



## COMMISSIONING TB SERVICES

[www.brit-thoracic.org.uk](http://www.brit-thoracic.org.uk)

This advice note has been prepared to assist colleagues who are developing a business case for presentation to PCT commissioners for the provision of TB Services in their area. It has been prepared by Professor Peter Ormerod based on his experiences in the North West of England, and will be “a living document”. Queries can be addressed to [tb@brit-thoracic.org.uk](mailto:tb@brit-thoracic.org.uk).

A discussion forum is also available to BTS members on <http://www.brit-thoracic.org.uk/Members/AdvisoryGroupForums/tabid/73/forumid/14/scope/threads/Default.aspx>

### PREPARE

Before engaging with your PCT(s) you should be familiar with and will have to know about:

- 1. NICE TB Guidelines**  
<http://www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=10980>
- 2. Department of Health TB Commissioning toolkit**  
[http://www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/Archive/FeaturesArchive/DH\\_074748](http://www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/Archive/FeaturesArchive/DH_074748)

(This is MANDATORY for all PCTs in England)

- 3. Statistics**
  - the local number of active TB cases for treatment per annum (and trend)
  - local numbers of TB contacts and new entrants for screening per annum (and trend) and numbers of contacts that needed treatment for latent TB infection and active disease
- 4. TB resources available within your Trust**
  - Consultant PA's (Clinical + supporting) specific to TB
  - WTE TB Nurses
  - WTE Administrative support for TB Service.
  - Lab costs if using a Interferon Gamma Release Assay (IGRA)
- 5. How the service is delivered**

Briefly map how your TB service works and who it interacts with (e.g. PCT, other secondary trusts, social services, HIV, paediatrics).
- 6. Are you going to be a Level 1, 2 or 3 Service?**

The DH Toolkit defines these levels. Note that commissioning for the MDR-TB elements of a Level 3 service will be done at Regional Specialist Commissioning level.

## 7 Costs

The recently published Guide to Coding of Respiratory Care from the BTS and related commentary documents will be of help:-

[http://www.brit-](http://www.brit-thoracic.org.uk/DeliveryofRespiratoryCare/tabid/159/Default.aspx)

[thoracic.org.uk/DeliveryofRespiratoryCare/tabid/159/Default.aspx](http://www.brit-thoracic.org.uk/DeliveryofRespiratoryCare/tabid/159/Default.aspx)

## THE COMMISSIONING LANDSCAPE – TOP TIPS

### 8. You need to know who is the nominated TB lead in your PCT (s).

This is sometimes difficult to determine. Each PCT is obliged to have such a lead (it is a requirement of the TB Action Plan in England). The Chief Medical Officer is auditing this, as will the Interdepartmental Working Group on TB (IDWGTB) next year with 'naming and shaming of PCT's' if they haven't. The Director of Public Health for the PCT is either the person or should know who it is if it is a delegated function. Your MP might be able to assist if you suspect that this position remains unfilled within your PCT.

9. The TB Lead will be your initial contact, along with the Commissioners of the PCT (who will be advised by their TB lead).
10. The **Clinical TB lead for the Trust** should be intimately involved with the negotiations, as you are likely to be the only one present who fully understands TB provision and clinical aspects!
11. You (the Trust) should be capturing under PBR those persons with active TB as new patient's OPD attendances or admission (per tariff) and their follow-up (per tariff) visits. Check that you are!
12. The Trust may not have been capturing all the TB nurse related work, particularly if this is being done in the community, for contact and new entrant screening, TB nurse patient visits and DOT, and potentially any IGRA costs.

### 13. TB Nurse costings

For patients seeing a nurse in an OP setting as part of contact tracing: the tariff can be found in Procedure Contact tracing (E95.4), grouped as HRG DZ42Z TB Nurse Support.

For Local negotiation are:

1. other TB nurse costs for other activities
2. system costs e.g. for admin & clerical support

There are a range of potential combinations to consider and cost up - for TB contact, new entrant screening, and other TB work e.g. patient visits, DOT etc.

- Under the Toolkit all the nurse work undertaken outside a clinic is priced as 'for local negotiation'. For contact and new entrant work as per NICE Guidelines this will range from:-

#### Contacts

- i) Nurse visit only
- ii) Nurse visit + chest X-ray
- iii) Nurse visit + tuberculin skin test + 2<sup>nd</sup> visit for reading
- iv) Nurse visit + tuberculin skin test + 2<sup>nd</sup> visit including IGRA test
- v) iv) plus chest X-ray (+ve IGRA)

#### New entrants

- i) Nurse visit only (pre-Entry X-ray certificate)
- ii) Nurse visit + Chest X-ray
- iii) Nurse visit + tuberculin skin test + 2<sup>nd</sup> visit for reading
- iv) Nurse visit + tuberculin skin test + 2<sup>nd</sup> visit including IGRA test
- v) iv) plus chest X-ray (+ve IGRA)
- vi) If pregnant or under age 11 (ii-v apply); i-v apply to others

These all need to be costed (and to include travel costs and an element of clerical support per encounter)

The PCT then has the option of agreeing costs per category and paying that times the numbers seen, or the costs can be averaged and payment made as average cost x number seen.

### 14. Patient support visits for active TB

These are recommended monthly for support, compliance and side-effect monitoring, may need to be more frequent for patients with multiple problems.

(The author's service also does this monthly for patients on treatment with 3RH prophylaxis for treatment of LTBI)

### 15. DOT

Those persons with chaotic life styles and other factors for non-adherence will need either daily or thrice weekly DOT. How this will be done will vary, from a family medication monitor to attendance at a local GP surgery, but this could require daily or thrice weekly visits for the duration of treatment (26 weeks or longer if drug resistance/side-effects). Note that in England patients prescribed TB drugs from a **TB Clinic** do not pay prescription charges. Wales has abolished prescription charges. Prescription charges are being phased out in Scotland by 2011.

These also all need to be costed (and to include travel costs and an element of clerical support). The PCT will then agree the costing per visit and billing per period or per patient.

#### **16. Interferon Gamma Release Assays (IGRA)**

These are NICE recommended for those who are being considered for treatment of LTBI found through contact or new entrant screening. Those in this category are those with an inappropriately positive tuberculin test – Mantoux 6mm or more without prior BCG history, or 15mm or more with a prior BCG history, and the IGRA test is largely to exclude false positives from either prior BCG effect or environmental mycobacteria. This is also endorsed by the recent HPA advice on IGRA testing.

NICE did NOT differentiate between the two commercially available tests; T-spot TB (Oxford Immunotec) and Quantiferon Gold in Tube (Cellestis Ltd). This area will be revisited by NICE in late 2009 before the full TB guideline review date.

The two tests use the same CFP10 and ESAT6 to see if activated T lymphocytes to these epitopes are present and producing gamma-interferon in response. T-spot uses counting of labelled stimulated T cells, and Quantiferon Gold (QFT) gamma interferon production in the supernatant measured by ELISA. Each has potential advantages and disadvantages. Costings per test given to the author by NHS labs with no affiliation to either company are £35 system costs for QFT (Royal Blackburn Hospital) and £100 for T-spot (Immunology Royal Preston Hospital).

Although NICE recommends IGRA, it is apparent that many PCTs have indicated that they won't pay for it. It is therefore important that Trusts demonstrate to the PCT(s) that their use is cost-effective.

(See Gray M, Ormerod LP. An economic evaluation of the use of interferon gamma release assays in the screening of contacts and new entrants for latent TB. Thorax 2007;Vol 62 Suppl III: S49A pA22 BTS Winter Meeting 2007.)

PCTs can be given 2 options.

- a) ALL persons up to age 35 with an inappropriately positive tuberculin test WILL be put on preventive TB treatment as per NICE recommendation, at a median cost per case of £450 (NICE 2006 economic data), OR
- b) IGRA testing to be done on those potentially for treatment of LTBI, and only those with a positive IGRA test given treatment (see Gray and Ormerod above).

The author of this advice note was sufficiently confident that if the PCT agreed to option (b), the Trust would report the results after 12 months and change if not cost-effective. These results, reported at the 2007 BTS Winter meeting for this purpose, certainly for QFT showed very substantial cost savings (the year 2 data are even stronger). Essentially the 'neutral' cut off point is an 8% false positive tuberculin test rate, if more than 8% have a negative QFT then there is net saving which increases with the proportion of negative IGRA testing. The false positive rate with T-spot would have to be higher to be of economic benefit, because of the higher system cost per item.

### **17. MDR-TB Provision**

It is suggested that this should only be provided, certainly on an inpatient basis, in a limited number of centres which have both the appropriate negative pressure facilities, and a clinician (or clinicians) highly experienced in the management of complex drug resistance, in close liaison with the HPA Mycobacterium Service. This will need to be sorted out by Regional Specialist Commissioning. However if a Trust is a provider, they need to know what the true cost per case is, including an Estates element for maintenance and monitoring of negative pressure rooms, cost of FP3 masks, drugs etc. The PCTs should be charged on a cost per individual case basis, either directly or through a regional commissioning arrangement. To be included in this the Trust will have to be a Level 3 Centre.

### **18 Patterns of Care**

Because of the very variable distribution of TB there are different models of care. NICE clearly states active TB should only be managed by secondary care. TB Nurses may be employed by secondary care, primary care, and sometimes by the HPA. This will need to be borne in mind, but TB nurses are usually responsible clinically to the Local TB Clinician in secondary care.

Peter Ormerod 29.10.08

Updated July 2009