Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 20 September 2023

Subject: Health Protection - Operational Local Health Economy Outbreak Plan Manchester and Update on Tuberculosis

Report of: Director of Public Health

Summary

This report provides background information about the refresh of the Operational Local Health Economy Management Plan for Manchester and includes the draft plan for approval. It also provides a detailed focus on current epidemiology and issues relating to tuberculosis (TB).

Recommendations

The Board is asked:

1. To approve the Operational Local Health Economy Outbreak Management Plan for Manchester.
2. To be aware of the current issues around TB and recommend that the Director of Public Health a) escalates migrant health related issues to the newly established NHS GM Migrant Health Group; b) advocates through professional networks for more latent TB testing to be available for all residents with higher risk of TB, not just new entrants and not just adults.

Our Manchester Outcomes Framework

Manchester Strategy outcomes	Summary of how this report aligns to the OMS/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	The Local Health Economy Outbreak Plan ensures that Manchester has the appropriate response arrangements to any outbreak of infectious diseases which will mitigate against health related harms across the life course. The work to prevent, detect and treat tuberculosis contributes to the Health and Wellbeing Strategy priorities of the city.
A highly skilled city: world class and home grown talent sustaining the city's economic success	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

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Background documents (available for public inspection): None

Introduction

Protecting and improving the health of our communities is at the heart of public service delivery. Health protection encompasses a range of activities including ensuring the safety and quality of food, water air and the general environment, preventing the transmission of communicable diseases and managing outbreaks and other incidents which threated public health.

Preventing the transmission of communicable disease requires action across the health and wider system on a number of fronts including infection prevention and control in settings, screening, vaccination and outbreak response under the oversight of the Director of Public Health; whose responsibility it is to work through local resilience forums and local health resilience partnerships to ensure tested and effective plans are in place.

The focus of this report is to share the refreshed Local Health Economy Action Plan for approval (Part One) and to provide a detailed picture of the situation and issues relating to tuberculosis in Manchester (Part Two), which is of particular concern.

1.0 Part One: Local Health Economy Outbreak Plan

1.1 The plan has been developed to ensure clarity on operational roles and responsibilities for each responding organisation in the event of an outbreak. It is intended to act as a companion to the Greater Manchester Multi-Agency Outbreak Plan, providing operational detail helping responders to quickly provide an effective and coordinated approach to outbreaks of communicable disease. The draft plan can be found as appendix 1.

1.2 Whilst the response to outbreaks isn't new and our local health economy routinely demonstrates that is has effective arrangements in place, it is important that we review the arrangements, and that the organisations and people who need to work together in partnership are aware of each other's roles and responsibilities for a range of scenarios.

1.3 In July 2017, the Greater Manchester Resilience Forum and Local Health Resilience Partnership approved the Greater Manchester Multi-Agency Outbreak Plan. It sets out the strategic principles for outbreak management in Greater Manchester, including the roles and responsibilities of key organisations.

1.4 All Greater Manchester Health and Wellbeing Boards were subsequently recommended to ensure completion of a local outbreak plan, using a template provided by the Civil Contingencies Resilience Unit.

1.5 This template was completed by the Manchester Public Health Team in early 2017, and the Plan was presented to the Health & Wellbeing Board and approved in 2019.

1.6 Many organisations have proven that they have a role to play in protecting the public from communicable disease during the last three years. We have refreshed our Local Outbreak Plan to consider learning from the pandemic, in addition to ensuring it reflects the current health economy in Manchester.

Part Two: Update on Tuberculosis

2.0 Background

2.1 Tuberculosis (TB) is a bacterial infection spread through inhaling tiny droplets from the coughs or sneezes of an infected person. It mainly affects the lungs (Pulmonary TB) but can also develop in areas outside the lungs, including the abdomen, glands, bones and nervous system (Extrapulmonary TB).

2.2 Symptoms of TB include a persistent cough that lasts more than 3 weeks and usually brings up phlegm, which may be bloody, weight loss, night sweats, high temperature, tiredness and fatigue, loss of appetite and swellings in the neck. In some cases, symptoms might not develop until months or even years after the initial infection.

2.3 If the person has symptoms, it's called active TB. Sometimes the infection does not cause any symptoms but the bacteria will remain in the body. This is known as latent TB. People with latent TB are not infectious to others but latent TB can develop into an active TB disease at a later date, particularly if the immune system becomes weakened.

3.0 TB treatment and notification

3.1 TB is a potentially serious condition but, in most cases, a six-month course of treatment with the right antibiotics will cure it. TB can become resistant very easily and drug resistant TB can be very difficult to treat. For that reason, only experienced personnel should manage these patients. A Consultant Respiratory Physician must manage all adult patients with TB and a Consultant Respiratory Paediatrician must manage all patients less than 16 years of age.

3.2 Parts of the world with high rates of TB include Africa (particularly sub-Saharan and west Africa), South Asia, Russia, China, South America and the western Pacific region.

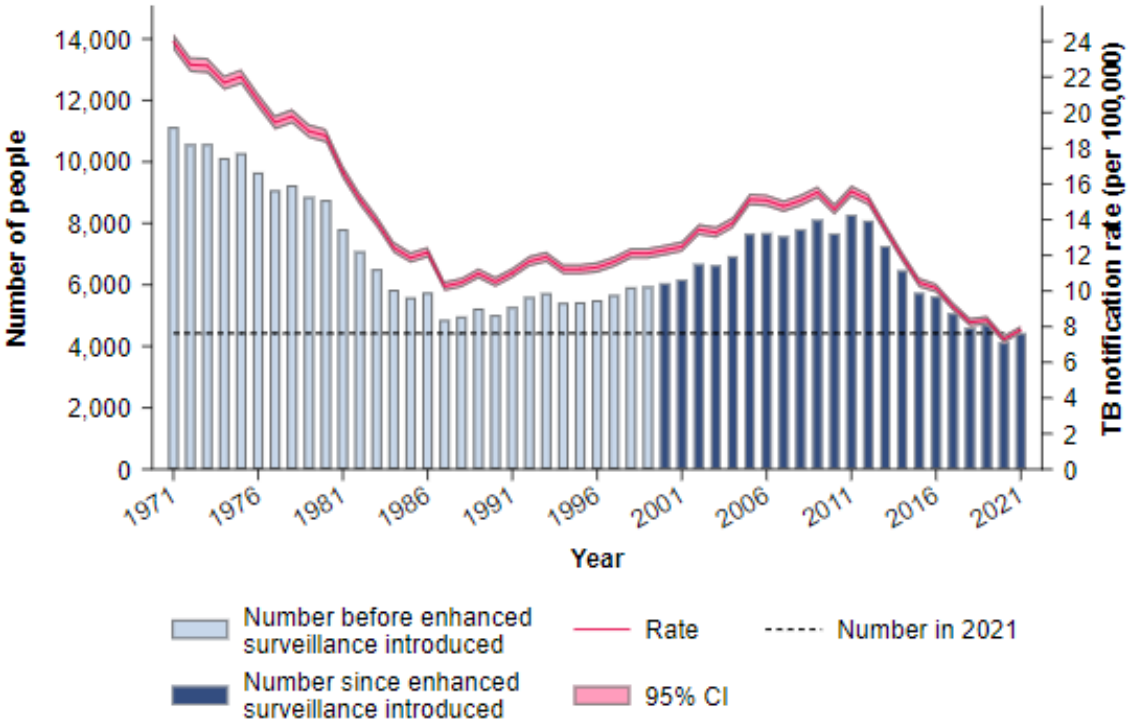
3.3 All new cases of TB must be notified to the UK Health Security Agency (UKHSA) on a web-based surveillance system. Although the incidence of TB is low nationally, it is higher in England than many other comparable countries and as it is concentrated in urban areas. There are pockets of very high incidence in some parts of our cities, including areas in Manchester. TB is a disease of inequality. In 2019, national rates of TB were 5 times higher in the most deprived decile compared with the least deprived decile.

4.0 TB incidence and epidemiology in England, 2021

4.1 In 2021, TB incidence was 7.8 per 100,000 - below the World Health Organisation threshold for a low incidence country (less than or equal to 10 per 100,000 population).

4.2 Nationally, TB incidence has decreased overall since 2011 but the rate of decline is slowing, and England is not currently on target to achieve the plan of reducing TB incidence by 90% from 2015 to 2035 (see figure 1 below).

Figure 1 - Number of TB notifications and TB notifications rate per 100,00, England, 1971-2021



4.3 TB incidence is not evenly distributed across the country and is concentrated in large urban areas. The disease disproportionately affects the most deprived populations, including groups at risk of exclusion and other health inequalities, and people born outside the UK.

4.4 Infectious pulmonary TB is more common in men, people with a history of imprisonment and people with a history of drug and alcohol misuse. Social risk factors (e.g. drug or alcohol misuse and history of imprisonment) in people with TB were more common in the UK-born population compared with the non-UK-born population. In contrast, homelessness, asylum seeker status and mental health needs were more common in the non-UK-born population with TB than in the UK-born population with TB.

4.5 The long-term effect of the global coronavirus (COVID-19) pandemic on TB incidence is difficult to determine but recent patterns mirror those seen in other countries.

5.0 Epidemiology of Tuberculosis (TB) in Manchester

5.1 The latest local epidemiological summary is based on published data up to the end of 2021 (Data published: November 2022) from the Enhanced Tuberculosis Surveillance (ETS) 2022. More information is available through the TB Strategy Monitoring Indicators tool: http://fingertips.phe.org.uk/profile/tb-monitoring

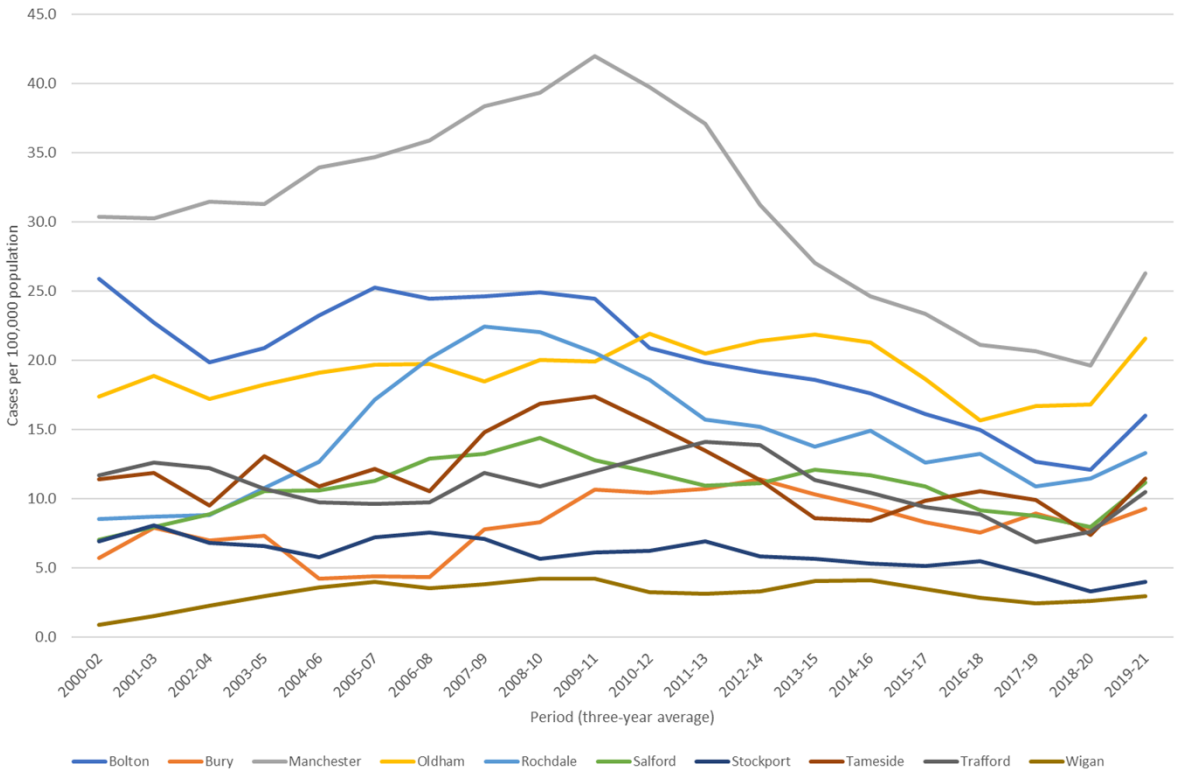
5.2 Table 1 shows the three-year average numbers of TB case notifications and rates by local authority in Greater Manchester, 2019-2021. The average annual rate per 100,000 population in Greater Manchester was 9.5. Among upper tier local authorities, the highest rates were in Manchester at 21.0 per 100,000 population; and in Oldham at 16.8 per 100,000 population. The areas with the lowest rates were Wigan and Stockport.

Table 1 - Three-year average numbers of TB case notifications and rates by local authority: Greater Manchester, 2019 to 2021

Local authority	Average annual no. of people	Average annual rate per 100,000	95% CI (Lower)	95% CI (Upper)
Bolton	35	12.0	9.8	14.6
Bury	13	7.0	5.0	9.5
Manchester	**117**	**21.0**	**18.9**	**23.4**
Oldham	40	16.8	14.0	20.1
Rochdale	19	8.7	6.6	11.2
Salford	23	8.7	6.7	11.0
Stockport	6	2.0	1.2	3.2
Tameside	19	8.4	6.3	10.8
Trafford	19	7.9	5.9	10.2
Wigan	7	2.2	1.4	3.4
Greater Manchester	298	9.5	7.6	11.7

5.3 TB incidence in Manchester has decreased overall since 2009-2011 but the rate of decline started slowing in 2016-18 and then started to increase from 2018-20 (see top line on the graph in figure 2 below). There is a similar uptick in TB incidence in most areas in Greater Manchester from 2018-20.

Figure 2 - TB incidence rate per 100,000 population, Greater Manchester, 2000-02 to 2019-21 (three-year average)



6.0 National Co-ordination of TB work

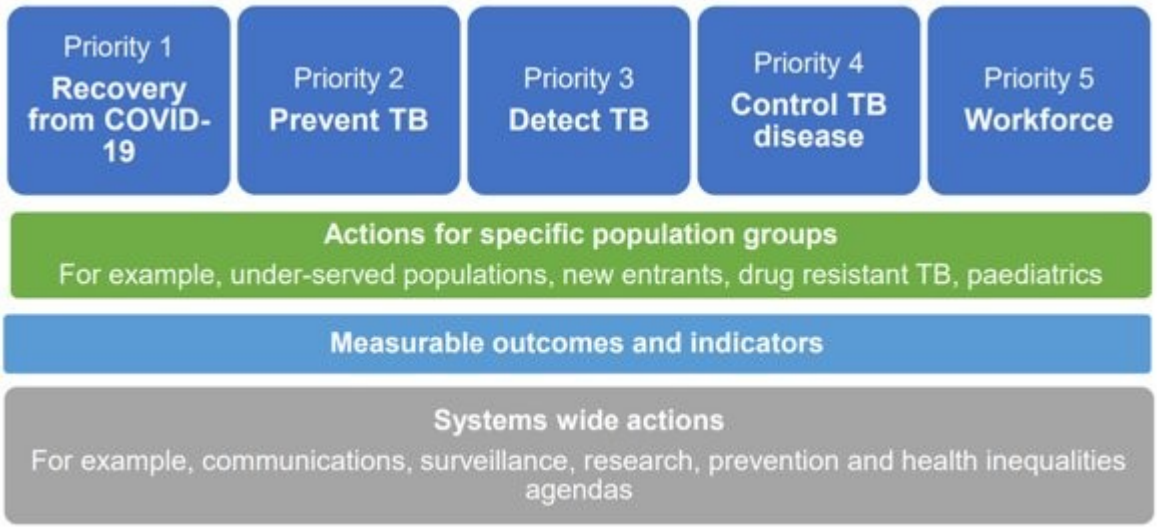
6.1 **National Action Plan** - For the UK to meet its commitment to achieve the World Health Organisation target of eliminating TB by 2035, a year-on-year reduction in people with TB disease is required, as well as addressing health inequalities that put people at risk of developing active TB disease.

6.2 To help address this, the UK Health Security Agency and NHS England jointly launched the TB action plan for England (2021 to 2026) in July 2021. This action plan is a road map for COVID-19 recovery of TB services and has 5 priority areas:

- recovery from COVID-19 pandemic – understanding and reporting the impact and learning from the pandemic
- prevent TB
- detect TB
- control TB disease
- workforce

6.3 The action plan aims to achieve these objectives through system wide actions involving close partnership working between the UK Health Security Agency with NHS and local authorities.

Figure 3 - TB Strategy for England: Priorities, Actions and Outcomes



7.0 Local plans and arrangements

7.1 The North West TB Control Board, chaired by the UK Health Security Agency, provides strategic leadership towards achieving TB elimination at a regional level. Sub-regional representation on the group comes from NHS commissioners, NHS providers, microbiology, field epidemiology and includes local authority public health representation. Manchester City Council's Assistant Director of Public Health (Health Protection Lead) represents Greater Manchester Directors of Public Health on the Board.

7.2 The Greater Manchester TB Collaborative leads the development and implementation of a multi-agency TB Control Strategy for GM based on the National TB Action Plan 2021-26. The Collaborative is responsible for providing assurance on the implementation of the GM TB action plan 2021-26, developing and implementing the GM TB control strategy 2022-2025, promoting service improvements that result in reductions in GM TB incidence and providing strategic oversight and direction on the commissioning, quality assurance and performance management of GM TB services. The GM TB Collaborative is accountable to the GM ICS (Population Health Board) and reports to the NW TB Control Board. The Collaborative reports quarterly progress against TB control metrics as outlined in the GM TB control strategy. Manchester City Council's Assistant Director of Public Health (Health Protection Lead) represents Greater Manchester Directors of Public Health on the GM TB Collaborative.

7.3 The Manchester Health Protection Board, chaired by the Director of Public Health, has responsibility for overseeing TB work at a local level. There have been several focussed discussions on TB at the Health Protection Board over the last 12 months, given the complexity of the work and the risks and issues associated with the current situation, described in more detail in section 3.69-3.81 of this paper. Manchester City Council's Assistant Director of Public Health (Health Protection Lead) shares information from the NW TB Control Board, the GM TB Collaborative, and local Manchester Health Protection

Steering Group. The Manchester Health Protection Board reports to this Health and Wellbeing Board.

7.4 As part of the Greater Manchester Health Protection Reform work, a workstream to share learning and further develop joint work on TB is being implemented. Support is being provided from the Local Government Association's National Sector Led Improvement Team and work is currently underway to map existing TB services and processes with all 10 local authorities and their partners. Manchester City Council's Assistant Director of Public Health (Health Protection Lead) is the lead for this workstream, supported by colleagues from within the Manchester Department of Public Health, other GM local authorities and colleagues from NHS Greater Manchester Integrated Care and UK Health Security Agency.

7.5 Learning from other areas of the country will help us to progress our work in Manchester and we are also keen to share what we have learned and influence work at a national level. Team members from the Manchester Department of Public Health are presenting our local work at the National TB Nurses and Allied Health Professionals Conference 2023 on 29th September and are contributing to a national toolkit on TB that is being developed.

8.0 TB Service Provision across Greater Manchester

8.1 Each locality within GM has health professionals who can care and treat a person with latent or active Tuberculosis and each locality has a specific TB consultant. Some areas have a full-time dedicated TB nurse, others may have a part time TB nurse who works in other areas of respiratory medicine or infectious diseases. Table 2 below shows the TB service provision in Manchester from Manchester University NHS Foundation Trust (MFT).

8.2 Any cases of multi drug resistant TB are cared for by a specialist centre such as North Manchester General Hospital Infectious Diseases Unit or the Manchester Royal Infirmary. Every person who has been identified with TB disease is notified to UK Health Security Agency.

8.3 Some patients require more intensive support through treatment with treatment option such as directly observed therapy. In such cases, the TB nurse will visit the patient three times per week and observe the patient taking the treatment.

8.4 In addition to screening and treatment as part of local TB outbreaks, the TB services across MFT have been heavily involved with a large scale TB screening programme for Afghan refugees and with providing TB screening and treatment for residents of a hotel housing asylum seekers in the area.

Table 2 - TB Service Provision in Manchester from Manchester University NHS Foundation Trust

TB Service Provision in Manchester from Manchester University NHS Foundation Trust	
North Manchester	• Team based at North Manchester General Hospital. • Dedicated infectious diseases unit with 6 negative pressure rooms. • Team of 6 TB nurses. • Dedicated paediatric infectious disease consultant also based here
Central Manchester	• Team based at Manchester Royal Infirmary. Part of Respiratory Medicine. • Two consultants and team of 6 nurses. • Facility to care for multi drug resistant TB patients. Hospital has capacity for 2 negative pressure rooms • Royal Manchester Children's Hospital provides TB care to children across the GM footprint. Two Paediatric constants with a special interest in TB based here.
South Manchester	• Team based at Wythenshawe Hospital. Part of Infectious Diseases Unit. • Team of infectious disease physicians and infectious disease nurses who care for people with TB

8.5 There is strong collaborative working between key organisations and teams involved in TB prevention, detection, and control in Manchester. Manchester City Council's Department of Public Health Team works closely with other teams in the Council, such as Housing, Education, Communications, and the No Recourse to Public Funds Team, as well as UK Health Security Agency, MFT TB Team and NHS Commissioners amongst others.

9.0 Delivery of National TB Programmes in Manchester and Greater Manchester

9.1 There are two national TB programmes - National Latent TB infection screening programme in high incidence areas and BCG vaccination programme.

Latent TB Infection Screening Programme

9.2 The Latent TB Infection (LTBI) programme aims to reduce TB by testing and treating latent TB in migrants aged 16 to 35 years who have arrived in England from countries with a high TB incidence (≥150 per 100,000 population or sub-Saharan Africa) within the last 5 years and had been living in that country for 6 months or longer. This has been extended to enable people who were unable to access an LTBI test in 2020 due to the COVID-19 pandemic.

9.3 The LTBI programme is funded by NHS England and implemented locally by ICSs. The delivery model of the LTBI programme is locally determined. There are three models:

1. TB services: Use Flag 4 data (GP registrations of new migrants), filtered for programme eligibility, to invite people in for a test. TB services are based in either secondary or community care.
2. Primary care: New registrations that meet the programme eligibility are offered the LTBI test
3. Dual/hybrid model: A combination of TB services and primary care delivery

9.4 In Manchester, delivery model 1 is used and the programme is run by the TB service at MFT.

3-year LTBI programme plan: Manchester, Bolton and Oldham, 2022-2025

9.5 Manchester, Bolton and Oldham within Greater Manchester ICP are three of the identified high TB burden areas in England able to receive additional funding from NHS England (NHSE) for the provision of an LTBI testing and treatment programme.

9.6 Funding for the national LTBI testing and treatment programme has been confirmed until 2024/25. The NHSE LTBI programme budget is sufficient to fund only 26% of the total number of eligible new registrations, as indicated in Flag 4 data for TB high burden areas.

9.7 Table 3 below is the proposed GM 3 year plan for the LTBI service, including the figure (column three) for 26% of Flag 4 data annual average number.

Table 3 – Greater Manchester 3 year plan for the LTBI service

Area	Planned Screening Activity (per year)	GM Total Planned Screening Activity (per year)	2022/23 expected LTBI activity based on Flag 4 numbers	GM 2022/23 requested NHSE funding allocation
Bolton	350	2,162 each year of the programme	287	£265,081.10 (£122.61 per test)
Manchester	1,512		1,371	
Oldham	300		220	

9.8 Commissioners and clinical colleagues across GM ICB and MFT have been working on a draft business case for the last 12 months. The aim of this business case is to secure additional funding to improve the current TB/LTBI service to enable an offer screening to all eligible patients across Greater Manchester. Delays in securing funding adds to the increasing backlog of people needing to be screened and increases the public health risk of more TB infection.

10.0 Migrant health and TB screening

10.1 The Department of Public Health is working in collaboration with Manchester Foundation Trust Clinicians, Go To Doc Health Care and other providers to implement screening and outbreak management programmes in various settings across the city. Discussions are now underway to ensure the appropriate funding streams are accessed to deliver programmes going forwards. However, there are a number of resource and capacity constraints which will need to be resolved in partnership with NHS Greater Manchester Integrated Care Board (NHS GM ICB).

10.2 A new Migrant Health Group will be established, co-ordinated by NHS GM ICB, that will meet for the first time in Autumn 2023 to oversee work that is best undertaken at Greater Manchester level as many areas of Greater Manchester are now experiencing similar challenges to Manchester.

11.0 BCG Vaccination Programme

11.1 The BCG (Bacillus Calmette-Guérin) immunisation programme was introduced in the UK in 1953 to protect against TB and has undergone several changes in response to changing trends in TB epidemiology.

11.2 The BCG vaccine is not given as part of the routine vaccination schedule but only when a child is at increased risk of coming into contact with TB. The BCG vaccine should only be given once in a lifetime.

11.3 Eligible babies include all new-born babies whose parent/s or grandparent/s was born in a country where the annual incidence of TB is 40 per 100,000 or greater or new-born babies living in areas of the UK where the annual incidence of TB is 40 per 100,000 or greater.

11.4 Traditionally, the BCG vaccine has been offered to babies soon after birth, often whilst the baby is still in hospital. Following an evaluation of the addition of screening for Severe Combined Immunodeficiency (SCID) to the routine new-born screening test at 5 days of age, the timing of the BCG vaccination offer has been moved to take place at around 14 to 17 days after birth. Current guidance states that eligible babies should be offered the BCG vaccine 28 days after birth (or soon after), although vaccination may be administered earlier than 28 days provided that a SCID screen outcome is available.

11.5 All local authorities in Greater Manchester run a selective vaccination programme. This type of programme covers all infants (aged 0 to 12 months)

with a parent or grandparent who was born in a country where the annual incidence of TB is 40 per 100,000 or greater. The Selective programme is run in areas that do not require a universal programme. No eligible population or coverage figures are reported for selective programmes.

11.6 In 2021-21, 2993 Manchester children had been vaccinated for BCG before their 1st birthday (see Table 5 below).

Table 4 - Children vaccinated for BCG by their 1st birthday by Local Authority, 2021-22

Local Authority	Number of children vaccinated
Bolton	1,272
Bury	501
Manchester	**2,993**
Oldham	1,242
Rochdale	850
Salford	681
Stockport	419
Tameside	498
Trafford	485
Wigan	195
Greater Manchester	9,136

Source: Childhood Vaccination Coverage Statistics, England, 2021-22. Copyright © 2022 NHS Digital.

11.7 In April to June 2022, Manchester had 70.7% BCG vaccine coverage of all eligible children at 3 months of age (see Table 6 below). This is a similar percentage to the Greater Manchester average (70%) but much less than the 83.7% achieved in Oldham, the area with the second highest TB rate in Greater Manchester.

Table 5 - BCG vaccine coverage at 3 months of age for eligible children in Greater Manchester local authorities: April to June 2022

Local Authority	Number of eligible children	Coverage (%)
Bolton	266	54.1
Bury	113	66.4
Manchester	**843**	**70.7**
Oldham	239	83.7
Rochdale	183	79.2
Salford	187	64.2
Stockport	94	61.7
Tameside	136	80.9

Trafford	82	58.5
Wigan	63	76.2
Greater Manchester	2,206	70.0

12.0 Managing active TB cases in community settings

12.1 Each case of active TB in a community setting can be very complex to respond to. There are many elements to consider to when considering an effective response. Addressing the risk to close contacts, recommending, planning and delivering screening sessions are vital in controlling spread of infection. Providing care for those identified as having latent TB, as a result of exposure, requires the expertise of many of Manchester's specialist teams working together.

12.2 Manchester City Council's Department of Public Health, Health Protection leads, and GM UK Health Security Agency Health Protection Team work closely with the TB Team at Manchester University NHS Foundation Trust (MFT) who provide clinical care and screening of identified contacts. There is increased demand on services once cases are identified via screening. The MFT TB team follow up with the case for the duration of their treatment, usually a six-month period.

12.3 The Manchester City Council (MCC) Health Protection lead role within the Department of Public Health is vital in ensuring the session runs safely and smoothly, including briefing councillors, the Director of Public Health, Adult Social Care, Education and other MCC leads with up-to-date situation reports.

12.4 Manchester City Council's Adult Social Care, Education, Communications Teams and others, along with care providers & school leaders, are integral to the IMT and respond to situations, providing reassurance to their responsible areas and wider community. Our Communications colleagues have been instrumental in the success of recent responses by developing bespoke easy read materials and translated products. This enables MCC to be consistent in messaging and aware of the specifics of the incident and actions to be taken.

13.0 Support for people with No Recourse to Public Funds

13.1 Housing is a key part of ensuring a person with TB is able to complete their treatment. If people have nowhere suitable to live, with good access to healthcare appointments, it can be difficult to comply with treatment. This puts them at increased risk of becoming very unwell, developing multidrug resistant TB and spreading it to others. Alongside accommodation it is important for TB recovery for patients to have sufficient income to ensure they are able to consume healthy, nutritious food.

13.2 For patients with no recourse to public funds who are homeless, there is no pathway to suitable temporary accommodation through existing accommodation services. Cases typically present at hospital and receive initial treatment as an inpatient and have nowhere to be discharged to.

13.3 National Institute for Health and Care Excellence Tuberculosis guideline recommends that local government and clinical commissioning groups should fund accommodation for homeless people diagnosed with active TB who are otherwise ineligible for state-funded accommodation, using health and public health resources, in line with the Care Act 2004.

13.4 As Clinical Commissioning Groups no longer exist, there is currently no identified funding for housing or subsistence under NHS GM Integrated Care Board arrangements and the financial cost is picked up by public health until this issue is resolved. This is in line with our approach to responding to public health risks outlined in the local outbreak management plan (see part one).

13.5 Whilst cases are small in number they are complex and require a multi-agency response to organise discharge, housing and subsistence payments as well as additional support such as primary care provision, language support and social care. Each response is different and is based on public health risk assessment and clinical and social needs. Treatment typically lasts for six months although it can be up to 12 months depending on clinical need. In Manchester our response is coordinated by public health working closely with UK Health Security Agency, MFT and the Council's No Recourse to Public Funds Team.

14.0 Summary and conclusions

14.1 There is strong collaborative working between key organisations and teams involved in TB prevention, detection, and control in Manchester. These strong working relationships have developed over time and from working through complex situations together.

14.2 The local systems are working as well as they can within the resource constraints set out above and Manchester is fortunate to have strong political support from the Executive Member for Healthy Manchester and Social Care. Through the Executive Member, the Public Health team have ensured that local members are briefed appropriately on any outbreaks that relate to their wards.

14.3 The Director of Public Health for Manchester and the Manchester Health Protection Team believe migrants should have screening for active TB before arrival in the UK. However, as this is not the case we are having to respond to cases as they arise and manage the public health risks appropriately.

14.4 We also believe that there should be equitable access locally and nationally to systematic and timely provision of inclusive and appropriately-funded TB screening. This should be accessible to all who are at high risk.

14.5 The newly established NHS GM Migrant Health Group provides the opportunity to review the provision for active and latent TB screening for new entrant migrants. The Group will consider how the appropriate funding and capacity is made available to enable appropriate screening, assessment and subsequent treatment.

15.0 Recommendations

15.1 The Board is asked:

1. To approve the Operational Local Health Economy Outbreak Management Plan for Manchester.
2. To be aware of the current issues around TB and recommend that the Director of Public Health a) escalates migrant health related issues to the newly established NHS GM Migrant Health Group; b) advocates through professional networks for more latent TB testing to be available for all residents with higher risk of TB, not just new entrants and not just adults.