DEFINING A MODEL FOR A GOLD STANDARD FOR A TB MDT GROUP AND ASSOCIATED NETWORKS

1. PURPOSE AND BACKGROUND

1.1 This document has been prepared in order to provide advice and input from the British Thoracic Society (BTS) to NHS England (NHSE), Public Health England (PHE) and other national stakeholders to strengthen TB control throughout the UK. It is intended to guide the development of local and regional multidisciplinary networks, which will enhance and facilitate the coordination of care for those affected by TB, carers and their communities in managing the burden of tuberculosis.

1.2 We will attempt to, where possible, provide input to guide appropriate commissioning of TB services for each network and local service, including appropriate levels of staffing, resources, and the infrastructure required for optimal care of active infections, and prevention of transmission to others.

1.3 We have referred to several key papers in the preparation of this document:

2. The most recent report from the BTS SAG - the BTS 2012 survey of UK Leads, Department of Health funded clinical networks and MDT project.

2. Overall aim of a TB network

2.1 To integrate regional services to enhance and improve care, reduce inequalities, service inequity, overcome geography, improve education and achieve NICE approved quality standards of care e.g. LTBI case finding in new entrants, address vulnerable groups, extend research projects and opportunities, and improve education.

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2.2 To set up regional and local MDT meetings to review of complex cases / drug resistance and facilitate cohort review.

2.3 To enhance the early detection and diagnosis of TB through ‘joined-up’ responses across the network.

2.4 To ensure that all local services reach a minimum standard of care, through audit, cohort review, regular sharing of good practice and local expertise and benchmarking against national standards.

2.5 To provide a coordinated national structure to inform NHS England, PHE and other national organisations of local demographics and pressures on individual services e.g. changes in migration patterns, prison services, college overseas recruitment etc.

3. **Benefits of partnerships between networks, providers and commissioners**

3.1 The link between networks and commissioning is important. The commissioning of TB services is currently contentious, with little possibility that TB services for England will be funded centrally. There is also concern that services could fragment if services are locally commissioned. A *model of collaborative commissioning appears to be a solution to the potential fragmentation of such services*. There is a strong economic case for effective management of TB with a public health imperative, a lack of national strategy and poor management of TB which can be costly in the long term. NHSe is also responsible for specialist commissioning. Notably, specialist commissioning applies to several rare malignancies which have similar numbers to TB (eg Oesophageal cancer 6,700 in 2009) and TB as a whole may be a suitable disease to consider in this regard.

3.2 Poor case management can lead to the emergence of drug-resistant cases which are much more expensive to treat.

3.3 To secure high-quality services, commissioners need to consider their local TB incidence and current and potential population demographics, for example new demands as a result of population migration.

3.4 Therefore we recommend that all CCGs plan TB services focusing on all elements of TB control e.g. diagnosis, treatment, contact tracing, case management, enhanced case management, DOT, active and latent case finding, treatment of LTBI and BCG vaccination. Every CCG should identify a named TB lead.

3.5 Where the number of active cases within a CCG is low, commissioning TB services on a collaborative basis is more likely to provide high-quality services.

3.6 TB should be diagnosed and managed by experienced TB specialists. While primary care clinicians may suspect a diagnosis of TB, a formal diagnosis – including treatment and care plans – is usually best made by specialist service providers. A systematic new entrant screening programme should be part of primary care active case screening.

3.7 We believe that the proposals we set out within this document for the structure of TB networks for both low and high incidence areas will inform commissioning bodies at a local level (CCGs) and nationally (NHS England and PHE), enabling informed decision-making on appropriate
funding of services, and raising concerns with any changes in demands over time. Stakeholders in public health and clinicians active in the field of TB have long been convinced that the use of specific tools to commission TB services is essential if the NHS is to respond effectively to the projected rise in TB over the next decade. Effective commissioning helps facilitate long-term planning and continuity in service development, including reconfiguration of services. Currently TB services are commissioned by CCGs through local commissioning processes with a lack of clarity about how best TB services could be commissioned or procured.

3.8 Good public health measures are essential for effective TB control. The response to TB needs to be planned, even in low-incidence areas, so that in the event of an incident, outbreak or significant change in the population demography, local health service providers can respond effectively.

3.9 Properly planned TB services will be required to achieve effective control of TB and reverse disease trends in the UK incorporating new entrant screening for LTBI as well as optimise active case detection.

3.10 The above approach depends on staff responsible for public health, clinical services and health protection being fully involved in the commissioning process.

3.11 For this reason, a key recommendation is that each CCG or lead CCG, even in low-incidence areas, identifies a TB lead. This could be part of the role of the CCG respiratory lead and could involve collaboration across CCGs or networking with other commissioners, as necessary.

3.12 Commissioners need to be aware that a diagnosis of TB is rarely confirmed in general practice and diagnosis and treatment of TB are best provided by specialist TB services. To ensure timely identification of those who do have the disease and rapid exclusion of those who do not, commissioned services need to include the management of suspected TB.

4. Findings of the 2012 BTS survey

4.1 In the last BTS survey of UK 2012, TB leads reported that 68% were part of a clinical network, a figure similar to the 2009 survey. The definition of a network was one that crossed administrative boundaries with a named coordinator.

4.2 Of those not involved in a network at the time of the survey, a large majority of TB leads indicated that they would be interested in being part of a network.

4.3 The majority of networks existing at the time of the 2012 survey consisted of multi-disciplinary teams (MDTs) formed within a hospital Trust (73%) with only 30% across Trusts. 45% of TB leads stated that they were also involved in a Regional Network, and at that time, 35% undertook formal cohort review.

4.4 There was a relatively low representation by commissioning organisations in TB management boards (67%, 8 of 12 respondents). There was also evidence of a lack of engagement with non-Governmental organisations in case discussions, where it is likely that complex social and adherence issues may benefit from input.

4.5 Each clinical network group submitting information to the 2012 survey appeared to have
good representation by microbiologists, and public health input for cohort reviews appeared promising (75%).

4.6 Clinical reference groups where present across the country appeared to function principally in guideline and service delivery.

4.7 A minority of networks received administrative support for their coordinated functioning (48%), with a lack of detail on the level of requirement or provision from the 2012 survey.

4.8 At the time of publication of the 2012 survey, it was apparent that many TB leads were unclear of the effects of NHS Commissioning boards, and CCGs on the TB networks with uncertainty over whether the new structures would enhance or worsen/fragment TB service delivery both in primary care and TB specialist care.

4.9 In the preparation of this manuscript, it has become clear that regions (‘centres’) around the country with higher TB incidence (e.g. ‘London integrated region/centre’ and Greater Manchester) have special requirements, demanding enhanced networks including their functioning, structure and make up.

4.10 The Model of Care: TB services in London document has elegantly laid out in great detail the make-up and structure of services including ‘delivery boards’ to address the variability of service provision in order to commission and provide excellent care.

5. Network footprints

Two existing structures within England appear to present a suitable to base for a Network structure/footprint:


5.2 Clinical Senates: See quote from ‘The Way Forward – Strategic Clinical Networks – NHS Commissioning Board 26 Nov 2012’-

“The NHS CB has divided England into 12 areas, broadly based around major patient flows into specialist or tertiary centres. The footprint of each area maps onto CCG and local authority boundaries. Each area will contain a number of different bodies including clinical senates, strategic clinical networks and academic health science networks. The work of these bodies will support and encourage the improvement of local health services. Clinical senates will have a particularly close relationship with strategic clinical networks. Each geographical area will have one clinical senate, taking a broader, strategic view on the totality of healthcare within that patch. Clinical senates will provide evidence-based advice to help commissioners put the needs of patients above those of organisations or professions. They are likely to play a key role in providing a strategic overview of major service change – for example, on service redesign and reconfiguration. Further information on the detail of how clinical senates will be developed and established will be the subject of a separate publication.”
Academic health science networks will bring together academia, NHS commissioners, providers of NHS services and industry. AHSNs will undertake a range of agreed core functions to bring about collaborations between education, training, research, informatics and healthcare delivery and encourage innovation and the improvement of patient and population health outcomes.”

5.3 Strategic clinical networks will be supported by 12 support teams, shared with the senates and hosted by NHS CB Area teams. The actual number of networks will be determined by local clinical relationships and patient flows. They will agree annual work plans with members and be held to account by the area team medical director.

5.4 Further information was set out in the November 12 NHS CB publication: Strategic clinical networks, an operating framework at http://www.commissioningboard.nhs.uk/resources/networks-senates (see Appendix).

6. Potential configurations

We therefore recommend that the orientation of TB networks across the UK should map to either:

6.1 Strategic clinical networks – these 12 network regions (see Appendix) also map to clinical senates and will be supported by 12 support teams, shared with the senates and hosted by NHS CB Area teams and may therefore most closely mirror commissioning. This alignment to the commissioning geographic footprint is our preferred model. The actual number of networks will be determined by local clinical relationships and patient flows but form the potential basis for TB clinical networks.

OR

6.2 the geographic outline of the PHE centre, its make-up and structure be dependent on the TB incidence within the ‘centre’ it falls within. This might mean that some currently existing networks need reshuffling or re-organising to conform to the new outlines of the PHE centres. This may enhance the quality of network and provision of data to inform national bodies and would aim to inform and improve local commissioning.

7. Components of a Whole Network Approach

7.1 We recommend that the network set-ups from either model should incorporate a proportion of the components defined within the ‘Model of care: TB Services in London’ paper, and maintain a nomenclature for each component of the network structure to avoid confusion or duplication of activities/committees/boards.

- ‘Pan-city’ find and treat service (akin to the Pan-London find and treat service, on the basis of its successes)

- a city-wide commissioning board (a control board to mirror the approach of New York’s fight against TB in the 1990’s). This would include the formal development of a fund to support temporary accommodation for homeless persons and this is reiterated in the latest NICE publication for local government and as has been set up in London.
- **a three level service provision**
  an established care pathway and a designated Level 3 provider which would offer expert advice and support as necessary (including accepting transfer of care if required) – for medically complex patients [Liaison will include maintaining a real-time register of cases which are medically complex and the participation in joint multi-disciplinary team reviews].

7.2 **A workforce development group** - We recommend that the proposed roles of each component of the network and the membership be defined to support the TB doctors and nurses e.g. Occupational Health input from the largest hospital Trust, microbiology, social services, PHE, third sector, paediatric input from specialists dealing with TB.

7.3 Performance monitoring should occur regularly both of the Commissioning boards and also delivery boards and individual service providers in local hospital trusts, this might include a Peer/Service review process, akin to that already occurring across cancer networks and with regular measurements against service specifications.

7.4 Two other cities in the United Kingdom have high incidences of TB, namely Birmingham, where TB rates in 2009 were 88 per 100,000 population and Leicester, which experienced rates of 72 per 100,000 population. These cities fall in the PHE centres of ‘Lincolnshire, Leicestershire, Nottingham and Derbyshire’ and ‘West Midlands’ where overall ‘centre’ incidence might fall below 20 per 100 000, but clearly have special requirements best dealt with by the approaches outlined above. There may therefore be a case for recommending these two areas are organised on a city basis and not in their designated PHE regions although the CSU in Birmingham has a potentially suitable footprint that would address their high incidence areas (see Appendix).

8. **The formation, integration and development of low incidence networks**

8.1 The majority of the country is served by PHE centres with an incidence of below 20 per 100 000 cases per year (East of England, East Midlands, North East, North West, South East, South Central, South West, West Midlands, Yorkshire, Wales Northern Ireland and Scotland), with some very low incidence areas.

8.2 We recognise that whilst these areas may be geographically large, and have varying needs for TB services, they may be best served by a formalized structure of a TB network, which aligns with the outline of the NHS England (a Clinical Network region) or PHE centre geographical shape, with a central ‘Hub’ at the Hospital Trust with the highest local TB incidence or recognized specialist centre to provide local expertise for advice on complex patients, isolation facilities for patients living across the network who require negative pressure room for highly infectious disease, and perhaps to host the network meetings, cohort review, and cross organizational MDT educational meetings.

8.3 Specific problems related to high risk groups may however arise in these lower incidence networks which require specific tailor-made solutions, namely those networks with a prison or with organisations dealing with trafficked people, networks with a local University or colleges with a high proportion of foreign students from high TB incidence countries and networks with a city with a higher incidence of TB. This will require the development of special measures to ‘find and treat’ both active and latent disease (case finding/screening)

8.4 **The structure of a typical lower incidence network might look like this:**

- Local TB multidisciplinary team meeting, with key workers involved (doctors, nurses, microbiologist, paediatrician) to discuss real time local cases, issues, with a frequency
of at least fortnightly. Other provincial TB services from the ‘Spokes’ could feed into these meetings for input on cases, or to enhance education (possibly by video-conference links if geographical area large)

- Quarterly Network meetings to discuss strategic issues, including outbreak and cluster management, commissioning issues, and quality assurance (adherence to NICE guidelines etc). This should preferably have a representative from each CCG, as well as membership from the local PHE, a medical and nursing representative from each hospital in the network, microbiologist, (radiologist and pharmacist for the network)

- A formalized structure for Cohort review should be in place, to meet and discuss cases from across the network post-hoc.

- An additional set up to provide regular educational opportunities for local specialists and primary care/GPs/ practice nurses should be in place, either within the network or through arrangement outside the network but sufficiently local for this to be accessible.

- A formal structure should be in place to support enhanced case management (ECM) of complex TB cases, coordinated by a named case manager working alongside a specialist multidisciplinary TB team able to provide expert clinical and psychosocial care and to engage effectively with the client group in the community. This must incorporate the basic and early engagement of each case with a TB case manager and to ensure adherence and smear conversion at the 2 month visit. ECM should be provided for all socially complex cases with suspected TB to reduce the risk of patients disengaging with services prior to a diagnostic conclusion.

- In addition to the standard services and expertise within a multidisciplinary TB team, local centres within the network providing ECM are able to provide patients access to:
  1. expert management for clinically complex cases, including spinal, CNS disease, HIV co-infection, significant other co-morbidities and rifampicin resistant disease
  2. negative pressure facilities appropriate for prolonged isolation
  3. skilled outreach and advocacy workers able to draw effectively on the services of allied agencies to address patients’ housing, addiction, welfare benefits and other social care needs
  4. flexible clinic opening hours, appointment systems and community DOT options.

8.5 A hub and spoke model is the preferred service model with all TB services able to provide standard case management and onward referral to the specialist hub of the network which can provide enhanced case management and ensure that all TB patients can access a level of care equal to their needs whilst ensuring that core delivery of care remains within their local services.

8.6 Each network should have the ability to access help from national groups such as the MDR TB advisory service on the BTS website, or ‘pan-London find and treat services’ for advice and input on managing socially complex/homeless TB cases.

8.7 The formation of a network delivery or ‘control’ board with the nomination of a lead clinician, nurse specialist, HPU lead to provide strategic direction and oversight and in place for each
network (refer to Levels of complex TB in London Model of Care). The New York model allowed for one responsible individual to allow clear leadership and accountability.

8.8 We would like to make a number of recommendations to support both doctors and nurses in their bid to incorporate these duties and responsibilities into individual job plans. This should be possible through the annual job plan review structure in place for consultants and through direct consultation with nurses’ line managers. Careful calculations should include travel and preparation time, and will vary from network to network depending on the frequency of these meetings, and their location. This information should be regularly made available to local CCGs to inform and update commissioning arrangements.

8.9 It is necessary to factor in the demands of case managing all suspected cases and the additional complexity of managing socially and clinically complex cases requiring ECM. Staffing levels should be planned on activity levels with reference the 2012 RCN guidelines on TB case management. Commissioners should also take into account the number of latent TB cases started on treatment and it has been proposed that these be counted as half a full active disease notification and with appropriate staffing levels (2012 Royal College of Nursing Guidelines).

8.10 Specialist TB nurse knowledge and skills in low to medium incidence can be used to provide nurse led clinics for screening and selective BCG immunisation programmes to ensure competency of other health care professionals involved in the delivery of these services. These might include midwives, school nurses, practice nurses, health visitors, occupational health and prison services.

8.11 Administrative and clerical support should also be factored in when planning services to facilitate good nursing practice and communication between stakeholders.

8.12 We recognise the advantages of collaboration through networks across England, particularly in avoiding duplication between various agencies, e.g. PHE and BTS, or to enhance communication when TB patients transfer between networks, or if contact tracing has to extend into other networks.

8.13 We would finally like to make a proposal for the development of an audit tool to benchmark against best practice for both high and low incidence networks. This tool could be set up through the British Thoracic Society website, once the components of each type of network is agreed and ratified, and provided funding is made available.

9. SCOTLAND

9.1 The Scottish situation is different, but the recommendations aim to develop common themes which are relevant.

9.2 Fourteen regional NHS Boards which are responsible for the protection and the improvement of their population’s health and for the delivery of frontline healthcare services.

9.3 Seven Special NHS Boards and one public health body who support the regional NHS Boards by providing a range of important specialist and national services.

9.4 The incidence and prevalence of TB in these regions can be very low, and this raises difficulties in the effective provision of services and expertise i.e. in many Health Boards, there would not be sufficient cases to support a whole nurse for instance, but when there are a few cases, s/he is not able to cope with the sudden burst of activity e.g. for screening. In addition in some of...
the lower incidence Boards, even the busiest hospital would only see single figures per year. In this setting it would be worthwhile looking at lower incidence Health Boards joining to manage resources effectively and having clinicians feed their cases into the MDTs of busier health boards (or at least having formal access to ECM). The Scottish Action Plan on TB (2011) goes along the TB MDT model stating that all Boards should have an MDT with various characteristics of MDTs specified.

9.5 A recent Scottish survey (‘A TB Action Plan For Scotland: ANNUAL REPORT 2013’) suggested that all Boards stated that they were providing these MDT’s but the SAG impression is that some of the MDTs are variable in quality. There should be consideration of Scottish Government funded central support for MDTs to help with administrative support and auditing of meetings, which will address the current situation where there is no support or resource to coordinate and run MDTs.

10. WALES

10.1 Following the reorganisation of NHS Wales which came into effect on October 1st, 2009 single local health organisations were created with responsibilities for delivering all healthcare services within a geographical area, rather than the Trust and Local Health Board system that existed previously. The seven Local Heath Boards (LHBs) in Wales now plan, secure and deliver healthcare services in their areas, replacing the 22 LHBs and the 7 NHS Trusts, which together performed these functions in the past. It is likely that the same issues that face Scotland in terms of providing appropriate networks for TB in low incidence areas operate.

10.2 We suggest that these are organised as per the recommendations for low incidence areas.

11 NORTHERN IRELAND

11.1 The NHS is referred to as HSC or Health and Social Care. In addition to health delivery in it also provides social care services.

11.2 The Department of Health, Social Services and Public safety has over all authority for health and social care services. Services are commissioned by the Health and Social Care Board and provided by five Health and Social Care Trusts – Belfast (the largest of the five), South Eastern, Southern, Northern and Western. Each Trust manages their own staff and services and controls their own budget.

11.3 The Department of Health, Social Services and Public Safety for Northern Ireland (DHSSPS) is one of 11 Northern Ireland Government Departments created in 1999 as part of the Northern Ireland Executive. Health and Social Care is one of the three main business responsibilities of the Department which are notably:

- Health and Social Care (HSC), which includes policy and legislation for hospitals, family practitioner services and community health and personal social services;
- Public Health, which covers policy, legislation and administrative action to promote and protect the health and well-being of the population;
- Public Safety, which covers policy and legislation for fire and rescue services.
11.4 The Health and Social Care Board sits between the DHSSPS and Trusts and is responsible for commissioning services, managing resources and performance improvement. The Board is also directly responsible for managing contracts for Family health services provided by GPs, dentists, opticians and community pharmacists. These are all services not provided by Health and Social Care Trusts. Inside the Board there are Local Commissioning Groups (LCGs) focusing on the planning and resourcing of services. The LCGs cover the same geographical area as the five Health and Social Care Trusts.

11.5 We suggest that the 5 Health and Social Care Trusts areas are therefore organised as per the recommendations for low incidence areas.
EXECUTIVE SUMMARY: RECOMMENDATIONS

A. FOR A HIGH INCIDENCE OR CITY BASED NETWORK:

- Incorporate a proportion of the components defined within the ‘Model of care: TB Services in London’ paper, and maintain a nomenclature for each component of the network structure to avoid confusion or duplication of activities/committees/boards.

- City-wide Commissioning board and Control (Delivery) board

- Three level service provision - Designated Level 3 provider which would offer expert advice and support as necessary (including accepting transfer of care if required) – for medically complex patients.

- A workforce development group

- ‘Pan-city’ find and treat service (akin to the Pan-London find and treat service)

- Peer review

B. FOR A LOW INCIDENCE NETWORK:

- Network-Regional Control Board and Commissioning Board with Lead Clinician, Lead Nurse, Lead PHE, Commissioning Lead and an accountable individual

- Local TB multidisciplinary team meeting at ‘Hub’ (ie unit with highest numbers or expertise within a network), with key workers involved (doctors, HIV team, paediatrician, nurses, microbiologist,) to discuss ‘real time’ local cases, issues, with a frequency of at least fortnightly - Other provincial TB services from the ‘Spokes’ to feed into these (possibly by video-conference links if geographical area large)

- Quarterly Network meetings to discuss strategic issues, including outbreak and cluster management, commissioning issues, and quality assurance (adherence to NICE guidelines etc.)

- Bespoke solutions for ‘pockets’ of high incidence or complexity (eg prison/ detention centres/colleges)

C. STAFFING CONSIDERATIONS

- Network activities should be incorporated into job plans

- Calculations to include preparation and travel time (including cohort review)

- Staffing levels should be in line with 2012 RCN guidelines

- Latent TB cases on treatment should be counted as half a notification

- Administrative and clerical support to be factored in

D. NETWORK FOOTPRINT

The current PHE regions or Clinical Senate regions appear to be suitable alternatives on which to base a Network footprint to allow most clinical or commissioning adjacencies.

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Ben Marshall, Nuala Whitehead and Onn Min Kon on behalf of the BTS SAG Dec 2013

Thanks to the following for their additional input:

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Appendix

Definition of terms

**TB Commissioning Board** - a Commissioning Board should bring together the functions of health care commissioning, health protection and public health to co-ordinate TB control across the capital.

The Board should, in time, take on responsibility for commissioning all specialist TB services, although further work is required to determine how it would operate following the current reorganisation of NHS organisations.

**TB Delivery Boards** - A Delivery Board will be responsible for ensuring network protocols for the assessment of risk, the use of DOT and cohort review are implemented and the outcome indicators specified by the commissioning board are achieved. This should be designed to ensure high quality TB care is delivered irrespective of where a patient lives.

(see London Model for Care document)
12 Clinical Network/Clinical Senate areas, broadly based around major patient flows to tertiary providers
Public Health England organisational design: Structure

Regions and centres

Public Health England will operate through four regions and 15 centres. These are shown on the map below.

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London TB organogram

London TB Control Board – relationships and stakeholders

PHE London

NHS England (London Region)

CCGs

National TB Oversight Group
PHE

London TB Control Board

NHS England Primary Care

CCG TB Commissioning Group

London TB Strategic Executive Group

London Clinical Senate
NHS England (London Region)

London TB Clinical Leadership Group

North Central London TB Network

North East London TB Network

North West London TB Network

South East London TB Network

South West London TB Network

Stakeholders to all bodies include health care providers, Local Authorities, communities, PHE (national and London), NHS England (London), housing, social services, TSOs, CCGs, CSUs, Public Health, APPG, GLA, GPs

March 2014
Greater Manchester
TB Control Collaborative

Salford CCG Lead

TB Control Collaborative

Local Government

NHSE

Local TB
Partnership
- Feedback on service use
- Voluntary sector activity

Commissioning Advisory Group
- Epidemiology
- Evidence base
- Strategy

Input from:
- Lead DPH
- PHE
- Clinicians
- Nurses
- Voluntary sector

- Salford CCG lead manager
- GP CCG member (Manchester?)
- NHSE
- Lead DPH
- PHE
- DASS?

Association of CCGs

Commissioning decisions on
- BCG immunisation
- Latent TB screening
- Treatment and care
- Nurse staffing
Birmingham & Solihull TB Programme Board Reporting Arrangements

Health and Wellbeing Board
  ▲
  Health Protection Forum

Health and Wellbeing Board
  ▲
  Health Protection Forum

Birmingham & Solihull
• Local TB Partnership
  • LTBP Operational
  • Key Stakeholder Engagement
  • Educational Settings

• TB Clinical Group
  • Incident Management
  • Cohort Review
  • Screening
  • Cluster
  • Imms & Screening AT Lead / BCG

NHS England

Sub Groups
• LTBP Operational
• Key Stakeholder Engagement
• Educational Settings

Sub Groups
• Incident Management
• Cohort Review
• Screening
• Cluster
• Imms & Screening AT Lead / BCG