Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Reference: FOI.ICB-2223/201

Subject: Fertility Policy

I can confirm that the ICB does hold the information requested; please see responses below:

QUESTION	RESPONSE
I have been unable to find all of the information I have been looking for in relation to the NHS Bristol, North Somerset and South Gloucestershire ICB fertility/assisted reproduction policy from your website or from previous FOI requests. Can you please provide the following information: The Fertility Policy currently online is past the review date (Nov 2020). What policy is currently in use and can I get an electronic copy?	The fertility policy on the ICB's website (document 1), https://bnssg.icb.nhs.uk/wp-content/uploads/2017/12/Fertility-Assessment-and-Treatment.pdf is the one currently in use. But there is a new policy going live on the 1 April 2023, new policy attached (document 2).
If the policy is currently under review, what policy is applied if someone would like to access fertility treatment on the NHS?	The policy is no longer under review as this has just been renewed. The policy on the ICB's website is the one that is applied if someone would like to access fertility treatment on the NHS, however this will change from the 1 April 2023.

Does the same policy cover the entire catchment area of the ICB?	Yes

The information provided in this response is accurate as of 21st February 2023 and has been approved for release by Jo Medhurst, Chief Medical Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

NHS
Bristol, North Somerset
and South Gloucestershire
Integrated Care Board

Commissioning Policy
Individual Funding Request

Fertility Assessment and Treatment

Prior Approval and Criteria Based Access Policy

Date Adopted: 01 December 2017

Version: 1718.3.03

Individual Funding Request Team

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1718.3.0	07/11/2017	Head of IFR	Agreed by JCE
1718.3.01	06/12/2017	IFR Co-ordinator	Admin change to clarify Referral Routes
1718.3.02	21/12/2017	IFR Co-ordinator	Admin change to Section F – commissioned by NHS England
1718.3.03	26/03/2018	IFR Coordinator	Rebranded to BNSSG CCG

REFERRAL FOR ASSESSMENT IS SUBJECT TO CRITERIA BASED ACCESS *(Sections B, C, G and I)*

TREATMENT UNDER THIS POLICY REQUIRES PRIOR APPROVAL *(Sections D, E and H)*

THIS POLICY RELATES TO ADULTS WITHIN THE AGE RANGES SPECIFIED BELOW

Fertility Assessment and Treatment

Policy Statement

Fertility assessment and treatment is not routinely funded by the CCG and is subject to this restricted policy.

General Principles

Funding approval will only be given in line with these general principles. Where patients are unable to meet these principles in addition to the specific treatment criteria set out in this policy, funding approval will not be given.

1. Primary Care clinicians should assess their patients against the criteria within this policy prior to referring patients for Assessment in Secondary Care. Referring patients to Secondary Care who do not meet the criteria not only incurs significant costs in out-patient appointments for patients that may not qualify for treatment, but inappropriately raises the patient's expectation of treatment.
2. In line with the published document "Guidance - Who Applies for Funding?", where referrals to secondary care are accepted without funding approval having been secured, responsibility for securing funding approval will fall to secondary care.
3. On limited occasions, the ICB may approve funding for an assessment only in order to confirm or obtain evidence demonstrating whether a patient meets the criteria for funding. In such cases, patients should be made aware that the assessment does not mean that they will be provided with treatment, and treatment will only be provided where it can be demonstrated that the patient meets the criteria to access treatment in this policy.
4. Where funding approval is given by the Individual Funding Panel, it will be available for a specified period of time, normally one year. Patients will be expected to have commenced the fertility pathway within this year but, given the potentially lengthy nature of the pathway, may not have completed their treatment within the year. As long as they have commenced treatment within a year of funding approval being given, funding will be available in line with this published policy to complete their pathway.

Background

Bristol, North Somerset and South Gloucestershire (BNSSG) ICB has limited resources to fund

fertility treatments and has therefore targeted the limited funds specifically in order to allow couples in a stable relationship, a chance to conceive. Given the limits on resources, provision of treatments under this policy is aimed at patients with a realistic clinical opportunity of having a child.

An estimated one in seven couples have difficulty conceiving. In the general population (which includes people with fertility problems), it is estimated that 84% of women would conceive within one year of regular unprotected sexual intercourse. This rises cumulatively to 92% after two years and 93% after three years.

Infertility can be primary, in couples who have never conceived, or secondary, in couples who have previously conceived. There are several possible reasons why it may not happen naturally. In men, a fertility problem is usually because of low numbers or poor quality of sperm. Female fertility decreases with increasing age. For women aged 35, about 95% who have regular unprotected sexual intercourse will get pregnant after three years of trying. For women aged 38, only 75% will do so.

Other factors which affect fertility success rates include obesity, smoking and social factors such as alcohol and drug misuse and therefore this policy has criteria on these subjects.

The following figures give the average success rate for In-Vitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI) treatment using a woman's own fresh eggs in the UK in 2009.

- 32.3% for women under 35
- 27.2% for women aged 35-37
- 19.2% for women aged 38-39
- 12.7% for women aged 40-42
- 5.1% for women aged 43-44
- 1.5% for women aged 45+

This policy sets out the limits within which BNSSG ICB will fund treatment with either Intra- uterine Insemination (IUI), ovulation induction medication or donor insemination (DI) as well as IVF treatment if necessary for patients who meet the criteria for treatment.

This policy also sets out treatments patients can expect to access prior to and following oncology treatment in order to preserve fertility as well as our commissioning stance on Cryopreservation, posthumous assisted reproduction, sperm washing and pre-implantation genetic diagnosis.

BNSSG ICB does not partially fund treatments for patients who do not meet the criteria within this policy. This includes patients who wish to access assisted conception advice and treatments such as testing and medications following a previous birth, patients who wish to harvest oocytes or sperm, or store embryos prior to third party surrogacy or patients who wish to preserve fertility prior to Gender Dysphoria treatment.

All statistics quoted in this section are referenced from the Human Fertilisation and Embryology Authority (HFEA) website at: https://www.hfea.gov.uk/ and NICE Guidelines on Fertility Treatments at: https://www.nice.org.uk/guidance/cg156

Glossary of Terms

AMH	Anti-Müllerian hormone - Comparison of an individual's AMH level with respect to average levels[13] is useful in fertility assessment, as it provides a guide to ovarian reserve and identifies women that may need to consider either egg freezing or trying for a pregnancy sooner rather than later if their long-term future fertility is poor.

Embryos	Refers to a fertilised Oocyteoocyte. It is called an embryo until about eight weeks after fertilisation and from then it is instead called a foetus.
FSH	Follicle-Stimulating Hormone - FSH regulates the development, growth, pubertal maturation, and reproductive processes of the human body.

ICSI	Intracytoplasmic Sperm Injection (ICSI) is a variation of in-vitro fertilisation in which a single sperm is injected into the inner cellular structure of an egg.
Infertility	In the absence of known reproductive pathology, infertility is defined as failure to conceive after regular unprotected sexual intercourse for 2 years.
IUI	Intrauterine Insemination (IUI) involves timed insemination of sperm into the uterus. This can be completed as part of a natural unstimulated cycle (unstimulated IUI) or following stimulation of the ovaries using oral anti-oestrogens or gonadotrophins (stimulated IUI).
IVF	In-Vitro Fertilisation (IVF) is a technique whereby eggs are collected from a woman and fertilised with a man's sperm outside the body.
Ooctye (Eggs)	Refers to a female gametocyte or germ cell involved in reproduction. In other words, it is an immature ovum, or egg cell.
Sperm	Refers to the male reproductive cells
Sperm, Oocyte or Embryo Cryopreservation	Sperm, Oocyte or Embryo Cryopreservation is the freezing and storage of Sperm, Oocyte or Embryos that may be thawed for use in future in-vitro fertilisation treatment cycles.

More information regarding Fertility Treatment is provided on the HFEA website at:

https://www.hfea.gov.uk/

Index

Policy - Criteria to Access Fertility Services

Section A - General Principles for all Patients

FERTILITY ASSESSMENT - CRITERIA BASED ACCESS/FERTILITY

REATMENT - PRIOR APPROVAL

Points that should be noted when considering whether patients are eligible to access NHS funded fertility treatments:

1. Fertility treatment should be offered in the least invasive format appropriate, namely investigation and assessment, followed by assisted conception and finally IVF or ICSI. All referrals for assessment and treatment should be made on the form published on the BNSSG websites and accompanied by a referral letter setting out detailed clinical information and background.
2. Couples who do not meet the eligibility criteria set out in the relevant section of this policy or have received NHS funded IVF treatment elsewhere are not eligible for treatment under this policy.
3. The prospective mother must not be older than 18 weeks before her 40th birthday at referral as no female patient will be placed on the waiting list for secondary care fertility assessment within 18 weeks of their 40th birthday.
4. Where a member of the couple has previously received NHS funded treatment as part of another couple, they will not be barred from accessing NHS funded treatment under their current relationship where they meet all criteria.
5. At least one partner must have no living offspring/children to qualify for funding. This includes genetic and legally adopted children and offspring who are adults but does not include foster children or step children. If the couple adopt a child or become pregnant naturally during assessment or treatment the couple are no longer eligible for fertility assessment or treatment.
6. Patients who have secondary sub-fertility will not be eligible to have NHS funded consultations with fertility services in order to assess their condition and secure treatment advice.
7. For the purposes of this policy, the commencement of IVF/ICSI cycle is defined as commencement of ovarian stimulation by fertility services, or if no drugs are used, when an attempt is made to collect eggs/oocytes. Any patient who completes this step, regardless of the outcome, is deemed to have had one full cycle of IVF/ICSI. Therefore if a cycle is abandoned for clinical reasons this is still counted as the fresh cycle that the couple are entitled to. One frozen cycle using frozen embryos will follow a fresh cycle if deemed clinically appropriate. Patients will not be eligible for further NHS funded investigation and fertility treatment following completion of this cycle.
8. A full IVF/ICSI treatment cycle includes:
   - Diagnostic tests, scans and pharmacological therapy
   - Counselling for couples
   - Stimulation of prospective mother's ovaries to produce oocytes
   - Harvesting of the oocytes
   - Fertilisation using IVF or ICSI (assisted hatching is not provided)
   - One fresh embryo transfer
   - If unsuccessful, within twelve months of cryopreservation, one frozen embryo transfer from remaining frozen embryos. [maximum of 2 embryos per cycle]
   - A follow up consultation with fertility services post IVF treatment
   - Where patients have completed their NHS funded full cycle of IVF treatment but have frozen embryos remaining in storage, they can elect to self-fund further treatment with the fertility services.
9. Both partners' GPs must have given their positive recommendation to proceed to treatment. Account must be taken of additional factors such as active hepatitis, alcoholism, intra-venous drug misuse that may adversely affect the welfare of any child born as a result of treatment or

give rise to complex treatment issues (see HFEA Code of Practice for details - https://ifqlive.blob.core.windows.net/umbraco-website/2062/2017-10-02-code-of-practice-8th-edition-full-version-11th-revision-final-clean.pdf)

Section B - Investigation, Assessment and Advice on Fertility Issues for Heterosexual Couples

CRITERIA BASED ACCESS

For review and consideration by the GP at time of referral to the Fertility Service

In order to access services to investigate and assess issues with fertility, couples must meet all of the following criteria:

1. The couple have been in a stable relationship for at least two years.
2. Hetero-sexual couples have failed to conceive after regular unprotected sexual intercourse for two years. Patients may be referred outside this timeframe if there is a known condition which is likely to affect the fertility of either partner (e.g. severe oligomenorrhoea or previous testicular surgery) or oncology treatment is likely to compromise the fertility of either the prospective mother or father.
3. Hetero-sexual couples who have failed to conceive after regular unprotected sexual intercourse for more than one year but less than two years and where the prospective mother will be older than 18 weeks before her fortieth birthday may also be referred.
4. Recurrent miscarriage is not an indication for patients to access fertility services although they may be referred for gynaecological investigations and treatments if appropriate.
5. At least one of the partners must be registered with a GP in the BNSSG area.
6. The couple must not have previously received a cycle of NHS funded fertility treatment to the level outlined in this policy.
7. Patients who have previously self-funded unsuccessful fertility treatment are eligible for NHS funded fertility treatment as long as they meet the criteria within this policy. Outcomes from previous fertility treatment will be considered as part of the clinical assessment and patients should be aware that multiple failures to conceive through fertility treatment is indicative of poor conception success rates.
8. Both partners must be non-smokers as confirmed in their primary care records. Individuals who are smokers should be referred to smoking cessation services and be able to demonstrate by compliance with that service that they are non-smokers prior to assessment. Prospective fathers who smoke should be informed that there is an association between smoking and reduced semen quality and, although the impact of this on male fertility is uncertain, they should cease smoking prior to treatment to improve sperm quality.
9. The prospective mother's body mass index (BMI) must be between 19 and 29.9 kg/m^2 for a period of six months as evidenced from her primary care record. The evidence is clear that obesity negatively impacts upon successful natural conception and fertility treatment. Prospective mothers with a BMI of 30 and above should be offered a referral to weight management services in order to reduce their weight prior to assessment and treatment by fertility services. (see https://www.nice.org.uk/guidance/cg156/chapter/Recommendations)
10. Where the prospective mother is aged between 37 and up to 18 weeks before her fortieth birthday, her BMI must be between 19 and 35 kg/m^2 prior to referral for assessment. Prospective mothers with a BMI above 29.9 in this age group should be referred to weight management services at the same time as being referred to fertility services in order assist her to lose weight and aid fertility.
11. The prospective father should aim to have a BMI of 29.9 and under. There is evidence that obesity negatively impacts upon successful natural conception and fertility treatment due to reduced sperm quality (see https://www.nice.org.uk/guidance/cg156/chapter/Recommendations)
12. The prospective father is aged 54 years or less. Male fertility has been shown to decrease with age, with evidence of greater incidence of disability poor sperm function and DNA degradation. [1, 2]
13. Neither partner has been sterilised in the past even if it has been reversed and the sterilisation is the cause of the fertility problems.

Section C - Investigation, Assessment and Advice on Fertility Issues for Same Sex Couples

CRITERIA BASED ACCESS

For review and consideration by the GP at time of referral to the Fertility Service

In order to access services to investigate and assess issues with fertility, couples must meet all of the following criteria:

1. The couple have been in a stable relationship for at least two years.
2. Same sex couples may be assessed if self-funded insemination on at least ten non-stimulated cycles over a period of two years has failed to lead to a pregnancy, or oncology treatment is likely to compromise the fertility of the prospective mother. NHS funding is not available for access to donor insemination facilities for fertile women or surrogacy.
3. Either **a.** both partners have fertility issues, i.e. blocked fallopian tubes or anovulation, **or b.** where only one partner is sub-fertile, where possible, the partner who is fertile should try to conceive before proceeding to interventions involving the sub-fertile partner.
4. Recurrent miscarriage is not an indication for patients to access fertility services although they may be referred for gynaecological investigations and treatments if appropriate.
5. At least one of the partners must be registered with a GP in the BNSSG area.
6. The couple must not have previously received a cycle of NHS funded fertility treatment to the level outlined in this policy.
7. Patients who have previously self-funded unsuccessful fertility treatment are eligible for NHS funded fertility treatment as long as they meet the criteria within this policy. Outcomes from previous fertility treatment will be considered as part of the clinical assessment and patients should be aware that multiple failures to conceive through fertility treatment is indicative of poor conception success rates.
8. The prospective mother must be a non-smoker as confirmed in their primary care records. Patients who are smokers should be referred to smoking cessation services and be able to demonstrate that they are non-smokers prior to assessment. Partners of prospective mothers who smoke should also be offered a referral to smoking cessation services in order to improve their health and support their partner.
9. The prospective mother's body mass index (BMI) must be between 19 and 29.9 kg/m^2. The evidence is clear that obesity negatively impacts upon successful natural conception and fertility treatment. Prospective mothers with a BMI of 30 and above should be offered a referral to weight management services in order to reduce their weight prior to assessment and treatment by fertility services.
10. Where the prospective mother is aged between 37 and up to 18 weeks before her fortieth birthday, her BMI must be between 19 and 35 kg/m^2 prior to referral for assessment. Prospective mothers with a BMI above 29.9 in this age group should be referred to weight management services at the same time as being referred to fertility services in order assist her to lose weight and aid fertility.
11. The partner of a prospective mother who has undertaken NHS funded fertility treatment, whether successful or not, will be deemed to have received their entitlement to NHS funded fertility treatment upon completion of this cycle in line with heterosexual couples and will not be eligible for a further NHS funded treatment with their partner.
12. The prospective mother has not been sterilised in the past even if it has been reversed and the sterilisation is not the cause of the fertility problems.
13. Both members of the couple must accept joint legal responsibility for any child produced through fertility treatment.

Section D - Assisted Conception

PRIOR APPROVAL

The Fertility Service is required to secure funding from the ICB following assessment and before treatment commences under Sections D, E and F.

Assisted conception services include IUI, ovulation induction medication and donor insemination. In order to access assisted conception services following investigation and assessment, couples must be assessed against the following criteria:

1. Each couple will be offered up to three treatment cycles of IUI and up to a total of six treatments of the three techniques.
2. The BMI of the prospective mother must remain between 19 and 29.9 kg/m^2 whilst accessing fertility treatment. This is because the success of fertility treatment is significantly reduced where the prospective mother is outside of these limits.
3. An assessment of a prospective mothers overall chance of successful pregnancy through natural conception or with IVF should be made with one of the following measures to predict the likely ovarian response to gonadotrophin stimulation in women who are considering treatment:
    a. anti-Müllerian hormone [AMH], or
    b. timed follicle-stimulating hormone [FSH] and Estrogen.
4. The prospective mother must have
    a. an AMH of greater than or equal to 5.4 pmol/l **or**
    b. a FSH level less than or equal to 15iu/l
5. The male partner must have normal sperm function (except for ICSI and donor sperm)
6. If donor sperm / oocytes are used the couple must be able to demonstrate in writing joint legal responsibility for any child born as a result of treatment.

Section E - In-Vitro Fertilisation or Intracytoplasmic Sperm Injection - PRIOR APPROVAL

For Fertility Service consideration when planning treatment – see above.

1. One full treatment cycle of IVF or ICSI (with oocyte donation and/or surgical sperm recovery if required) in line with **Section A Points 7 and 8**, will be offered to couples where other assisted conception techniques have failed.

In addition to all of the criteria above, the following criteria must also be satisfied at the time of treatment:

2. The prospective mother's serum FSH must be less than or equal to 12iu/l at the time of treatment or an AMH of greater than or equal to 5.4 pmol/l.
3. The prospective father's serum FSH level must be less than 15 iu/l or testicular volume must be greater than 8ml (as assessed by a fertility specialist) for surgical sperm recovery and storage to be undertaken.

Section F - Surgical Sperm Retrieval for Male Infertility - NHS England

This treatment is funded by **NHS England** please refer to the NHS England Clinical Commissioning Policy **Surgical Sperm Retrieval for Male Infertility** at:

https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/05/16040_FINAL.pdf

Or contact NHS England for more information.

NB: Patients must meet the criteria to access treatment under this policy in order to access treatment under the NHS England policy

Section G - Fertility Preservation Prior to Oncology Treatment

CRITERIA BASED ACCESS

For Oncology and Fertility Service consideration when planning treatment

1. Patients who are to be treated with oncology treatments which are likely to compromise their fertility are eligible for fertility preservation treatment including:
    a. for single individuals or those not in a stable relationship: sperm collection and storage, or oocyte harvesting and storage, or
    b. storage for couples in a stable relationship: oocyte harvesting, fertilisation and embryo Cryopreservation prior to any oncology treatment to allow subsequent IVF treatment in line with this policy as long as they meet the requirements for funding below.
2. Patients must have commenced puberty and not be older than the limits for treatment set out in this policy (18 weeks before the prospective mother's fortieth birthday and under 55 for a prospective father)
3. At the time of fertility preservation treatment, patients do not need to be able to demonstrate that they comply with the requirements of this policy in respect of smoking and BMI, as delaying treatment until a patient could comply may compromise oncology treatment.
4. Fertility preservation for the following patients is not commissioned and will not be funded by BNSSG where:
    a. the patient wishes to undergo a vasectomy or female sterilisation and wishes to preserve fertility, or
    b. the patient wishes to delay conception, or
    c. the patient has living offspring and therefore does not qualify for funding for fertility preservation treatment. This includes genetic and legally adopted children and offspring who are adults but does not include foster children or step children.
    d. the patient has previously received an NHS funded cycle of fertility treatment as set out in Section A, point 7, either locally or elsewhere in the UK.

Section H - Fertility Treatment including Assisted Conception and IVF following Fertility Preservation Treatment

PRIOR APPROVAL

For Fertility Service consideration when planning treatment

1. Once the patient has completed oncology treatment and been advised by clinicians that they may safely commence fertility treatment, they must meet all of the requirements of this policy to be eligible for treatment.
2. Sperm, oocyte and embryo storage will be handled in line with the BNSSG Cryopreservation policy in place at the time of collection as set out in this policy.

Section I - Cryopreservation of Sperm, Oocytes and Embryos – CBA

Cryopreservation is term use to describe the freezing and storage of sperm, oocytes and embryos for patients.

1. BNSSG will fund Cryopreservation for patients on the fertility pathway for up to one year.
2. Patients who have had sperm, oocyte or embryo cryopreserved prior to oncology treatment will be funded for Cryopreservation:
    a. until a patient is two years post remission (up to a maximum of five years post collection, freezing and storage), or
    b. until a patient's 25th birthday (up to a maximum of ten years)
3. Funding for storage will cease six months following the death of the patient, or if the patient or their partner reaches the upper age limit.
4. Once the period of NHS funding ceases, patients or their family can elect to self-fund for a further period, not to exceed appropriate HFEA regulations on length of storage.
5. Patients with cryopreserved sperm, oocytes or embryos must comply with all requirements of the fertility services and the HFEA or NHS funding for these products will cease. This includes Consent, in a manner as set down by HFEA regulations, must be obtained at the outset and at regular intervals (usually annually) during the period of storage for storage to continue.
6. Commencement of Cryopreservation does not entitle patients to fertility treatments. There is the potential for patients to meet the access criteria for Cryopreservation and not to meet the criteria for fertility treatments at a later date. Patients in this category may elect to self-fund further fertility treatment using the cryopreserved sperm, oocytes or embryos.

Section J - Posthumous Assisted Reproduction - IFR

Funding approval must be sought by the GP or the Fertility Service prior to referral by submission of an Individual Funding application form

Patients who wish to use cryopreserved sperm, oocytes or embryos following the death of their partner, may only do so where appropriate consents have been obtained prior to the death of their partner, as set down in HFEA guidelines.

1. BNSSG does not fund fertility treatments associated with posthumous assisted reproduction.

Section K - Sperm Washing – IFR

Funding approval must be sought by the GP or the Fertility Service prior to referral by submission of an Individual Funding application form

Sperm washing is a technique used to decrease the risk of HIV transmission in HIV positive prospective fathers, because the HIV infection is carried by the seminal fluid rather than the sperm. Research has shown that it can reduce the risk of transmission by 96%. However, there may still be a small risk of HIV transmission which some couples may find unacceptable.

Patients can be seen, assessed and treated by local fertility services although a sperm-washing service is only available at the Chelsea & Westminster (C&W) Hospital in London, and at the time of drafting this policy, no other clinics in the UK offer a sperm-washing service.

1. BNSSG will approve funding for sperm washing with one full cycle of fertility treatment in conjunction with this policy where:
    a. the couple qualify for fertility treatment under this policy, and
    b. the prospective father is HIV positive.

Prospective mothers who are HIV positive should be advised that there is a risk of between 5% and 40%

of Mother-to-Child transmission of HIV during pregnancy, labour and delivery or by breastfeeding and should seek advice from their managing clinicians prior to conception in order to minimise the risk. http://www.who.int/hiv/topics/mtct/en/index.html

Section L - Pre-Implantation Genetic Diagnosis

This is funded by **NHS England** – please contact them for more information.

Section M - Funding of Surrogacy Arrangements and Treatments - IFR

Funding approval must be sought by the GP or the Fertility Service prior to referral by submission of an Individual Funding application form

Background

In a surrogacy arrangement a woman agrees to bear a child for another woman or couple and surrender it at birth. The commissioning couple are the people (or in some cases, person) who wish to bring up the child after his or her birth.

Patients may wish to utilise surrogacy arrangements for a number of reasons:

- absence or malformation of the womb (either congenital or through hysterectomy for e.g. cancer or postpartum haemorrhage or menorrhagia)
- recurrent pregnancy loss or repeated in vitro fertilisation (IVF) implantation failures
- where pregnancy would be a life-threatening condition, or
- a prospective single father (or fathers in a same sex relationship) wishes to have a child.

The Commissioner has limited resources to provide fertility services and therefore has to target those patients with a realistic clinical opportunity to conceive (with assistance) and carry a child to birth.

Policy

The Commissioner does not support or fund treatments for surrogacy. In addition support and funding will not be provided for any associated treatments (including fertility treatments) related to those in surrogacy arrangements.

The Commissioner will not therefore:

- Be involved in the recruitment of surrogate mothers.
- Fund that element of treatment which relates specifically to addressing fertility treatments directly associated with surrogacy arrangements.
- Fund any payments to the surrogate mother (to cover expenses, legal costs, treatments abroad or transport costs).

This section of the policy has been developed taking into account that surrogacy is specifically excluded from NICE guidelines.

Maternity Care Arrangements

The Commissioner commissions maternity services to provide appropriate support, guidance and care to women during and after pregnancy and these services will continue to be available to surrogates.

Exceptionality

Notwithstanding this general policy on Surrogacy, Clinicians may on behalf of patients apply for exceptional funding for fertility treatments to assist surrogacy arrangements. In doing so, the Clinician should demonstrate why their case is exceptional in comparison to the large cohort of patients who may

wish to access such treatments. In addition, funding approval would normally only be provided where it can be demonstrated that the patients meet the criteria.

Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy.

Individual cases will be reviewed at the ICB's Individual Funding Request Panel upon receipt of a completed application form from the patient's GP, Consultant or Clinician. Applications cannot be considered from patients personally.

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Patient Advice and Liaison Service on 0800 073 0907 or 0117 947 4477.

This policy has been developed with the aid of the following references:

NICE – Fertility Guidelines Consultation
https://www.nice.org.uk/guidance/cg156

HFEA – Guidance and Protocols including PGD
http://www.hfea.gov.uk/

Chelsea and Westminster – Sperm Washing
http://www.chelwest.nhs.uk/services/womens-health-services/assisted-conception-unit-acu/treatment-options/sperm-washing

Paternal age and reproduction, Human reproduction update, Jan;Feb 2010, vol./is. 16/1(65-79), 1460-2369 (2010 Jan-Feb)Sartorius G.A.,Nieschlag E.

http://www.fertstert.org/article/S0015-0282%2800%2901679-4/abstract

Approved by (committee):	**Clinical Policy Review Group**		
Date Adopted:	**01/12/2017**	**Version:**	**1718.3.03**
Produced by (Title)	**Head of Individual Funding Requests Team**		
EIA Completion Date:		**Undertaken by (Title):**	
Review Date:	**Earliest of either NICE publication or three years from approval.**		

Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Infertility Assessment & Treatment

Criteria Based Access/Prior Approval

Assessment of Infertility – Criteria Based Access
Treatment of Infertility – Prior Approval

Funding for the assessment and treatment of infertility will only be granted by the ICB for:

- Heterosexual couples who have not conceived after two years of regular unprotected sex (exceptions apply in certain circumstances as described within the policy).
- Single women who have not conceived after two years of regular unprotected sex.
- Single women who have not conceived after 6 unstimulated cycles of independently funded Human Fertilisation and Embryology Authority (HFEA) approved Intrauterine Insemination (IUI)
- Same sex couples who have undergone 6 independently funded unstimulated cycles of HFEA approved IUI and have not conceived.
- Men who have been shown to have low or zero sperm counts can also be assessed.

Section A - General Principles for all Patients

Points that should be noted when considering whether patients are eligible to access NHS funded infertility assessment and treatments:

1. Fertility treatment should be offered in the least invasive format appropriate, namely investigation and assessment, followed by assisted conception. All referrals for assessment and treatment should be made on the form published on the BNSSG websites and accompanied by a referral letter setting out detailed clinical information and background.
2. Individuals who do not meet the eligibility criteria set out in the relevant section of this policy or have received NHS funded In Vitro Fertilisation (IVF) treatment elsewhere are not eligible for treatment under this policy.
3. The prospective mother must not be older than their 39th birthday at referral and the prospective father should be not older than their 54th birthday at referral.
4. Where a prospective mother has previously received NHS funded treatment as part of another couple, they will not be barred from accessing NHS funded treatment under their current relationship where they meet all criteria. They will not be managed as single women within the scope of this referral.
5. The individual requiring assessment must have no living offspring/children to qualify for funding. This includes genetic and legally adopted children and offspring who are adults but does not include foster children or step children. If the individual or couple adopts a child or becomes pregnant naturally during assessment or treatment, they are no longer eligible for fertility assessment or treatment.
6. Individuals who have had unsuccessful NHS funded fertility treatment, or have a child, will not be eligible to have NHS funded consultations with fertility services to assess their condition and secure treatment advice.
7. For the purposes of this policy, the commencement of IVF/ Intracytoplasmic Sperm Injection (ICSI) cycle is defined as commencement of ovarian stimulation by fertility services, or if no drugs are used, when an attempt is made to collect eggs/oocytes. Any patient who completes this step, regardless of the outcome, is deemed to have had one full cycle of IVF/ICSI. Therefore, if a cycle is abandoned for clinical reasons this is still counted as the fresh cycle that the couple are entitled to. One frozen cycle using frozen embryos will follow a fresh cycle if deemed clinically appropriate. Patients will not be eligible for further NHS funded investigation and fertility treatment following completion of this cycle.
8. A full IVF/ICSI treatment cycle includes:
    - Diagnostic tests, scans and pharmacological therapy
    - Counselling for couples
    - Stimulation of prospective mother's ovaries to produce oocytes
    - Harvesting of the oocytes
    - Fertilisation using IVF or ICSI (assisted hatching is not provided)
    - One fresh embryo transfer
    - If unsuccessful, within twelve months of cryopreservation, one frozen embryo transfer from remaining frozen embryos [maximum of 2 embryos per cycle]

Continued below

Section A - General Principles for all Patients (cont'd)

- A follow up consultation with fertility services post IVF treatment.
- Where patients have completed their NHS funded full cycle of IVF treatment but have frozen embryos remaining in storage, they can elect to self-fund further treatment with the fertility services.

9. The individual's GP must have given their positive recommendation to proceed to treatment. Account must be taken of additional factors such as active hepatitis,

Section B - Investigation, Assessment and Advice on Infertility Issues
Criteria Based Access for Heterosexual Couples

For review and consideration by the GP at time of referral to the Fertility Service.
In order to access services to investigate and assess issues with infertility, individuals must meet all of the following criteria:

1 An individual maybe referred if:
   a. The individual has failed to conceive after two years of regular unprotected sexual intercourse
      Or
   b. If the individual has undergone 6 cycles of independently funded unstimulated IUI using sperm from an HFEA approved source.
      Or
   c. If there is a sexual health condition where the patient is unable to have penetrative sex. Individuals must have completed all relevant therapy provided by Psychosexual or Andrology services.

2 **Patients may be referred outside this timeframe if**:
   a. there is a known condition which is likely to affect fertility (e.g., severe oligomenorrhoea, low sperm count <1 million per ml taken on two occasions 3 months apart, bilaterally blocked fallopian tubes, azoospermia, stage 4 endometriosis or premature ovarian insufficiency)
      Or
   b. there is known premature ovarian insufficiency, defined as follicle-stimulating hormone (FSH) greater than 25, measured 2 months apart - coupled with oligomenorrhea or amenorrhea
      Or
   c. Alternatively, an anti-Müllerian hormone (AMH) marker of less than 1
      Or
   d. FSH > 25 on 2 occasions 3 months apart.

3 If the female being assessed will be older than their 39th birthday within the two year time frame, they can be referred after one year as long as they can still be referred before their 39th birthday.

4 Recurrent miscarriage is not an indication for patients to access fertility services although they may be referred for gynaecological investigations and treatments if appropriate.

5 Individuals, or if in a couple, both prospective parents must be registered with a BNSSG GP.

6 The individual must not have previously received a cycle of NHS funded fertility treatment to the level outlined in this policy.

7 Patients who have previously self-funded unsuccessful fertility treatment are eligible for NHS funded fertility treatment as long as they meet the criteria within this policy. Outcomes from previous fertility treatment will be considered as part of the clinical assessment and patients should be aware that multiple failures to conceive through fertility treatment is indicative of poor conception success rates.

Continued Below

Section B - Investigation, Assessment and Advice on Primary Infertility Issues for Heterosexual Couples. Criteria Based Access (cont'd)

8 Individuals must be non-smokers as confirmed in their primary care records. This includes prospective fathers or partners. Individuals who are smokers can be referred to a fertility service but should also be referred to smoking cessation services and be able to demonstrate by compliance with that service that they are non-smokers prior to commencing assessment. Prospective fathers and partners who smoke should be informed that there is an association between smoking and reduced semen quality and, although the impact of this on male fertility is uncertain, they should cease smoking prior to treatment to improve sperm quality.

9 The prospective mother's Body Mass Index (BMI) must be between 19 and 29.9 kg/m2 for a period of six months as evidenced from her primary care record. The evidence is clear that obesity negatively impacts upon successful natural conception and fertility treatment. Prospective mothers with a BMI of 30 and above should be offered a referral to weight management services to reduce their weight prior to assessment and treatment by fertility services (see NICE Recommendations).

10 Where the prospective mother is aged between 37 and up to her 39th birthday, her BMI must be between 19 and 35 kg/m2 prior to referral for assessment. Prospective mothers with a BMI above 29.9 in this age group should be referred to weight management services at the same time as being referred to fertility services to assist her to lose weight and aid fertility.

11 A prospective father is not older than their 54th birthday. Male fertility has been shown to decrease with age, with evidence of greater incidence of disability poor sperm function and DNA degradation.

12 Neither the prospective mother, nor any partner, has been sterilised in the past even if it has been reversed and the sterilisation is the cause of the fertility problems.

Section C - Investigation, Assessment and Advice on Infertility Issues for Same Sex Couples. Criteria Based Access

For review and consideration by the GP at time of referral to the Fertility Service.
In order to access services to investigate and assess issues with fertility, couples must meet all of the following criteria:

1. Same sex couples may be assessed if self-funded insemination on at least 6 non-stimulated cycles from an HFEA approved clinic has failed to lead to a pregnancy. NHS funding is not available for access to donor insemination facilities for fertile women or surrogacy.
2. Same sex couples where either:
   a. both partners have fertility issues, i.e., blocked fallopian tubes or anovulation
   Or
   b. where only one partner is sub-fertile, where possible, the partner who is fertile should try to conceive before proceeding to interventions involving the sub-fertile partner.
3. Recurrent miscarriage is not an indication for patients to access fertility services although they may be referred for gynaecological investigations and treatments if appropriate.
4. Both the individual being assessed, and their partner must be registered with a BNSSG GP.
5. The couple must not have previously received a cycle of NHS funded fertility treatment to the level outlined in this policy.
6. Patients who have previously self-funded unsuccessful fertility treatment are eligible for NHS funded fertility treatment as long as they meet the criteria within this policy. Outcomes from previous fertility treatment will be considered as part of the clinical assessment and patients should be aware that multiple failures to conceive through fertility treatment is indicative of poor conception success rates.
7. The prospective mother must be a non-smoker as confirmed in their primary care records. Patients who are smokers may still be referred to a fertility service, but should also be referred to smoking cessation services and be able to demonstrate that they are non-smokers prior to assessment. Partners of prospective mothers who smoke should also be offered a referral to smoking cessation services in order to improve their health and support their partner.
8. The prospective mother's Body Mass Index (BMI) must be between 19 and 29.9 kg/m2. The evidence is clear that obesity negatively impacts upon successful natural conception and fertility treatment. Prospective mothers with a BMI of 30 and above should be offered a referral to weight management services in order to reduce their weight prior to assessment and treatment by fertility services.
9. Where the prospective mother is aged between 37 and up to her 39th birthday, her BMI must be between 19 and 35 kg/m2 prior to referral for assessment. Prospective mothers with a BMI above 29.9 in this age group should be referred to weight management services at the same time as being referred to fertility services in order assist her to lose weight and aid fertility.
10. The partner of a prospective mother who has undertaken NHS funded fertility treatment, whether successful or not, will be deemed to have received their entitlement to NHS funded fertility treatment upon completion of this cycle in line with heterosexual couples and will not be eligible for a further NHS funded treatment with their partner.

Section C - Investigation, Assessment and Advice on Primary Infertility Issues for Same Sex Couples. Criteria Based Access (cont'd)

11. The prospective mother has not been sterilised in the past even if it has been reversed and the sterilisation is not the cause of the fertility problems.
12. Both members of the couple must accept joint legal responsibility for any child produced through fertility treatment.

Section D. Investigation, Assessment and Advice on Primary Infertility Issues for Single Women. Criteria Based Access

For review and consideration by the GP at time of referral to the Fertility Service.
In order to access services to investigate and assess issues with fertility, single women must meet all of the following criteria:

1. Single women may be assessed if:
    a. they have undergone 6 independently funded non-stimulated cycles of IUI from an HFEA approved source and have not conceived.
    b. The individual has failed to conceive after two years of regular unprotected sexual intercourse
2. Patients may be referred outside of the two-year timeframe if:
    a. there is a known condition which is likely to affect fertility (e.g., severe oligomenorrhoea, bilaterally blocked fallopian tubes, stage 4 endometriosis, premature ovarian insufficiency)
    Or
    b. there is a sexual health condition where the patient is unable to have penetrative sex. Individuals must have completed all relevant therapy provided by a Psychosexual or Andrology service
    Or
    c. there is known ovarian failure, defined as follicle-stimulating hormone (FSH) greater than 25, - measured 2 months apart - coupled with oligomenorrhea or amenorrhea
    Or
    d. they have an anti-Müllerian hormone (AMH) marker of less than 1
    Or
    e. their FSH > 25 on 2 occasions 3 months apart
3. NHS funding is not available for access to donor insemination facilities for fertile women or surrogacy.
4. Recurrent miscarriage is not an indication for patients to access fertility services although they may be referred for gynaecological investigations and treatments if appropriate.
5. The individual being assessed must be registered with a BNSSG GP.
6. The individual must not have previously received a cycle of NHS funded fertility treatment to the level outlined in this policy.
7. Patients who have previously self-funded unsuccessful fertility treatment are eligible for NHS funded fertility treatment as long as they meet the criteria within this policy. Outcomes from previous fertility treatment will be considered as part of the clinical assessment and patients should be aware that multiple failures to conceive through fertility treatment is indicative of poor conception success rates
8. The prospective mother must be a non-smoker as confirmed in their primary care records. Patients who are smokers may still be referred to a fertility service, but should also be referred to smoking cessation services and be able to demonstrate that they are non-smokers prior to assessment.

Continued below

Investigation, Assessment and Advice on Primary Infertility Issues for Single Women

Continued

9. The prospective mother's Body Mass Index (BMI) must be between 19 and 29.9 kg/m2. The evidence is clear that obesity negatively impacts upon successful natural conception and fertility treatment. Prospective mothers with a BMI of 30 and above should be offered a referral to weight management services in order to reduce their weight prior to assessment and treatment by fertility services.

10. Where the prospective mother is aged between 37 and up to her 39th birthday, her BMI must be between 19 and 35 kg/m2 prior to referral for assessment. Prospective mothers with a BMI above 29.9 in this age group should be referred to weight management services at the same time as being referred to fertility services in order assist her to lose weight and aid fertility.

11. The individual who has undertaken NHS funded fertility treatment, regardless of previous relationship status, whether successful or not, will be deemed to

Section E - Assisted Conception. Prior Approval
The Fertility Service is required to secure funding from the CCG following assessment and before treatment commences under Sections E, F and G.

If IVF has been unsuccessful, patients will not be eligible for further IUI.

Assisted conception services include Intrauterine Insemination (IUI), ovulation induction medication and donor insemination. In order to access assisted conception services following investigation and assessment, couples must be assessed against the following criteria:

1. Each prospective mother will be offered up to three treatment cycles of IUI and up to a total of six treatments of the three techniques.
2. The BMI of the prospective mother must remain between 19 and 29.9 kg/m2 whilst accessing fertility treatment. This is because the success of fertility treatment is significantly reduced where the prospective mother is outside of these limits.
3. An assessment of a prospective mother's overall chance of successful pregnancy through natural conception or with IVF should be made with one of the following measures to predict the likely ovarian response to gonadotrophin stimulation in women who are considering treatment:
   a. anti-Müllerian hormone [AMH]
   Or
   a) b. timed follicle-stimulating hormone [FSH] and Estrogen.
4. The prospective mother must have;
   a) an AMH of greater than or equal to 5.4 pmol/l
   Or
   b) a FSH level less than or equal to 15iu/l.

Where AMH/FSH levels are outside of this, donor eggs will be the expected pathway.

5. If donor sperm is used the couple must be able to demonstrate in writing joint legal responsibility for any child born as a result of treatment.

Section F - In-Vitro Fertilisation or Intracytoplasmic Sperm Injection
PRIOR APPROVAL
For Fertility Service consideration when planning treatment – see above.
1. One full treatment cycle of IVF or ICSI (with oocyte donation and/or surgical sperm recovery if required) in line with Section A Points 7 and 8, will be offered to individuals where other assisted conception techniques have failed or carry a very low chance of success

In addition to all the criteria above, the following criteria must also be satisfied at the time of treatment:
1. The prospective mother's serum, if using their own eggs, FSH must be less than or equal to 12iu/l at the time of treatment or an AMH of greater than or equal to 5.4 pmol/l.

Continued Below

Continued

2. The prospective father's serum FSH level must be less than 15 iu/l or testicular volume must be greater than 8ml (as assessed by a fertility specialist) for surgical sperm recovery and storage to be undertaken.
3. If donor sperm / oocytes are used the couple must be able to demonstrate in writing joint legal responsibility for any child born as a result of treatment.

Section F - Surgical Sperm Retrieval for Male Infertility - NHS England
This treatment is funded by NHS England please refer to the NHS England Clinical Commissioning Policy Surgical Sperm Retrieval for Male Infertility at:
https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/05/16040_FINAL.pdf
Or contact NHS England for more information.

NB: Patients must meet the criteria to access treatment under this policy in order to access treatment under the NHS England policy.

Section G - Sperm Washing – Exceptional Funding Request

Funding approval must be sought by the GP or the Fertility Service prior to referral by submission of an Individual Funding application form.

In cases where suppression of viral load is not possible then sperm washing could be available but only on recommendation from a specialist in communicable disease based on U=U guidelines.

BNSSG will approve funding for sperm washing with one full cycle of fertility treatment in conjunction with this policy where:

a. the couple qualify for fertility treatment under this policy, and
b. the prospective father is HIV positive.

Sperm washing is a technique used to decrease the risk of Human Immunodeficiency Virus (HIV) transmission in HIV positive prospective fathers, because the HIV infection is carried by the seminal fluid rather than the sperm. Research has shown that it can reduce the risk of transmission by 96%. However, there may still be a small risk of HIV transmission which some couples may find unacceptable.

Patients can be seen, assessed and treated by local fertility services although a sperm-washing service is only available at the Chelsea & Westminster (C&W) Hospital in London, and at the time of drafting this policy, no other clinics in the UK offer a sperm-washing service.

Section H - Pre-Implantation Genetic Diagnosis
This is funded by NHS England – please contact them for more information.

Section I - Funding of Surrogacy Arrangements and Treatments – Individual Funding Request
The CCG does not fund any element of surrogacy. Funding approval must be sought by the GP or the Fertility Service prior to referral by submission of an Individual Funding application form.

Maternity Care Arrangements
The Commissioner commissions maternity services to provide appropriate support, guidance and care to women during and after pregnancy and these services will continue to be available to surrogates.

BRAN

For any health- related decision, it is important to consider **"BRAN"** which stands for:

- **B**enefits
- **R**isks
- **A**lternatives
- Do **N**othing

Benefits

The primary benefit of fertility treatment is to provide the opportunity for people who are unable to become pregnant naturally to become pregnant.

This assessment stage can support the development of treatment of plans that can help to reduce some of the adverse elements of pregnancy. This can also enable patients to adopt health lifestyle practices that can optimise them for treatment and increase the likelihood of conception.

Risks

Fertility treatments are generally considered safe, carrying small risks to the patient. Fertility treatment, and the conditions described within this policy to support said treatment, will not completely negate the impact of pregnancy.

The main risks of fertility treatment are multiple pregnancy and Ovarian Hyperstimulation Syndrome (OHSS), which can happen if the ovaries are over-stimulated. This can make some women very ill, and they may need to spend time in hospital and have intensive treatment.

Women who receive IVF treatment are at a slightly higher risk of an ectopic pregnancy. The potential impact on the patient's mental health and wellbeing is likely to be impacted following ectopic pregnancy. Consequently, clinicians in primary care and those providing fertility treatment should recognise the potential risks and discuss with each patient as appropriate.

Similarly, IVF can become less successful with age. The risks of miscarriage and birth defects can increase with the age of the recipient.

It is likely that women may experience side effects to certain medications used during IVF. Due consideration should be given to the impact this might have on their general health and wellbeing, including the emotional impact of the process.

Alternatives

Studies exploring alternatives such as the use of Complementary and Alternative Medicine have concluded this is not associated with improved pregnancy rates. The National Institute for Health and Care Excellence (NICE) states further research is needed before such interventions can be recommended.

Adoption is a further alternative.

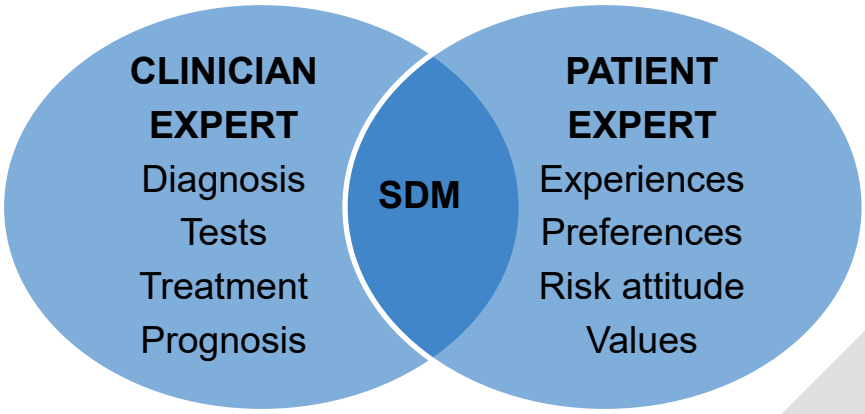
Do Nothing

Remember, you always have the option to do nothing. Doing nothing is an equally reasonable option to doing something. Sometimes "not yet" is a good enough answer until you gather more information.

Shared Decision Making

If a person fulfils the criteria for Infertility, it is important to have a partnership approach between the person and the clinician.

Shared Decision Making (SDM) is the meeting of minds of two types of experts:



It puts people at the centre of decisions about their own treatment and care and respects what is unique about them. It means that people receiving care and clinicians delivering care can understand what is important to the other person. The person and their clinician may find it helpful to use 'Ask 3 Questions':

1. What are my options? (see sections above)
2. What are the pros and cons of each option for **me**?
3. How can I make sure that I have made the right decision?

Infertility – Plain Language Summary

An estimated one in seven couples have difficulty conceiving. In the UK it is estimated that 84% of women would conceive within one year of regular unprotected sexual intercourse. This rises to 92% after two years and 93% after three years. This includes women with fertility problems.

In men, a fertility problem is usually because of low numbers or poor quality of sperm. Female fertility decreases with increasing age. For women aged 35, about 95% who have regular unprotected sexual intercourse will get pregnant after three years of trying. For women aged 38, only 75% will do so.

Other factors which affect fertility success rates include obesity and social factors such as alcohol and drug misuse and therefore this policy has criteria on these subjects.

In vitro fertilisation (IVF) is one of several techniques available to help people with fertility problems have a baby.

During IVF, an egg is removed from the woman's ovaries and fertilised with sperm in a laboratory.

The fertilised egg, called an embryo, is then returned to the woman's womb to grow and develop.

It can be carried out using your eggs and your partner's sperm, or eggs and sperm from donors.

Intracytoplasmic sperm injection (ICSI) is a type of IVF treatment that involves drawing up a single sperm into a very fine glass needle and injecting it directly into the centre of the egg. The fertilised egg (embryo) can then be transferred into the womb of the woman as in a normal IVF cycle. The live birth rates for ICSI and conventional IVF are similar.

The major development of ICSI means that as long as some sperm can be obtained fertilisation is possible.

Intrauterine insemination (IUI), also known as artificial insemination, is a fertility treatment that IUI involves separating sluggish, non-moving or abnormally shaped sperm and injecting directly into the womb.

This policy has been developed with the aid of the following:

1. NICE (2017) Fertility Problems: Assessment & Treatment (Clinical Knowledge Summary) www.nice.org.uk
2. National Library of Medicine (2015) 'Live Birth Rate Associated with Repeat Invitro Fertilisation Cycles'.

Due regard

In carrying out their functions, the Bristol, North Somerset and South Gloucestershire Clinical Policy Review Group (CPRG) are committed to having due regard to the Public Sector Equality Duty (PSED). This applies to all the activities for which the CCGs are responsible, including policy development and review.

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

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Must have any of (primary only):

Support

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Customer Services Team on: **0117 900 2655** or **0800 073 0907** or email them on BNSSG.customerservice@nhs.net.

Glossary

AMH	Anti-Müllerian hormone (AMH) - Comparison of an individual's AMH level with respect to average levels is useful in fertility assessment, as it provides a guide to ovarian reserve and identifies women that may need to consider either egg freezing or trying for a pregnancy sooner rather than later if their long-term future fertility is poor.
Azoospermia	Azoospermia is where he testicles are either producing no sperm or very low numbers of sperm and sperm is not present in the ejaculate.
Embryos	Refers to a fertilised Oocyteoocyte. It is called an embryo until about eight weeks after fertilisation and from then it is instead called a foetus.
Endometriosis	Endometriosis is a condition where tissue similar to the lining of the womb starts to grow in other places, such as the ovaries and fallopian tube.
FSH	Follicle-Stimulating Hormone (FSH) regulates the development, growth, pubertal maturation, and reproductive processes of the human body.
ICSI	Intracytoplasmic Sperm Injection is a variation of in-vitro fertilisation in which a single sperm is injected into the inner cellular structure of an egg.
Infertility	In the absence of known reproductive pathology, infertility is defined as failure to conceive after regular unprotected sexual intercourse for 2 years.
IUI	Intrauterine Insemination (IUI) involves timed insemination of sperm into the uterus. This can be completed as part of a natural unstimulated cycle (unstimulated IUI) or following stimulation of the ovaries using oral anti-oestrogens or gonadotrophins (stimulated IUI).
IVF	In-Vitro Fertilisation (IVF) is a technique whereby eggs are collected from a woman

	and fertilised with a man's sperm outside the body.
Ooctye (Eggs)	Refers to a female gametocyte or germ cell involved in reproduction. In other words, it is an immature ovum, or egg cell.
Oligomenorrhoea	Oligomenorrhoea is infrequent menstruation defined by a cycle length between 6 weeks and 6 month
Regular Unprotected Sex	Unprotected sex is sex without any contraception or condom. The NHS recommends that people trying to get pregnant have sex every 2-3 days across the days mid cycle around the time of ovulation.
Sperm	Refers to the male reproductive cells
Sperm, Oocyte or Embryo Cryopreservation	Sperm, Oocyte or Embryo Cryopreservation is the freezing and storage of Sperm, Oocyte or Embryos that may be thawed for use in future in-vitro fertilisation treatment cycles.