Our Ref: JF 16-0909.2

Specialised Commissioning
Skipton House
80 London Road
London
SE1 6LH

Mr Ian Green
Chief Executive
Terrence Higgins Trust

By email to Ian.Green@tht.org.uk

9 September 2016

Dear Mr Green,

NHS England statement on PrEP

Thank you for your letter. Simon Stevens is currently away so I have been asked to reply as the Director for Specialised Commissioning.

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 and 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.

Further, 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.

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.

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.

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

Yours sincerely,

Dr Jonathan Fielden FRCP FRCA FICM MFMLM
Director of Specialised Commissioning
Deputy National Medical Director
NHS England