
	Barnet	94.3	25.9	1.20
	Bexley	31.0	13.2	0.39
	Brent	298.7	95.0	3.79
	Bromley	33.7	10.8	0.43
	Camden	59.0	26.2	0.75
	Central London (Westminster)	38.0	23.7	0.48
	City and Hackney	89.3	34.3	1.13
	Croydon	120.3	32.5	1.53
	Ealing	233.7	68.7	2.97
	Enfield	74.3	23.3	0.94
	Greenwich	115.7	44.6	1.47
	Hammersmith and Fulham	54.0	29.9	0.69
	Haringey	106.7	41.3	1.35
	Harrow	161.0	66.5	2.04
	Havering	24.7	10.4	0.31
	Hillingdon	123.3	43.7	1.57
	Hounslow	178.7	69.2	2.27
	Islington	71.7	34.1	0.91
	Kingston	27.7	17.1	0.35

TB Control Board/PHE Centre	CCG	TB numbers, average 2011 - 2013	TB rates, average 2011 - 2013	% total TB numbers England
	Lambeth	91.0	29.4	1.16
	Lewisham	86.7	30.9	1.10
	Merton	65.3	32.2	0.83
	Newham	357.3	113.6	4.54
	Redbridge	155.3	54.4	1.97
	Richmond	13.7	7.4	0.17
	Southwark	109.3	37.1	1.39
	Sutton	28.7	15.0	0.36
	Tower Hamlets	119.7	45.5	1.52
	Waltham Forest	121.7	46.4	1.54
	Wandsworth	80.7	26.2	1.02
	West London (K&C&Qpp)	60.3	27.3	0.77
London total		3292.3		41.80
North East	Darlington	4.7	4.7	0.06
	Durham Dales, Easington and Sedgefield	5.3	1.8	0.07
	Gateshead	6.7	3.5	0.08
	Hambleton, Richmondshire and Whitby	3.7	2.6	0.05
	Hartlepool and Stockton-On-Tees	16.3	5.6	0.21
	Newcastle North and East	13.0	9.2	0.17
	Newcastle West	27.7	19.8	0.35
	North Durham	4.3	1.7	0.06
	North Tyneside	6.7	3.5	0.08
	Northumberland	6.3	1.9	0.08
	South Tees	22.7	8.4	0.29
	South Tyneside	4.0	2.7	0.05
	Sunderland	20.7	7.6	0.26
North East total		142.0		1.80
North West	Blackburn with Darwen	52.3	35.2	0.66
	Blackpool	20.7	14.8	0.26
	Bolton	54.7	19.7	0.69
	Bury	20.0	10.7	0.25
	Central Manchester	106.3	58.4	1.35
	Chorley and South Ribble	8.3	4.8	0.11
	Cumbria	18.3	3.6	0.23
	East Lancashire	45.7	12.4	0.58
	Eastern Cheshire	8.3	4.1	0.11
	Fylde and Wyre	7.3	4.2	0.09
	Greater Preston	38.7	19.3	0.49
	Halton	0.7	0.8	0.01
	Heywood, Middleton and Rochdale	33.7	16.0	0.43

TB Control Board/PHE Centre	CCG	TB numbers, average 2011 - 2013	TB rates, average 2011 - 2013	% total TB numbers England
	Knowsley	4.0	2.7	0.05
	Lancashire North	8.0	5.1	0.10
	Liverpool	44.0	9.4	0.56
	North Manchester	54.7	32.9	0.69
	Oldham	46.7	20.8	0.59
	Salford	26.3	11.0	0.33
	South Cheshire	5.7	3.4	0.07
	South Manchester	26.3	16.2	0.33
	South Sefton	4.3	2.3	0.06
	Southport and Formby	5.7	5.3	0.07
	St Helens	4.3	2.3	0.06
	Stockport	20.0	7.0	0.25
	Tameside and Glossop	32.3	12.6	0.41
	Trafford	32.3	14.0	0.41
	Warrington	10.0	4.9	0.13
	West Cheshire	7.3	3.1	0.09
	West Lancashire	1.3	0.9	0.02
	Wigan Borough	10.3	3.1	0.13
	Wirral	10.7	3.1	0.14
North West total		769.5		9.77
South East	Ashford	10.3	8.3	0.13
	Bracknell and Ascot	9.3	6.8	0.12
	Brighton and Hove	23.3	8.3	0.30
	Canterbury and Coastal	13.0	6.5	0.17
	Chiltern	35.7	11.3	0.45
	Coastal West Sussex	22.3	4.6	0.28
	Crawley	25.0	23.1	0.32
	Dartford, Gravesham and Swanley	38.0	15.3	0.48
	East Surrey	12.0	6.8	0.15
	Eastbourne, Hailsham and Seaford	8.7	4.9	0.11
	Fareham and Gosport	9.0	4.6	0.11
	Guildford and Waverley	11.7	5.8	0.15
	Hastings and Rother	10.3	5.5	0.13
	High Weald Lewes Havens	7.7	4.8	0.10
	Horsham and Mid Sussex	14.0	6.3	0.18
	Isle of Wight	4.7	3.6	0.06
	Medway	21.3	7.8	0.27
	Newbury and District	7.0	6.7	0.09
	North and West Reading	7.7	8.0	0.10
	North East Hampshire and Farnham	30.7	15.0	0.39

TB Control Board/PHE Centre	CCG	TB numbers, average 2011 - 2013	TB rates, average 2011 - 2013	% total TB numbers England
	North Hampshire	12.0	5.6	0.15
	North West Surrey	36.3	10.6	0.46
	Oxfordshire	68.0	10.5	0.86
	Portsmouth	19.7	9.7	0.25
	Slough	82.7	56.5	1.05
	South Eastern Hampshire	3.7	1.9	0.05
	South Kent Coast	15.7	7.9	0.20
	South Reading	46.7	43.8	0.59
	Southampton	42.7	18.0	0.54
	Surrey Downs	17.7	6.4	0.22
	Surrey Heath	5.3	5.3	0.07
	Swale	2.0	1.8	0.03
	Thanet	10.0	7.4	0.13
	West Hampshire	13.3	2.4	0.17
	West Kent	20.7	4.5	0.26
	Windsor, Ascot and Maidenhead	10.3	7.2	0.13
	Wokingham	12.0	7.7	0.15
South East total		740.3		9.40
South West	Bath and North East Somerset	8.0	4.5	0.10
	Bristol	89.3	20.6	1.13
	Dorset	29.7	4.0	0.38
	Gloucestershire	35.3	6.0	0.45
	Kernow	17.7	3.3	0.22
	North, East and West Devon	35.7	4.1	0.45
	North Somerset	7	3.4	0.09
	Somerset	16.3	3.0	0.21
	South Devon and Torbay	16.3	5.9	0.21
	South Gloucestershire	16.0	6.0	0.20
	Swindon	23.7	11.1	0.30
	Wiltshire	14.0	2.9	0.18
South West total		309.0		3.92
West Midlands	Birmingham Crosscity	208.0	28.9	2.64
	Birmingham South and Central	78.0	39.1	0.99
	Cannock Chase	2.3	1.5	0.03
	Coventry and Rugby	128.0	30.2	1.62
	Dudley	35.0	11.2	0.44
	East Staffordshire	13.0	10.5	0.17
	Herefordshire	6.0	3.2	0.08
	North Staffordshire	8.0	3.7	0.10
	Redditch and Bromsgrove	16.0	9.0	0.20

TB Control Board/PHE Centre	CCG	TB numbers, average 2011 - 2013	TB rates, average 2011 - 2013	% total TB numbers England
	Sandwell and West Birmingham	241.0	50.7	3.06
	Shropshire	11.7	3.9	0.15
	Solihull	19.7	9.6	0.25
	South East Staffordshire and Seisdon Peninsula	3.0	1.3	0.04
	South Warwickshire	16.7	6.6	0.21
	South Worcestershire	14.0	4.8	0.18
	Stafford and Surrounds	9.0	6.0	0.11
	Stoke on Trent	41.0	15.9	0.52
	Telford and Wrekin	11.0	6.6	0.14
	Vale Royal	2.0	2.0	0.03
	Walsall	56.7	21.0	0.72
	Warwickshire North	19.7	10.6	0.25
	Wolverhampton	82.7	33.1	1.05
	Wyre Forest	1.3	1.0	0.02
West Midlands Total		1023.7		13.00
Yorkshire and Humber	Airedale, Wharfdale and Craven	15.7	10.1	0.20
	Barnsley	6.7	3.0	0.08
	Bassetlaw	3.3	2.6	0.04
	Bradford City	67.7	82.7	0.86
	Bradford Districts	85.0	25.5	1.08
	Calderdale	20.7	10.2	0.26
	Doncaster	21.0	6.9	0.27
	East Riding of Yorkshire	8.0	2.5	0.10
	Greater Huddersfield	42.0	17.6	0.53
	Harrogate and Rural District	4.7	3.2	0.06
	Hull	21.7	8.6	0.28
	Leeds North	21.7	11.0	0.28
	Leeds South and East	54.3	22.7	0.69
	Leeds West	28.3	8.8	0.36
	North East Lincolnshire	3.3	1.9	0.04
	North Kirklees	53.7	28.9	0.68
	North Lincolnshire	15.7	9.5	0.20
	Rotherham	20.7	8.1	0.26
	Scarborough and Ryedale	3.7	3.6	0.05
	Sheffield	93.0	16.7	1.18
	Vale of York	8.0	2.3	0.10
	Wakefield	18.0	5.5	0.23
Yorkshire and Humber total		616.7		7.83
England total		7877.3		

Annex B – Full year effect (FYE) notional allocations per Control Board and national developments in 2015/16 (Actual amounts payable are dependent upon Control Board plans and progress in delivery)

Control Boards	Details	
East Midlands	£	488,701
East of England	£	554,033
London	£	3,489,914
North East	£	150,522
North West	£	815,644
South East	£	784,762
South West	£	327,579
West Midlands	£	1,085,099
Yorkshire and Humber	£	653,745
National		
National TB team - Database support	£	500,000
LTBI test analysis (1)	£	1,150,000
Totals	**£**	**10,000,000**

(1) The £1,150,000 for LTBI test analysis will be utilised by agreement between NHS England, lead CCGs and their TB control boards to reflect local LTBI testing workload.

Annex C - Local Plan for new migrant LTBI testing and treatment services

We encourage you to seek advice as required from the national programme team as you complete this template. Please email queries jointly to england.reducingprematuremortality@nhs.net and to tbscreening@phe.gov.uk.

The completed plan should be submitted to the local TB Control Board with a copy to the above email addresses.

1. TB Control Board area
2. CCG area(s) covered by this plan
3. Proposed start date for LTBI testing and treatment service
4. TB epidemiology of the (CCG) area(s) covered by the plan and evidence of need for LTBI testing and treatment services
5. Service description and proposed service / care pathway (please be succinct)
a) Target population for LTBI testing
b) Mode of identification for eligible screening recipients
c) Method of invitation to new migrants (by whom and how)
d) Setting and pathway for testing
e) Testing arrangements (including interim arrangements for transport and laboratory processing until nationally procured arrangements are in place)
f) Setting and pathway for LTBI treatment
g) Referral criteria for active and LTBI treatment
h) Treatment arrangements

i) Proposed additional activities (e.g. awareness raising)
j) Proposed additional tests (e.g. BBVs)
k) Other important information
6. Has agreement been reached with local GPs/LMC on a local GP incentive scheme for LTBI testing? If so, please set out the arrangements agreed. If not, please set out the timescale for doing so, highlighting any key risk factors and how these are being addressed.
7. Has agreement been reached with the local TB secondary care providers for any additional capacity with respect to the treatment of LTBI positive patients? If so, please set out the arrangements agreed. If not, please set out the timescale for doing so, highlighting any key risk factors and how these are being addressed.
8. Are appropriate arrangements in place with respect to laboratory capacity for the LTBI tests, including interim arrangements whilst the conclusion of specific procurement arrangements is awaited? If so, please set out the details. If not, please set out the timescale for doing so, any key risk factors and how these are being addressed.
9. In what ways will existing services and other resources be used to support delivery of LTBI testing and treatment?
10. Expected local outcomes e.g. the expected number of patients to be tested and treated in 2015/16, wider community awareness of LTBI
11. Outline of the proposed evaluation and monitoring arrangements
a) Data collection and collation mechanism and interface to PHE LTBI surveillance system
b) Monitoring and reporting arrangements
12. Are all CCGs affected by the above proposals supportive of them?
13. Estimated funding requirements **(on a month by month basis for 2015/16)**
a) Number and costs of expected tests

b) Cost of GP incentives
c) Number of patients expected to need LTBI treatment and agreed additional costs for local TB services
d) Number of patients expected to need full TB treatment and agreed additional costs for local TB services
e) Other (including set up costs)
f) Total funding requirements on a month by month basis for 2015/16 (excluding costs of tests and laboratory services)
g) Funding requirements for laboratory analysis services for LTBI tests on a month by month basis for 2015/16, including for the costs of the tests themselves (until nationally procured arrangements are in place)

Key stakeholders involved in the development and delivery of this plan

(Please adapt as relevant locally but should include as a minimum CCG, NHS England and provider representation)

Stakeholder	Name	Role	Email / telephone number
Local LTBI Plan development lead (i.e. lead who has coordinated development of this plan)			
CCG TB Lead			
Secondary care LTBI lead			
Lead TB nurse			
CCG GP representative for LTBI			
NHS England team representative			
PHE TB lead			

Date plan prepared:

Confirmation of lead CCG support for the plan by the CCG Chief Officer

I confirm CCG support for the above plan and the financial implications and funding requirements therein.

Name: _____ Signature:_____

Title: _____

Date: _____

Confirmation by the relevant TB Control Board director that the Control Board supports the above plan

I confirm that the TB Control Board gave its support to the above plan and funding requirements on (insert date)

Name _____ Signature _____

Title: _____

Date _____

When a Control Board has supported a plan, it should be sent to england.reducingprematuremortality@nhs.net and to tbscreening@phe.gov.uk.