Our Ref: JF 16-0902.1

Specialised Commissioning
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Ms Deborah Gold
Chief Executive
National Aids Trust

By email to Deborah.gold@nat.org.uk

2 September 2016

Dear Ms Gold

NHS England statement on PrEP

Thank you for your letter to Simon Stevens that I have been asked to respond to.

I am sure that we can all agree that all parties have a duty to make their points in an open, factual and reasonable way, and not seek to attribute incorrect motives or minimise the complex question at hand - which runs wider than this specific intervention - of which statutory body is responsible for commissioning preventative sexual health services.

While we cannot be held responsible for the editorial stance of any media outlet, corrections have been sought, and achieved, where factually incorrect reporting has been observed.

To address your specific concerns, you will be aware that the language used in the statement setting out the implications of, and our response to, the High Court's ruling accurately describes the group most likely to benefit from PrEP. This is based on the PROUD and IPERGAY clinical trials, which were conducted exclusively amongst men who have sex with men (MSM).

It is also accurate that those on the trial had multiple partners - the IPERGAY cohort reported a median of eight over two months, and PROUD participants reported ten over three months - and that those who are at highest risk of contracting HIV are individuals who are less likely to wear condoms.

As currently drafted, the commissioning proposition for PrEP recommends access for specific patient populations where there is some evidence for clinical and cost effectiveness, based on individual assessment of risk of HIV, which takes into account frequency of condomless sex.

In addition to high risk MSM, the draft proposition recommends access for a small group including trans women and trans men (extrapolated from the evidence for high risk MSM), partners of people living with HIV but not known to be receiving successful HIV treatment, and heterosexuals assessed to be at similar high risk to MSM.

However, the overwhelming majority of those likely to benefit from PrEP will be in the MSM group described by NHS England's statement. The review of the evidence commissioned by NHS England did not support the clinical and cost effectiveness of routinely commissioning PrEP for other groups, such as intravenous drug users.

Overall, the evidence of clinical and cost effectiveness is highly sensitive to ensuring that PrEP is targeted to those at the highest risk of HIV, which in the UK setting is mainly the MSM population where HIV incidence remains highest.

The draft policy on PrEP was developed by a working group which included HIV clinicians, public health experts, local authority representatives, individuals with lived experience of HIV and representatives of HIV voluntary sector groups, including the Terrence Higgins Trust as well as with the National Aids Trust. Engagement will continue, in good faith and without prejudice to the current appeal, during and after the public consultation, which will now provide an opportunity for members of the public to comment on the draft policy and the groups that might benefit from PrEP.

On 10 August we launched a 45 day consultation on the PrEP proposition. For reference the public consultation can be accessed via these links

https://www.engage.england.nhs.uk/consultation/specialised-services
https://www.england.nhs.uk/2016/08/prep-consultation/

We do not accept that the process will have been unfair should it generate a range of views. Consultation is an important aspect but it is only part of the information considered in the prioritisation process.

The press statements issued during this period reflect that it is incumbent on NHS England to be clear about what this judgement means for patients waiting for certainty on the 22 commissioning propositions in this year's prioritisation round. Doing so was in line with the draft Court Order, which was agreed by the National AIDS Trust and the Local Government Association.

NHS England does not have infinite resources for new specialised services, which is why the Clinical Priorities Advisory Group assesses and compares each potential new intervention on their clinical benefits and costs relative to each other. This process was drawn up from the best evidence available and consulted upon publically earlier this year prior to its agreed use for prioritisation. This is not done to pit different groups of patients against each other, but to discharge the duty we have to achieve the greatest possible benefit for patients within the fixed resources provided by Parliament. The examples of other policies cited by NHS England accurately reflect the policies under consideration.

We are working with drug manufacturers to ensure best prices have been offered for relevant proposals in order that the health benefit from our funding can be maximised. In terms of publically quoted figures due to the commercial in confidence nature of pricing discussions we have no option but to use list/published prices when making any public statements about price. We will also have undertaken demand modelling which may include different scenarios to those used by the pharma company. The financial impact is assessed in the same way across proposals and will include any agreed price reductions within the financial modelling. We do not accept that the media interest or public discussion will impact on CPAG's decision making process as the group has clear criteria

for considering each proposal, including the equality impact.

You will also recognise the importance, given the necessity for this prioritisation process, of not giving the false expectation that, should the Court of Appeal ultimately agree with the High Court ruling that NHS England has the power to commission PrEP, funding will automatically be allocated in this year. In those circumstances, as our statement set out to describe, PrEP will be considered alongside the 13 other treatments still in line for prioritisation.

NHS England takes very seriously its duties in relation to tackling health inequalities and progressing the equalities agenda. As such we work in partnership with a wide range of stakeholders to improve health for all communities, and in relation to HIV in particular, in our role as the commissioner of care and treatment services for people with diagnosed HIV. Whilst I do not accept we have misrepresented the facts of the PrEP policy proposition and the evidence which supports it, I can assure you that all the proposals will be subject to the same robust assessment of clinical and cost effectiveness as well as the impact on people from vulnerable and protected groups and relative prioritisation within the resources available

Thank you again for your letter and I hope this reply has addressed your concerns.

Yours sincerely

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Deputy National Medical Director
NHS England