New entrant screening in a low prevalence area

Meg Goodrick 2016

Providing Quality Care

2000 -2010

Hull becomes a designated dispersal area for Asylum.

Method of screening of international students changed.

HV role changed/port of entry forms

Homeless HV team disbanded

Increase in number of Index cases

Not all new entrants especially EU citizens referred in by GP

Health Protection Agency already in discussions with PCT to enhance TB service 2008

2010 re-commissioning of Service

Came about following negotiations to obtain Flag 4 data. Suspicion that numbers were greater was confirmed

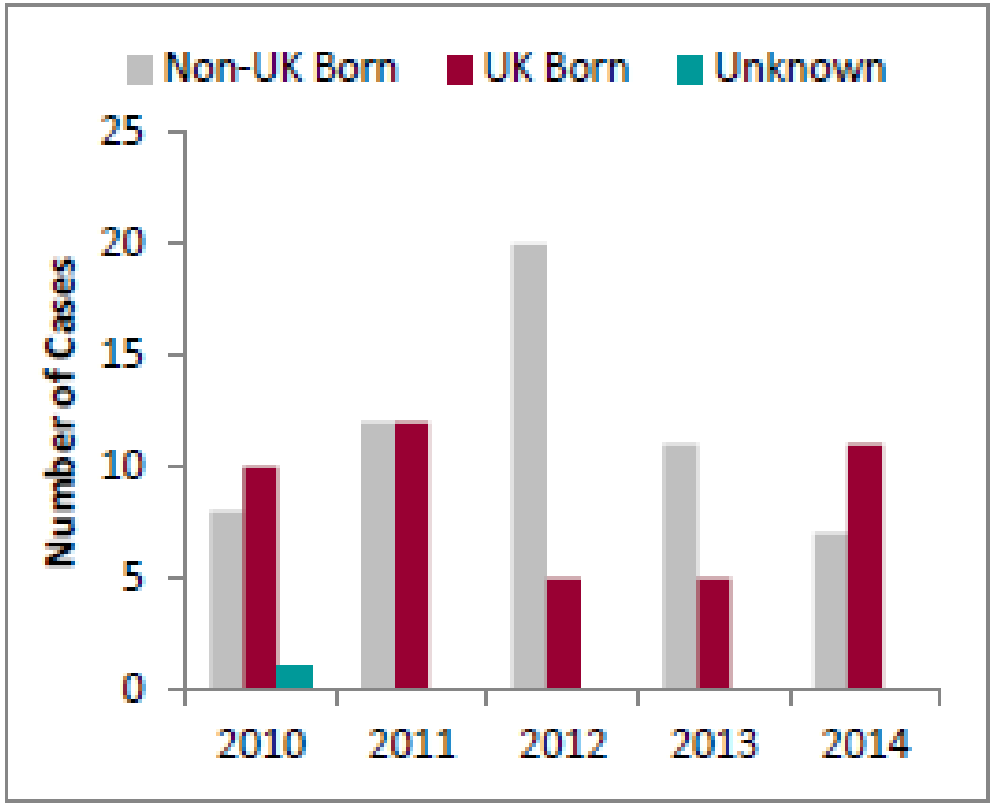
Given extra money to deal with back log.

(early adopters of IGRA)

Needed to look at new ways of working to capture those not registered with GPs (identified problem in Hull)

Hull Index Cases since 2010

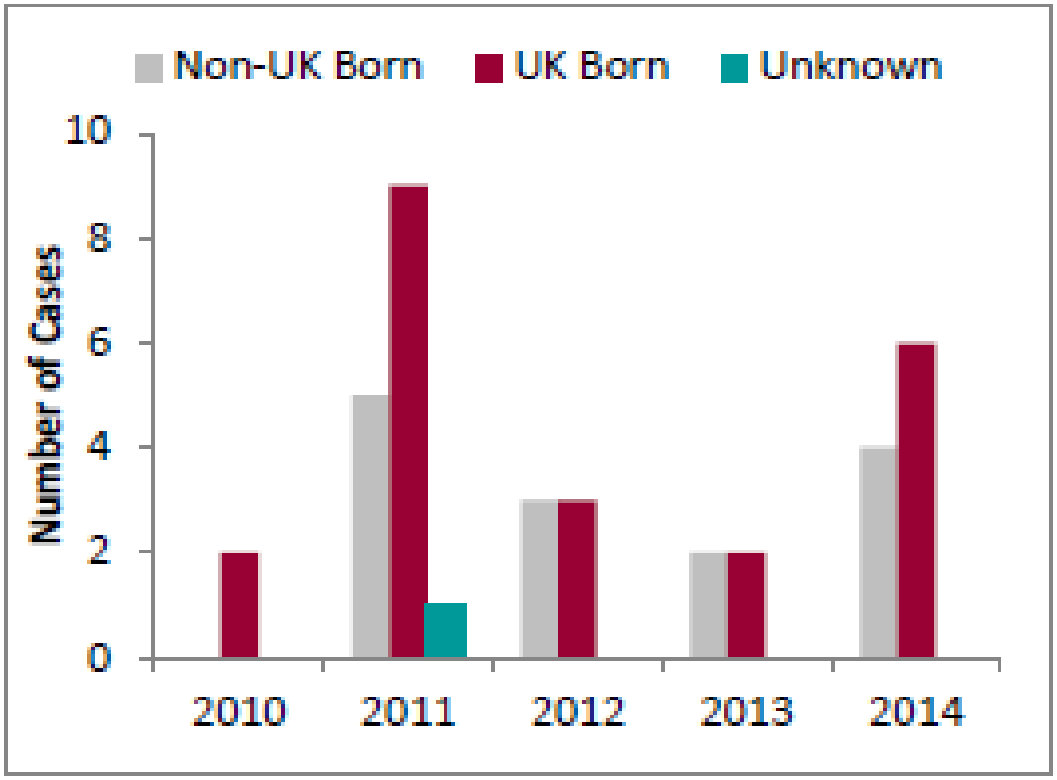
Figure 5: Tuberculosis case reports by country of Birth, 2010 -2014



Source: ETS 2015

East Riding Index Cases

Figure 5: Tuberculosis case reports by country of Birth, 2010 -2014



Source: ETS 2015

How to screen larger numbers?

Mapping exercise highlighted:

- Capacity issues
- Need to increase staff numbers
- Providing flexibility of clinic availability
- Work more closely with other multi-agencies
- Forge links with voluntary agencies
- Complexity of capacity model / ratio of contact for finance

What we did

Developed KPI to give us benchmarks

Contracted with local path labs to enable IGRA testing for new entrants

Increased clinic availability across the city and East Riding from 4 clinics per week to 16 clinics per week+Ad hoc (still only working hours)

Cont:

Approached voluntary sector to screen at city venues and accepted.

Worked collaboratively with other HCW to provide HIV screening.

Developed a nurse-led LTBI clinic to assist consultant led clinic with increased numbers.

Things to consider to overcome obstacles

Demographics of patients (know your client group (static/fluid)

Time/transport considerations.

Patient opinion.

Flexibility of service / opportunistic

SMS messaging to reduce DNA rate

Poster drops/raising awareness (how often)

Providing patient information (written/verbal)

Cont:

- Be awareness of changing socio-economic climate in your area.
- Working in close collaboration with secondary care may help
- Use of interpretation service is vital.
- Be adaptive (not one size fits all)
- MECC

Cont:

- Have open access to all referrals not just those already registered with GPs look at possibility of gaining access to register patients with local GP PMS)
- Use of mobile working.
- Develop template for TB assessment (System1 open share)

Ongoing considerations

- Availability of Flag 4 data
- Constant change CCG/ Third sector/ secondary care / NICE
- Retendering of services
- Where do we sit in TB strategy in a low prevalence area
- Constantly driving forward , innovations , being proactive
- Political drivers