



Public Health
England

Protecting and improving the nation's health

People with tuberculosis, no money, no recourse to public funds and no accommodation

A directory of information for local
authorities and clinical commissioning
groups

June 2019

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Contents

Executive summary	4
Background	6
What can be done about TB?	9
What can local authorities do to tackle TB?	10
What can clinical commissioning groups do to tackle TB?	11
People with nowhere to live	12
What are the costs of looking after patients with TB and NRPF and nowhere to live?	14
What are the legal considerations?	18
How should it be determined whether a patient is NRPF?	22
Appendix	25
Acknowledgements	29
References	30

Executive summary¹

There have been a number of cases of people in Yorkshire and Humber with tuberculosis (TB), no money, no recourse to public funds (NRPF) and nowhere to live that have been very challenging to manage. There is no nationally agreed pathway for how best to support these people. This document brings together key resources to aid commissioners in developing local pathways to improve the care of patients in these situations, reduce health inequalities and reduce costs.

An 2017 overview of statutory guidance, lessons learnt from previous cases, and the current approach (i.e. no clear local pathways) to supporting these people in Yorkshire and Humber reached the following broad consensus:

- A heightened clinical risk due to possible non-adherence to treatment regimen
- Excessive costs of situational management over and above the costs associated with providing additional support to patients, which constitutes a poor use of public funds
- A drain on the energy and resilience of the regional workforce (across multiple organisations)
- A significant detrimental impact on patient and family experience

An economic analysis of two real-life situations in Yorkshire and Humber found high non-commissioned costs (£18,255 to £36,450) to managing these situations. This is in addition to potential costs from unnecessary hospital bed occupancy.

Whilst numbers and rates of TB notifications have fallen in England since 2011, our rates are higher than in other parts of Europe, and the proportion of people with one or more social risk factors is increasing.

Under-served populations, including those with nowhere to live, are one of the key areas identified that needs addressing in the Collaborative TB Strategy. Accommodation is a crucial part of TB management. Without somewhere to live, people with TB are less able to take their treatment appropriately, attend healthcare appointments and recover from the infection. This puts not only their health at risk, but increases the likelihood of multidrug resistance and spread to others.

The National TB Specification identifies 'evidence of local arrangements to ensure that people diagnosed with active pulmonary TB who are homeless are identified' as a key performance indicator and that people with active pulmonary TB who are homeless should be offered accommodation for the duration of their treatment. The National Institute for Health and Care Excellence guidelines state local government and clinical commissioning groups should fund

¹ Please note this document was correct at the time of writing but colleagues are responsible for ensuring it is still current at the time of use. This can be done by contacting the TB programme manager at PHE Yorkshire and Humber.

People with tuberculosis, no money, no recourse to public funds and no accommodation

accommodation for homeless people diagnosed with active TB who are otherwise ineligible for state-funded accommodation. The Local Government Association and Public Health England highlight local authorities have a key role in encouraging NHS commissioners, local authorities, housing departments and hostel accommodation providers to agree a process for providing accommodation for people with TB who are vulnerable or homeless and otherwise ineligible for funded accommodation.

Background

There have been cases of people with tuberculosis with no money, no recourse to public funds and no accommodation in Yorkshire and Humber in the last few years which have been very difficult to manage. They result in complex treatment and accommodation pathways, at high financial and time costs to local commissioners and the health service. It has been highlighted that many areas do not have agreements in place to best manage this situation when it occurs, so some areas have begun to explore the development of pathways to address this. It is a very challenging issue, requiring multi-agency collaboration and understanding of the clinical, legal and social factors that influence managing these cases. This document aims to act as a resource for commissioners in the process of developing these pathways.

What is tuberculosis?

Tuberculosis (TB) is an infectious disease caused by *Mycobacterium tuberculosis complex* bacteria that can affect many parts of the body including the respiratory system, lymph nodes, gastrointestinal system, bones, nervous system, and genitourinary system.¹ More than half of people infected with TB have respiratory symptoms, which allows the infection to be spread through the air by droplets when people with active tuberculosis cough or sneeze.¹ Others may develop disease in other parts of the body.

Unlike many other bacterial infections, tuberculosis has unusual features, which can make it challenging to manage:²

- There is often a 'latent' phase after initial infection where people with TB have the infection but have no symptoms, and the infection can reactivate some time later causing active disease
- Treatment with antibiotics takes much longer than other respiratory infections – typically 6 months but can be as long as 24 months
- Many of the bacteria are becoming resistant to antibiotics leading to multi-drug resistant TB (MDR-TB) and extra-drug resistant-TB (XDR-TB)
- It has major health and social impacts for those affected
- It contributes to increasing health inequalities in already deprived populations – there are marked inequalities associated with TB in terms of who gets TB and the outcome of their care

How common is it?

The number of TB notifications in England steadily declined until 1987, followed by a subsequent rise from 1987 to 2004 against a background of poor global TB control. In 1993 the World Health Organisation declared TB a global public health emergency. The rate of TB in England peaked in 2011, followed by a gradual decline. A total of **5,102 people were notified with TB in England in 2017**, a rate of 9.1 per 100,000 (Figure 1). Whilst this falls below the <10 per 100,000 definition for a low incidence country,¹ rates of TB in the UK remain higher than other parts of Europe. In 2016, TB caused or contributed to at least 107 deaths.

Figure 1. Number of TB notifications and rates, England, 2000 – 2017¹

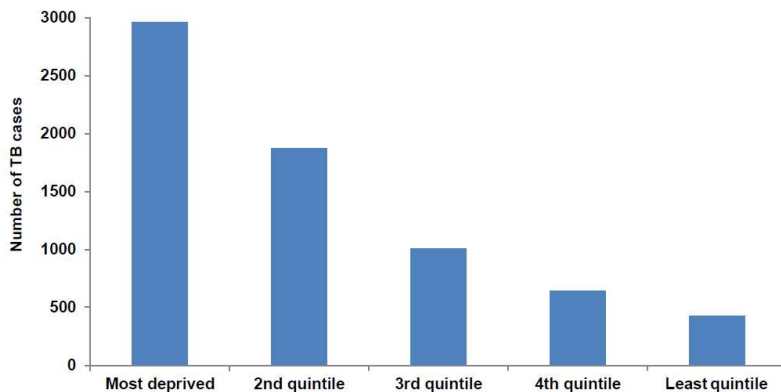


The incidence of TB varies substantially across England, with the highest rate being in London (21.7 per 100,000). Further information on the epidemiology of TB can be found in the Public Health England [Tuberculosis in England: Annual report \(2017 data\)](#), [Tuberculosis in Yorkshire and Humber Yorkshire and Humber Annual review \(2017 data\)](#) and at [Public Health England Fingertips](#).

Who does TB affect the most?

- The rate of TB among people both outside of the UK is 13 times higher than those born in the UK. People born outside of the UK accounted for 71% of TB notifications in 2017¹
- There is marked variation by deprivation (Figure 2). In 2017, the rate of TB in the most deprived 10% of the population, was more than 7 times higher than in the least deprived¹

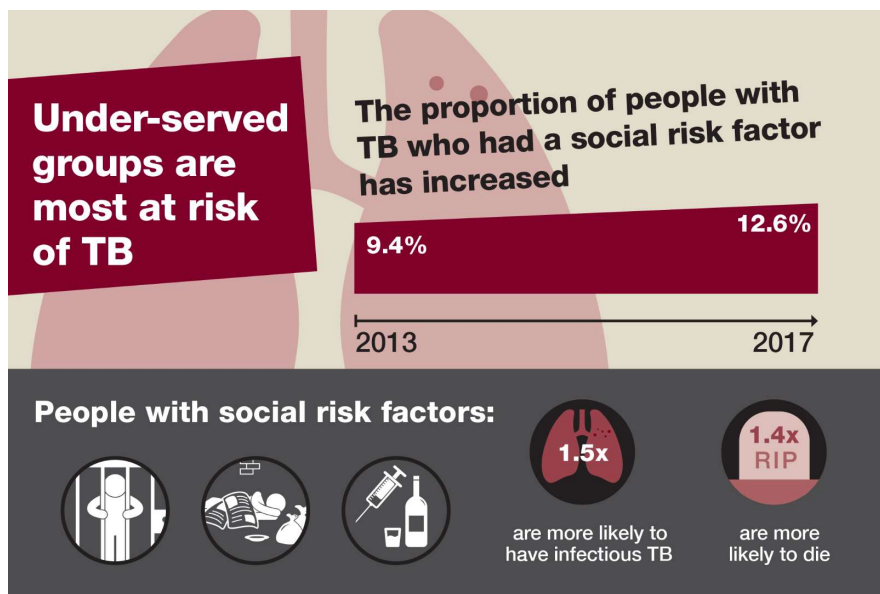
Figure 2. Number of TB case reports by deprivation quintile of area of residence (Index of Multiple Deprivation 2010, UK, 2013)²



People with tuberculosis, no money, no recourse to public funds and no accommodation

- Data is collected on the presence or absence of four social risk factors: current alcohol misuse that would impact on the patient's ability to take treatment, current or history of drug misuse, homelessness and/or imprisonment. The proportion of people with at least one social risk factor has been increasing, reaching 1 in 8 people (12.6%) in 2017 (Figure 3). The proportion of people with a social risk factor was higher in those born in the UK (21%) compared with those born outside the UK (9.4%).¹

Figure 3. Tuberculosis in England 2018 Report Infographics - Underserved groups¹



- 20% of people with TB in England have at least one co-morbidity, the most common being diabetes (11.6%).¹
- 19.4% of people with TB in England in 2017 had travelled abroad in the two years prior to their diagnosis, 6.2% had received a visitor from outside the UK. One quarter (26.6%) of people born outside the UK had travelled abroad, compared with 6.4% of those born in the UK.¹ Modern slavery and people trafficking has been identified as a problem in Yorkshire and Humber.

What does no recourse to public funds mean?

No recourse to public funds (NRPF) is a condition set by the Home Office on people from abroad who are subject to immigration control and as such have no entitlement to certain welfare benefits, homelessness assistance and an allocation of social housing through the council register.^{3,4} Public funds are defined under the Immigration Rules. UK Visas and Immigration has published [Guidance: Public Funds](#) which explains what UK public funds foreign nationals claim and what action must be taken if funds are claimed that they are not entitled to.³

What can be done about TB?

TB is a largely preventable disease. It can be controlled by effective management and public health control measures.

The [National Institute for Health and Care Excellence Tuberculosis guideline](#)⁵ highlights the key principles of TB control are:

- early diagnosis and **active case-finding**
- support treatment (including **directly observed therapy**)
- drug resistance
- awareness of drug interactions (including factors such as effect on contraception efficacy)
- **contact investigation** after diagnosing an active case
- the importance of adhering to treatment
- treatment for TB is free for everyone (irrespective of eligibility for other NHS care)
- social and cultural barriers to accessing health services (for example, fear of stigma and staff attitudes)
- local referral pathways, including details of who to refer and how
- the role of allied professionals in awareness-raising, identifying cases and helping people complete treatment
- misinformation that causes fear about TB, including concerns about housing people with the condition
- the best ways to effectively communicate all the above topics with different groups.

Collaborative Tuberculosis Strategy for England in 2015 to 2020

The [Collaborative Tuberculosis Strategy for England in 2015 to 2020](#)² sets out a strategy to organise and resource services to tackle TB. It identifies 10 key areas, of which **tackle TB in under-served populations** is one.

What can local authorities do to tackle TB?

The Local Government Association and Public Health England have published 'Tackling tuberculosis: Local government's public health role'.⁶ It highlights the following key areas for local authorities to tackle TB. Most of these are supported by development of a pathway for people with TB and NRPF:

- “Ensure a joined-up, multi-agency approach to TB patient care and support
- Encourage local health and social service commissioners to prioritise the delivery of appropriate clinical and public health services for TB
- Promote local leadership of TB at all levels
- Encourage NHS commissioners, local authorities, housing departments and hostel accommodation providers to agree a process
- Support where possible an individual's social needs
- Invite a local TB nurse to raise awareness of TB among local authority staff.
- Ensure information about TB is cascaded into key local authority teams
- Facilitate appropriate access to information and advice on TB
- Promote registration with GPs for new migrants, vulnerable or marginalised people
- Work, via the DPH, with CCGs and NHS England to ensure that screening, immunisation and treatment services reach out to diverse populations
- Consider how third sector organisations can help improve access to TB services and patient support,
- Include TB in the local authority's Joint Strategic Needs Assessment
- Encourage multi-agency working on TB via the HWB and health protection board
- Consider undertaking a scrutiny committee review of TB”.

What can clinical commissioning groups do to tackle TB?

The National TB Specification (2018)⁷ sets expected outcomes, service standards and key performance indicators for commissioners to use when commissioning TB services. It supports implementation of the [Collaborative Tuberculosis Strategy for England: 2015 to 2020](#)² and use of [NICE guidance, NG33, Tuberculosis, 2016](#).⁵

“Commissioners are expected to work with providers to contribute to national and locally defined outcomes to provide high quality TB services that best meet the needs of the local population and patients.”

Expected outcomes

The National TB Specification⁷ states the following outcomes:

- “increased awareness of TB across statutory and non-statutory health and non-health care providers and communities
- a reduction in the local incidence of TB
- achieve the target of 85% TB treatment completion rates aiming to achieve over 90%
- a reduction in the incidence of drug resistant TB
- increase in numbers of suspected pulmonary (infectious) TB patients assessed by TB services within two working days of referral
- increase in numbers of contacts of a case of TB identified and assessed for active and latent TB achieving an average minimum of five close contacts per pulmonary TB case aiming to achieve at least 10 close contacts per pulmonary TB case
- ensure 100% of all eligible neonates are offered BCG vaccination
- a reduction in people with LTBI developing active TB disease”

Local Key Performance Indicators

The national service specification recommends 3 Key Performance Indicators (KPIs) plus development of locally appropriate KPIs. This includes a local KPS such as:

- “People with active pulmonary TB who are homeless are offered accommodation for the duration of their treatment.
KPI - Evidence of local arrangements to ensure that people diagnosed with active pulmonary TB who are homeless are identified”.

People with nowhere to live

Under-served populations

People with nowhere to live are an important under-served population. [Tackling Tuberculosis in Under-Served Populations: A Resource for TB Control Boards and their Partners](#) defines under-served populations as including:⁸

- Some migrant groups, including asylum seekers, refugees and those in immigration detention
- People in contact with the criminal justice system
- People who misuse drugs or alcohol
- People with mental health needs
- People who are homeless

What are the challenges of managing cases of TB in people with no accommodation?

Accommodation is a key part of ensuring a person with TB manages to complete their treatment. If people have TB and have nowhere to live, it is very difficult for them to complete their treatment and attend healthcare appointments. This puts them at increased risk of becoming very unwell, developing multidrug resistant TB and spreading it to others.

In 2016, Public Health England (PHE) Yorkshire and Humber compiled a narrative report of case reports and clinician experiences associated with the treatment of complex cases. A number of common themes with significant implications on the ability of cases to complete treatment were identified that included housing:

- Eastern European Cohort with drug resistant TB – increase in number of patients seen, group is not eligible for screening under the national new entrants programme
- Patients with risk factors – patients e.g. homeless or substance misusers often disengaged from mainstream service provision
- Commissioning complexities regarding multi-drug resistant TB – lack of clarity regarding where costs fall, what costs can be recovered, complications regarding the ability to deliver direct observed treatment, lack of clarity regarding funding for family support
- Insufficient paediatric service provision - to meet the needs of paediatric cases with multi-drug resistant TB
- Cultural and language barriers
- Reference laboratories – complications and concerns regarding pathways, timeliness of reporting and communications
- Social factors – social complexities are “the norm” for cases of multi-drug resistant TB with basic issues such as access to benefits, housing,

People with tuberculosis, no money, no recourse to public funds and no accommodation

psychosocial support creating difficulties through support not being available, case not being eligible for support, systems being complex to navigate.

National Institute for Health and Care Excellence guidelines on accommodation

The [National Institute for Health and Care Excellence Tuberculosis guideline](#)⁵ makes the following recommendations about accommodation during treatment:

- “Multidisciplinary TB teams should **assess the living circumstances of people with TB**. Where there is a housing need they should work with allied agencies to ensure that all those who are entitled to state-funded accommodation receive it as early as possible during their treatment, for example, as a result of a statutory homelessness review and identified need
- Multidisciplinary TB teams, commissioners, local authority housing lead officers and other social landlords, providers of hostel accommodation, hospital discharge teams, Public Health England and the Local Government Association should **work together to agree a process for identifying and providing accommodation for homeless people diagnosed with active pulmonary TB who are otherwise ineligible for state-funded accommodation**. This includes people who are not sleeping rough but do not have access to housing or recourse to public funds. The process should detail the person's eligibility and ensure they are given **accommodation for the duration of their TB treatment**
- **Local government and clinical commissioning groups should fund accommodation for homeless people diagnosed with active TB who are otherwise ineligible for state-funded accommodation**. Use health and public health resources, in line with the [Care Act 2014](#)
- Multidisciplinary TB teams should make people who would not otherwise be entitled to state-funded accommodation aware that they **may lose this accommodation if they do not comply with treatment**. They should ensure plans are made to **continue housing people once their TB treatment is completed**
- Public Health England, working with the Local Government Association and their special interest groups, should consider working with national housing organisations such as the [Chartered Institute of Housing](#), [Homeless Link](#), [Sitra](#) and the [National Housing Federation](#) to raise the profile of TB. This is to ensure **people with TB are considered a priority for housing**
- Consider **training housing commissioners and frontline staff** on TB and the need for housing support, so that they understand that **a stable home life is a prerequisite to successful TB treatment**”

What are the costs of looking after patients with TB and NRPF and nowhere to live?

There is no nationally agreed pathway for providing accommodation for people with TB, no money and no recourse to public funds. The legal and ethical considerations are complex. Hospital costs for patients that have been inpatients but have no accommodation to be discharged to when their treatment ends can be substantial. Local authorities can be required to reimburse the NHS where a delay in assessing and/or meeting care and support needs leads to un-necessary hospital bed occupancy.⁴ Situational management costs and additional support costs for both hospital and community based care can be substantial.

In 2017, an economic analysis of two real-life situations of multi-drug resistant TB (MDR-TB) in patients with NRPF estimated the costs to the public sector associated with addressing these complex social circumstances.

- Situation 1: a single case of MDR-TB in a female migrant from Eastern Europe – total costs £174,650
- Situation 2: a case of MDR-TB in a female migrant from Eastern Europe with three children where 9 adult and 8 child contacts were identified as having latent TB, of which one adult case of latent TB in a female migrant from Eastern Europe converted to active MDR-TB – total costs £398,200

Total costs breakdown show non-commissioned costs (additional support plus situational management costs) of £36,450 for situation 1 and £18,225 for situation 2 (Figure 4 & Figure 5). There may be additional costs from delayed discharges from lack of accommodation not captured in this analysis.

Figure 4. Summary costs of two situations of patients with multi-drug resistant TB and NRPF

Situation	Total	Inpatient Costs	Outpatient Costs including Direct Observed Therapy (DOT)	Treatment Support (transport / translation)	Additional Support	Situational Management
Situation 1	£174,650	£84,125	£ 54,075	NA	£11,250	£25,200
Situation 2 – Case 1	£398,200	£80,850	£118,075	£2725	£3425	£14,575
Situation 2 – Case 2		£37,500	£139,750	£1075	£225	

Figure 5. Breakdown of situational management costs of two situations of patients with multi-drug resistant TB and NRPF

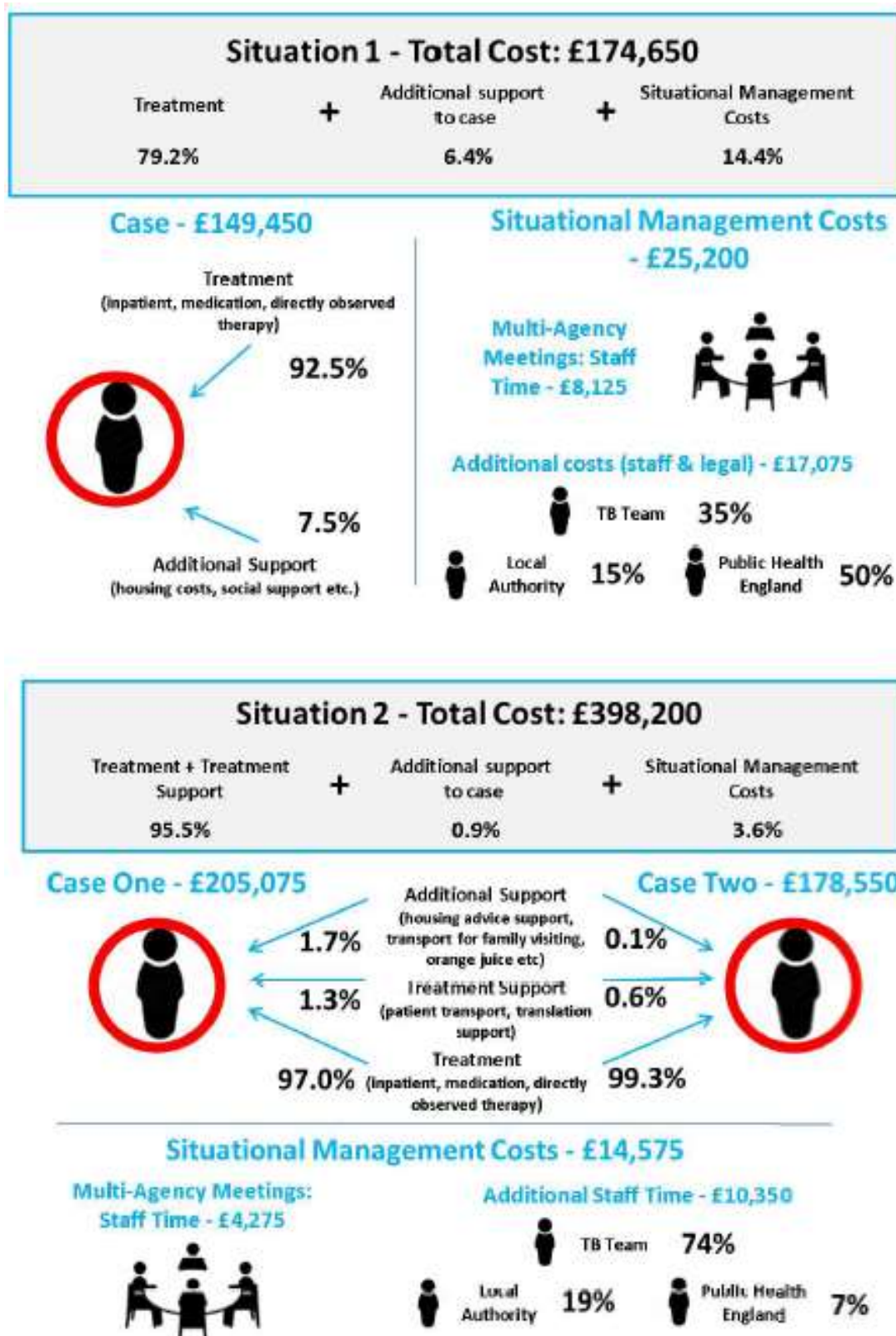
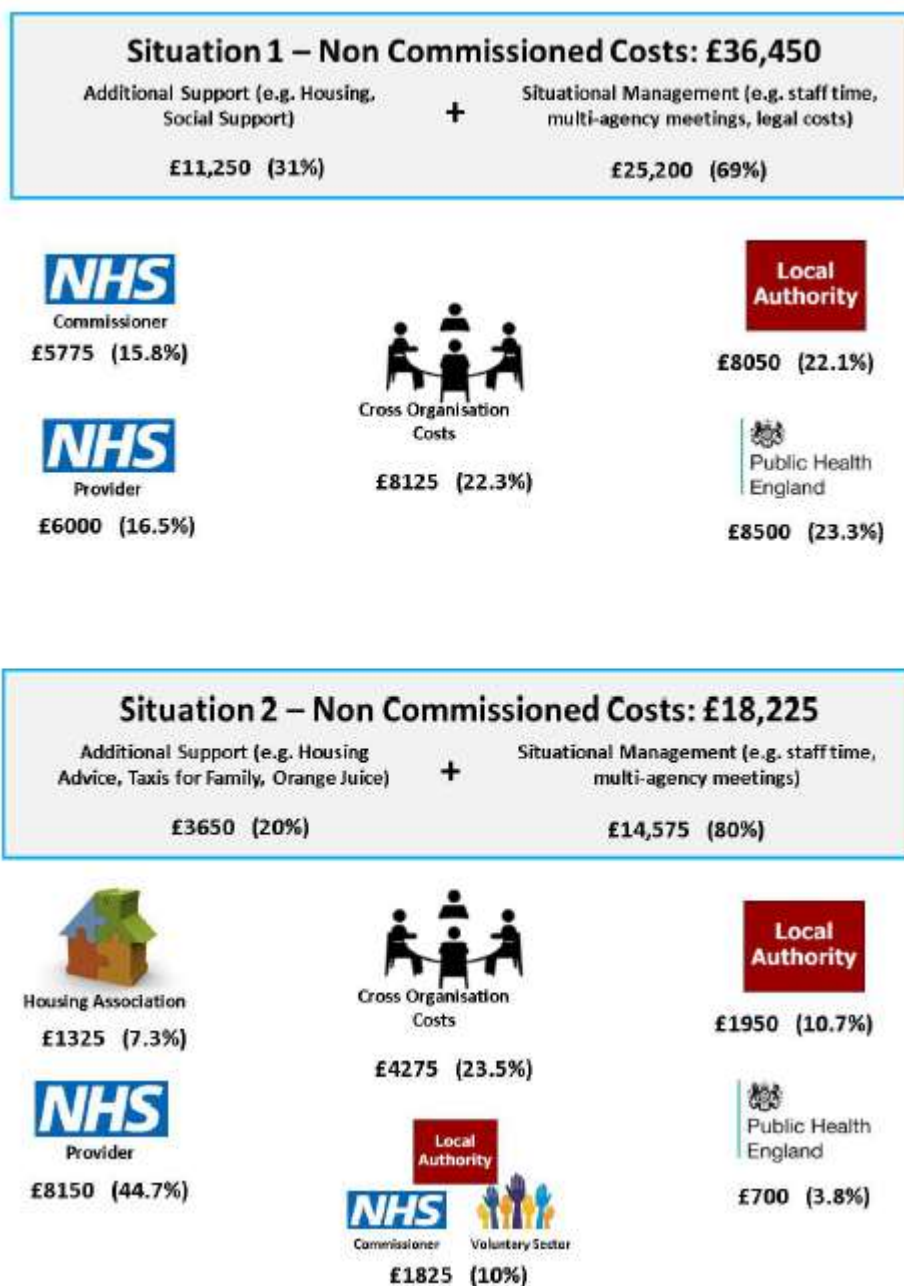


Figure 6. Breakdown of non-commissioned costs of two situations of patients with drug resistant TB and NRPF



Three options were identified from this analysis:

1. **Do nothing – continuing the current situation** – this leaves clinical staff in a position where they are having to work to resolve non-healthcare needs faced by patients in order to ensure that treatment can be successfully completed and is not an efficient use of resources
2. **Maintain strategic oversight** – Consideration should be given to developing and adopting a formalised local cross-organisational approach to managing future MDR-TB cases where appropriate and necessary, led by the Director of Public Health. Developing guidance, such as that utilised for Outbreak Control Meetings as an

People with tuberculosis, no money, no recourse to public funds and no accommodation

example, would assist in clarifying roles, responsibilities and expectations and streamline the management of future cases.

3. **Risk pool approach** – adopting a risk pool approach with contributions from each Commissioner pooled into a central fund (or other agreed arrangements). This has the advantages of:

- Sharing the risk
- Reducing the opportunity costs
- Providing some certainty to cases of a stable environment in which they can complete their environment
- Aligns services to national recommendations and NICE guidelines.

Implementing a combination of Options 2 and 3 were identified as the best way of maximising potential gains.

What are the consequences of not having a clear funding mechanism for these people?

In 2017, an overview of the statutory guidance, lessons learnt from previous cases, and current approach to supporting treatment in NRPF patients, was presented to various partners, stakeholders and commissioners across Yorkshire and Humber. This included the regional Association of Directors of Public Health, Local Authorities, Quality and Steering Groups (whose members include CCGs, Voluntary Sector, and NHS England), and NHS Specialised Commissioning.

A broad consensus emerged through this engagement process that the lack of a clear funding mechanism to support NRPF patients has the potential following consequences:

- A heightened clinical risk due to possible non-adherence to treatment regimen
- Excessive costs of situational management over and above the costs associated with providing additional support to patients, which constitutes a poor use of public funds
- A drain on the energy and resilience of the regional workforce (across multiple organisations)
- A significant detrimental impact on patient and family experience.

What are the legal considerations?

The legal considerations can be complex. The **No Recourse to Public Funds network** is a network of local authorities and partner organisations focusing on the statutory response to migrants with care needs who have no recourse to public funds. The network has produced **practice guidance** for local authorities to refer to when providing people who have no recourse to public funds with social services' support:⁴

Section 115 of the Immigration and Asylum Act 1999

The definition of 'subject to immigration control' is set out in section 115 (9) of the Immigration and Asylum Act 1999 who:⁹

- Require leave to enter or remain in the UK but does not have it
- Has leave to enter or remain in the UK which is subject to a condition that they have no recourse to public funds (NRPF)
- Has leave to enter or remain in the UK that is subject to a maintenance undertaking

Benefits that do not count as public funds

According to **Guidance: Public Funds**:³

"Benefits not considered as public funds under the Immigration Rules include:

- Contribution based Jobseeker's Allowance
- Guardian's allowance
- Incapacity Benefit
- Contribution-based Employment and Support Allowance (ESA)
- Maternity allowance
- Retirement pension
- Statutory maternity pay
- Statutory sickness pay
- Widow's benefit and bereavement benefit"

"National Health Service (NHS) treatment, state-funded schooling (academy and maintained schools) and education in 16-19 academies **are not considered to be public funds.**"

What treatment can be provided by the NHS for patients with TB?

The **National Health Service (Charges to Overseas Visitors) Regulations 2011** details which services the NHS can charge for. TB treatment is exempt from treatment charges for any overseas visitor as it is listed as a disease in **schedule 1** of the regulations.

When can housing and financial support be provided?

The **No Recourse to Public Funds network** has identified when housing and financial support can be provided:⁴

There are provisions which require local authorities to provide some people with NRPF with housing and/or financial support in order to prevent homelessness or destitution. Such assistance can be provided to:

- Families, where there is a child in need (for example, because the child is homeless or the parent cannot afford to meet the family's basic living needs)
- Young people who were formerly looked after by a local authority, for example, because they were an unaccompanied asylum seeking child (UASC), or other separated migrant child
- **Adults requiring care and support due to a disability, illness or mental health condition**

The legislation which sets out these responsibilities differs in England, Wales, Scotland and Northern Ireland and is set out in the table below.

	Legislation which sets out eligibility requirements for support			
	England	Wales	Scotland	Northern Ireland
Families with a child in need	Section 17 Children Act 1989	Section 37 Social Services and Well-being (Wales) Act 2014	Section 22 Children (Scotland) Act 1995	Article 18 of the Children (Northern Ireland) Order 1995
Young person formerly looked after by the local authority	Sections 23C, 23CA, 24A, 24B Children Act 1989	Sections 103-118 Social Services and Well-being (Wales) Act 2014	Sections 29 & 30 Children (Scotland) Act 1995	Article 35 or 36 of the Children (Northern Ireland) Order 1995.
Adults with need for care and support	Part 1 of the Care Act 2014	Section 35 Social Services and Well-being (Wales) Act 2014	Section 12 and 13A Social Work (Scotland) Act 1968	Article 7 and 15 The Health and Personal Social Services (Northern Ireland) Order 1972

Care Act 2014

When a parent or other adult in the household has needs arising from a physical or mental impairment or illness, they may be eligible for care and support under the Care Act 2014, and would need to be referred to adult social services (or the mental health team as appropriate) for an assessment of need. The Care Act 2014 requires a local authority to undertake an assessment where it appears that a person may have needs for support if the adult is ordinarily

People with tuberculosis, no money, no recourse to public funds and no accommodation

resident in the authority's area or is present in its area but of no settled residence. The NRPF condition does not prevent care and support being provided by social services and a person with NFPR should be assessed and provided with this in the same way as any other adult ([Assessing and supporting adults who have no recourse to public funds](#)).⁹

Once the needs have been assessed, the local authority must determine whether these meet the eligibility criteria in accordance with section 13(1) of the Care Act 2014 and the Care and Support (Eligibility Criteria) Regulations 2015. These regulations contain a three stage test (p.23 [Assessing and supporting adults who have no recourse to public funds](#)).⁹

Local authorities have no duty of Care under the Care Act 2014 to provide accommodation when this is needed **solely** to manage a public health risk.⁴

Housing and homelessness assistance

According to [Guidance: Public Funds](#) (UK Visas and Immigration, 2014), people who are subject to immigration control and are owed a duty under the Care Act 2014 (England) can be granted a non-secure tenancy, or licence of housing accommodation by a local housing authority in England.

Exception to the Care Act: needs arising solely from destitution

Section 21 of the Care Act 2014 prevents a local authority from meeting needs, or providing preventative assistance under section 2(1) to some people with NRPF:

'(1) A local authority may not meet the needs for care and support of an adult to whom section 115 of the Immigration and Asylum Act 1999 ("the 1999 Act") (exclusion from benefits) applies and whose needs for care and support have arisen solely—
(a) because the adult is destitute, or
(b) because of the physical effects, or anticipated physical effects, of being destitute.'

This exception only applies to people who are 'subject to immigration control' (p.25 [Assessing and supporting adults who have no recourse to public funds](#)).⁹

What can be provided if the person is in a group excluded from social services support? - Schedule 3 of the Nationality, Immigration and Asylum Act 2002

The [No Recourse to Public Funds Network](#) identifies:⁴

"When a person or parent is in a group excluded from social services support, this means that social services can only provide housing and financial support when this is necessary to **prevent a breach of the person or family's human rights** or rights under the European treaties. When the exclusion applies, social services will need to carry out a human rights assessment as well as a needs assessment to establish whether help can be given.

People with tuberculosis, no money, no recourse to public funds and no accommodation

The five groups are:

- European Economic Area (EEA) nationals (not British citizens)
- People who are unlawfully present in the UK (including: visa overstayers; illegal entrants and refused asylum seekers who claimed asylum in-country, rather than at port of entry)
- People with refugee status that has been granted by an EEA country
- Refused asylum seekers who have failed to comply with removal directions
- Refused asylum seeking families that the Home Office has issued with certification confirming that they have failed to take steps to leave the UK voluntarily

The exclusion is set out in Schedule 3 of the Nationality, Immigration and Asylum Act 2002 and also applies to the dependants of the people above. The exclusion does not apply to children, but when a parent is in an excluded group, the whole family may be prevented from receiving housing and financial support. The exclusion does not mean that a person or family can automatically be refused assistance, and **in practice**, there will be often be a reason why support can be provided.”

Human rights assessment

The **No Recourse to Public Funds Network**⁴ describes when a **human rights assessment** should be done:

“ A person who is in an excluded group can only be provided with support or assistance under the Care Act 2014 where this is necessary for the purpose of avoiding a breach of a person’s rights under the European Convention on Human Rights (ECHR) or European Union (EU) treaty rights.

The Court of Appeal, in the case of *R (Kimani) v LB Lambeth* (2003), found that:

‘A State owes no duty under the Convention to provide support to foreign nationals who are permitted to enter their territory but who are in a position freely to return home.’

The local authority will therefore conduct a human rights assessment to establish whether the person is able to return to their country of origin to avoid remaining destitute and homeless in the UK, therefore preventing a breach of Article 3 of the ECHR. This will involve consideration of whether there are any legal or practical barriers in place which may prevent the person from doing so.

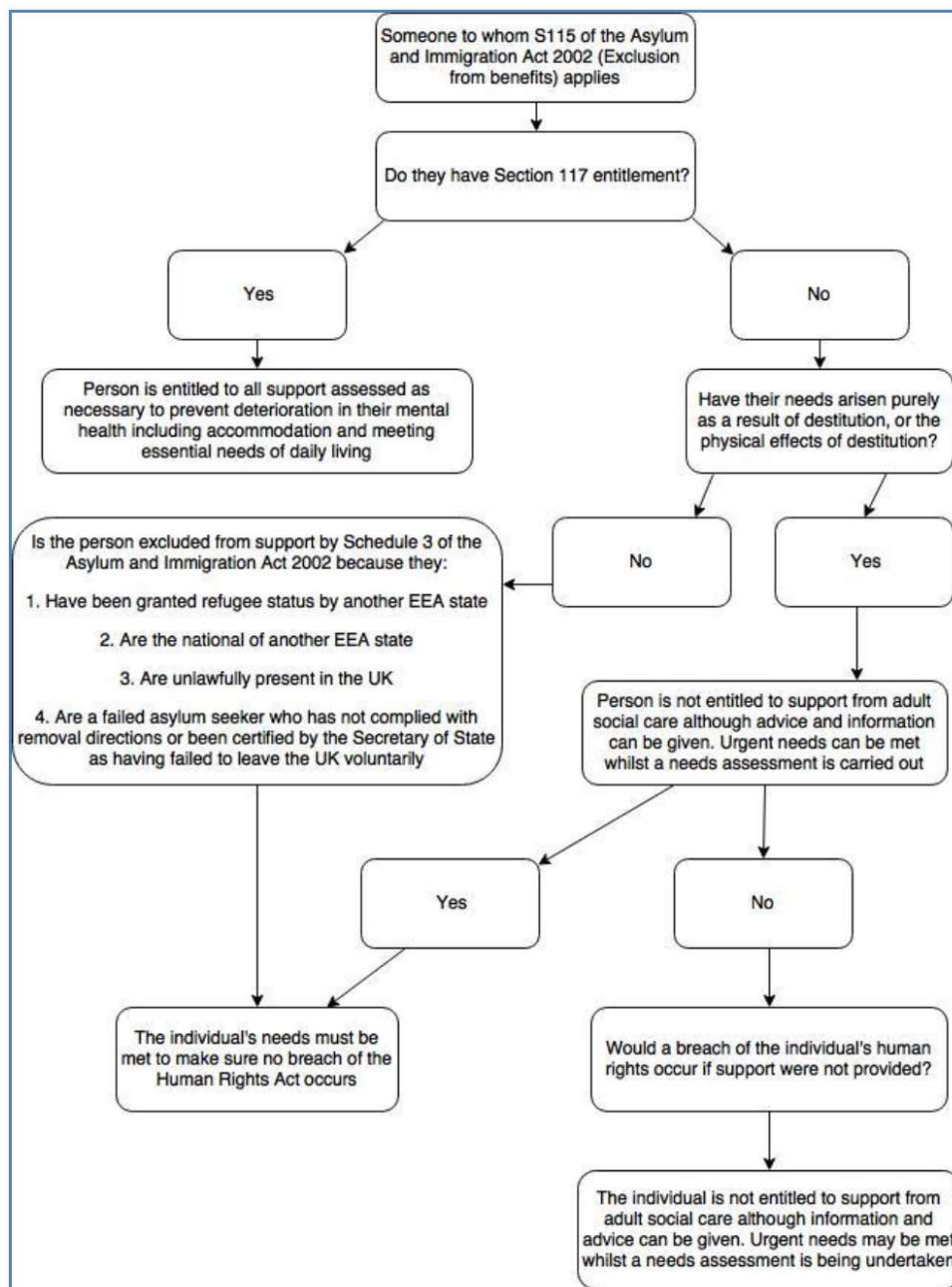
A practical way of approaching the human rights assessment is to consider key questions in a staged process:

1. Can the person freely return to their country of origin?
2. If so, would return result in a breach of the person’s human rights under the ECHR?
3. Would return result in a breach of the person’s rights under European treaties? (EEA nationals and dependent family members)”

How should it be determined whether a patient is NRPF?

A suggested flow diagram for patients with NRPF who have TB was proposed by PHE Yorkshire and Humber in 2018 (Figure 7) and framework for developing pathways for people with TB, NRPF, no accommodation and no money (Figure 8).

Figure 7. Suggested flow diagram for determining whether a patient is NRPF



People with tuberculosis, no money, no recourse to public funds and no accommodation

Figure 8. Proposed framework by PHE Yorkshire and Humber for developing pathways for managing people with TB, NRPF, no accommodation and no money.

Process	Responsible team
1. <u>Establish eligibility for state funding in order to confirm the patient is NRPF</u> <ul style="list-style-type: none"> What is the immigration status of the patient? 	Local Authority (Welfare Benefits Advice / Adult Social Care)
2. <u>Identify patients' local connections</u> , including: <ul style="list-style-type: none"> Last known address Whether they are registered with a GP Where any family are located Street where individual was habitually rough sleeping Inform HPT of this information.	TB Case Manager
3. Conduct a needs assessment <ul style="list-style-type: none"> Does the individual meet the criteria for housing under the Care Act? Are they subject to Schedule 3 of the Nationality, Immigration and Asylum Act 2002? 	Local Authority Adult Social Care team
4. Conduct Human Rights Assessment <ul style="list-style-type: none"> Would not providing support be a breach of individual's human rights? 	Local Authority Adult Social Care team
5. Conduct Mental Health Assessment <ul style="list-style-type: none"> Is the individual entitled to accommodation and support under Section 117? 	TB Case Manager
6. If patient is NRPF and not eligible for support, arrange a case conference	TB Case Manager

Factors to consider when developing a pathway for people with TB, no accommodation and no recourse to public funds

PHE Yorkshire and Humber developed a checklist of factors to consider when developing an accommodation pathway for people with TB, NRPF, no accommodation and no money based on experiences of local areas in developing these pathways (Figure 9).

People with tuberculosis, no money, no recourse to public funds and no accommodation

Figure 9. Factors to consider in developing an accommodation pathway for people with TB and NRPF

Discussion Topic	Comments
1. What is the scope of the policy? Who does it include? All TB patients who have no housing, no money, no recourse to public funds?	Similar policies elsewhere have included all groups of people with TB, no money and no recourse to public funds to ensure inequalities in provision are minimised.
2. Who will be responsible for completing assessment of eligibility for benefits, housing need, and available financial support?	Social Care teams may be best situated to make the relevant assessments due to complexity of legislation, with support from TB Case Managers
3. Who will be responsible for notifying eligible patients to the local social care team?	TB Case Managers are likely to be best situated to make relevant assessment and referral
4. If, following social care assessment, patients are found not to be eligible for usual local authority (LA) support, and are therefore eligible to receive funding via the new pathway, who should be responsible for coordinating management?	This could either be TB Case Managers, LA Social Care team, or someone from Clinical Commissioning Group (CCG) or public health LA team. It will require liaising with the Social Care team to enable housing placement etc.
5. Who will be responsible for managing the patient once they are deemed eligible for funding via the pathway?	TB Case Manager may be best placed to coordinate management and produce a Support Plan to briefly detail how the funding will be used to support patient
6. How will any housing support be funded?	Possible option is shared funding on a proportional basis between commissioners – CCG and LA (either LA public health or LA social care or LA housing team)
7. How will LA social care team receive funding for housing?	What mechanism will allow Social Care team to receive funding from partners listed above?
8. How long should housing support be funded for?	Possible option is for the duration of treatment, with a grace period on completion of treatment for patient to find alternative housing and/or employment
9. What will any subsistence support cover?	This may include food / household bills / clothing to allow patient to remain compliant with treatment. This could be left to the discretion of the TB case manager (or other professional involved in monitoring the delivery of the pathway/funding)
10. How will any subsistence support be funded?	Possible option is shared funding on a proportional basis between commissioners – CCG and LA (either PH or social care team)
11. How long should subsistence support be funded for?	This could mirror the arrangement for housing as decided above
12. How will the subsistence payment be delivered to patient?	This may be delivered via the TB Case Manager, who could create a Support Plan based on patient's needs and funding made available via pathway
13. How will the TB team (or other relevant team) receive funding for subsistence payment?	As for housing, what mechanism will allow TB team to receive funding from relevant partners
14. Once in place, who needs to be aware of the existence of the pathway? How could this best be disseminated?	All partners involved in pathway Circulation of final agreed pathway within relevant teams Publication via the Health Protection Board (?and regional TB Control Board)
15. Exit from pathway	Agree in advance how people will exit the pathway and what 'treatment' means, one area in Yorkshire and Humber has used the definition 'whilst under the care of the TB service' whilst another is considering 'until one month after the medication course is completed'. Once a duration is given, consider what happens next as the pathway is exited?

Appendix

Examples of pathways that have been developed

There is no single national pathway option that suits all areas.

London

A business case was put forward in London in 2016 appraising 4 options (Public Health England, 2016):

1. Do nothing/do minimum
2. Local pathway by CCG
3. Pan-London Pathway
4. STP footprint pathway

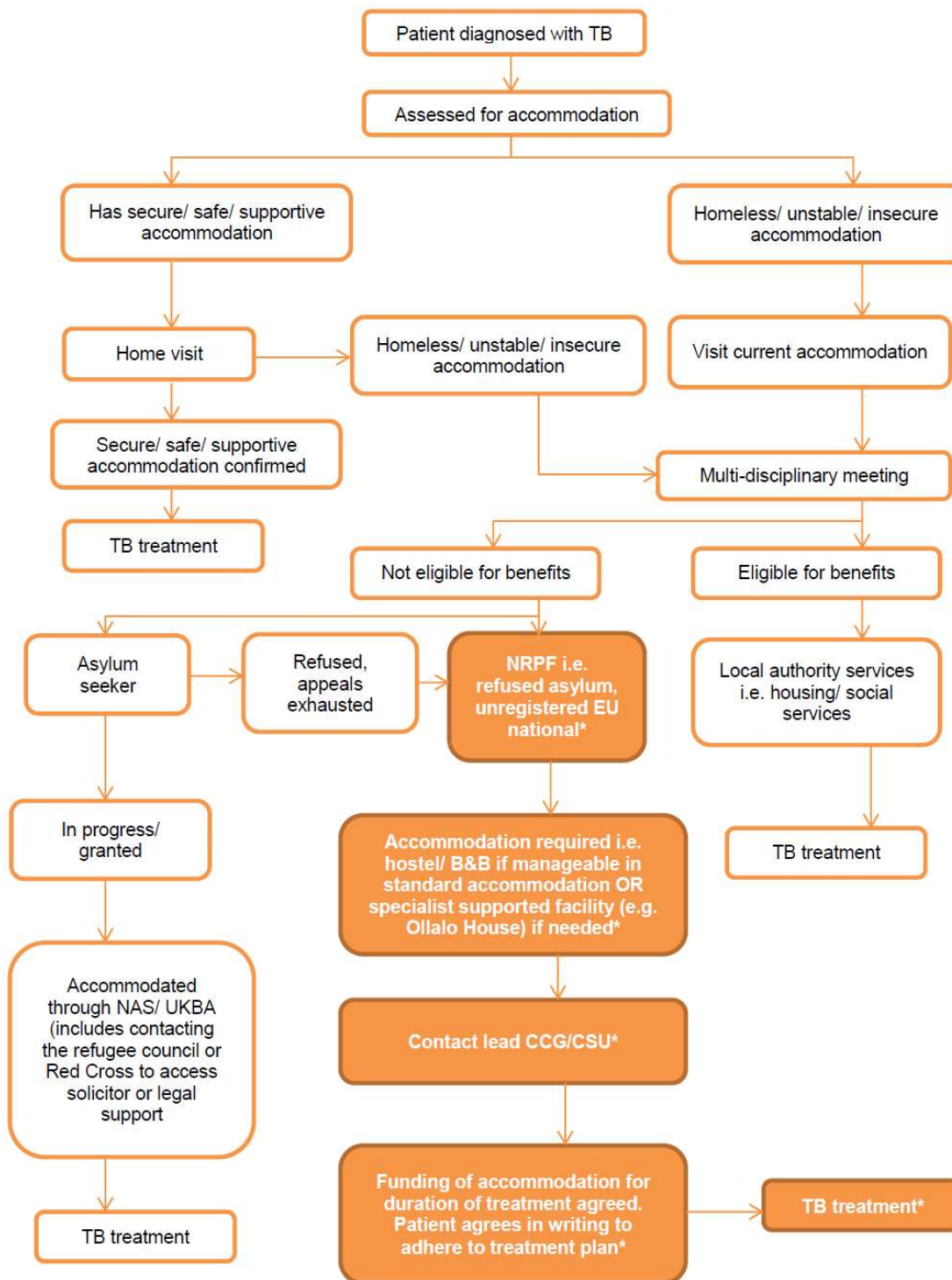
Options 3 or 4 were recommended as these provide a standardised approach across London, a financial risk sharing through all CCGs and the organisation where one CCG takes the lead and administers the system through an agreed patient pathway.

Local services are still responsible for the care of the patient, but this can be done in a bespoke manner. The lead CCG has the responsibility to allocate the monies according to a business case by the CCG in which the local services need to demonstrate value for money. A template would need to be developed for this as to provide an equitable approach to this funding taking into account the different localities and costs of finding accommodation.

The patient pathway is shown in Appendix Figure 1. A Pan-London pathway was initially adopted in 2017 using a pooled fund, it is now (as of May 2019) in its third year, administered by a lead CCG funded by London CCGs but no longer with pooled funding for the pathway.

People with tuberculosis, no money, no recourse to public funds and no accommodation

Appendix Figure 1. Patient Pathway recommended in Accommodation for patients with Tuberculosis and No Recourse to Public Funds - Business Case¹⁰



* Risk share is applicable only to this part of the patient pathway.

Leeds

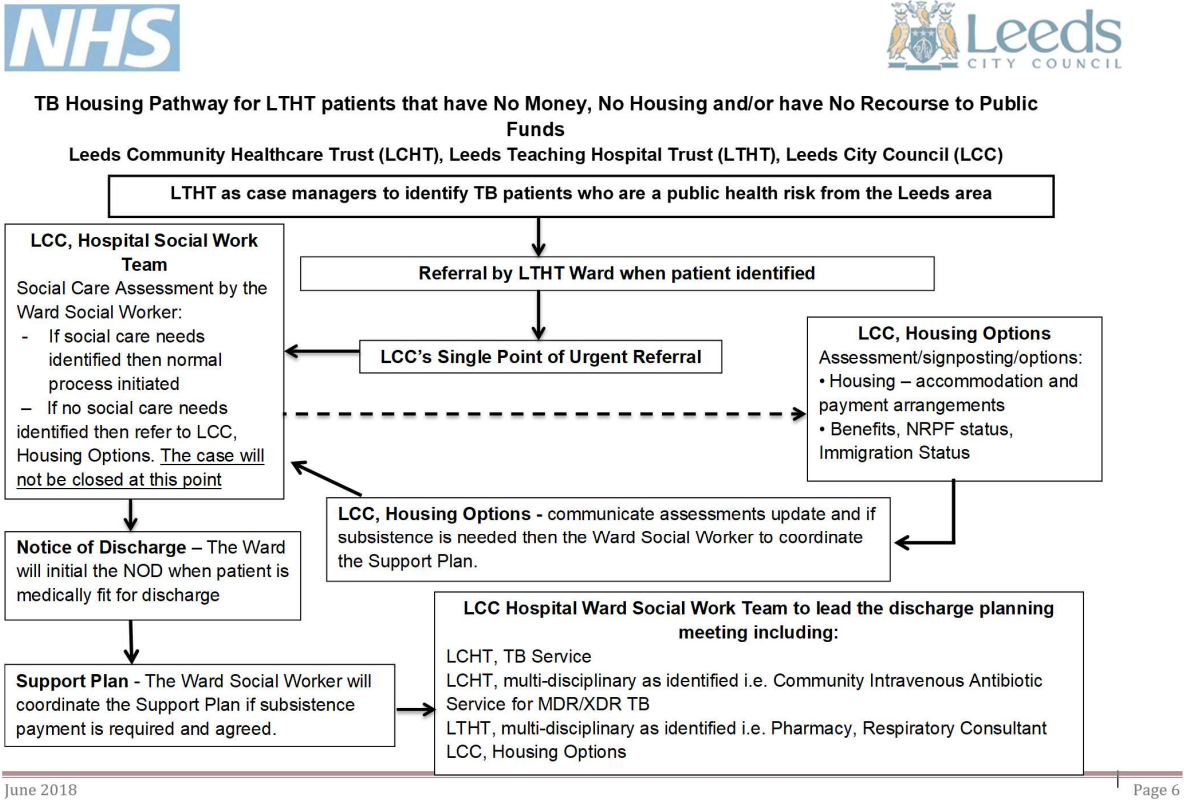
Leeds City Council have developed their own pathway (Appendix and Appendix Figure). A patient was successfully managed through this pathway in 2018/19:

“NHS Leeds Community Healthcare Trust (LCHT), NHS Leeds Teaching Hospital Trust (LTHT) and Leeds City Council have agreed the following to support treatment compliance and protect public health:

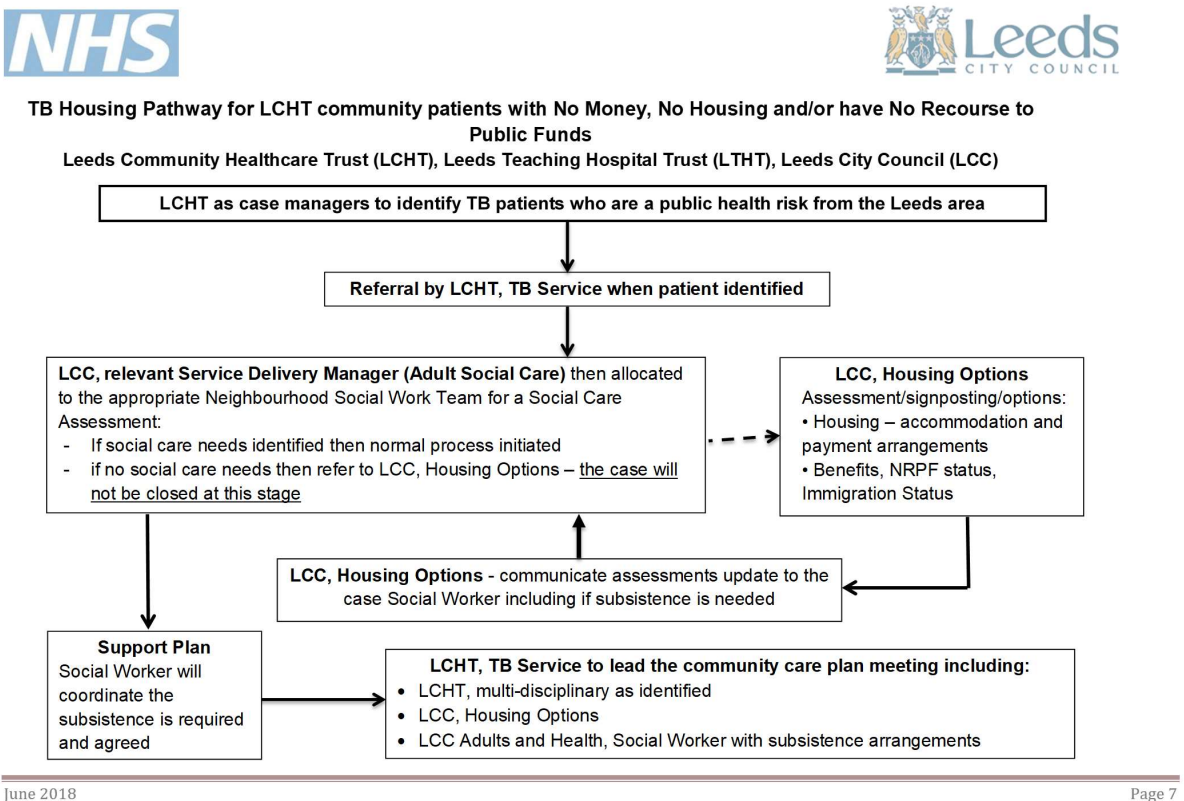
- The relevant hospital ward will refer TB patients to the LCC Adult Social Care hospital based Single Point Urgent Referral process
- The LCH TB Service will refer community based TB patients to the appropriate geographical Adult Social Care Service Delivery Manager
- On completion of the Social Care Assessment by the nominated Social Worker:
- If social care needs identified then normal process initiated
- If no social care needs identified then the case will not be closed at this point but referred to Leeds City Council, Housing Options for housing, migration status, benefits and NRPF status.
- On completion of the Housing Options assessment the results and support options/arrangements will be communicated to the case Social Worker to be included in the development of hospital discharge or community care plans. This process may include the patient with a TB nurse, interpreter and Housing Options visiting potential accommodation.
- Leeds City Council's Housing Support agreed that in cases for people with NRPF, the local authority would fund accommodation to ensure that there were no delays in hospital discharge or community based care for the duration of their treatment.
- Leeds City Council should seek appropriate reimbursement from the Home Office.
- Leeds City Council's Adult Social Care agreed funding subsistence payments for those patients with TB with NRPF and no social care needs for the duration of their treatment. The case Social Worker will arrange the delivery or collection arrangements for these weekly payments.”

People with tuberculosis, no money, no recourse to public funds and no accommodation

Appendix Figure 2. Leeds City Council TB Housing Pathway for hospital inpatients



Appendix Figure 3. Leeds City Council TB Housing Pathway for community patients



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