

# NHS Rotherham Clinical Commissioning Group

Operational Executive –

Strategic Clinical Executive –

GP Members Committee (GPMC) –

**Clinical Commissioning Group Governing Body - 4 March 2020**

## Access to Infertility Treatment Commissioning Policy

Lead Executive:	Ian Atkinson, Deputy Chief Officer
Lead Officer:	Jacqui Tuffnell, Head of Commissioning
Lead GP:	Phil Birks, SCE GP Lead

### Purpose:

To brief the Operational Executive on the updates to the Access to Infertility Treatment Commissioning Policy and the results of patient engagement in relation to these changes.

### Background:

In January 2017, CCGs across Yorkshire and the Humber produced a joint commissioning policy setting out the commissioning requirements for specialist fertility services across the region. All CCGs within the region adopted and implemented the policy which set out the service pathway and eligibility criteria.

The recent refresh of the Commissioning Policy for specialist fertility services for adults saw a number of changes and clarifications.

The first clarification is around the need for patients required to pay an NHS surcharge for treatment of 'Assisted Conception Services' as it is no longer eligible for them under the NHS. This has been in place since 21 August 2017 when the amendments to the NHS (Charges to Overseas Visitors) Regulations 2015 came into force, but it had not previously been made clear in the policy.

For women with anovulatory infertility, funding will now be available for up to 6 cycles of ovulation induction with the Gonadotropin therapy. This had not previously been available. **Gonadotropin therapy is a method of inducing ovulation in women where ovaries do not release an oocyte (immature egg cell) during a menstrual cycle.**

There is now an expectation that couples requiring a referral for infertility treatment will be non-smokers for a period of 3 months prior to referral. Non-smoking status will be confirmed in secondary care with a carbon monoxide breath test.

For same sex couples, the requirement to self-fund 6 rounds of Intrauterine Insemination (IUI) prior to accessing 6 rounds of IUI via the NHS has now been removed. **IUI is separate from IVF treatment; however, the couple may then access IVF treatment if appropriate.** Same sex couples can now access NHS funding without

having to fund privately first.

With regards to patient feedback on the policy changes, the engagement took place between 8 August 2019 and 6 October 2019. Responses have been received from 28 residents across South Yorkshire and Bassetlaw, with only one Rotherham resident providing feedback – *“i think they need to take care of all people whatever their sexuality, race, religion please do not discriminate due to austerity aka spending cuts”*

#### **Analysis of key issues and of risks**

Legal challenges regarding eligibility have been considered in the refresh of the policy and resulting proposed changes.

The relaxation of eligibility around same sex couples, as well as the requirement to fund ovulation induction with the Gonadotropin therapy will have an impact on the overall contract value. It is not possible at present to determine what this impact will be as it is not possible to identify how many same sex couples have undertaken private procedures.

#### **Patient, Public and Stakeholder Involvement:**

Patient engagement took place between 8 August 2019 and 6 October 2019. The engagement information has been made available on the CCG website and also circulated to interest groups.

#### **Equality Impact:**

An Equality Impact Assessment has been undertaken by Philippa Doyle at Hempsons Solicitors as part of the development of the policy and one has also been undertaken locally which is still draft.

#### **Financial Implications:**

##### **IUI Cycles**

For same sex couples, the requirement to self-fund 6 rounds of Intrauterine Insemination (IUI) prior to accessing 6 rounds of IUI via the NHS has been removed from the policy. Same sex couples can now access NHS funding without having to fund privately first.

There is likely to be a financial impact for IUI procedures as there is no activity in plan for this. For the period 1/4/17 to 31/3/18 there were 20 couples receiving IUI through Care Sheffield, with a total of 26 IUI procedures carried out (an average of 1.3 procedures per couple). For the period 1/4/18 – 31/3/19, there were 26 privately funded IUI cycles undertaken for same sex couples (x19 couples in total). Five couples had two cycles each, with one couple paying for three cycles. The remaining 13 couples received one cycle of IUI. Care Sheffield cannot determine which of these patients would be classed as a Rotherham registered patient as they received private treatment.

The cost of a single IUI procedure is currently £838. Therefore the additional cost could be approximately £21,788 if these are all Rotherham registered patients however it is expected to be higher as we anticipate that more patients will request this procedure once it is NHS funded.

## Ovulation induction with Gonadotropin Therapy

With regards to patients requiring ovulation induction with Gonadotropin therapy, women with anovulatory infertility were not previously eligible for NHS funding. However, they will now be eligible for up to 6 cycles of ovulation induction with the Gonadotropin therapy.

Care Sheffield has confirmed that in the period 01/09/18 – 31/08/19 x 5 cycles were provided (x4 patients). The cost of this procedure at Care Sheffield is currently £875 per ovulation induction cycle plus medication at approx. £400 per cycle. Therefore if activity remains as current levels the cost would be £6,375 however it is expected that this will be higher as we anticipate that more patients will request this procedure once it is NHS funded.

### Human Resource Implications:

Not applicable

### Procurement Advice:

Not applicable

### Data Protection Impact Assessment

Not applicable

### Approval history:

### Recommendations:

This is a Yorkshire and Humber Policy and whilst all CCGs have had the opportunity to contribute and comment, ultimately this is a consensus policy. It is considered that the revisions to the policy ensure the CCGs are offering fair and equitable access the fertility treatment and that RCCG should therefore approve the adoption of this policy noting the financial risk this poses.

**Paper is for Approval**

**Access to Infertility Treatment –  
Commissioning Policy Document  
Yorkshire and Humber**

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**Adopted by  
NHS Rotherham CCG  
January 2020 – April 2023**

<b>Document Title:</b>	Access to Infertility Treatment – Commissioning Policy Document Yorkshire and Humber
<b><u>Author/Lead</u></b> <b>Name:</b> <b>Job Title:</b>	Michelle Thompson Assistant Director Women’s and Children’s Services
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CHANGE RECORD			
Version	Author	Nature of Change	Date placed on Intranet
11	Hempsons Solicitors/Michelle Thompson/Sara Hartley	Changes relating to overseas visitor regulations – advice from legal advisors	

**Any locally held old paper copies must be destroyed. When this document is viewed as a paper copy, the reader is responsible for checking that it is the most current version. This can be checked on the NHS Rotherham CCG website.**

## Commissioning Policy Statement:

### Commissioning

This document represents the commissioning policy of NHS Rotherham CCG for the clinical pathway which provides access to specialist fertility services. This commissioning policy has been developed in partnership with the Yorkshire and Humber Expert Fertility Panel. It is intended to provide a framework for the commissioning of services for those couples who are infertile and require infertility interventions.

The policy was developed jointly by Clinical Commissioning Groups in the Yorkshire and Humber area and provides a common view of the clinical pathway and criteria for commissioning services which have been adopted by NHS Rotherham CCG.

### Funding

The policy on funding of specialist fertility services for individual patients is a policy of NHS Rotherham CCG and is not part of the shared policy set out in the rest of this document. The number of full IVF cycles currently funded by the NHS Rotherham CCG for patients who meet the access criteria set out in the shared policy is two. This is unchanged from the previous funding policy in March 2016. This policy will be updated in accordance with the review period of the policy or earlier should sufficient changes in practice or evidence base require it.

## Immigration Health Surcharge; Removal Of Assisted Conception Services

Amendments to the NHS (Charges to Overseas Visitors) Regulations 2015 were introduced into Parliament on 19 July 2017. As a result, from 21 August 2017, assisted conception services are no longer included in the scope of services. ~~Individuals who are required to pay the NHS surcharge are not eligible for fertility investigations in secondary care. Individuals who are required to pay the NHS surcharge are no longer eligible for NHS funded assisted conception.~~

~~Where there is discordance in requirements to pay the NHS surcharge, assisted conception treatment will not be funded if one partner is not eligible as the policy applies as a couple.~~

**However, the October 2019 Guidance on Implementing Overseas Visitors Regulations says that: 'Where two people are seeking assisted conception services with NHS funding, and one of the two people is covered by health surcharge arrangements and the other is ordinarily resident in the UK and therefore not subject to charge, the services required by the health surcharge payer will be chargeable. Any services required by the ordinarily resident person will continue to be freely available, subject to the established local or national commissioning arrangements'.**

**Our eligibility criteria for access to assisted conception services relates to couples rather than individuals. Therefore in light of this guidance, to enable the ordinarily resident person to have freely available access to services, where at least one partner is eligible for these services, the couple will be considered as eligible for services.**

### ~~Panel Members: (March 2017)~~

~~Dr Virginia Beckett — Consultant in Obstetrics and Gynaecology — Bradford Teaching Hospital FT~~

~~Dr Fiona Day — Consultant in Public Health Leeds and Associate Medical Director Leeds CCG~~

~~Chris Edward — Accountable Officer - Rotherham CCG~~

~~Dr Steve Maguiness — Medical Director — The Hull IVF Unit, Hull Women and Children's Hospital and honorary contract with HEY~~

~~Dr John Robinson — Scientific Director - IVF Unit, Hull and East Yorkshire Hospitals FT~~

~~Prof Adam Balen — Professor of Reproductive Medicine and Surgery — Leeds Teaching Hospitals NHS Trust~~

~~Michelle Thompson — Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG~~

~~Richard Maxted — Service Manager, Directorate of Obstetrics, Gynaecology and Neonatology — Sheffield Teaching Hospital NHS Trust~~

~~Dr Margaret Ainger — Clinical Director for Children, YP and Maternity — NHS Sheffield CCG~~

~~Dr Bruce Willoughby — Lead for Planned Care — NHS Harrogate and Rural District CCG~~

~~Dr Clare Freeman — Medical Advisor to IFR Panel — South Yorkshire and Bassetlaw CCGs~~

## ~~Panel Members (amendments January 2018)~~

~~Dr Virginia Beckett — Consultant in Obstetrics and Gynaecology — Bradford Teaching Hospital FT~~

~~Dr Fiona Day — Consultant in Public Health Leeds and Associate Medical Director Leeds CCG~~

~~Michelle Thompson — Assistant Director, Women's and Children's Services — NHS North East Lincolnshire CCG~~

~~Dr Bruce Willoughby — Lead for Planned Care — NHS Harrogate and Rural District CCG~~

~~Jonathan Skull — Consultant in Reproductive Medicine & Surgery — Sheffield Teaching Hospital NHSFT~~

~~Karen Thirsk — Fertility Policy Manager — NHS England~~

~~Brigid Reid — Chief Nurse — NHS Barnsley CCG~~

~~Helen Lewis — Head of Planned Care — NHS Leeds CCG.~~

~~Clare Freeman — Lead Medical Advisor — Sheffield CCG.~~

## ~~Panel Members (amendments June 2018)~~

~~Dr Virginia Beckett — Consultant in Obstetrics and Gynaecology — Bradford Teaching Hospital FT~~

~~Dr Fiona Day — Consultant in Public Health Leeds and Associate Medical Director Leeds CCG~~

~~Michelle Thompson — Assistant Director, Women's and Children's Services — NHS North East Lincolnshire CCG~~

~~Jonathan Skull — Consultant in Reproductive Medicine & Surgery — Sheffield Teaching Hospital NHSFT~~

~~Brigid Reid — Chief Nurse — NHS Barnsley CCG~~

~~Helen Lewis — Head of Planned Care — NHS Leeds CCG~~

~~Dr Bryan Power — (GP) — NHS Leeds CCG~~

~~Adam Balen — (Consultant) — Leeds Fertility~~

~~Clare Freeman — Lead Medical Advisor — Sheffield CCG~~

## ~~Panel Members (amendments January 2019)~~

~~Dr Virginia Beckett — Consultant in Obstetrics and Gynaecology — Bradford Teaching Hospital FT~~

~~Jonathan Skull — Consultant in Reproductive Medicine & Surgery — Sheffield Teaching Hospital NHSFT~~

~~Michelle Thompson — Assistant Director, Women's and Children's Services — NHS North East Lincolnshire CCG~~

~~Martine Tune — Acting Chief Nurse — NHS Barnsley CCG~~

~~Liz Micklethwaite — Business Manager IFR — NHS Leeds CCG~~

## ~~Commissioner Final Proof Read Panel (Amendments November 2019)~~

~~Michelle Thompson — Assistant Director, Women's and Children's Services — NHS North East — Lincolnshire CCG~~

~~Helen Lewis — Head of Planned Care — NHS Leeds CCG~~

~~Clare Freeman — Lead Medical Advisor — Sheffield CCG~~

~~Karen Leivers — Head of Strategy and Delivery, Planned Care — Doncaster CCG~~

~~Debbie Stovin — Commissioning Manager — Elective Care — Sheffield CCG~~

## ~~Conflicts of Interest~~

~~See appendix E~~

## ~~Working group membership and Conflicts of Interest~~

~~See appendices E and F~~

### **For Further Information about this policy.**

Please contact your local Clinical Commissioning Group:

NHS Rotherham CCG  
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## Contents

1.	Aim of Paper .....	7
2.	Background.....	7
3.	Clinical Effectiveness .....	8
4.	Cost Effectiveness .....	8
5.	Description of the Treatment .....	9
5.1	Principles of Care .....	9
5.2	The Care Pathway for Fertility Investigation and Referral (fig, 1) .....	10
5.3	Definition of a Full Cycle .....	12
5.4	Frozen Embryo .....	12
5.5	Abandoned Cycles.....	12
5.6	IUI and DI .....	12
5.7	Gametes and Embryo Storage .....	13
5.8	HIV/HEP B/ HEP C.....	14
5.9	Surrogacy .....	14
5.10	Single Embryo Transfer .....	14
5.11	Counselling and Psychological Support.....	14
5.12	Sperm Washing and Pre-implantation Diagnosis.....	14
5.13	Service Providers .....	14
6.	Eligibility Criteria for Treatment .....	14
6.1	Application of Eligibility Criteria.....	14
6.2	Overarching Principles.....	15
6.3	Existing Children.....	15
6.4	Female Age .....	15
6.5	Pre-Referral Requirements for Assisted Conception.....	15
6.6	Reversal of Sterilisation .....	16
6.7	Previous NHS funded Full Cycles .....	16
6.8	Length of Relationship .....	16
6.9	Welfare of the Child .....	16
	<b>Appendix A</b> .....	<b>17</b>
	<b>Appendix B</b> .....	<b>18</b>
	<b>Appendix C</b> .....	<b>19</b>
	<b>Appendix D</b> .....	<b>22</b>
	<b>Appendix E</b> .....	<b>27</b>
	<b>Appendix F</b> .....	

## 1. Aim of Paper

- 1.1 This document represents the commissioning policy for specialist fertility services for adults registered with a Clinical Commissioning Group (CCG) in the Yorkshire and Humber region.
- 1.2 The policy aims to ensure that those most in need in keeping with current eligibility, are able to benefit from NHS funded treatment and are given equitable access to specialist fertility services across the Yorkshire and Humber Area, by identifying the clinical care pathway and relevant access criteria.

## 2. Background

- 2.1 On April 1<sup>st</sup>, 2013 Clinical Commissioning Groups (CCGs) across the Yorkshire and the Humber regions adopted the existing Yorkshire and the Humber Fertility policy<sup>1</sup>. In February 2013 NICE published revised guidance<sup>2</sup> which was reviewed and updated in 2016.
- 2.2 CCGs across the Yorkshire and the Humber agreed to work collaboratively to update the existing policy in light of the new NICE guidance and changing commissioning landscape.
- 2.3 In this policy document infertility is defined as:

### ***Definition of Infertility:***

*The inability to conceive through regular sexual intercourse for a period of 2 years in the absence of known reproductive pathology, or less than 2 years if there is specific reproductive pathology identified.*

*Where attempting to conceive by regular sexual intercourse is not possible (for example for people with a physical disability, people with psychosexual disorders or transgender and same sex couples) this will be considered as inability to conceive for the purposes of this policy.*

- 2.4 Fertility problems are common in the UK and it is estimated that they affect 1 in 7 couples with 80% of couples in the general population conceiving within 1 year, if:
  - The woman is aged under 40 years and
  - They do not use contraception and have regular sexual intercourse (NICE 2013)Of those who do not conceive in the first year about half will do so in the second year (cumulative pregnancy rate is 90%).

The remaining 10% of couples will be unable to conceive without medical intervention and

<sup>1</sup> Yorkshire and the Humber Commissioning Policy for Fertility Services, 2010.

<sup>2</sup> Fertility: Assessment and treatment for people with fertility problems 2012, NICE Clinical Guideline 156.

are therefore considered infertile.

- 2.5 In 25% of infertility cases, the cause cannot be identified. However, it is thought that in the remaining couples about 30% of cases are due to the male partner being unable to produce or ejaculate sufficient normal sperm, 30% are due to problems found with the female partner such as failure to ovulate or blockage to the passage of the eggs, and 10% are due to problems with both partners.
- 2.6 The most recent DH costing tool estimates that there are 98 attendances at a fertility clinic for every 10,000 head of population. In Yorkshire and the Humber, this could range between 4000 and 5000 attendances per year which would result in approximately 1450 couples likely to be assessed as eligible for IVF treatment.
- 2.7 Specialist fertility services include IUI, ICSI and IVF. They may also include the provision of donor sperm and donor eggs. The majority of treatment in the UK is statutorily regulated by the Human Fertility and Embryo Authority (HFEA)<sup>3</sup>. All specialist providers of fertility services must be licensed with the HFEA in order to be commissioned under this policy.
- 2.8 NICE Clinical Guidelines 156 (2013) covering infertility recommends that:

Up to three full cycles of IVF will be offered to eligible couples where the woman is aged between 18 and 39 and 1 cycle for eligible couples where the woman is aged 40 - 42.

NHS Rotherham CCG will fund *two* cycles of IVF treatment. Where an individual feels that they have exceptional circumstances that would merit consideration of an additional cycle being funded by the NHS they should speak to their doctor about submitting an individual funding request to their local CCG.

- 2.9 In addition to commissioning effective healthcare, CCGs are required to ensure that resources are allocated equitably to address the health needs of the population. Therefore CCGs' will need to exercise discretion as to the number of cycles of IVF that they will fund up to the maximum recommended by NICE.

### 3. Clinical Effectiveness

It is considered to be clinically effective by NICE to offer up to 3 stimulated cycles of IVF treatment to couples where the woman is aged between 18 – 39 and 1 cycle where the woman is aged between 40 – 42 and who have an identified cause for their infertility or who have infertility of at least 2 years duration.

### 4. Cost Effectiveness

- 4.1 Evidence shows (NICE 2013) that as the woman gets older the chances of successful pregnancy following IVF treatment falls. In light of this, NICE has recommended that the most cost effective treatment is for women aged 18 – 42 who have known or unknown

<sup>3</sup> <https://www.hfea.gov.uk/>

fertility problems.

4.2 As research within this field is fast moving, new interventions and new evidence needs to be considered on an on-going basis to inform commissioning decisions.

#### 4.3 **Risks**

Fertility treatment is not without risks. A summary of potential risks is outlined below:

##### **Risks**

- There are risks of multiple pregnancies during fertility treatment, which is associated with a higher morbidity and mortality rate for mothers and babies.
- Women who undergo fertility treatment are at slightly higher risk of ectopic pregnancy.
- Ovarian hyper stimulation, which is a potentially fatal condition, is also a risk. The exact incidence of this has not been determined but the suggested number is between 0.2 – 1% of all assisted reproductive cycles.
- Current research shows no cause for concern about the health of children born as the result of assisted reproduction.
- A possible association between ovulation induction therapy and ovarian cancer in women who have undergone treatment is uncertain.
- Further research is needed to assess the long-term effects of ovulation induction agents.

## **5 Description of the Treatment**

### **5.1 Principles of Care**

5.1.1 Couples who experience problems in conceiving should be seen together because both partners are affected by decisions surrounding investigation and treatment.

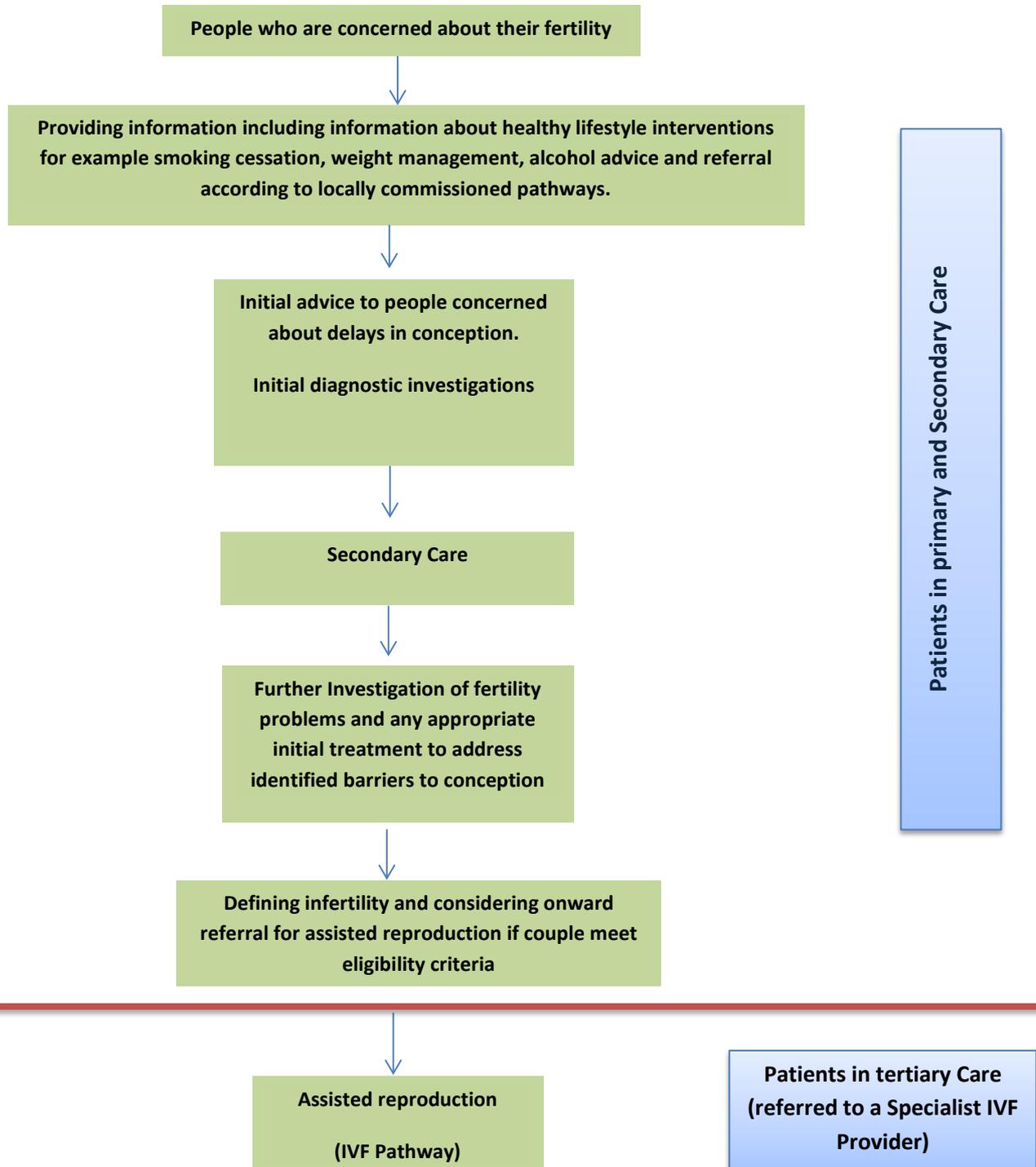
5.1.2 People should have the opportunity to make informed decisions regarding their care and treatment via access to evidence-based information. These choices should be recognised as an integral part of the decision-making process.

Information should be provided in the following formats:

- Face to face discussions with couples
- Written information and advice
- Culturally sensitive
- Sensitive to those with additional needs e.g. physical or cognitive, or those for whom English is not their first language.

5.1.3 As infertility and infertility treatments have a number of psychosocial effects on couples, access to psychological support prior to and during treatment should be considered as integral to the care pathway.

## 5.2 The Care Pathway for fertility investigation and referral (fig, 1)



The Care pathway for fertility investigation and referral will take account of NICE guidance.

5.2.1 Treatment for infertility problems may include counselling, lifestyle advice, drug treatments, surgery and assisted conception techniques such as IVF.

- Providers of specialist fertility services are expected to deliver appropriate interventions to support lifestyle behaviour changes which are likely to have a positive impact on the outcome of assisted conception techniques and resulting pregnancies. Recommendations covering screening, brief advice and onward referral are outlined in NICE Public Health Guidance (PH49) and, specifically in relation to fertility and pre-conception, smoking (PH 26, PH48), weight management (PH27, PH53), healthy eating and physical activity (PH11, NG7) and alcohol (PH24).
- Use any appointment or meeting as an opportunity to ask women and their partners about their general lifestyle including smoking, alcohol consumption, and physical activity and eating habits. If they practice unhealthy behaviours, explain how health services can support people to change behaviour and sustain a healthy lifestyle.
- Offer those who would benefit from this, a referral to local wellbeing services and/or locally commissioned lifestyle services. For those that are unable or do not want to attend support services direct them to appropriate self-help information such as the national 'One You' website or local websites.
- Record this in the hand-held record or accepted local equivalent.

The care pathway (fig 1) begins in primary care, where the first stage of treatment is general lifestyle advice and support to increase a couple's chances of conception without the need for medical intervention.

If primary care interventions are not effective, initial assessment such as semen analysis will take place. Following these initial diagnostics, it may be appropriate for the couple to be referred to secondary care services where further investigation and potential treatments will be carried out, such as hormonal therapies to stimulate ovulation. It may be appropriate at this stage for the primary care clinician to consider and discuss the care pathway and potential eligibility for IVF. It may also be appropriate for healthy lifestyle interventions to be further discussed.

If secondary care interventions are not successful and the couple fulfils the eligibility criteria in section 6.0, they may then be referred through to specialist care for assessment for assisted conception techniques, such as IVF, DI, IUI, and ICSI.

5.2.2 IVF involves:

- Controlled ovarian stimulation
- Monitoring the development of the eggs in the ovary
- Ultrasound guided egg collection from the ovary
- Processing of sperm
- Production of a fertilized embryo from sperm and egg cells in the laboratory
- Culture of embryos to blastocyst (*if clinically appropriate*)

- Single embryo transfer (subject to multiple birth minimisation policy)
- Use of progesterone to make the uterus receptive to implantation
- Transfer of selected embryos and freezing of those suitable but not transferred

The panel will review annually, following the HFEA<sup>4</sup> annual review via their traffic light report, any other emerging technologies which may then need consideration for incorporation in this policy.

### 5.3 Definition of a Full Cycle

Full cycle is the term used to define a full IVF treatment; it should include one episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryo(s) (NICE 2013). Or

The definition of a single full treatment cycle is the replacement of a fresh embryo and subsequent sequential replacement of all frozen embryos derived from the cycle until pregnancy is successful or harvested embryos have been exhausted.

Adherence in this way to the NICE guidelines would encourage and not disadvantage patients agreeing to single embryo transfer.

### 5.4 Frozen Embryo

Embryos that are not used during the fresh transfer should be quality graded using the UK NEQAS embryo morphology scheme and may be frozen for subsequent use within the cycle.

All stored and viable embryos should be used before a new cycle commences. This includes embryos resulting from previously self-funded cycles.

### 5.5 Abandoned Cycles

An abandoned IVF/ICSI cycle is defined as the failure of egg retrieval, usually due to lack of response (where less than three mature follicles are present) or excessive response to gonadotrophins; failure of fertilisation and failure of cleavage of embryos. Beyond this stage, a cycle will be counted as complete whether or not a transfer is attempted. One further IVF/ICSI cycle only will be funded after an abandoned cycle. Further IVF/ICSI cycles will not be offered after any subsequent abandoned cycles.

### 5.6 IUI and DI

IUI and DI are separate from IVF treatment; however, the couple may then access IVF treatment if appropriate.

#### 5.6.1 People with physical disabilities, psychosexual problems, or other specific conditions with infertility (as defined in section 2.3 Definition of Infertility):

Where a medical condition exists, such as physical disability up to 6 cycles of IUI may be funded, followed by further assisted conception if required. In some circumstances, IUI may

<sup>4</sup> <https://www.hfea.gov.uk/>

be impractical and so is not a requirement for further fertility treatment.

**5.6.2 IUI and DI in same-sex relationships:**

Up to 6 cycles of IUI will be funded as a treatment option for people in same-sex relationships, followed by further assisted conception if required.

**5.6.3 People with unexplained infertility, mild endometriosis or mild male factor infertility, who are having regular unprotected sexual intercourse:**

IUI either with or without ovarian stimulation will not be funded routinely (exceptional circumstances may include, for example, when people have social, cultural or religious objections to IVF), instead couples should try to conceive for a total of 2 years (this can include up to 1 year before their fertility investigations) before IVF will be considered, in keeping with current NICE guidance.

**5.6.4 Gonadotrophin Therapy - for women with anovulatory infertility, ovulation induction with gonadotrophin therapy should be funded for up to 6 cycles, with or without IUI depending on the circumstances of the couple.**

**5.6.5 Donor Gametes including azoospermia:**

Patients who require donor gametes will be placed on the waiting list for an initial period of 3 years, after which they will be reviewed to assess whether the fertility policy eligibility criteria is still met. If it is anticipated that there will be difficulty finding a suitable donor exceptionality would need to be considered. At this point consideration may need to be given to sourcing from alternative providers via IFR.

**Donor Sperm**

Where clinically indicated up to six cycles of donor insemination will be offered. This is dependent on the availability of donor sperm which is currently limited in the UK.

The cost of donor sperm is included in the funding of treatment for which it is required, to be commissioned in accordance with this policy and the funding policy of the CCG.

**Donor Eggs**

Patients eligible for treatment with donor eggs, in line with NICE recommendations, will be placed on the waiting list for treatment with donor eggs. Unfortunately, the availability of donor eggs remains severely limited in the UK. There is, therefore, no guarantee that eligible patients will be able to proceed with treatment.

**5.7 Gametes and Embryo Storage**

The cost of egg and sperm storage will be included in the funding of treatment for which it is required, to be commissioned in accordance with this policy and the funding policy of the CCG. Storage will be funded by the CCG for a maximum of 3 years or until 6 months post successful live birth, whichever is the shorter. This will be explained by the provider prior to the commencement of treatment. Following this period continued storage may be self-funded.

Any embryos frozen prior to implementation of this policy will be funded by the CCG to remain frozen for a maximum period of 3 years from the date of policy adoption.

Any embryo storage funded privately prior to the implementation of this policy will remain

privately funded.

## 5.8 **HIV/HEP B/ HEP C**

People undergoing IVF treatment should be offered testing for HIV, hepatitis B and hepatitis C (NICE 2013).

People found to test positive for one or more of HIV, hepatitis B, or hepatitis C should be offered specialist advice and counselling and appropriate clinical management (NICE 2013).

## 5.9 **Surrogacy**

Any costs associated with use of a surrogacy arrangement will not be covered by funding from CCGs. We will, however, fund provision of fertility treatment (IVF treatment and storage) to identified (fertile) surrogates, where this is the most suitable treatment for a couple's infertility problem and the couple meets the eligibility criteria for specialist fertility services set out in this policy.

## 5.10 **Single Embryo Transfer**

Please refer to 5.3 for the definition of a full cycle.

Multiple births are associated with greater risk to mothers and children and the HFEA<sup>5</sup> therefore recommends that steps are taken by providers to minimize them. This is currently achieved by only transferring a single embryo for couples who are at high risk.

We support the HFEA guidance on single embryo transfer and will be performance monitoring all specialist providers to ensure that HFEA targets are met. All providers are required to have a multiple births minimisation strategy. The target for multiple births should now be an upper limit of 10% of all pregnancies.

We commission ultrasound guided embryo transfer in line with NICE Fertility Guideline.

## 5.11 **Counselling and Psychological Support**

As infertility and infertility treatment has a number of negative psychosocial effects, access to counselling and psychological support should be offered to the couple prior to and during treatment.

## 5.12 **Sperm washing and pre-implantation diagnosis**

Sperm washing and pre-implantation genetic diagnosis are not treatments for infertility and fall outside the scope of this policy. Prior approval is required.

## 5.13 **Service Providers**

Providers of fertility treatment must be HFEA registered and comply with any service specification drawn up by Yorkshire and the Humber Clinical Commissioning Groups.

# 6.0 **Eligibility Criteria for Treatment**

## 6.1 **Application of Eligibility Criteria**

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<sup>5</sup> <https://www.hfea.gov.uk/>

Eligibility criteria should apply at the point of referral to specialist care. Women aged between 40-42 will need further assessment within specialist care in order to ascertain whether or not they are eligible, see section 6.4.

## 6.2 **Overarching Principles**

6.2.1 All clinically appropriate individuals/couples are entitled to medical advice and investigation. Couples may be referred to a secondary care clinic for further investigation.

6.2.2 Assisted conception is only funded for those couples who meet the eligibility criteria.

6.2.3. Treatment limits are per couple and per individual. Referrals should be as a couple and include demographic information for both partners in heterosexual and same-sex couples.

## 6.3 **Existing Children**

Neither partner should have any living children (this includes adopted children but not fostered) from that or any previous relationship.

## 6.4 **Female Age**

Age as a criterion for access to fertility treatments is applied in line with the NICE Clinical Guideline on Fertility which is based on a comprehensive review of the relationship between age and the clinical effectiveness of fertility treatment.

The woman intending to become pregnant must be between the ages of 18 – 42 years. No new cycle should start after the woman's 43<sup>rd</sup> birthday. Referrers should be mindful of the woman's age at the point of referral and the age limit for new cycles.

Women aged 40–42 years who meet the eligibility criteria for infertility in Section 2.3, will receive 1 full cycle of IVF, with or without ICSI, provided the following criteria are fulfilled:

- they have never previously had IVF treatment and there is no evidence of low ovarian reserve (defined as FSH 9 IU/l or more (using Leeds assay); OR antral follicle count of 4 or less; OR AMH of 5 pmol/l or less
- there has been a discussion of the additional implications of IVF and pregnancy at this age
- where investigations show there is no chance of pregnancy with expectant management and where IVF is the only effective treatment, women aged between 40-42 should be referred directly to a specialist team for IVF treatment

## 6.5 **Pre – Referral Requirement for Specialist Care**

### 6.5.1 **Female BMI**

The female patient's BMI should be between 19 and 30 prior to referral to specialist services. Patients with a higher BMI should be referred for healthy lifestyle interventions including weight management advice. Patients should not be re-referred to specialist services until their BMI is within the recommended range.

### 6.5.2 **Smoking Status**

GP should discuss smoking with couples prior to referral to secondary care, support their efforts in stopping smoking by referring to a smoking cessation programme.

People should be informed that maternal and paternal smoking can adversely affect the success rates of assisted reproduction procedures, including IVF treatment.

### 6.6 **Reversal of Sterilisation**

We will not fund IVF treatment for patients who have been sterilised or have unsuccessfully undergone reversal of sterilisation.

### 6.7 **Previous Cycles**

Previous cycles whether self-funded or NHS funded will be taken into consideration when assessing a couple's ability to benefit from treatment and will count towards the total number of cycles that may be offered by the NHS. This includes where either person has had a previous cycle with a previous partner.

### 6.8 **Length of Relationship**

The stability of the relationship is very important with regards to the welfare of children; as such couples must have been in a stable relationship for a minimum of 2 years and currently co-habiting to be entitled to treatment.

### 6.9 **Welfare of the child**

HFEA guidance concerning the welfare of the child should be followed.

## Appendix, A

### Abbreviations

<b>Abbreviations used</b>	
<b>BMI</b>	<b>Body Mass Index</b>
<b>DI</b>	<b>Donor Insemination</b>
<b>GP</b>	<b>General Practitioner</b>
<b>HFEA</b>	<b>Human Fertilisation and Embryology Authority</b>
<b>ICSI</b>	<b>Intracytoplasmic sperm injection</b>
<b>IUI</b>	<b>Intra-uterine insemination</b>
<b>IVF</b>	<b>In vitro fertilisation</b>
<b>NICE</b>	<b>National Institute of Clinical Excellence</b>
<b>CCG</b>	<b>Clinical Commissioning Group</b>

## Appendix, B

### Contents

Term	Definition	Further information
<b>BMI</b>	The healthy weight range is based on a measurement known as the Body Mass Index (BMI). This can be determined if you know your weight and your height. This is calculated as your weight in kilograms divided by the square of your height in metres. In England, people with a body mass index between 25 and 30 are categorised as overweight, and those with an index above 30 are categorised as obese.	BBC Healthy Living <a href="http://www.bbc.co.uk">http://www.bbc.co.uk</a> NHS Direct <a href="http://www.nhsdirect.nhs.uk">http://www.nhsdirect.nhs.uk</a>
<b>ICSI</b>	<b>Intra Cytoplasmic Sperm Injection (ICSI):</b> Where a single sperm is directly injected into the egg.	Glossary, HFEA <a href="http://www.hfea.gov.uk">http://www.hfea.gov.uk</a>
<b>IUI</b>	<b>Intra Uterine Insemination (IUI):</b> Insemination of sperm into the uterus of a woman.	As above
<b>IVF</b>	<b>In Vitro Fertilisation (IVF):</b> Patient's eggs and her partner's sperm are collected and mixed together in a laboratory to achieve fertilisation outside the body. The embryos produced may then be transferred into the female patient.	As above
<b>DI</b>	<b>Donor Insemination (DI):</b> The introduction of donor sperm into the vagina, the cervix or womb itself.	As above

## Appendix, C

### Equality Impact and Engagement Assessment

Equality Impact and Engagement Assessment Form - Draft				
<b>Section one – Project or plan details</b>				
1.1	<b>Project Title:</b> Access to Infertility Treatment – Commissioning Policy			
1.2	<b>Project Lead:</b> Sara Hartley	<b>Contact Details:</b> 01709 308803		
1.3	<b>This activity /project is:</b> Policy			
1.4	<b>Describe the activity/project</b> The commissioning policy details the clinical pathway for access to specialist fertility services. It has been developed in partnership with the Yorkshire and Humber Expert Fertility Panel and its purpose is to enable officers of the CCG to exercise their responsibilities properly and transparently in relation to commissioned treatments. This includes individual funding requests, and provides advice to general practitioners, clinicians, patients and members of the public about the fertility policy. Implementing the policy ensures that commissioning decisions are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of the CCG. This policy relates to requests for specialist fertility treatment.			
1.5	<b>Timescales</b> To be introduced February 2020			
2	<b>Equality Impact Assessment</b>			
2.1	<b>Gathering of Information:</b> This is the core of the analysis; how might the project or work impact on protected groups, with consideration of the General Equality Duty. Please add any general information here. NICE fertility guidance <a href="https://www.nice.org.uk/guidance/cg156">https://www.nice.org.uk/guidance/cg156</a> (last updated September 2017)			
2.2	<b>Screening</b>			
	<b>Please complete each area)</b>	<b>What key impact have you identified?</b>		<b>Information Source</b>
		<b>Positive Impact</b> - will actively promote or improve equality of opportunity.	<b>Neutral Impact</b> - where there are no notable consequences for any group.	<b>Negative Impact</b> negative or adverse impact causes disadvantage or exclusion. <b>If such an impact is identified, the EIA should ensure, that as far as possible, it is</b>
				What action, if any, is needed to address these issues and what difference will this make? For example: <i>At this point no action is required. Further EIA screenings will be</i>

			<b>either justified, eliminated, minimised or counter balanced by other measures.</b>	<i>developed in future once there are recommendations to assess.</i>
Human Rights	<b>N</b>	<b>Y</b>	<b>N</b>	
Age	<b>Y</b>	<b>N</b>	<b>Y</b>	IVF is only available to women aged between 18 and 42. As a woman ages the chances of successful pregnancy fall. Action cannot be taken to prevent this, it is therefore incumbent to ensure clear age limitations apply.
Carers	<b>N</b>	<b>Y</b>	<b>N</b>	
Disability	<b>Y</b>	<b>N</b>	<b>N</b>	The policy has been enhanced to offer funding to couples who by reason of disability cannot conceive naturally.
Sex	<b>N</b>	<b>Y</b>	<b>N</b>	
Race	<b>N</b>	<b>Y</b>	<b>N</b>	
Religion or belief	<b>N</b>	<b>Y</b>	<b>N</b>	
Sexual Orientation	<b>Y</b>	<b>N</b>	<b>N</b>	The policy has been revised to offer funding to couples in a same sex relationship without having to demonstrate they have self-funded other trials
Gender reassignment	<b>N</b>	<b>Y</b>	<b>N</b>	
Pregnancy and maternity	<b>Y</b>	<b>N</b>	<b>N</b>	The policy enhances the ability to access fertility treatment

					and the potential to achieve pregnancy.
	Marriage/civil partnership (only eliminating discrimination)	N	Y	N	
	Other relevant groups	N	Y	N	
<b>3</b>	<b>Engagement Assessment</b>				
3.1	<p><b>What is the level of service change?</b> – see diagram 3 above</p> <p><b>If your project is classed as a ‘significant variation’ (level 3) or ‘major change’ (level 4)</b> please contact <a href="mailto:england.yhclinicalstrategy@nhs.net">england.yhclinicalstrategy@nhs.net</a> for a preliminary discussion to support planning and agree whether the service change needs to follow the NHS England Service Change Assurance process.</p> <p>The assurance process generally looks at the ‘case for change’ The key players in the process include overview and scrutiny teams, and the clinical senates. You can also refer to the DH guidance: (please note that level 4 changes will require considerable long term planning and this DH guidance is mandatory for all level 4 changes)  <a href="http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/nhs_public_involvement_-_hempsons_stp.pdf">http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/nhs_public_involvement_-_hempsons_stp.pdf</a> DH 2013</p> <p><b>Circle or highlight the appropriate level of service change</b></p> <p><b>Level 1</b>                      Level 2                                      Level 3                                      Level 4</p> <p><b>Add additional information and rationale for this scoring below</b></p>				
3.2	<p><b>Who are your stakeholders?</b></p> <p>Consider using a mapping tool to identify stakeholders - who is the change going to affect and how?  Complete below or attach or link to a mapping document</p> <p>The change to the policy will positively affect protected characteristic groups which have not previously been able to access fertility services on the NHS. There will no longer be a requirement for same-sex couples to demonstrate that they have undertaken privately funded treatment prior to accessing NHS funded treatment. Similarly, women with anovulatory infertility will now be able to access treatment of up to 6 cycles of ovulation induction with the Gonadotropin therapy. This had not previously been available.</p>				
3.3	<p><b>What do we already know?</b></p> <p>What do you already know about peoples’ access, experience, health inequalities and health outcomes? Use intelligence from existing local, regional or national research, data, deliberative events or engagements.</p>				

	<p>In relation to treatment for same-sex couples, for the period 1/4/17 to 31/3/18 there were 20 couples receiving IUI through Care Sheffield, with a total of 26 IUI procedures carried out (an average of 1.3 procedures per couple). For the period 1/4/18 – 31/3/19, there were 26 privately funded IUI cycles undertaken for same sex couples (x19 couples in total). Five couples had two cycles each, with one couple paying for three cycles. The remaining 13 couples received one cycle of IUI.</p> <p>For patients requiring ovulation induction with Gonadotropin therapy, Care Sheffield has confirmed that in the period 01/09/18 – 31/08/19 x 5 cycles were provided outside of NHS funding (x4 patients).</p> <p>The policy has, in addition been developed in order to address inequalities previously highlighted, and to ensure parity across the region.</p> <p><b>Describe any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight?</b> How will the insight available to you help to inform your decision?</p> <p>Patient engagement took place between 8 August 2019 and 6 October 2019. The engagement information has been made available on the CCG website and also circulated to interest groups.</p> <p>The responses have been collated across SYB; and have been generally very positive regarding the proposal</p> <p><b>Briefly describe how the existing or proposed engagement will be ‘fair and proportionate’, in relation to the activity?</b></p> <p>Engagement was targeted at those most likely to be impacted; and was proportionate to the numbers potentially impacted.</p>
3.4	<p><b>Reaching out to overlooked communities</b></p> <p>Are additional arrangements for patient and public involvement required for this activity and in particular how will you ensure that ‘seldom-heard’ groups, those with ‘protected characteristics’ under the Equality Act, and those experiencing health inequalities are involved</p> <ul style="list-style-type: none"> <li>• Seldom-heard groups Yes/No</li> <li>• Nine Protected Characteristics Yes/No</li> <li>• Health inequalities Yes/No</li> </ul> <p>If yes, please provide a brief outline of your approach and objectives for any additional patient participation targeted at these groups</p> <p>Not applicable</p>

	Do you need to make any of your resources accessible (i.e. for people with learning disabilities, sight impairments, or alternative languages?)
	Not applicable
3.5	<b>What resources do you need for this?</b> Consider the sections above <ul style="list-style-type: none"> <li>• The timescales</li> <li>• The need to reach overlooked communities</li> <li>• Accessible materials</li> <li>• Gaps in knowledge</li> </ul>
	Not applicable
4	<b>Feedback and Evaluation</b>
4.1	How will you use the feedback – who does it need to be shared with?
	The feedback was made available to all CCGs looking to adopt the policy.
4.2	Provide a brief outline of how the information collected through patient and public participation will be used to influence the plan/activity.
	As the feedback has been generally very positive regarding the proposal there will not be any changes to the proposed policy.
4.3	How will the outcomes of participation be reported back to those involved?
	The policy will be made available on the CCG website.
4.4	How will you assess the ongoing impact of the change on patients and the public after it has been completed?
	The CCG will monitor requests for individual funding requests for this treatment and will identify if there are issues with the policy which require a refresh. The policy will also be reviewed if there is any change to national guidance.

5	<b>Engagement and Equality Impact Plan</b>				
	<b>Action</b>	<b>Approx. Timescale</b>	<b>Lead</b>	<b>Deadline</b>	<b>Comments/progress</b>
	N/A				
6	Form details				
	Completed by:	Sara Hartley			
	Job title:	Contracts and Service Improvement Manager (Primary Care)			

	Date	28 January 2020
	Reported to	

## Appendix D, Version Control

VERSION	DATE	AUTHOR	STATUS	COMMENT
V11	Feb 19	H Lewis and M Thompson		<p><b>Changes to page 3 – immigration health surcharge – reworked following updated advice</b></p> <p><b>Moved list of panel members to Appendix for easier access to contents of document</b></p>
V10	November 2019	M Thompson on behalf of Panel		<p>Changes to:</p> <ul style="list-style-type: none"> <li>- Page 2 &amp; 3 – Immigration Health Surcharge – sentences reworded</li> <li>- 6.5.2 – Smoking Status – sentences reworded</li> <li>- 6.7 – Previous Self-funded Cycles – titles changed to Previous Cycles - sentences reworded</li> <li>- 6.8 – Previous Self-Funded Cycles - sentence removed</li> <li>- 6.10 – Welfare of the Child - sentence reworded</li> </ul>

V9	January 2019	M Thompson on behalf of Panel	Draft	<p>Changes to:</p> <ul style="list-style-type: none"> <li>- Funding - Immigration health surcharge – sentence added</li> <li>- 1.2 - sentence reworded</li> <li>- 2.3 – change of order in sentence in brackets</li> <li>- 5.2 – sentence included after pathway</li> <li>- 5.2.1 – third bullet point, wording changed</li> <li>- 5.2.2 – first two bullet points replaced with Controlled Ovarian Stimulation</li> <li>- 5.4 – heading changed to Frozen Embryo</li> <li>- 5.6.1 – sentence reworded</li> <li>- 5.6.3 – link to mild male factor infertility removed</li> <li>- 5.6.3 – wording added</li> <li>- 5.6.4 – spelling corrected</li> <li>- 5.6.5 – new paragraph inserted</li> <li>- 5.6.5 - Donor Sperm - sentence reworded</li> <li>- 5.7 – sentence reworded</li> <li>- 6.2.1 and 6.2.2 - swapped around and reworded</li> <li>- 6.5.2 – title changed</li> <li>- 6.5.2 – sentence reworded</li> <li>- 6.9 – sentence reworded</li> </ul>
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v8	June 2018	M. Thompson on behalf of Panel	Draft	<p>Changes to:-</p> <ul style="list-style-type: none"> <li>- 2.3 Definition of Infertility</li> <li>- 5.2.2. – IVF involves – additional bullets added</li> <li>- 5.3 – Definition of cycles – removed sentence in brackets</li> <li>- 5.6.4 - Gonadotrophin Therapy added</li> <li>- 5.6.5 – renumbered – added “all couples” where this is a clinical requirement (to replace the reference to male azoospermia) added limited to UK</li> </ul> <p>Added additional sentence</p> <ul style="list-style-type: none"> <li>- 6.5 – title updated to – Pre-referral requirement to specialist care</li> <li>- 6.5.2 – non-smokers section added.</li> <li>- 6.9 – Updated to include the stability of the relationship</li> </ul>
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v7	Jan 2018	M. Thompson on behalf of Panel	Draft	<ul style="list-style-type: none"> <li>- Changes to 5.2 pathway</li> <li>- Changes to funding – adding refugees and asylum seekers</li> <li>- Removal of summary of CCGs</li> <li>- 2.3 – clarification of definition of infertility</li> <li>- 6.7 updated to NHS Funded full cycles</li> <li>- 6.10 – added section</li> <li>- Change tertiary to specialist throughout the policy.</li> </ul>
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Review 2017	22.2.17	F Day on behalf of panel	Final draft	<ul style="list-style-type: none"> <li>- changes to the definition of infertility for same sex and patients with psychosexual issues and disabilities to be more clear</li> <li>- the addition of public health requirements for providers in line with NICE guidance</li> <li>- clarification of the definition of an abandoned cycle</li> <li>- sections on intrauterine insemination and also egg donation updated in line with NICE guidance</li> <li>- Addition of People with unexplained infertility, mild endometriosis or <a href="#">mild male factor infertility</a>, who are having regular unprotected sexual intercourse in line with NICE guidance</li> <li>- wording changed in various sections based on patient feedback to be more clear, not materially changed in content</li> <li>- embryo transfer wording updated to reflect NICE guidance</li> <li>- Addition of definition of low ovarian reserve (previously undefined)</li> </ul>
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## **Appendix E**

### **Panel Members: (March 2017)**

**Dr Virginia Beckett** Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT

**Dr Fiona Day** Consultant in Public Health Leeds and Associate Medical Director Leeds CCG

**Chris Edward** Accountable Officer - Rotherham CCG

**Dr Steve Maguiness** Medical Director - The Hull IVF Unit, Hull Women and Children's Hospital and honorary contract with HEY

**Dr John Robinson** Scientific Director - IVF Unit, Hull and East Yorkshire Hospitals FT

**Prof Adam Balen** Professor of Reproductive Medicine and Surgery - Leeds Teaching Hospitals NHS Trust

**Michelle Thompson** Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG

**Richard Maxted** Service Manager, Directorate of Obstetrics, Gynaecology and Neonatology - Sheffield Teaching Hospital NHS Trust

**Dr Margaret Ainger** Clinical Director for Children, YP and Maternity - NHS Sheffield CCG

**Dr Bruce Willoughby** Lead for Planned Care - NHS Harrogate and Rural District CCG

**Dr Clare Freeman** Medical Advisor to IFR Panel - South Yorkshire and Bassetlaw CCGs

### **Panel Members (amendments January 2018)**

**Dr Virginia Beckett** Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT

**Dr Fiona Day** Consultant in Public Health Leeds and Associate Medical Director Leeds CCG

**Michelle Thompson Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG**

**Dr Bruce Willoughby Lead for Planned Care - NHS Harrogate and Rural District CCG**

**Jonathan Skull Consultant in Reproductive Medicine & Surgery – Sheffield Teaching Hospital NHSFT**

**Karen Thirsk Fertility Policy Manager – NHS England**

**Brigid Reid Chief Nurse – NHS Barnsley CCG**

**Helen Lewis Head of Planned Care – NHS Leeds CCG.**

**Clare Freeman Lead Medical Advisor – Sheffield CCG.**

### **Panel Members (amendments June 2018)**

**Dr Virginia Beckett Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT**

**Dr Fiona Day Consultant in Public Health Leeds and Associate Medical Director Leeds CCG**

**Michelle Thompson Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG**

**Jonathan Skull Consultant in Reproductive Medicine & Surgery – Sheffield Teaching Hospital NHSFT**

**Brigid Reid Chief Nurse – NHS Barnsley CCG**

**Helen Lewis Head of Planned Care – NHS Leeds CCG**

**Dr Bryan Power (GP) - NHS Leeds CCG**

**Adam Balen (Consultant) - Leeds Fertility**

**Clare Freeman Lead Medical Advisor – Sheffield CCG**

## **Panel Members (amendments January 2019)**

**Dr Virginia Beckett** Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT

**Jonathan Skull** Consultant in Reproductive Medicine & Surgery – Sheffield Teaching Hospital NHSFT

**Michelle Thompson** Assistant Director, Women’s and Children’s Services - NHS North East Lincolnshire CCG

**Martine Tune** Acting Chief Nurse – NHS Barnsley CCG

**Liz Micklethwaite** Business Manager IFR - NHS Leeds CCG

## **Commissioner Final Proof Read Panel (Amendments November 2019)**

**Michelle Thompson** Assistant Director, Women’s and Children’s Services – NHS North East Lincolnshire CCG

**Helen Lewis** Head of Planned Care – NHS Leeds CCG

**Clare Freeman** Lead Medical Advisor – Sheffield CCG

**Karen Leivers** Head of Strategy and Delivery, Planned Care - Doncaster CCG

**Debbie Stovin** Commissioning Manager – Elective Care – Sheffield CCG

## **Appendix F Relevant Conflicts of Interest Declared:**

**Dr Steve Maguiness:**

**IVF in Hull is provided by a private company (ERFS Co Ltd), of which I am a Director and employee.**

**Prof Adam Balen:**

**NHS Consultant in Reproductive Medicine and Clinical lead for the Leeds Centre for Reproductive Medicine, which performs all fertility treatments funded by the NHS. Partner in Genesis LLP, the private arm of the Leeds Centre for Reproductive Medicine, which performs self-funded fertility treatments using identical protocols to the NHS. Chair, British Fertility Society. Chair, NHS England IVF Pricing Development Expert Advisory Group. Chair World Health Organisation Expert Working Group on Global Infertility Guidelines: Management of PCOS. Chair, British Fertility Society. Consultant for ad hoc advisory boards for Ferring Pharmaceuticals, Astra Zeneca, Merck Serono, Gideon Richter, Uteron Pharma. Research funding received in the past. Pharmasure / IBSA- Key note lecture at ESHRE 2016 & hospitality to attend meetings. OvaScience- Member of international ethics committee. Clear Blue National medical advisory board. IVI, UK- Chair, Clinical Board**

**Virginia Beckett FRCO:**

**I have a private practice where I see fertility patients.**

**I have received sponsorship from Pharmasure, Ferring & Serono to attend conferences.**

## ~~Appendix E Relevant Conflicts of Interest Declared:~~

### ~~Dr Steve Maguiness:~~

~~IVF in Hull is provided by a private company (ERFS Co Ltd), of which I am a Director and employee.~~

### ~~Prof Adam Balen:~~

~~NHS Consultant in Reproductive Medicine and Clinical lead for the Leeds Centre for Reproductive Medicine, which performs all fertility treatments funded by the NHS. Partner in Genesis LLP, the private arm of the Leeds Centre for Reproductive Medicine, which performs self-funded fertility treatments using identical protocols to the NHS. Chair, British Fertility Society. Chair, NHS England IVF Pricing Development Expert Advisory Group. Chair World Health Organisation Expert Working Group on Global Infertility Guidelines: Management of PCOS. Chair, British Fertility Society. Consultant for ad hoc advisory boards for Ferring Pharmaceuticals, Astra Zeneca, Merck Serono, Gideon Richter, Uteron Pharma. Research funding received in the past. Pharmasure / IBSA- Key note lecture at ESHRE 2016 & hospitality to attend meetings. OvaScience- Member of international ethics committee. Clear Blue National medical advisory board. IVI, UK- Chair, Clinical Board~~

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