British HIV Association
BHIVA

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Andrew George MP
Chair, APPG on TB
House of Commons
London SW1

By email to: logans@parliament.uk

Dear Mr George

APPGA ON TB – consultation on Britain's response to the growing threat if drug-resistant tuberculosis

Please find on the following pages the response to the consultation on behalf of the British HIV Association (BHIVA).

If you have any queries, please do not hesitate to contact me.

Yours sincerely

Professor Jane Anderson
Chair
British HIV Association (BHIVA)

Your details

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The BHIVA comments are presented in numbered paragraphs as requested and also shown in red text.

SECTION 1: Improving efforts to tackle DR TB (United Kingdom)

Detection and Treatment targets

- Treatment completion rates for TB and DR TB are not meeting the World Health Organisation (WHO) target of 85%. What barriers are there to meeting and/or exceeding this target and how can we improve completion rates in the UK?

1. Staffing-still need to have adequate TB specialist nurse to patient ratios
2. Improving DOTs coverage –increased use of community based DOT e.g. pharmacies, use new technology e.g. watching patients take medication over internet

- Drug resistance is a man-made problem, resulting from misuse of anti-TB drugs and poor management of the disease. How important is it to manage drug susceptible cases effectively to avoid resistance developing?

1. Can't avoid transmitted resistance but can avoid inappropriate management
2. Diagnostics are still relatively slow and use of new technology such as Gene Xpert may give rapid results regarding resistance
3. Staffing and adherence issues as above
4. Retaining patients in care an issue because of homelessness and migration-good community liaison and support with Hostel and GP involvement important

Active Case finding

- What more could be done to strengthen the control of DR TB through improved detection and diagnosis and what role does active case finding have in reducing incidences of DR TB.

1. Use of rapid easy diagnostics
2. Need adequate funding or Test and Treat schemes

3. Ensuring adequate staffing for contact tracing which is essential to find and treat and impact on incidence
4. Ensuring good community liaison for screening high risk groups
5. Ensuring Health Care professionals screen high risk patients for TB-

Variations in Screening and Care

- What guidance exists on the drug treatment and clinical management of MDR and XDR TB and what can be done to ensure that the clinical management of all MDR and XDR TB patients is optimal?

1. HPA, BTS and DOH guidance -would be good to Have new NICE approved guidance covering all aspects of management, care, diagnosis, infection control, HIV, etc.
2. There is an MDRTB discussion forum service managed now by BTS-needs ongoing support
3. Ensure adequate staffing ratios and admin support and supporting a case based management approach and ensuring that all outbreaks are managed and resourced effectively

- What are the main issues re accessing, prescribing and monitoring second line drugs?

1. Sometimes there are stock outs
2. Should only be prescribed by those with experience
3. Need enhanced side effect monitoring
4. Drug interactions are mainly un-researched especially with HIV drugs and so are not predictable
5. New drugs are still very difficult to get as patients have to fit very restricted categories- there needs to be pressure on the pharmaceutical industry to allow more rational use in MDR e.g. for patients who can't tolerate some of the traditional second line drugs

- Are current recommendations and resources for the treatment supervision and case management of DR TB effective? Please give examples.

1. Many are but a coordinated document that includes all aspects of diagnosis, care, public health and infection control would be welcome as one benefit would be improved patient pathways

2. Increase use of new technology –texting emails and Internet
3. Funding for case management needs to be adequate

Commissioning of TB services

- What impact will the Health and Social Care Act 2012 have on the commissioning of TB services in the future?

1. There must be collaborative commissioning arrangements for TB prevention and control services, for the changes to be effective – e.g. for cities or large metropolitan areas. Any fragmentation or disinvestment will impact on TB incidence, morbidity and mortality

- "If Clinical Commission Groups (CCG'S) commission TB services collectively and at scale and if services for complex cases of TB such as MDR and XDR were commissioned by the NHS Commissioning Board in the new structure", as outlined in the POST Note would this improve coordination of TB services under the new structures? Please explain your reasoning for agreeing or disagreeing.

1. There would need to be national tariffs that would take into account the complexity of inpatient and outpatient DR cases and a reassurance these cases would be adequately funded because of the public health relevance. This would need agreement on currency definitions.
2. Co-ordination and agreement between the CCGs and Commissioning board re case definition, data management etc is important

- How do you think the DR TB prevention, care and control could be improved under NHS Reforms?

1. No BHIVA response here.

TB and Immigration

- The UK Borders Agency is now rolling out pre-entry screening for Active form of TB. What impact – if any – will this have on rates of TB in the UK?

1. This needs to be coordinated with a water tight follow up policy for those suspected of TB and also for those with no TB but who may develop it shortly after arrival
2. In South Africa screening asymptomatics with new technology Gene Xpert etc has proven useful in finding cases

- “Experts argue that new pre-entry screening system will only be fully effective if combined with screening for latent TB in high-risk new arrivals”. Do you agree with this statement? Please explain why you do or do not agree.

    1. Agree IGRA testing may be easier than skin tests but again watertight follow up is needed to ensure that results are acted upon

SECTION 2: Improving efforts to tackle DR TB (Globally)

Work to support diagnosis and treatment

- What policies, actions and resources are needed to reverse the rise in DR TB globally?

    1. Has to be support by DFID in countries where DR is prevalent e.g. Eastern Europe India China southern Africa –need infrastructure, diagnostic drug availability and training support

- Should there be a focus on increasing completion rates of drug susceptible TB instead of shifting focus to tackle the transmission and the growing treat of DR TB in high burden settings, or is it possible to focus on both given the resources available?

    1. Needs to be a comprehensive policy as DR is spread in the same way as drug sensitive i.e. droplet nuclei but is generated by poor diagnostics, poor management, lack of public health measures 9eg putting cases on an open ward especially where HIV is prevalent), etc.

- Should and (if so) in what ways could the UK Government increase its support for reversing the increase in DR TB?

    1. Increased targeted funding, supporting TB programmes

- What is the current availability/affordability of test for DR TB? How could the availability of these tests be improved?

    1. New technology e.g. Genee Xpert that can detect rifampicin resistance in a few hours is expensive but may be feasible where there are existing lab facilities-use in rural setting is being explored

Research and development

- What impact would advances in the development of drugs, diagnostics and vaccines have and what role – if any - does the UK Government have in encouraging the development of new tools to tackle TB?

    1. All vital to combating TB
    2. Government should support both research and innovation in this field