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The Health Protection Tapestry: Weaving Together People, Protection and Preparedness

TB in the West Midlands: Prioritising TB in local systems

Session Outline

Welcome and TB epidemiology overview	Will Proto, Consultant in Health Protection UKHSA WM
Prioritising TB in the Region	Katie Spence, Regional Deputy Director UKHSA WM and Helen Webster, Consultant in Public Health, OHID Midlands
Embedding TB as a strategic priority in a local system	Chris Baggott, Public Health Portfolio Principal, Birmingham City Council
Case Study: Economic analysis of TB incident response	Dan Lange, Public Health Speciality Trainee, UKHSA WM
Case Study: Whole systems approach to TB: from TB outbreak to primary care drop-ins	Riva Eardley, Principal Health Protection Practitioner, Wolverhampton City Council
Q&A	Will Proto, Consultant in Health Protection UKHSA WM
Close	

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Overview TB Epidemiology and the West Midlands

Will Proto
West Midlands ADPH Conference
27 March 2026

TB in England

Data for 2024

of people diagnosed with TB born abroad

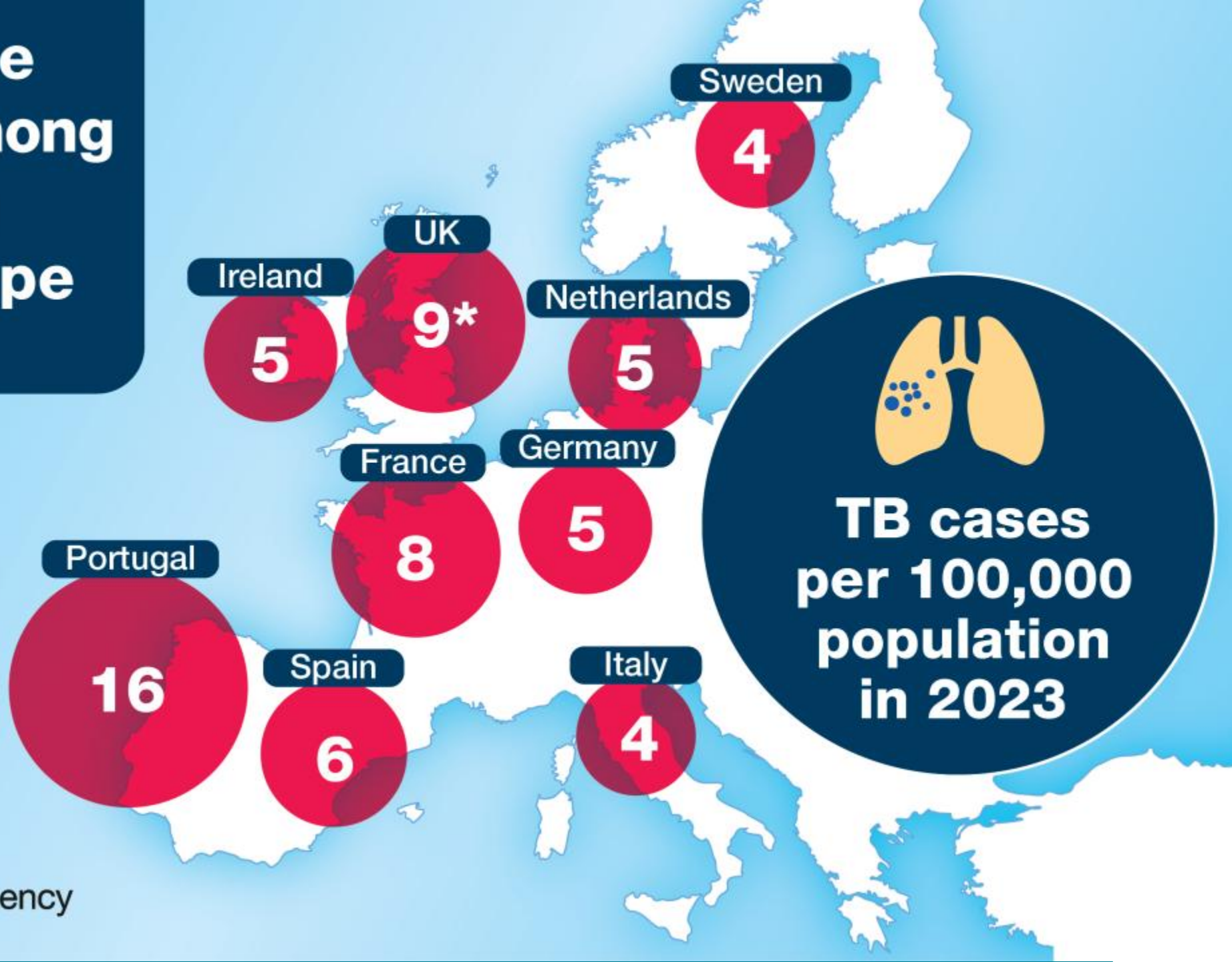
26% increase in TB notifications from 2022 to 2024

TB increased by 30% in non-UK born

and by 9% in UK born population since 2022

TB rates in the UK remain among the highest in Western Europe

*UK is the only figure from 2024



WHO (2024). Global Tuberculosis Report 2024. Country, regional and global profiles.

UKHSA (2025). Reports of cases of TB to UK

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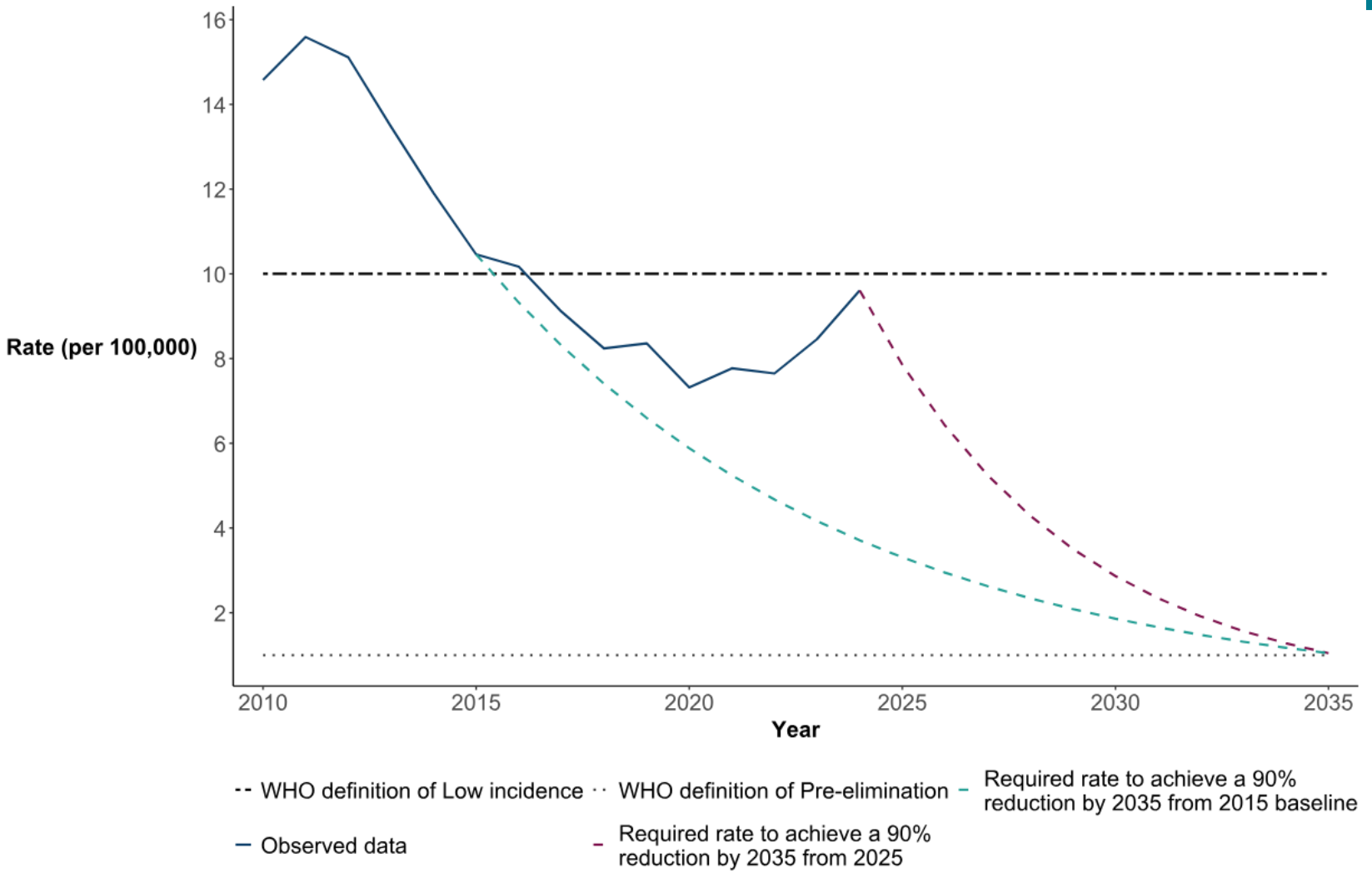
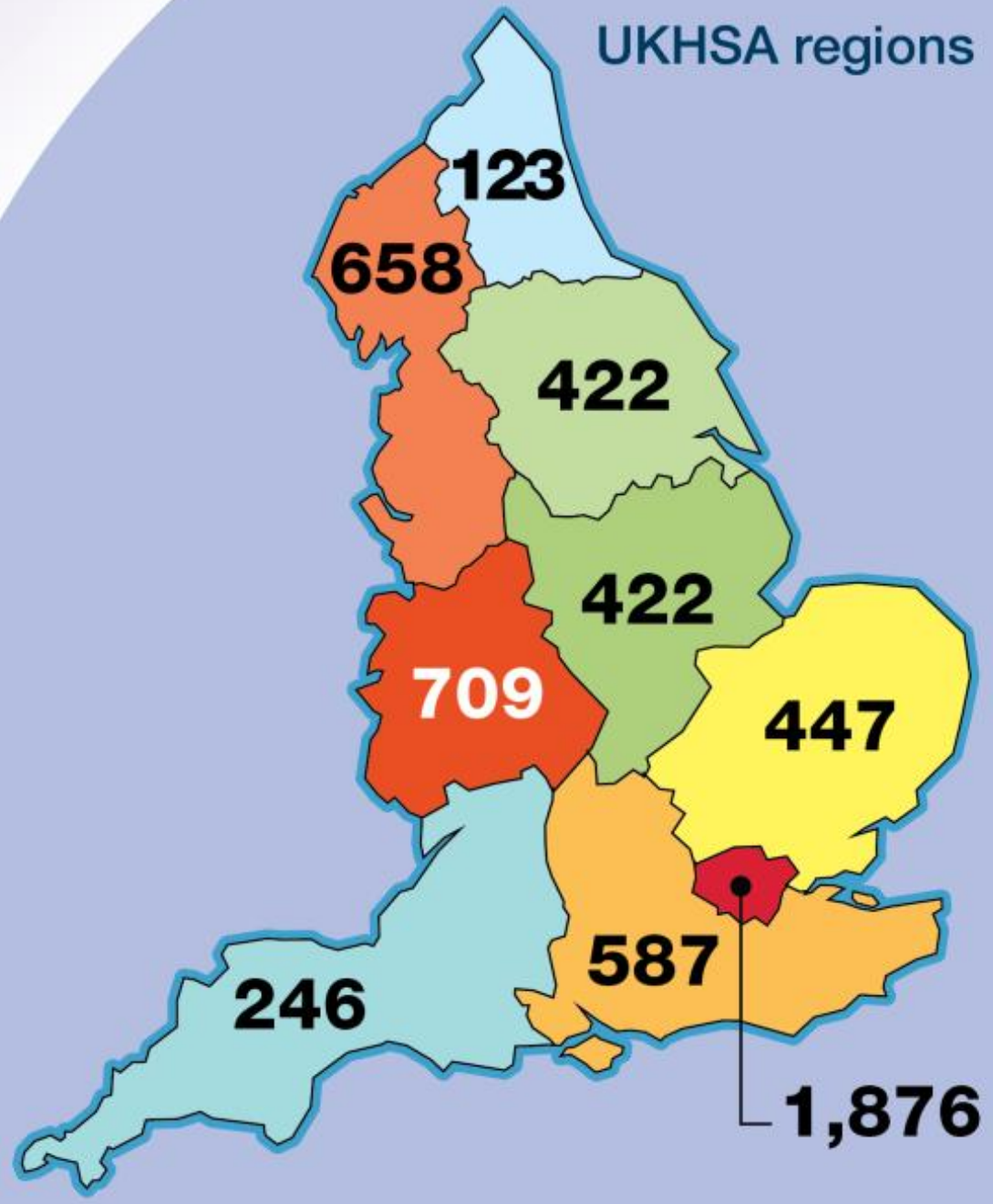
England TB rates compared to WHO End TB Goal, 2010 to 2035



Number of TB notifications in England in 2024

incidence per 100,000 population

- London — Incidence 20.6
- West Midlands — Incidence 11.5
- North West — Incidence 8.5
- South East — Incidence 6.3
- East of England — Incidence 6.5
- East Midlands — Incidence 8.3
- Yorkshire & the Humber — Incidence 7.4
- South West — Incidence 4.2
- North East — Incidence 4.5



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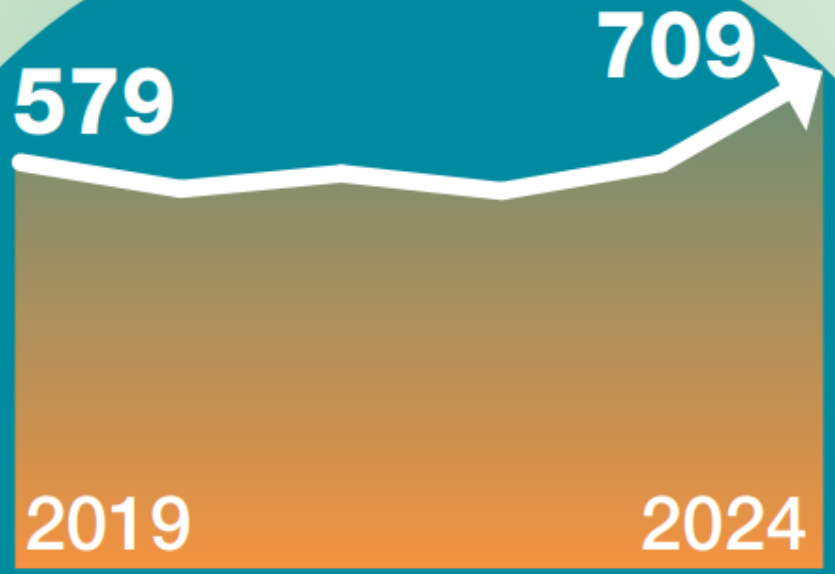
TB in West Midlands

75%

of people diagnosed with TB in 2024 were born abroad



32% increase in TB notifications from 2022 to 2024

TB increased by 44% in non-UK born

TB increased by 4% in UK born population compared with 2022

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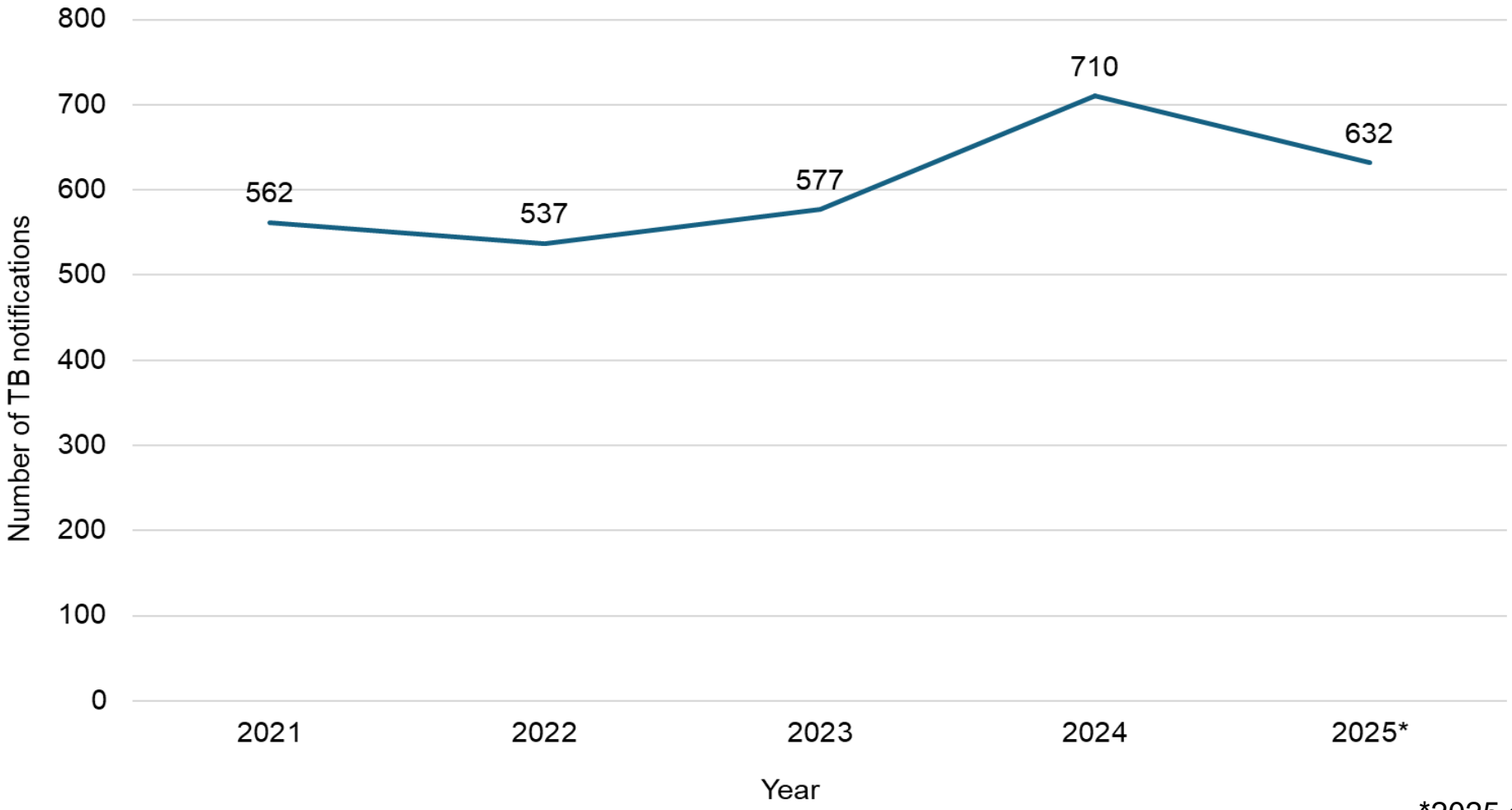
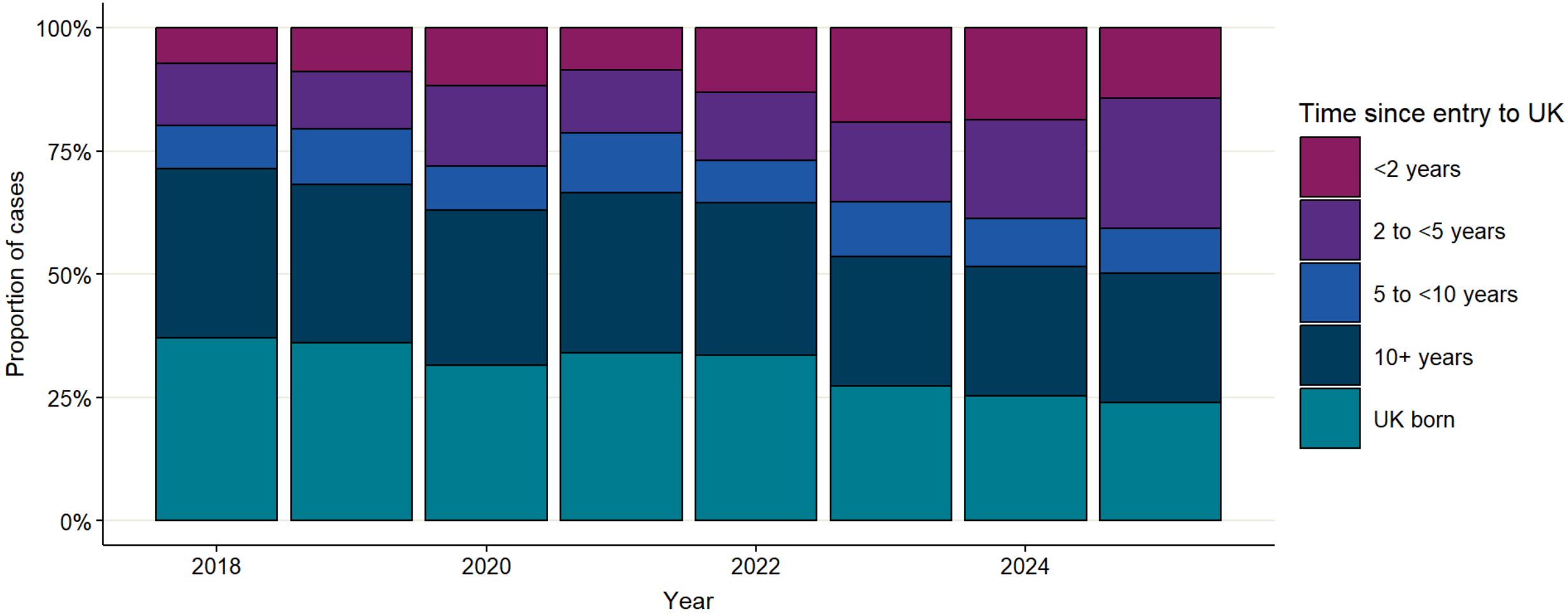
TB notifications, West Midlands residents, 2021 – 2025*



*2025 data are provisional.

Time since entry to the UK, West Midlands, 2018-2025*



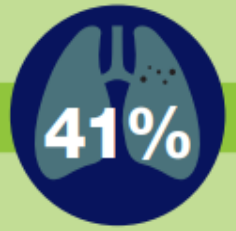
*2025 data are provisional.

Those with social risk factors are most at risk of TB

1 in 5 (18.4%)
People with TB born in the UK have at least one social risk factor

1 in 8 (11.9%)
People with TB born outside the UK have at least one social risk factor

People with social risk factors are:*



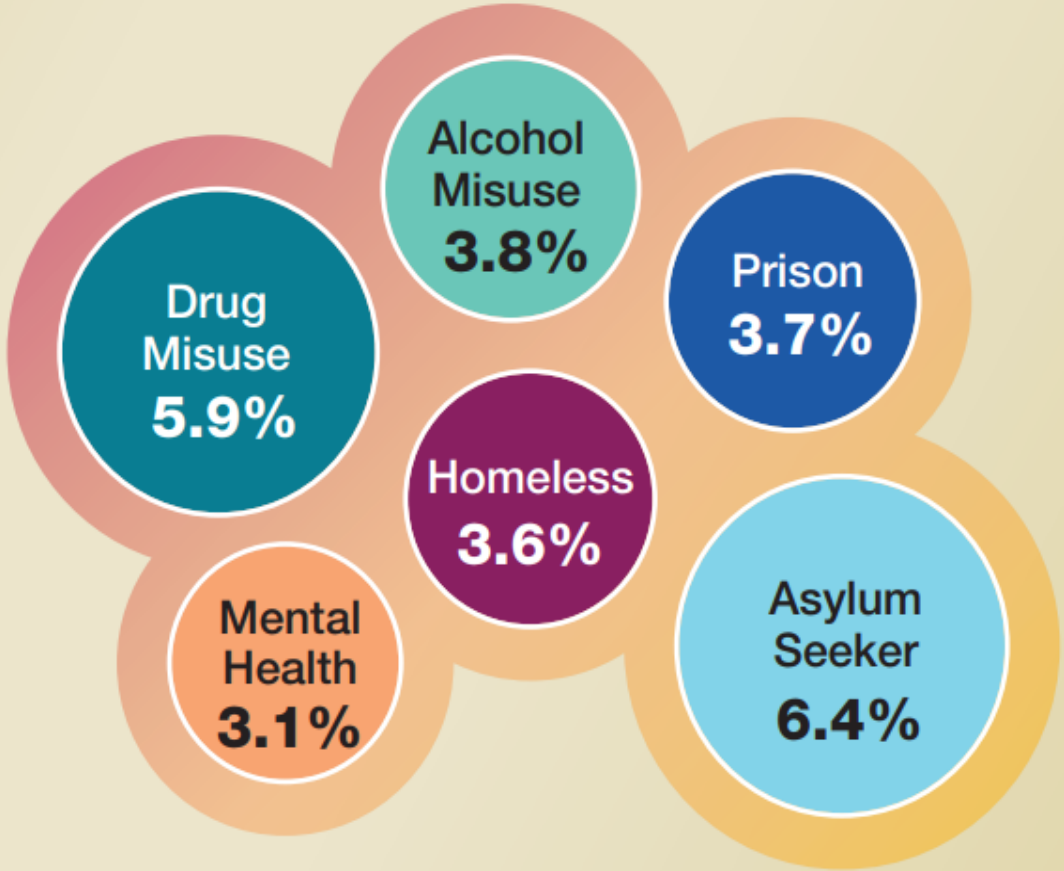
more likely to have infectious TB

more likely to die

less likely to complete treatment†

Social Risk Factors (2024)

Data for those aged 15 years or older



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* Data aggregated over the last 3 years
† Risk ratios are regional unless marked with a cross, which indicates a national risk ratio

TB in West Midlands

Contact tracing TB is the most important activity in TB prevention

In 2024, screening close contacts of **393** people notified with active pulmonary TB resulted in:

1,122 contacts identified

72% were screened, the same as the national percentage screened for active and latent TB infection

Resulting in **21** people diagnosed with TB disease and **150** people with LTBI

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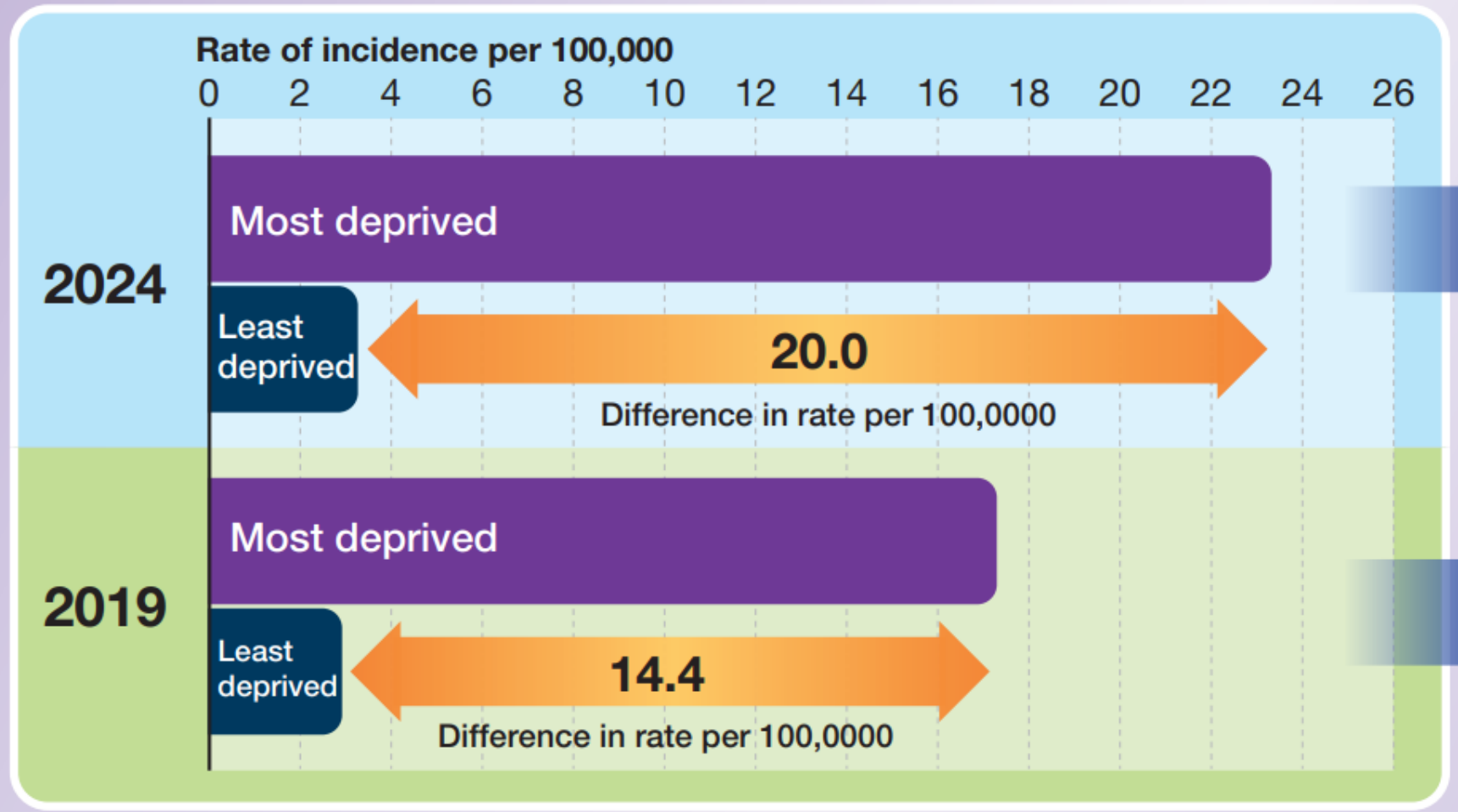
TB health inequalities are widening

2024

Widening inequality in TB rate between most deprived and least deprived



TB rate was **7.0X** higher in most deprived compared to least deprived

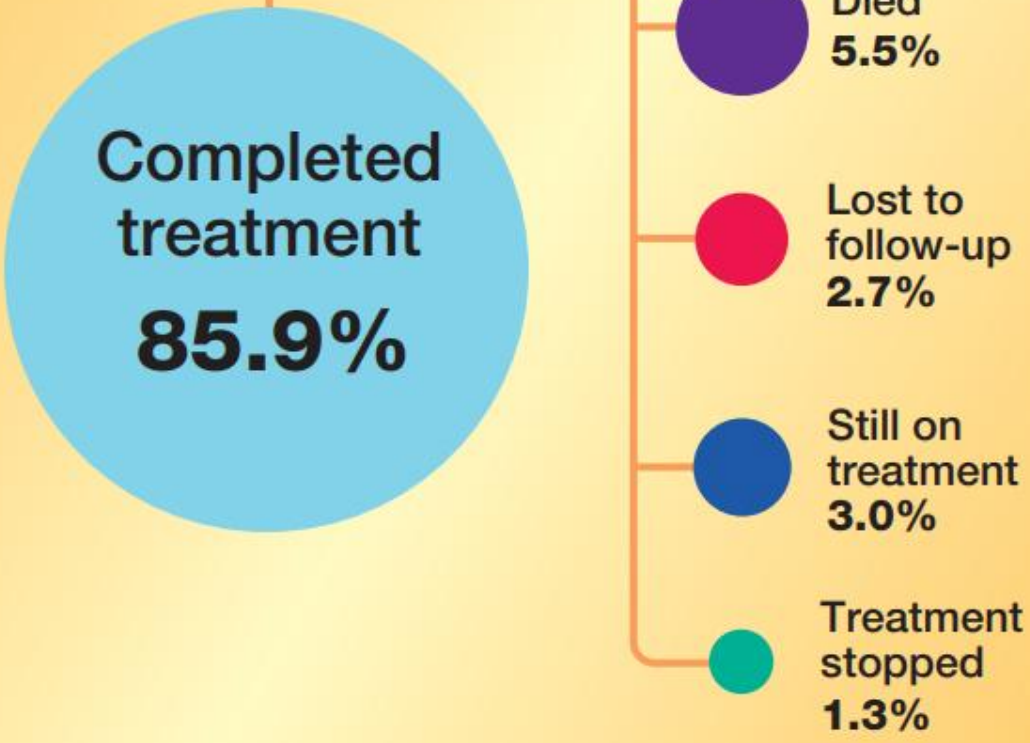
TB rate was **6.0X** higher in most deprived compared to least deprived

Rates grouped by IMD quintile

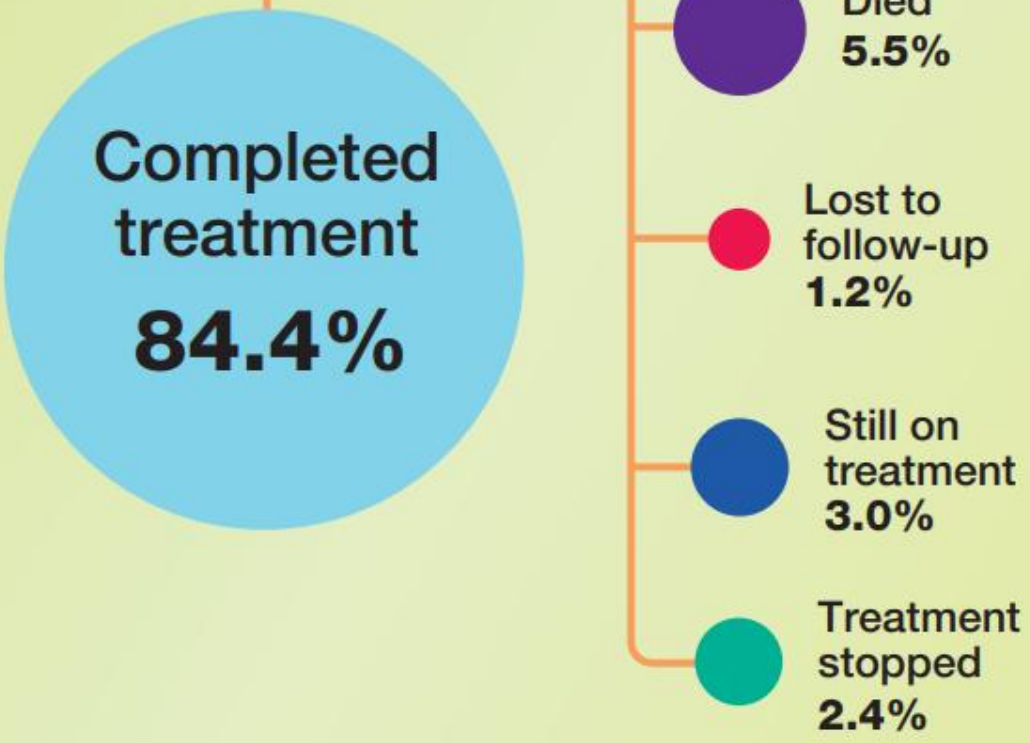
Treatment outcomes

2024

Treatment outcomes for those notified in 2018



Treatment outcomes for those notified in 2023



Available data

Available data:

- TB in England, 2025 report (data to end 2024) Tuberculosis in England, 2025 report - GOV.UK
- National quarterly reports https://www.gov.uk/government/statistics/tuberculosis-in-england-national-quarterly-reports
- Fingertips https://fingertips.phe.org.uk/profile/tb-monitoring
- West Midlands annual report (2024 data) West Midlands: tuberculosis in 2024 - GOV.UK and Tuberculosis (TB) regional reports 2024 supplementary data - GOV.UK
- West Midlands ICB and LA reports (2024 data) have been circulated

Office for Health Improvement & Disparities

UK Health Security Agency

NHS England

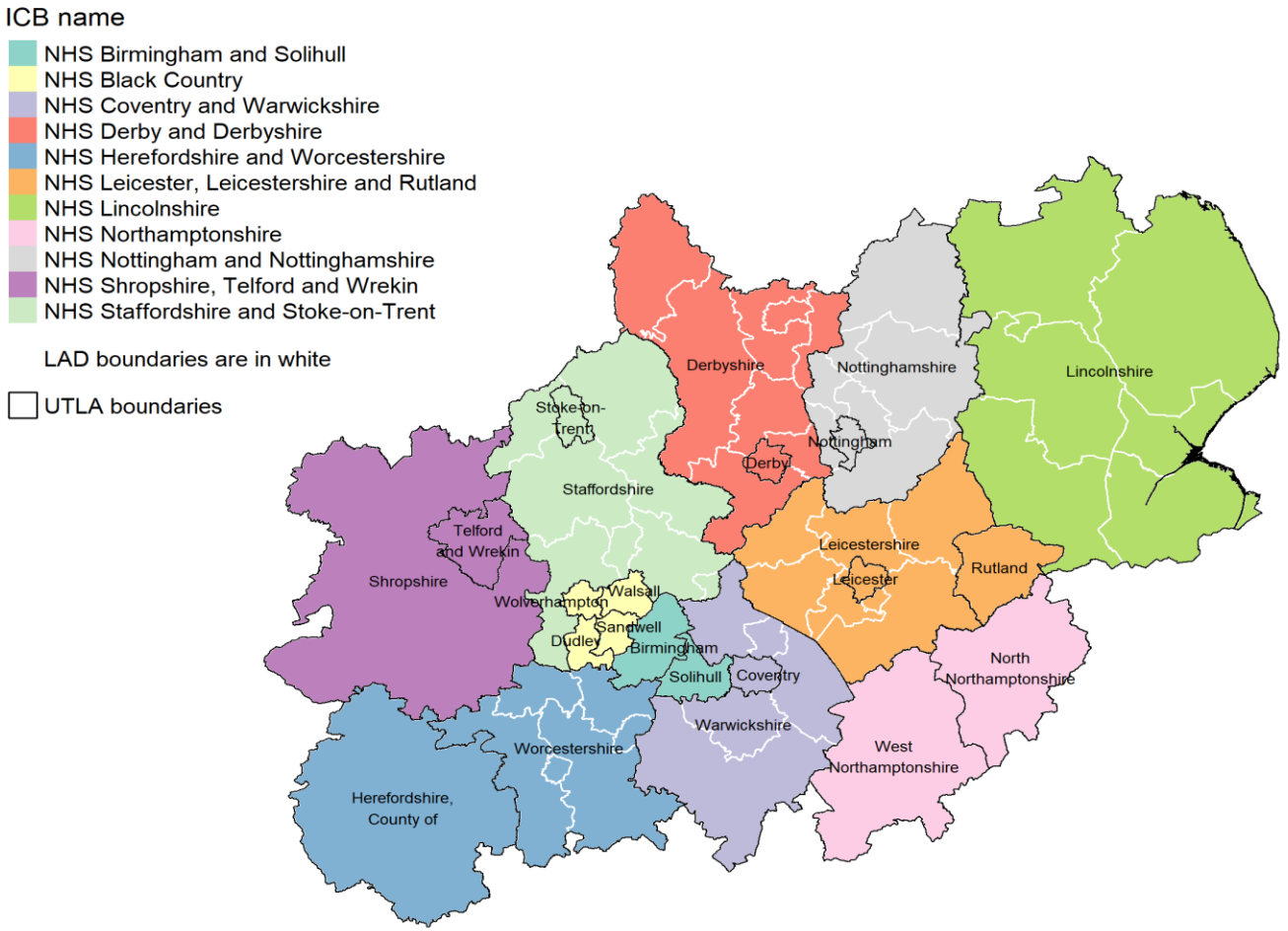
Regional Response:

Tuberculosis Regional Strategic Oversight Group

Presented by:
Katie Spence, Regional Deputy Director Health Protection UKHSA West Midlands and
Helen Webster, Acting Consultant in Public Health, OHID Midlands

Map of the Midlands showing NHS and local authority boundaries

- **24** Upper Tier (County & Unitary) Local Authorities (UTLAs)
- **65** Lower Tier (District & Unitary) Local Authorities (LTLAs)
- Previously **11** Integrated Care Systems – now merged into **5**



Context and background to RSOG development

- **External Drivers:**
  - Worsening epidemiology in the Midlands
  - CMO review on health of people in prison, on probation and in the secure NHS estate in England
  - GIRFT review
  - Imminent NHSE/DHSC transformation
- **Regional Senior Leader Engagement:**
  - East and West Midlands DPH Alliance meetings – UKHSA: Epidemiology highlighted
  - Regional Director of Public Health (RDPH) and Deputy Director of Healthcare Public Health at NHS England
- **Midlands Leadership Team – paper proposing TB RSOG**
  - Buy in from ICB Chief Executives – Cluster level Senior Responsible Office
  - Secured governance for TB in time of transition
- **Crucial to success**
  - RDPH role - brings NHS to table
  - DPH engagement and assurance

Establishing the TB RSOG – November 2025

Purpose:

- Regional oversight of TB prevalence and assurance of **system-wide actions** to improving outcomes
- Maintain focus on TB during time of significant system transformation.

Inclusion criteria:

- UTLA's with three year average incidence equal to or above 10 per 100,000 OR areas of concern
- Total 10 UTLA's: Birmingham, Coventry, Walsall, Sandwell, Wolverhampton, Stoke-on-Trent, Leicester, Nottingham, Lincolnshire, Derby

Membership:

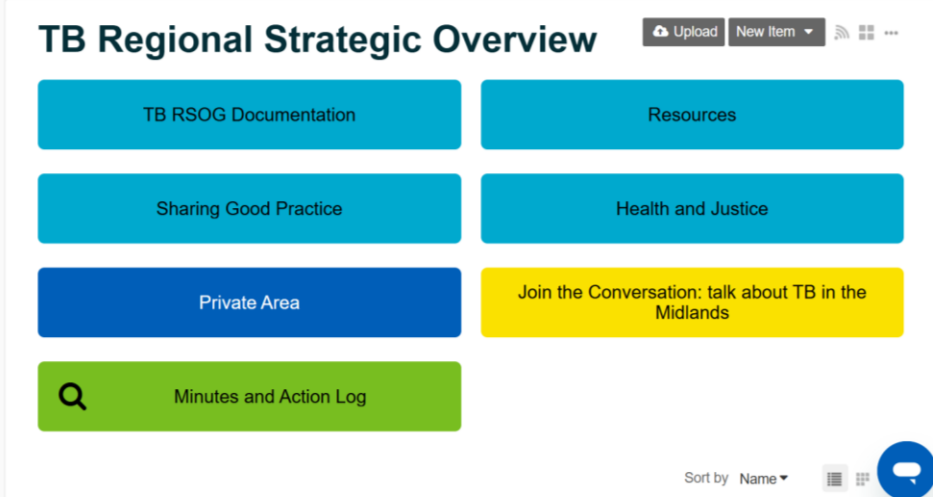
- SROS's: ICB Cluster (command control over resourcing) and Local Authority (DPH)
- UKHSA: Deputy Directors and TB Leads
- NHSE: Prevention Lead, Regional Lead microbial stewardship, Assistant Director Infection, Prevention and Control

Sit Rep template: Epidemiology, GIRFT progress, LTBI, access to diagnosis and treatment, BCG, awareness raising, inclusion groups, screening, action plan summary

Governance: RSOG reports to Regional Executive Team (NHSE) – escalate as needed

Progress so far (holding systems to account)

- Call to Action
- Full RSOG focusing on all 10 areas
- Sit Reps – all 10 received, but only 8 prior to RSOG
- Summary from each system – questioned and challenged on areas of concern from Sit Rep
- Shared learning from success, shared help for challenges faced
- NHS Futures: repository and information sharing



Challenges and Next Steps

- ICB Cluster SRO engagement – biggest challenge
- Two full RSOG then moving to ICB Cluster themed meetings where required – SRO focus
- Action plan and governance in Sit Rep
- Paper to Regional Executive Team after second full RSOG
- Full RSOG towards the end of the year – where are we now? How do we move forward?

Additional Regional Work on TB

- Reducing TB Incidence: One of Critical Six for 2026 RDPH report
- Letter to Providers – occupational health screening and retaining TB service capacity
- Letter to Chief Executives of ICB Clusters and Provider Trusts – summary of TB situation in their area and RSOG
- GIRFT Conference, plus planned production of summary to GIRFT

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Helen Webster: helen.webster@dhsc.gov.uk

Birmingham City Council

Embedding TB as a strategic priority in a local system

Chris Baggott

Public Health Portfolio Principal
(Health Protection, Built & Natural Environment, Physical Activity)
Birmingham City Council

Chris.Baggott@birmingham.gov.uk

Birmingham context

- Fast-Track Cities Plus (2022)
- TB GIRFT (Feb 2024)
- Complex cases (2024-25)
  - Debriefs
- TB National Action Plan
- High rates of TB and complexity
  - IMTs and case conferences
- **Lots of good practice and willingness to resolve issues, but opportunities for a more strategic approach**

Already in place

- NRPF Homeless/Housing Pathway
- Housing and homelessness officers integrated in hospital discharge pathways
- Pathways to support patients using drugs and alcohol
- Missing patient protocol
- Part 2A use checklist and guide
- TB Ways of working group
- Cohort review meetings
- Cluster review meetings
- **Lots of effective relationships**

What we did

- Re-established TB Programme Board for Birmingham and Solihull in May 2025
- Aims:
  - Provide strategic direction for TB treatment and prevention
  - Minimise the burden of ill health associated with TB and reduce inequalities in health outcomes.
  - Improve management of social risk factors.
  - Ensure a holistic approach to TB control and management.
  - Manage risks identified by reporting groups.
  - Reflect, learn and improve systems and processes

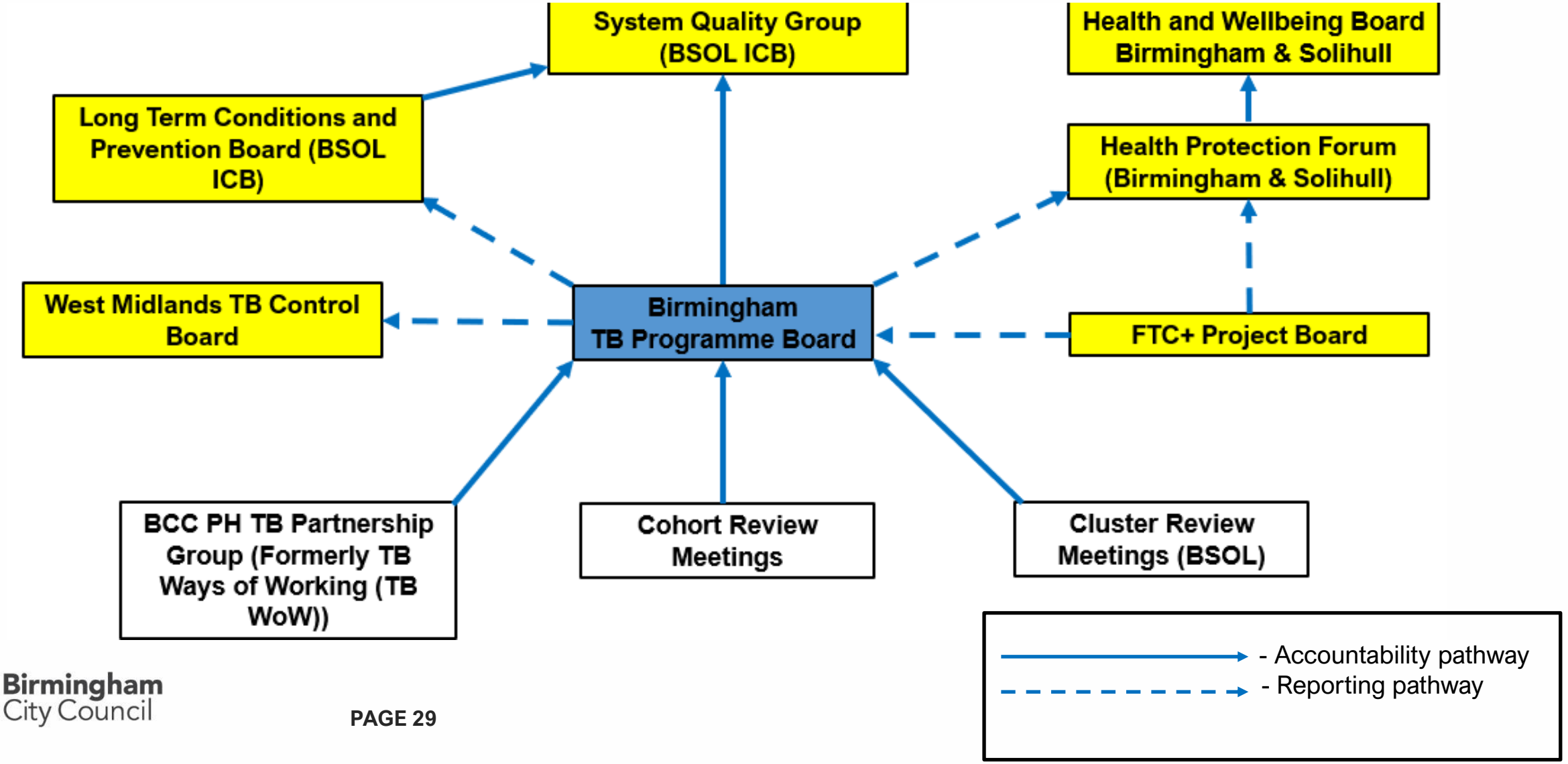
What we did

- Action Plan themes:
  - Prevention
  - Diagnosis
  - Clinical treatment
  - Social risk management
  - Workforce
  - Learning and continuous improvement (from TB incidents)

Programme Board Governance

- Terms of reference
- Risk register
- Action plan
- Subgroups
  - Governance required
- Membership
  - LA Public Health
  - UKHSA
  - ICB
  - Trust

Birmingham & Solihull TB Programme Board Governance



Challenges and opportunities

- Need to make sure the governance processes work effectively
  - Subgroups
  - Accountability
  - Escalation
  - Risk management
- System changes mean capacity, focus and engagement can be challenging
  - Needs ongoing attention
- The Programme Board and subgroups need to maintain focus at the correct strategic and operational levels
  - Membership needs to reflect the purpose of the Board/sub-group
- Single view of the current situation – currently working on a more effective dashboard

Lessons learned

- Understand your local system
  - Partners
  - Challenges
  - Opportunities
  - Priorities
- Make the action plan and priorities useful for everyone
- Review the effectiveness of the Board
- Need to review how actions are identified and implemented in response to learning
- Governance and accountability is really important

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Economic analysis of a TB incident response

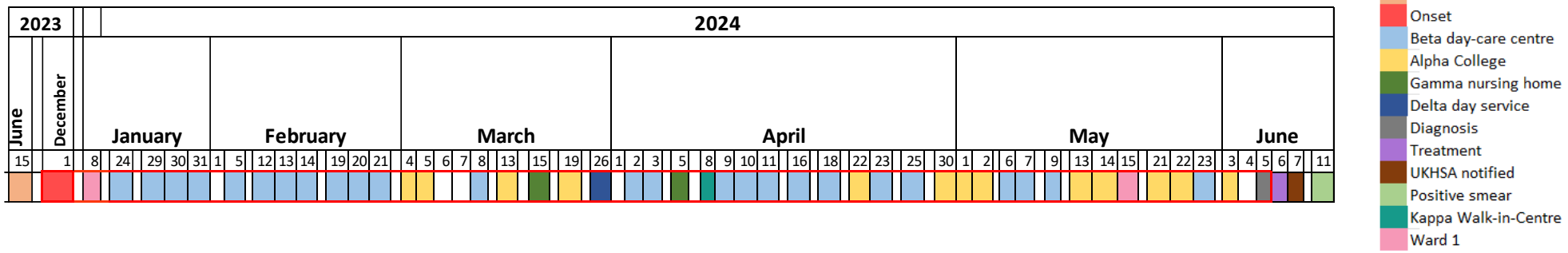
27th March 2026
West Midlands Public Health Alliance Conference

Dan Lange ● William Proto

Overview of incident

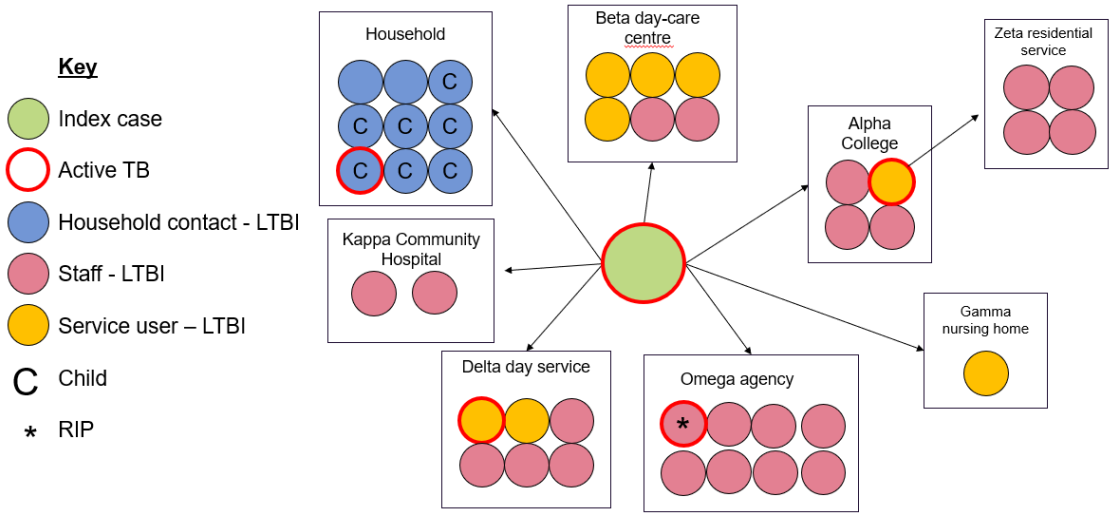
- Index case **entered the UK** in June 2023.
  - Pre-entry TB screening: no evidence of TB on chest X-ray.
- **Symptom onset**: December 2023.
- **Active TB diagnosis**: June 2024.

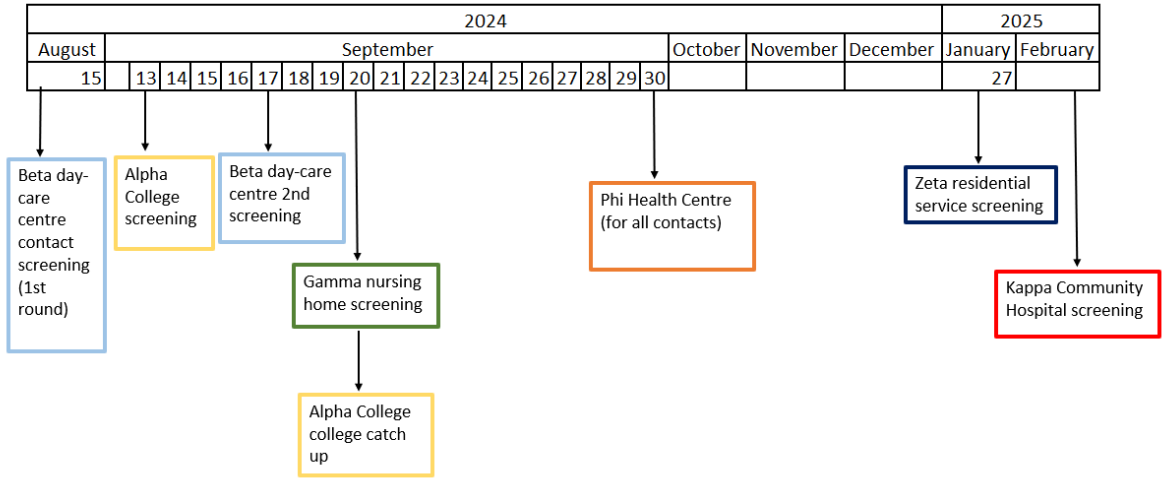
- Risk assessment noted risk of infection to others.
- Worked in **multiple care and education settings** between symptom onset and diagnosis.



Overview of incident response

OVERALL (excludes index)								
Total number	**Screened**	**Positive**		**Negative**	Under follow up	Prior TB infection	Previously known LTBI	**Not screened**
		Active TB	**LTBI**					
361	**313**	**4**	**36**	**270**	0	3	6	42





Economic analysis

TB care costs

Activity	Number of cases (n)	Cost per case (£/case)	Cost incurred (£)
TB screening (total)	**323**	**-**	**23,928.16**
Local University Hospitals NHS Trust	110	62	6,820
Sigma TB testing service	213	80.32	17,108.16
Active TB treatment (total)	**4**	**-**	**16,096**
Medium intensity, DOT	1	4,122	4,122
Mild intensity, DOT	2	4,081	8,162
Mild intensity, no DOT	1	3,812	3,812
LTBI treatment (total)	**36**	**2,267**	**79,452**
Total	**-**	**-**	**119,476.16**

Health protection response

	UKHSA staff grade	Time spent on incident response (hours)	Cost incurred (£)
Total	Ranging from Band 3 to Band 8d	143.75	**6,832.55**

Estimated financial costs associated with incidence response totaled **£126,308.71**:

- **£95,548** in clinical management of active and latent TB cases,
- **£23,928.16** in screening of contacts,
- **£6,832.55** in UKHSA staff time for health protection activities.

Discussion

Learning points

Complex incident response requiring considerable resource investment.

Gaps in occupational health TB screening for social care workforce.

Limited local capacity for LTBI screening programme delivery.

Inequalities experienced by people with learning difficulties (PLD).

Assumptions and limitations

Not possible to have certainty that:

- All cases were identified.
- All cases are linked.

Likely to be an underestimate

- Only estimates UKHSA and NHS costs.

Costs/impacts not considered:

- Productivity losses, financial impacts for workers.
- Wellbeing and educational needs of PLD.
- Mental health and wellbeing of being given a diagnosis of TB.

Suggested actions

Action 1

- Improve awareness of TB and local pathways for clinical assessment in social care workforce.

Action 2

- Prioritise implementation of the new-entrant LTBI testing and treatment programme.

Action 3

- Develop guidance and supporting resources to facilitate discussions about infectious disease exposure risk and consenting to screening for PLD.

With thanks to:

- Emma Adamson
- Angela Cartwright
- Kate Duffield
- Lowri Foster-Davies
- Srobana Ghosh
- Melissa Harrison
- Sophie Logan

A Whole Systems Approach to TB

Case study:
From TB outbreak → integrated primary care support

Riva Eardley
Principal Health Protection Practitioner, Wolverhampton City Council

West Midlands ADPH Conference
27 March 2026

A Whole Systems Approach to TB

Case study: From TB outbreak → integrated primary care support

Outbreak summary 2019–2021 outbreak in 71 bed hostel; not formally commissioned. 8 active pulmonary TB cases (+1 index case); 28 latent cases. First case: 01/09/2020 → Last case: 28/10/2021.

Profile of residents

- Mostly male (89%)
- Mean age 45
- High prevalence of infectious diseases (25%), mental ill-health (86%), SMI (36%). High levels of alcohol (57%) and drug dependency (50%). Dual diagnosis (43%).

Complex needs

- Trauma, chaotic lifestyles, MH conditions. Drug/alcohol dependence; unmanaged chronic disease.
- Barriers to GP access → crises & ED use.
- Non-compliance often linked to unmet needs, not behaviour

Why this outbreak became a catalyst

- IMT recognised TB management alone wasn't enough.
- Residents struggled to access GP services and relied on emergency care.
- TB nurses delivered onsite in-reach care (testing, DOT, supported treatment, mobile X-ray).
- Trust built with residents who avoided mainstream services.
- Led directly to the Healthier Hostel pilot.

Key learning

- Regular onsite presence stabilised engagement and strengthened trust.

The Healthier Hostel Pilot

Improving access • Building trust • Preventing outbreaks • Reducing inequalities

Aim: Extend the successful TB in-reach model by piloting GP drop-ins to improve access, engagement, and outcomes for residents with severe multiple disadvantage.

What the pilot delivered

- 28 residents registered with the delivering GP practice.
- 2–4 onsite clinics/month; avg. 8 attendances.
- Holistic care: physical health, mental health, medication reviews, vaccines, monitoring.

Key outcomes

- GP appointments & med reviews more than doubled.
- Major increases in BP and glucose checks.
- 9 x rise in referrals (MH, substance use, social care, secondary care).
- Higher trust, satisfaction, and earlier help-seeking.
- Hostel staff routinely register new arrivals and undertake TB symptom screening

Why the Pilot Worked

A whole-system, partnership-driven model

Partnership Approach:

City Council • TB team (RWT) • Primary care • BC ICB • Hostel staff

In-Reach Model:

- Care delivered in a familiar, low-barrier environment.
- Trauma-informed, flexible, person-centred.
- Addressed infectious disease, chronic conditions, mental health, substance use & safeguarding.

The Big Lesson

- Access + trust + partnership + flexibility = improved outcomes
- **TB control in complex settings only succeeds when the whole system meets people where they are.**

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Q & A
and
Thank you