2006 - 2009

The Policy on Fertility Services

Cheshire, Merseyside
and West Lancashire
Primary Care Trusts

Contents

Document Purpose	Action
Title	The Policy on Fertility Services
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Publication Date	5 April 2006
Target Audience	PCT CEs, PCT PEC Chairs, Hospital Fertility Clinicians, Directors of Commissioning, Directors of Public Health, NHS and Foundation Trust CEs, Medical Directors, General Practitioners, Service Users.
Description	This document sets out the policy on access to fertility services for the residents of the Cheshire, Merseyside and West Lancashire PCTs wherever they receive treatment. It also covers the types of assessments, investigations and treatments that will be commissioned for the residents of the above PCTs.
Cross Ref	N/A
Superseded Documents	All individual PCT policies on fertility treatments prior to 1 April 2006.
Action Required	Adherence to this policy except in exceptional circumstances in which instant referral should be made to the Exceptional Case Provision of the respective PCT.
Timing	With effect from 1 April 2006.
For Further Copies	These can be obtained from your Commissioning Lead at your local Primary Care Trust or direct from Dimension Creative Limited.
For Recipient Use	

Introduction 1

This Policy describes in detail how NHS Fertility Services should operate for the people who live in Cheshire, Merseyside and West Lancashire regardless of where they have treatment. It includes the latest guidance on good practice[1] to make sure people receive the most effective forms of treatment. Following this Policy is the way we prioritise patients for treatment.

Family doctors, hospital specialists who provide fertility services, and those who plan fertility services in the Primary Care Trusts (PCTs) use this document. Because of this, it contains some very technical details.

However, because it is just as important that people who have fertility problems are able to use the document too, we have added a short explanation beside each section. This has been written for the general reader without specialist knowledge.

The Policy describes the circumstances in which Cheshire, Merseyside and West Lancashire PCTs will fund fertility treatment and the type of treatments that will be available. It takes the form of conditions under which the NHS will fund treatment routinely.

The PCTs are committed to improving fertility services over the coming years. However, currently, local services vary and so it will take time for some changes to come into effect. In general these differences relate to the most complex fertility treatments. As individual PCT positions will change over time, details of the current situation for residents of a PCT can be found by contacting the Commissioning Department of that PCT.

[1] National Institute for Health and Clinical Excellence: Fertility, assessment and treatment for people with fertility problems Feb.2004. www.nice.org.uk

2 General Principles

We will fund investigations and treatment for sub-fertility that follow Clinical Guideline 11 from the National Institute for Health and Clinical Excellence (NICE). We expect that management of those with fertility problems in primary, secondary and tertiary care will be in line with the clinical practice algorithm contained in this guidance.

We realise that clinical guidance does not override the responsibilities of professionals involved in managing people with fertility problems. There may be instances in which the circumstances of any individual patient may suggest to the clinician that to manage the case appropriately, they need to make an exception to this advice. In this case, it is the responsibility of the clinician to discuss the situation with the commissioning body prior to taking any action.

IN PLAIN ENGLISH WE MEAN

We want our residents to be treated according to the good practice guidance produced by the National Institute for Health and Clinical Excellence (NICE). This will make sure the advice, investigations and treatments people receive will give them their best chance of having a child. However, occasionally a doctor may feel that it is in the best interest of a patient to have treatment that is different to the guidelines. If this is the case, the doctor can contact us to discuss the matter and agree on a course of action that is best for the patient.

3 Routine Access to Services

3.1 Investigations

There is no restriction on access to investigations for fertility problems. However, fertility treatments, which are subject to access criteria, are described in the next section.

The access criteria do not apply to:

- The primary treatment of conditions found during investigation (e.g. ablation of endometrial tissue found at laparoscopy).
- Changes to treatment regimes of pre-existing pathological conditions that reduce fertility, in order to maximise existing fertility.
- The use of assisted conception techniques for reasons other than to treat sub-fertility (for example, as part of a screening process to exclude inherited abnormalities, as in pre-implantation genetic diagnosis).

IN PLAIN ENGLISH WE MEAN

Anyone who has fertility problems can be referred to a hospital specialist for investigations of their problems. However, there are restrictions on who can routinely receive NHS funding for treatment. These restrictions are in the next section.

These restrictions will not

- Apply to people who have any investigations for fertility problems (these will still be available to everyone).
- Prevent doctors who treat people who have other medical problems that make it more difficult for them to conceive from changing their treatment, or the medicines they take, if there is a possibility that those changes might improve the chances of natural conception.
- Apply to people who are using the fertility medicines or treatments for another reason. For example, in some families with very serious inherited diseases, IVF techniques are used to screen embryos to try to avoid the family having a child affected by that serious disease.

3.2 Fertility Treatments

Funding for sub-fertility treatment will be available if a couple does not have a living child from their relationship nor any previous relationship. A child adopted by the couple, or adopted in a previous relationship, is considered to have the same status as a biological child.

Very rarely, those who would not be eligible for treatment because they do not meet this criterion may, because of their personal circumstances, receive NHS-funded treatment. This would take place after consideration of those circumstances within the procedure the PCT has for funding exceptional cases. If such circumstances are thought to exist, the patient or their general practitioner should contact the relevant PCT to discuss how an application might be made. There is separate guidance on this, please refer to Applying for Consideration for Exceptional Case Status.

IN PLAIN ENGLISH WE MEAN

The aim of NHS-funded fertility treatment is to help those who want to have a family life that includes a child to do so if possible. Given the limited resources available within the NHS, in common with other areas of the country, we consider that it would not be appropriate for the treatments to be routinely available to all couples. Following the results of a public consultation on this, priority will be given to people who are childless. In the case of couples, this means that both partners would have no living children.

Health policies like this one are written to describe how services will work for most people who use them. Occasionally, people who want fertility treatment may have such unusual personal circumstances that their PCT would be willing to fund their fertility treatment even though they would not normally be eligible for NHS treatment. If you think that this might be the case for you, although you can apply to the PCT directly yourself, it is always helpful to discuss this with your hospital specialist or GP. They will be able to discuss the situation and advise you whether NHS treatment might be available. Most commonly, your GP or specialist will contact the local PCT on your behalf.

3.3 Reversal of sterilisation and treatment following reversal of sterilisation

Fertility treatment will be available as long as the sub-fertility is not the result of a sterilisation procedure in either partner. The surgical reversal of either male or female sterilisation will only be funded in exceptional circumstances.

In cases in which sub-fertility remains after a reversal of sterilisation, funding will only be available in exceptional circumstances. If the individual's situation is thought to justify consideration, the patient's GP should contact the relevant PCT to discuss how an application may be made. There is separate guidance on Applying Consideration for Exceptional Case Status.

IN PLAIN ENGLISH WE MEAN

Sterilisation is offered within the NHS as an irreversible method of contraception. At the time someone is considering sterilisation they are asked to confirm that they do not want to have any more children under any circumstances. Most requests to reverse sterilisation are because someone has a new partner [2, 3, 4, 5]. We consider that it is not appropriate to use NHS funds to reverse sterilisation unless there are exceptional circumstances.

The chances of conception after reversing sterilisation depend on a number of factors. We believe that the NHS should not routinely fund these procedures, so we also believe that if a person has had a sterilisation reversed and there are still problems conceiving, we should only fund further fertility treatment if there are exceptional circumstances.

As before, this part of the policy describes how services will run for most people who use them. If you feel you have such unusual personal circumstances that your PCT might be willing to fund your treatment, you can discuss the matter with your GP or hospital specialist or you can contact the PCT directly yourself.

[2] Cahill DJ Wardle PG Coulson C Harris S Ford WCL Hull MGR Reversing vasectomy (letter) BMJ 1992 305 52
[3] Wright GM Cato A Webb DR Microsurgical vasovasotomy in military personnel Aust. N.Z. Surg 1995 Jan; 65 (1): 20-6
[4] Calvert J.P. Reversal of female sterilisation Br. J. Hosp. Med 1995 53 (6) 267-270
[5] Wilcox LS, Chu SY, Eaker ED, Zeger SL, Peterson HB. Risk factors for regret after tubal sterilisation: 5 years of follow up in a prospective study. Fertil Steril 1991; 55 927-33

Treatment for sub-fertility will be funded for those that have been attempting to conceive for at least 24 months[6]. This criterion should not be applied in circumstances in which there is a diagnosed condition or congenital abnormality that would make natural conception impossible or extremely unlikely, or if there is other relevant clinical information.

Pharmacological ovulation induction will be funded if the menstrual follicle stimulating hormone (day 3 FSH) level is less than 13iu/L[9]. The number of cycles that may be given should keep to current clinical guidance for the agent to be used. The requirement for follicular tracking during ovulation stimulation means that this treatment should not be undertaken in primary care settings unless there are formal shared care arrangements in place.

We will provide funding for cycles of IVF, ICSI or IUI (including DI) if the cycle will begin before the female partner has reached the age of 40.

IN PLAIN ENGLISH WE MEAN

The likelihood of people becoming pregnant increases with the length of time they have been trying to conceive. In people trying to have a child:

- After trying for one year it is likely that 16% of couples will not have conceived
- After two years of trying, only 4% are likely to still not have conceived
- After three years, only 1% will not have conceived [7, 8]

Because it is not a sensible use of NHS resources to treat people who are likely to conceive naturally, we ask people to try to conceive for at least two years before starting treatment.

Obviously there are some people who will not be able to conceive naturally because of a medical problem or because of a condition they have had since birth. These people will not have to wait for two years.

There may be times when other clinical information will mean that people may receive treatment after trying to conceive for less than two years.

Drugs can be used to stimulate a woman's ovaries to produce eggs. Measuring the level of a hormone (FSH) at a specific point in the woman's cycle shows how well her ovaries are likely to respond to this treatment. High levels of this hormone are associated with a strong probability that she will not respond well to treatment.

The likelihood of having a child following the more complicated fertility treatments (IUI, IVF and ICSI) depends on how old the woman is when she has treatment. As part of the natural ageing process, women become less fertile as they get older and if they do become pregnant, they are more likely than younger women to have a miscarriage.

The Human Fertilisation and Embryology Authority (HFEA) publish information on the number of children born as a result of the most complicated treatments. Their most recent figures suggest that in women aged over 40 having a cycle of IVF treatment, between 6% and 7% would have a child as a result of the treatment. The situation is very different for younger women. For example, in women aged between 31 and 36, it is likely that between 20% and 21% would have a child following a cycle of treatment. We will follow the NICE guidance and make sure we spend NHS resources on those most likely to have successful treatment.

[6] Defined as unprotected intercourse at least three times a month.

[7] National Institute for Clinical Excellence Fertility; assessment and treatment for people with fertility problems page 7 February 2004. www.nice.org.uk

[8] Effective Health Care. The management of subfertility. Effective Health Care Bulletin 1992 **3** 13 University of York.

[9] Gurgan T, Urman B, Yarali H, Duran H.E. Follicle stimulating hormone levels on cycle day three to predict ovarian response in women undergoing controlled ovarian stimulation for in vitro fertilisation using a flare-up protocol. Fert.- Steril.1997 68 483 - 487.

4 Fertility Treatments in Detail

We plan to phase in the guidance given by NICE on the number of cycles of IVF or ICSI funded by the NHS. Consequently, currently two cycles of IVF or ICSI10[10] are funded for women aged under 40 years at the time of treatment.

We will take account of any treatments received previously, whether these treatments were funded by the NHS or privately, when deciding the number of cycles a couple may receive. This will mean the woman will not receive more than a total of three IVF/ICSI cycles. If a cycle of treatment results in a live birth, the only further treatment funded by the NHS will be embryo replacement.

We will provide funding for fertility treatment in women whose body mass index is within the range 19 to 29. Women should be within this range at the point at which they join any waiting list for treatment

IN PLAIN ENGLISH WE MEAN

Most people who have a child after IVF or ICSI treatment need one or two cycles of treatment. The NICE guidance suggests that over the first three cycles of treatment, the likelihood of having a child is the same. The success rate of further cycles of treatment is uncertain. They have suggested that the NHS should offer up to three cycles.

In Cheshire and Merseyside we offer two cycles of IVF/ICSI treatment. We need to change many aspect of our fertility services and because we already offer more cycles of IVF/ICSI than many other areas of the country, we have decided not to increase the number of cycles available straight away. However, we are committed to offering an extra cycle as soon as possible. The NICE guidance says that the success rate is the same for the first three cycles of IVF. For further cycles, the success is less certain. Because of this, we will fund IVF treatment even if a patient has had some treatment in another area or paid for it themselves, as long as the total number of treatments is not more than three. In practice this means that someone can have had one cycle of treatment elsewhere and still have two cycles of NHS treatment or two cycles elsewhere and one cycle of NHS treatment.

Women who are not at their ideal body weight, either underweight or overweight, are less likely to benefit from fertility treatment [11, 12]. There is a weight range in which the chance of success from treatment is highest. We will fund fertility treatment for women within this range and encourage doctors and nurses to help and advise women on how to lose or gain weight.

[10] A cycle of treatment is defined beginning drug therapy to induce follicular development. If a cycle is abandoned for a cause unrelated to the fertility problem being treated, we will ignore it for the purpose of fertility treatment.

[11] Wittemer C, Ohl J, BaillyM, Bettahar-LebugleK. NisandI. Does body mass index of infertile women have an impact on IVF procedure and outcomes? J. Assist. Reprod. Genet 2000 17 547-552

[12] Nichols JE, Crane MM, higdon HL, Miller, PB Boone WR Extremes of body mass index reduce in vitro fertilisation pregnancy rates. Fertil Steril 2003 79 645-647

Access to Services for People not in Parnerships and for Same Sex Couples

5

Funding will be available for sub-fertility treatment for individuals not in a partnership or same-sex couples as long as there is proven sub-fertility. In these people sub-fertility can be defined as no live birth following insemination at or just before the known time of ovulation on at least 10 non-stimulated cycles or six cycles of clinically delivered insemination or a fertility problem proven during investigation.

In the case of same-sex couples in which only one partner is sub-fertile, clinicians should discuss the possibility of the other partner becoming the biological parent before carrying out interventions involving the sub-fertile partner.

NHS funding will not be available for access to insemination facilities for fertile women who are not in a partnership or are part of a same-sex partnership.

In circumstances in which individuals or those in a same-sex partnership are eligible for sub-fertility treatments, the other conditions for eligibility for sub-fertility treatments will apply as well.

Individuals and same-sex couples should have access to experts in reproductive medicine for advice on the options available to them to allow them to make an informed choice on those options.

IN PLAIN ENGLISH WE MEAN

In the case of a single individual or those in a same-sex relationship, deciding that someone has a fertility problem can be more difficult than in a heterosexual couple. However, because we believe that NHS resources should be available to treat childless people with fertility problems, we have worked with fertility experts and members of the gay and lesbian community to create a definition that we can use in deciding on whether fertility problems are present.

6 Practice in Hospitals and Clinics Delivering Fertility Services

The Human Fertilisation and Embryology Authority (HFEA) regulates, using a licensing system, any treatment that involves creating, keeping and using human embryos outside the body. Within the code of practice of the HFEA are requirements for clinics to take account of the welfare of individuals who want treatment and that of any child who may be born or affected as a result of the treatment. All our hospitals and clinics providing fertility treatments must meet this requirement regardless of any eligibility criteria set by any PCT.

We also ask that hospitals and clinics providing fertility treatments keep to the National Institute for Clinical Excellence clinical guidance on assessing and treating people with fertility problems in terms of the principles of care, presence of multidisciplinary teams and treatment protocols of units.

IN PLAIN ENGLISH WE MEAN

There is a code of practice that people working in fertility services must follow to keep within the law covering these services. All hospitals and clinics with which we have an agreement must provide fertility services that meet these requirements. Also, all those who provide fertility services must offer those services in keeping with the NICE guidance on how clinics should be set up and run.

Further Copies

Further copies of this Policy can be obtained by contacting the Commissioning Lead at your local Primary Care Trust.

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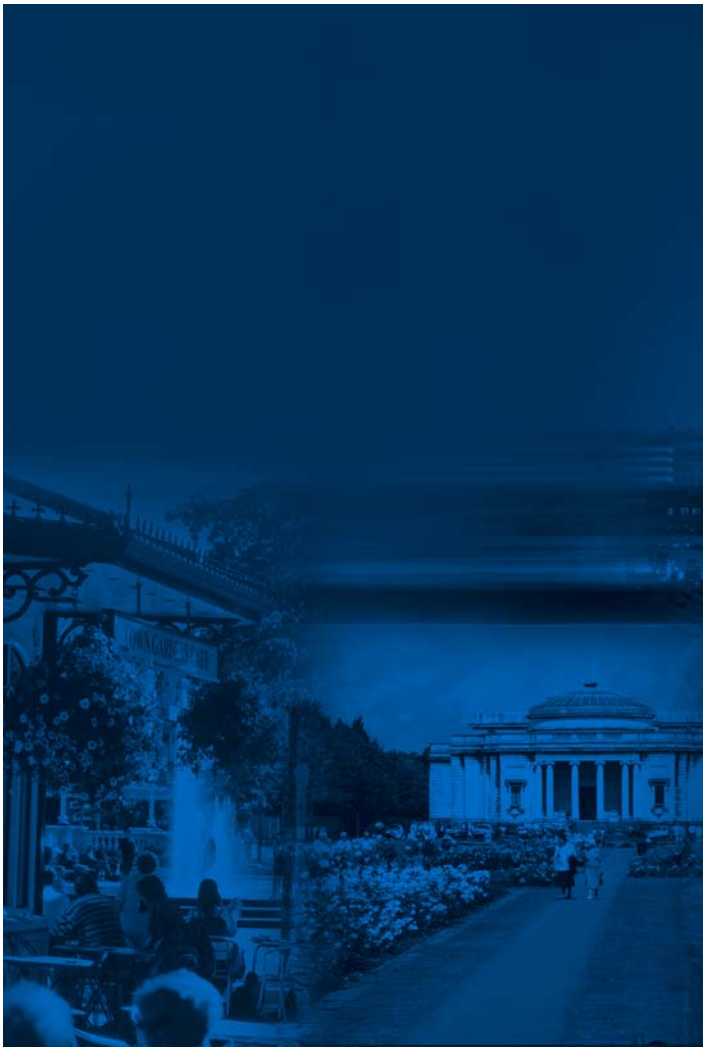

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