Assisted Conception Policy
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1. Definitions

1.1 Exceptional - refers to a person who demonstrates characteristics, which are highly unusual, uncommon or rare.

1.2 Exceptional clinical circumstances are clinical circumstances pertaining to a particular patient, which can properly be described as exceptional, when compared to the clinical circumstances of other patients with the same clinical condition and at the same stage of development of that condition (i.e. similar patients). A patient with exceptional clinical circumstances will have clinical features or characteristics which differentiate that patient from other patients in that cohort and result in that patient being likely to obtain significantly greater clinical benefit (than those other patients) from the intervention for which funding is sought.

1.3 A Similar Patient is a patient who is likely to be in the same or similar clinical circumstances as the requesting patient and who could reasonably be expected to benefit from the requested treatment to the same or a similar degree. The existence of more than one similar patients indicates that a decision regarding the commissioning of a service development or commissioning policy is required of the Commissioner.

1.4 An individual funding request (IFR) is a request received from a provider or a patient with explicit support from a clinician, which seeks exceptional funding for a single identified patient for a specific treatment.

1.5 An in-year service development is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the Commissioner agrees to fund outside of the annual commissioning round. Such unplanned investment decisions should only be made in exceptional circumstances because, unless they can be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.

1.6 Infertility/Sub Fertility – For the purposes of this document infertility is defined as either: Absence of Known Reproductive Pathology - “A woman of reproductive age who has not conceived after 2 years of regular unprotected vaginal sexual intercourse or 12 cycles of unstimulated artificial insemination, in the absence of any known cause of infertility”.

OR

Known Reproductive Pathology - Diagnosis of a recognised condition that renders a patient infertile or reduces fertility, including confirmed diagnosis of:

- Polycystic Ovarian Syndrome (PCOS, including amenorrhea and oligomenorrhea)
- Early onset of menopause
- Complete amenorrhea
- Endometriosis which has previously been surgically treated
- Clinically significant fibroids
- Pelvic Inflammatory Disease
- Ovarian Failure including Turner's syndrome and other genetic abnormalities
- Azoospermia
- Undescended testes
- Tubal disorders and/or damage as a result of disease or trauma (e.g. blocked fallopian tubes, blocked seminal tubes); this does not include patients who have chosen to receive sterilisation surgery.
- A physical disability preventing vaginal sexual intercourse
- Planned/received treatment that may/has resulted in infertility e.g. cancer treatment

1.7 Coasting - refers to a clinical process used, when clinically appropriate, to avoid the over stimulation of the ovaries and to help couples achieve a fresh cycle. Coasting is defined as the discontinuation of stimulation injections, with daily measurement of blood oestrogen hormone levels and then continuing with treatment when the blood oestrogen hormone levels have dropped to a safe level.

1.8 Artificial Insemination (AI) – refers to the deliberate introduction of semen into a female's vagina or oviduct for the purpose of achieving a pregnancy through fertilisation by means other than sexual intercourse.

1.9 Intra-cervical Insemination (ICI) – refers to the clinical delivery of sperm into the cervix usually by injecting it with a needleless syringe.

1.10 Intra-uterine Insemination (IUI) - refers to a relatively simple reproductive procedure in which a fine catheter (tube) is inserted through the cervix (the natural opening of the uterus) into the uterus (the womb) to deposit a sperm sample directly into the uterus. The purpose of IUI is to achieve fertilisation and pregnancy.

1.11 Intra-Cytoplasmic Sperm Injections (ICSI) - refers to a reproductive technology in which an egg is removed from a woman and a sperm cell from a man is injected directly into the egg. If the cells fuse (achieve fertilisation) a single cell (zygote) is formed, which then starts dividing becoming an embryo. When the zygote/embryo is only a few cells large, it is implanted into the woman’s uterus and, if successful, will develop as a normal embryo.

1.12 In Vitro Fertilisation (IVF) - refers to a reproductive technology in which an egg is removed from a woman, joined with a sperm cell from a man in a test tube (in vitro). The cells fuse (achieve fertilisation) to form single cell called a zygote, which then starts dividing, becoming an embryo. When the zygote/embryo is only a few cells large, it is implanted in the woman's uterus and, if successful, will develop as a normal embryo.
2. Scope of policy

2.1 This policy applies to all patients for whom Herefordshire Clinical Commissioning Group (HCCG) have responsibility including:
   - People provided with primary medical services by GP practices which are members of HCCG and
   - People usually resident in the area covered by HCCG and not provided with primary medical services by any CCG.

2.3 Where a patient’s clinical presentation does not clearly meet the requirements for secondary care referral within the context of this policy, and where a GP is uncertain or concerned about the appropriate treatment/management pathway, referral for Advice & Guidance should be considered as an alternative to a referral for clinical assessment.

2.4 There may be occasions when a GP referral is made for specialist assessment which appears to meet the policy requirements, but which on specialist clinical examination either does not meet the clinical criteria or is not considered clinically suitable for intervention. Such patients should be discharged without intervention.

2.5 For patients who do not fall within the eligibility criteria set out in the policy but where there is demonstrable evidence that the patient has exceptional clinical circumstances, an Individual Funding Request may be submitted for consideration. The referring clinician should consult the Commissioner’s “Operational Policy for Individual Funding Requests” document for further guidance on this process. For a definition of the term “exceptional clinical circumstances”, please refer to the Definitions section of this document.

2.6 The policy applies to patients experiencing difficulty with conception who are being managed on an NHS pathway of care.

2.7 Funding for Military Serving Personnel

Assisted conception services for current serving personnel and their partners is contained with the specific NHS England policy at [https://www.england.nhs.uk/commissioning/policies/ssp/](https://www.england.nhs.uk/commissioning/policies/ssp/) as NHS England are the responsible commissioner.

Veterans who are in receipt of compensation for loss of fertility (received as a result of service/partner of same) and require access to assisted conception treatments, are also the commissioning responsibility of NHS England [https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/10/armed-forces-comms-intent-1617-1819.pdf](https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/10/armed-forces-comms-intent-1617-1819.pdf)
HCCG will direct clinicians and patients towards these policies to access central NHS England funding. Veterans without relevant injury impacting on fertility are the commissioning responsibility of CCGs and the content of this policy applies.

2.8 Pre-Implantation Genetic Diagnosis (PiGD) and Surrogacy, along with the associated in-vitro fertilization (IVF) / Intracytoplasmic sperm injection (ICSI) is not covered by this commissioning policy as it is the commissioning responsibility of NHS England. Patients should be referred to the Genetic Centre at Birmingham Women’s & Children’s Hospital.

2.9 The evidence base for the use of assisted conception techniques and their long-term safety is given in NICE Clinical Guideline CG156. Service providers are expected to follow the pathways and guidance outlined within CG156 which forms the basis of the following criteria for accessing assisted conception treatment in Herefordshire. Where there are deviations with NICE CG156 a rationale is provided.
### 3. Background

#### 3.1
The NHS constitution which details principles and values that guide the NHS have been applied in the agreement of this policy.

#### 3.2
Herefordshire Clinical Commissioning Group consider all lives of all patients whom they serve to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability except where a difference in the treatment options made available to patients is directly related to a particular patient’s clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.

#### 3.3
Infertility can be primary, in people who have never conceived, or secondary, in people who have previously conceived. It is estimated that infertility affects one in six heterosexual couples in the UK. A typical Clinical Commissioning Group may therefore expect to see around 230 new consultant referrals (couples) per 250,000 population per year. The causes of primary infertility in the UK occur in the following approximate proportions:

- unexplained infertility (no identified male or female cause), 25%
- ovulatory disorders, 20%
- tubal damage, 15%
- factors in the male causing infertility, 30%
- uterine or peritoneal, 10%.

In about one third of cases, disorders are found in both the man and the woman. Other factors may play a role, including uterine or endometrial factors, gamete or embryo defects, and any other pelvic condition such as endometriosis.

#### 3.4
Over 80% of couples in the general population will conceive within 1 year if:

- the woman is aged under 40 years and
- they do not use contraception and have regular sexual intercourse.

Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate over 90%).
4. Relevant National Guidance and Facts

These guidelines outline recommendations for management of patients based on an assessment of available evidence.

4.2 Human Fertilisation and Embryology Authority (HFEA) Code of Practice
The HFEA is the UK's independent regulator overseeing use of gametes and embryos in fertility treatment. Its Code of Practice sets out both mandatory requirements and recommended guidance (incorporating an interpretation of mandatory guidance) for organisations involved in this area of health care.
5. Patient Eligibility

5.1 The Commissioner considers all lives of all patients whom it serves to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability except where a difference in the treatment options made available to patients is directly related to the patient’s clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.

5.2 All of the following criteria apply to couples seeking Assisted Conception Treatment:

5.2.1 Age

Funding will be provided for women in the age range 19 to 39 at the time of treatment, i.e. up to their 40th birthday. Referrals into the service should be made in appropriate time to ensure that treatment can take place by the woman’s 40th birthday. Referrals should be made on or before the female’s 39th birthday (i.e. at least 12 months before her 40th birthday), to ensure relevant investigations can be completed and treatment commenced prior to her 40th birthday).

Where it is determined that a woman needs egg donation they must meet all applicable clinical eligibility criteria and be below the age of 40 at the time this clinical decision is made.

There is an increasing body of evidence that male fertility declines with age. It is advised that patients are informed about this.

The male partner in a heterosexual couple, at the time of treatment, must be over 25 years of age and under 55 years of age.

Rationale:

i. The decline in normal fertility with age increases markedly from the late 30s and infertility treatment is much less successful in women at this age. This is particularly evident for women aged 40 and above, where the balance of cost-effectiveness becomes uncertain.

ii. For women aged 18-22 there is a lack of robust data but no evidence of ineffectiveness. The legal age for sexual consent is 16 years; the defined age for treatment of 19 years allows for 2 years proving fertility problems and a further 1 year of investigations in secondary care before treatment is initiated.

5.2.2 Body Mass Index (BMI)

Women should have a body mass index (BMI) in the range 19 to 29 inclusive. Patients/couples should be informed of this criterion at the earliest possible opportunity in their progress through infertility investigations in primary and secondary care.
Male BMI should be 29 or below, as per NICE guidance.

*Rationale:*

i. There is clinical evidence to demonstrate that a female BMI within this range improves pregnancy rates, reduces miscarriage and prevents pre-term delivery.

ii. Men who have a BMI above 29 are likely to have reduced fertility arising from altered sperm quality and erectile function (where co-existing risk factors).

5.2.3 Nature of Infertility

Infertility treatment is available for patients with infertility as defined in section 1.6 of this document. This applies to all heterosexual and same sex couples. Where a patient has recently registered with a GP Practice, the new GP should seek and evidence the period of reported infertility in the patient/couple’s medical notes (see also 5.2.10 Residency).

- A referral for fertility treatment should not be made until the GP is satisfied that a patient/couple has tried unsuccessfully to conceive for 2 years, including a minimum non-smoking period of 6 consecutive months immediately prior to referral.

- For same sex couples or those with a physical disability, the equivalent evidence would constitute 12 cycles of unstimulated artificial insemination at a Human Fertilisation & Embryology Authority licensed clinic, including a minimum non-smoking period of 6 consecutive months immediately prior to referral.

Earlier referral, after one year, for specialist investigation and treatment should be offered to:

- Women aged 36-39 years
- Individuals with a known clinical cause of infertility or a history of predisposing factors (see identified causes listed in section 1.6)

The following groups require referral to a specialist centre with appropriate facilities and expertise; they are not covered by this policy.

- People with chronic viral infections; e.g. HIV
- Genetic issues

*Rationale:*

i. Diagnosis of infertility based on a failure to conceive within 1 year has been argued to exaggerate the risk of infertility, since up to 50% of women who do not conceive in the first year are likely to do so in the second year.

ii. The required evidence for assuring infertility is extrapolated from NICE
Clinical Guidelines

iii. Resources are limited and this guides the extended requirement for evidence assurance. iv. See section 5.2.8 in relation to smoking.

5.2.4 Living Children
Treatments for assisted conception will only be funded if the patient/couple do not have any living children (regardless of age of the child at the time of presentation) from either the current or a previous relationship. This includes a child adopted by the patient/couple or a child from a previous relationship, but excludes fostered children. Once accepted for treatment, should a child be adopted or a pregnancy leading to a live birth occur the patient/couple will no longer be eligible for NHS funded treatment. There must be an explicit and recorded assessment that the social circumstances of the family unit have been considered within the context of the assessment of the welfare of the child.

Rationale:
i. Local resources are limited and therefore priority is given to couples with no children.

5.2.5 Previous Assisted Conception
Where any prior attempts of assisted conception (IVF/ICSI) for fertility problems have been received by either partner, regardless of whether the treatment was funded by the NHS or privately, no further NHS funding will be available.

| Note 1: | This does not affect a new patient’s ability to receive fertility investigations if their partner has undertaken prior assisted conception treatment for fertility problems within an earlier relationship. Fertility investigations of this nature are undertaken before a patient or couple are considered for assisted conception/fertility treatment and may be resolved by a different course of action. |
| Note 2: | Where assisted conception was undertaken for the purpose of cryopreservation under an NHS pathway of care, 1 single treatment utilising any resultant gametes/embryos will be funded at NHS expense, subject to compliance with all other eligibility criteria within this policy. |

Rationale:
i. The chance of success declines with each attempt at assisted conception.

5.2.6 Sterilisation
NHS funded fertility treatment will not be available if the patient or either partner within a couple has received a sterilisation procedure or has undertaken a reversal of sterilisation procedure.

**Rationale:**

i. Resources are limited therefore priority is given to individuals with greatest need. Patients undergoing sterilisation receive counselling and all the consequences are explained to them at the time.

**5.2.7 HFSA Code of Practice**

Patients/couples who do not conform to the HFSA’s current Code of Practice (latest version, 8th edition – revised April 2017) will be excluded from having access to NHS funded assisted fertility treatment. This includes consideration of the “welfare of the child which may be born”. This will take account of a patient/couple’s ability to provide a stable and supportive environment for a child and family medical histories. Treatment Centres will undertake this assessment.

**5.2.8 Smoking**

Couples (both partners) who smoke are not eligible for NHS-funded fertility assessment by either a secondary or tertiary care provider.

Couples should be informed of this criterion at the earliest opportunity and should be provided with information on the impact of smoking on their ability to conceive naturally and the adverse health impacts of maternal and passive smoking on the foetus and resultant child.

Smokers should be advised to stop smoking and directed to nationally accredited resources to support smoking cessation e.g. NHS Choices website ‘Stop Smoking’; Smoke free NHS Advice. Stopping smoking offers the best outcomes for individuals, partners and any resultant child; it is recognised that there are products available to facilitate smoking cessation where clinically appropriate.

Couples are not eligible for referral to secondary or tertiary care fertility services until they have stopped smoking for a consecutive period of 6 months. Evidence of this will be sought following referral and couples will be advised that random carbon monoxide breath tests and where appropriate, urine tests (cotinine), or blood tests, will be undertaken during investigations and treatment to enforce this requirement.

Where it is identified that during fertility treatment the individual/couple no longer complies with the eligibility criteria within this section of the policy (i.e. has resumed smoking), NHS funded fertility treatment will be deferred until there is evidence to support compliance (i.e. 6 consecutive months non-smoking status); following the deferral period patients will be required to meet all eligibility criteria within the assisted conception policy applicable at the time they recommence the pathway, in order to receive NHS funded assisted conception.
Rationale:

i. Maternal and paternal smoking can adversely affect male and female fertility and the success rates of assisted reproduction procedures.

ii. ii. Smoking during the antenatal period leads to increased risk of adverse pregnancy outcomes.

iii. iii. Children exposed to smoke in the womb are more likely to experience respiratory disease and ENT problems, and psychological and behavioural problems which may impact on educational performance.

iv. iv. There are many other associations of smoking for both parent and child in terms of ill-health; i.e. cancer, heart disease and diabetes.

5.2.9 Other Lifestyle Issues

- Additional lifestyle advice in relation to fertility should be given regarding (see section 9):
  - Diet
  - Alcohol
  - Caffeinated beverages
  - Tight underwear
  - Prescribed, over-the-counter and recreational drug use
  - Complimentary therapy
  - Folic acid supplementation
  - Occupation

5.2.10 Residency

Patients must be permanently registered with a GP in Herefordshire for at least 12 months and have a documented history of sub-fertility as defined in section 5.2.3 in this document before being considered for NHS funded fertility treatment, unless a prior arrangement is made with commissioners to transfer care from an existing pathway elsewhere in the country with commissioner confirmation of the funding arrangement.
6. Assisted Conception Treatment
The treatment options undertaken will depend on diagnosis and clinical appropriateness in accordance with this policy. Treatment options should be undertaken in the following sequential order; i.e. it is not appropriate to receive IUI after failure of IVF/ICSI.

6.1 Male Factor Infertility
The NICE CG pathway should be followed for suspected male factor infertility. Where corrective surgery is not appropriate, men with obstructive azoospermia may receive at NHS expense, either one needle aspiration or one open testicular biopsy for surgical sperm recovery. A decision to use the most appropriate procedure to recover a patient’s sperm should be made by the specialist clinician during the treatment process.

In extremely rare cases, a second aspiration or biopsy procedure will be funded if the sperm taken at the initial biopsy was not of a satisfactory quality once thawed and a second procedure is required on the day of the female partner’s treatment.

Where patients choose to have this test done privately, the outcome cannot be used to inform an NHS funded treatment pathway (as this would constitute co-payment, see section 8).

6.2 Artificial Insemination (AI)
AI including intra-cervical insemination (see 6.3 for intra-uterine insemination) is not routinely funded and does not form part of the NHS funded specialist fertility treatment pathway.

6.3 Intra-Uterine Insemination (IUI)
IUI is not routinely funded for patients with unexplained infertility, mild endometriosis or mild male factor infertility.

Unstimulated IUI may be considered as a treatment option for the following groups who have demonstrated infertility in accordance with section 1.6 of this document:

- people who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem who are using partner or donor sperm
- people in same-sex relationships

Stimulated IUI may be considered as a treatment option for patients with “known reproductive pathology” as defined in section 1.6 (excluding those patient groups defined above), where this is clinically appropriate.

IUI will be funded at NHS expense for up to 3 attempts. Where donor sperm is required as part of the treatment pathway this will also be funded at NHS expense.
Rationale:

i. Resources are limited but this serves to ensure that where appropriate, all effective interventions

6.4 In-Vitro Fertilisation (IVF) / Intra-cytoplasmic sperm Injection (ICSI)

Ovarian reserve testing will be used to predict the likely ovarian response to IVF. Women are required to meet 2 or more of these measures to determine clinical appropriateness of treatment; these tests will also determine the required dosing schedule for treatment:

1. Total Antral Follicle Count (AFC) ≥ 4 on at least one ovary
2. Anti-Müllerian Hormone (AMH) ≥ 3.0 pmol/l
3. Follicle-Stimulating Hormone 10 IU/l or less

These measures do not necessarily apply to women with known reproductive pathology (for example, patients with poly-cystic ovarian syndrome, ovarian failure).

Couples who meet all defined clinical eligibility criteria outlined in section 5.2 and have satisfactory ovarian reserve testing, will be able to receive NHS funding for:

1 fresh cycle of in-vitro fertilisation (IVF) or intra-cytoplasmic sperm injection (ICSI) (with or without ovarian stimulation and with or without donor sperm or donor egg as clinically appropriate).

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<td>Note 2:</td>
<td>Where eggs are retrieved, but embryo development is not achieved or not clinically satisfactory then this cycle is considered complete without embryo transfer.</td>
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<td>Note 3:</td>
<td>Frozen gametes/embryo’s may be used as part of the NHS funded cycle in patients who have undertaken prior NHS cryopreservation and who meet all other eligibility criteria within this policy.</td>
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<td>Note 4:</td>
<td>If the woman reaches the age of 40 during treatment, the cycle should be completed.</td>
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<td>Note 5:</td>
<td>NICE CG 156 Recommendations (informed by HFEA criteria) should be followed for embryo transfer to reduce multiple pregnancies following fertility treatment. The number of embryo’s transferred with depend on a number of factors including female age, cycle of treatment and quality of the embryos: a maximum of 2 embryos (or 3 eggs) will be transferred per treatment</td>
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some patients will be assessed as suitable for single embryo transfer (eSET); where more than 1 embryo or egg is transferred, this clinical decision must be clearly documented in the patient’s medical records and reported appropriately.

6.5 **Donor Sperm and Eggs**

Donor sperm will only be funded if it is included within the NHS treatment cycle in the circumstances previously defined.

Donor eggs will be funded for managing fertility problems associated with the following conditions:

- Premature ovarian failure
- Gonadal dysgenesis including Turner syndrome
- Bilateral oophorectomy
- Ovarian failure following chemotherapy or radiotherapy
- Prior treatment cycle resulting in failure of fertilisation.

Egg donation is also advocated in certain cases of repeated IVF failure but as only 1 cycle of IVF is being funded, this does not apply. As a result egg donation will not be funded for managing fertility problems associated with repeated failure of IVF.

6.6 **Cancelled Cycles, Declining and Withdrawal from Treatment**

Where a clinical decision is made to cancel a treatment cycle prior to egg retrieval, then patients remain eligible for up to 1 further cycle in accordance with the policy.

6.7 **Cryopreservation of semen, oocytes and embryos**

A separate policy covers NHS eligibility for cryopreservation.

6.8 **Prescribing within Treatment Pathway**

For couples who meet the clinical criteria for NHS funded treatment for assisted conception, the prescribing of any drugs to increase fertility and/or assist with conception should be undertaken by the Provider to which that couple was referred. These drugs include, but are not limited to: gonadotrophin drugs for men with hypogonadotrophic hypogonadism and anti-oestrogens, gonadotrophins and gonadotrophin-releasing hormone analogues in women. Under no circumstances should the patient's GP be approached to prescribe these drugs as they are part of the treatment pathway provided by the Service Provider. All drugs should be provided in accordance with the recommendations of NICE CG156.

The Commissioner does not support the NHS funding of any drugs to assist in conception outside of an agreed NHS treatment pathway.
7. Principles in NHS Funded Treatment Options

7.1 NHS principles have been applied in the agreement of this policy.

This policy covers the fertility treatments of:
- Artificial insemination (AI)
- Intrauterine insemination (IUI)
- In vitro fertilisation (IVF)
- Intra cytoplasmic sperm injection (ICSI)
- Egg and sperm donation

8. Co-Payment and Retrospective Funding

8.1 The Commissioner has adopted the NHS England Commissioning Policy “Defining the boundaries between NHS and private care”, which provides further clarification on the Commissioner’s position on co-payment and retrospective funding. This, along with all other commissioning policies, is available at the following internet address:

https://www.herefordshireccg.nhs.uk/

8.2 Co-payment is seldom permitted in the NHS, other than where, pursuant to Regulations made under the National Health Service Act 2006, specified patients are required to make a specified contribution e.g. prescriptions.

| Note: | A patient or couple who has chosen to pay privately for an element of their care, such as a diagnostic test (or insemination to prove fertility problems) is entitled to access other elements of care as NHS commissioned treatment, provided that the patient or couple meet the clinical eligibility criteria identified to receive NHS funded treatment. However, at the point that the patient or couple seeks to transfer back to NHS care:
| o the commissioner is at liberty to request that the patient/couple be reassessed by an NHS clinician (or to have an NHS clinician review the clinical notes pertinent to the treatment pathway)
| o the patient/couple will not be given any preferential treatment by virtue of having accessed part of their care privately; AND
| o the patient/couple will be subject to standard NHS waiting times

8.3 The Commissioner will not make any contribution to the privately funded care to cover the cost of treatment that the patient could have accessed via the NHS.
9. Initial GP Assessment and Referral

9.1 An initial assessment of a patient/couple’s sub-fertility should be undertaken by their GP. This should include lifestyle advice in accordance with NICE recommendations, for example on BMI, smoking cessation, occupational hazards, alcohol and caffeine consumption and prescribed, over the counter and recreational drug use in order to optimise fertility. For example:

- Patient/Couples should be advised that excess weight resulting in BMI above 29 can significantly affect fertility and other pregnancy related outcomes. Weight loss through weight management programmes should be encouraged.
- Patient/Couples should be informed that the consumption of more than one unit of alcohol per day reduces the effectiveness of assisted reproduction procedures, including in vitro fertilisation treatment.
- Patient/Couples should be informed that either partner smoking can adversely affect the success rates of assisted reproduction procedures, including in vitro fertilisation treatment.
- Patient/Couples should be informed that caffeine consumption has adverse effects on the success rates of assisted reproduction procedures, including in vitro fertilisation treatment.

9.2 Patients/couples who remain infertile despite lifestyle modification and who meet all of the commissioning eligibility criteria in this policy should be referred by their GP to secondary care. Patients may choose a provider from the gynaecology choice menu. However, the Commissioner recommends referral to IVI Midland for secondary care clinical investigations of infertility.

9.3 Following secondary clinical investigation, patient/couples who require sub-fertility treatment will be referred to a tertiary centre. The preferred tertiary referral pathway for Herefordshire patients is to IVI Midland.

9.4 Patients identified as having a **Blood Bourne Viral Disease** requiring specialist screening and treatment will be referred onto a regional specialist.
10. Supporting Documents

- Herefordshire CCG’s: Individual Funding Request Process
- NHS England: In-Year Service Developments
- NHS England: Defining the boundaries between NHS and private care
- NHS England: Implementation and Funding of NICE Guidance
- National Institute of Health and Clinical Excellence (NICE) Clinical Guidelines CG156: Fertility
- HFEA Statement on Elective Single Embryo Transfer Guidelines:
  - http://www.hfea.gov.uk/401.html#guidanceSection3909
- HFEA (Human Fertilisation Embryology Authority) Code of Practice 8th Edition – revised April 2017
- NHS Choices; Stop Smoking: http://www.nhs.uk/livewell/smoking/Pages/stopsmokingnewhome.aspx