SCOTTISH HEALTH PROTECTION NETWORK
Promoting and Supporting Good Practice

NHS National Services Scotland

External Guidance Addendum

This guidance has been approved for use in Scotland by the Scottish Health Protection Network Guidance Group (SHPN-GG). The guidance should be used in conjunction with the addendum outlined below.

Guidance name:	NICE Tuberculosis Guidance, 2016
Name of sponsor SHPN-Topic/ Coordination Group and individual providing addendum information:	SHPN-RIG
Date of guidance sign-off by SHPN-GG:	01/03/17
Addendum required:	The Scottish TB network agreed to adopt the updated NICE guidelines in Scotland as minimum standards. These are summarised into the areas below. NHS boards can implement their own local policy above and beyond these updated NICE recommendations should local evidence support such an approach. Additional recommendations made on the basis of local evidence are given below. It is acknowledged that service organisation is very different in Scotland and therefore chapter 1.8 is not directly applicable in the Scottish context. An updated Green Book chapter and health clearance document are awaited which will give further clarity and consistency around screening of healthcare workers. **Area 1: Identification of latent infection [Updated recommendations 2016]** • Offer TB testing to close contacts of people with pulmonary or laryngeal TB, people who are immunocompromised and at high risk of TB, and new entrants from high incidence countries presenting for health care. • The upper age limit for offering to test and treat latent infection is now 65 years (rather than 35) • In any patient, regardless of BCG history, consider a Mantoux test as positive if skin induration is ≥5 mm • If any test for latent infection is positive, assess for active TB; if this assessment is negative, offer treatment for latent TB infection. Additional activity for Scotland: • Offer TB testing to close contacts of children aged under sixteen years with non-pulmonary TB (expert consensus agreement) • Offer TB testing to close contacts aged under sixteen years of people with non-pulmonary TB (expert consensus agreement) • Offer TB testing to close contacts of people with non-pulmonary TB if local

	evidence supports this approach (expert consensus agreement) **Area 2: Infection control measures [Updated recommendations 2016]** • Minimise the number and duration of visits a person with TB makes to an outpatient department while they are still infectious • Put people with suspected infectious or confirmed pulmonary or laryngeal TB who will remain in hospital in a single room. If this is not possible, keep the persons waiting times to a minimum. This may involve prioritising their care above that of other patients • Do not admit people with suspected infectious or confirmed pulmonary TB to a ward containing people who are immunocompromised • Explain to inpatients with suspected infectious or confirmed pulmonary or laryngeal TB that they will need to wear a face mask whenever they leave their room. Ask them to continue wearing it until they have had at least two weeks of treatment • Offer patients advice on simple respiratory hygiene measures, such as covering the mouth and nose with a tissue when coughing or sneezing and disposing of the tissue in a waste basket • For people deemed to be at high risk of multidrug resistance, provide care in a negative pressure room • Staff and visitors should wear FFP3 face masks during contact with a person with suspected or known multidrug resistant TB while the person is thought to be infectious **Area 3: People at increased risk of developing active TB [Updated recommendations 2016]** • People with HIV, diabetes, chronic kidney disease, or silicosis, or receiving haemodialysis • Children younger than 5 years old • People with an excessive alcohol intake or who are injecting drug users • People who have had solid organ transplantation • People who have a haematological malignancy or are receiving chemotherapy • People who have had a gastrectomy or jejunoileal bypass • People who are having treatment with anti-tumour necrosis factor alpha or other biologic agents **Area 4: Enhanced case management for TB [Updated recommendations 2016]** • This comprises a package of supportive care tailored to the person's needs, for someone with clinically or socially complex needs • DOT is offered as part of enhanced case management in people who −Do not adhere to treatment (or have not in the past) −Have been treated previously for TB −Have a history of homelessness or drug or alcohol misuse −Are in prison or have been in the past five years −Have a major psychiatric, memory, or cognitive disorder −Are in denial of the TB diagnosis −Have multidrug resistant TB −Request DOT after discussion with the clinical team −Are too ill to administer the treatment themselves. **Area 5: Strategies to encourage people to follow their treatment plan [Updated**

	recommendations 2016] • Enhanced case management, including DOT • Reminder letters, printed information, telephone calls, texts, and apps using an appropriate language • Health education counselling and patient centred interviews • Tailored health education booklets from quality sources • Home visits • Random urine tests and other monitoring (such as pill counts) • Access to free TB treatment for everyone (irrespective of eligibility for other NHS care) and information about help with paying for prescriptions • Social and psychological support (including cultural case management and broader social support) • Advice and support for parents and carers • Incentives and enablers to help people follow their treatment regimen Additional specific advice is offered on laboratory diagnosis of active disease, re-establishing treatment after interruptions because of adverse events and measures that can be taken to improve BCG vaccine uptake.