English HIV and Sexual Health Commissioners Group

BASHH 100 YEARS 1922-2022 British Association for Sexual Health and HIV

Association of Directors of Public Health

BHIVA British HIV Association

FSRH The Faculty of Sexual & Reproductive Healthcare

From the Chairs and Presidents

Please reply to **all** authors

6th October, 2022

Dr Jeanelle de Gruchy
Deputy Chief Medical Officer
Office of Health Improvement and Disparities
Department of Health and Social Care

Dame Jenny Harries, Chief Executive
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Steve Russell, National Director of
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cc.
Susan Hopkins Chief Medical Adviser, UK Health Security Agency
Partner Agencies in the roundtable of Friday 23rd September 2022
Matthew Taylor, Chief Executive, NHS Confederation

Dear Colleagues

Monkeypox – impact of unfunded monkeypox (MPX) activity on sexual health and HIV

This letter is jointly sent, further to the meeting on 23rd September 2022. Together our organisations provide, commission and represent the professionals leading the services which are the front-line for assessment, response and care of those experiencing the highest burden of preventable morbidity in the current outbreak.

As you know, the meeting on 23rd September 2022 agreed we need to reconvene because we did not have sufficient time to consider the issues we raised. We are writing

1. to summarise our position,
2. to offer our further evidence of impact
3. to appraise you of concerns raised by providers and commissioners with us in the last few days
4. to ask for a further urgent meeting to resolve these issues

Level of displacement of activity

We have made clear in repeated fora that unfunded monkeypox clinical assessment and treatment activity in sexual health clinics has been displacing routine sexual health testing, assessment, treatment and other clinical activity. We have stated clearly that this represents 25-30% of activity displacement in many clinics across the country. You will recall that BASHH provided evidence from clinics that this was the case.

We now have further evidence that this is the case. Activity data collated by Commissioners from Provider Trusts has established that in those areas most impacted by MPX displacement of routine sexual health activity is running at 30%. We are happy to supply this to you.

We have had repeated requests from government for verification of our statements. In our view we have provided this on more than one occasion, without result. At this juncture, we feel it right to point out that government does have access to data which would confirm the situation we now find ourselves in.

It would, we suggest, be a relatively straightforward task to collate positive for MPX (using GUMCAD and other data sources), and then use this as the basis of a cost and resource assessment for cases, linked to the costings work which BASHH undertook and which was shared with you some time ago. That would at least provide a basis from operational data.

Impact of the displacement and Situation coming to light during the week beginning 26th September 2022

It has become clear during this week from provider data submitted to commissioners as part of routine activity monitoring that a number of providers have seen a drop in core work in sexual health activity of 30% over several months because of the work they have been undertaking to vaccinate for MPX and assess and treat presentations, along with associated cleaning and the need to have suspected and confirmed MPX cases properly separated from other service users to prevent spread of infection. Ongoing advice and support for pain management, other symptom management and the significant emotional consequences of MPX are also part of this burden.

In some cases this displacement in financial terms means a potential loss of income to clinics of over £600,000 per quarter. This level of loss of income risks destabilising clinics, with loss of staff and, as some providers have warned us, the potential exit from the market of some providers. This situation is, we hope you would agree, potentially very serious because it would have long term consequences for access to and availability of sexual health services and consequences for peoples' health. Vaccination funding at £15 per capita has yet to reach any clinics, does not meet clinic expenditure on vaccination or enable providers to recover costs of vaccination and work displacement. Loss of income to some providers risks destabilising the provider financially and operationally and may result in some sexual health services declining to manage MPX as it is not commissioned activity.

Displacement of routine sexual health activity by MPX activity has serious consequences for the health of our population:

1. People are already finding it difficult or impossible to get appointments for assessment and treatment, with the result that infections persist, people develop complications either requiring costly admission to hospital or chronic morbidity may become more unwell, and infections spread. We have already indicated that we are aware of outbreaks of STIs in several areas associated with this. While this is particularly the
2. The risk of people developing treatment resistant infections grows if people cannot access treatment services
3. The risk that people will not get treated, become asymptomatic and believe the infection has gone, means people may have persistent infections which worsen and present with serious morbidity later on, in addition to spreading infection
4. If people cannot access Pre-exposure prophylaxis for HIV or post-exposure prophylaxis the risk of new HIV infections is increased
5. The risk that people present to Accident and Emergency services with pain or symptoms increases
6. Women are unable to access contraceptive services. Reduced access to contraceptive services has multiple impacts:

    a. Reduced access to contraceptive services, particularly long-acting reversible contraception (LARC) will worsen the health, financial, societal and psychological costs of unplanned pregnancies, including further cost to the NHS and other agencies.

    b. Reduced access to experts in complex contraception means that the most high risk women with comorbidities are unlikely to be able to access effective contraception or preconception care. We are aware that reduced access to complex LARC removals is already discouraging women from using these methods to present for care.

c. Displacement from contraceptive services may mean people are diverted back to General Practice for contraception. As you know, the General Medical Services contract still places a duty on primary care to provide contraception. Sexual Health Services may need to divert people back to primary care if displacement from monkeypox continues, further increasing pressure on the NHS.

In addition to existing poorer health for individuals as a result of displacement and lack of access, provider collapse or market exit would exacerbate significantly both harm to individuals and populations and concomitant rise in cost as people are displaced to Accident and Emergency or Primary Care. This potentially compromises the duty of the Secretary of State to provide a comprehensive health service pursuant to the NHS Act 1966, of which sexual health services remain a part, and in so being compromised the Secretary of State is placed in a situation where residents may seek remedy before the courts through judicial review.

It is possible to prevent this situation

Sexual health clinics are the right place for gay and bisexual men and men who have sex with men to be assessed, treated and cared for. This fact has been well established in previous meetings. But we need to be able to both continue sexual health service provision and to ensure suspected and actual MPX cases in GBMSM are assessed, treated and cared for through these services.

We have been very clear that the exceptional nature of this epidemic, the transmission routes and its impacts are an unfunded burden which should not be borne by the Public Health Grant or by sexual health clinics. This needs funding centrally to reduce risk of serious further impact on the NHS by market exit or provider collapse, to help eliminate the epidemic locally and to prevent the sexual health of the population from worsening. We believe, as has been stated in the *Consensus Statement* , that this funding would be less than the cost of not funding services, and that doing nothing is justifiable neither on economic nor on public health grounds.

We look forward to discussing with you urgently the need for funding to address these issues and to resolving this together. There are limited levers open to us temporarily to act to prevent provider collapse or market exit, but these have consequences for non MPX sexual health activity and performance which are not recoverable. We need a solution which recognises equitably the impact of this novel epidemic on our GBMSM populations.

As a starting point, our understanding is that NHS England has responsibility for the supply and distribution to NHS Trusts of vaccine and commissioning of services to deliver vaccination programmes. The responsibility of local commissioners is to commission the overall SRH and GUM service. That does not include MPX activity which is not in scope as part of national commissioning. Services will rightly expect reimbursement for their activity on monkeypox. We believe this should come from

national sources, and that is a matter for discussion between all of us. The situation now risks provider collapse or market exit. This must be addressed urgently.

We look forward to meeting.

Yours sincerely

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