right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

MERTON CLINICAL COMMISSIONING GROUP
GOVERNING BODY

Date of Meeting: 15 December 2016

Agenda No: 3.2 **Attachment:** 03

Title of Document: Review of IVF	**Purpose of Report:** Commence Review
Report Author: Andrew Moore, Programme Director – Financial Recovery	**Lead Director:** Andrew Moore
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Executive Summary:

The report sets out the case for Merton CCG to put the current criteria for accessing for IVF and specialised fertility treatments into review.

The CCG will commence a period of review and engagement with some key stakeholders to develop a specific recommendation including relevant safeguards and to clarify the process for making any change to the policy.

Once a specific proposal has been developed, the governing body will be presented with a formal option and a clear process for consultation on, and implementation of, that change.

Key sections for particular note (paragraph/page), areas of concern etc: Nil

Recommendation(s): The governing body agree to put the current policy for access to IVF and specialised fertility treatments under review, with a view to making a decision at a future meeting to change the criteria for access to these treatments.

Committees which have previously discussed/agreed the report: This proposal has been discussed by the Clinical Reference Group, Executive Management Team and Finance Committee.

Financial Implications: Depending on the option finally recommended, change in access to these treatments would be expected to release resources for re-investment in 2017-18, with full effect in 2018-19.

How has the Patient voice been considered in development of this paper: As the paper is seeking approval to commence a review of current policy there has been no patient engagement or consultation to date. Some patient involvement and engagement will be sought as part of the review. If the recommendation arising from the review is to significantly change the access to treatment, then a more extensive consultation with the local population will be undertaken**.**
Other Implications: (including patient and public involvement/Legal/Governance/Risk/Diversity/ Staffing) There is no particular legal implication of commencing a review. Any recommendations for change will include examination of legal and governance risks.
Equality Assessment: As the paper is seeking approval to commence a review of current policy an equality impact assessment has not been carried out.
Information Privacy Issues: N/A
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution) – Engagement plan detailed below

1. Context and introduction

In 2016/17 Merton CCG has been set a financial control total of a deficit of £0.6m. This breaches the NHS business rules and statutory requirements in relation to CCGs finances. For 2017/18, Merton CCG is expected to return to surplus and in order to do so, must off-set a range of financial pressures and identify substantial new savings initiatives.

This has led Merton CCG to undertake a wide ranging review of all areas of expenditure and the outcomes have been reported to the governing body as part of the planning for 2017-18 and beyond.

One area which the CCG notes that has been examined in other CCGs, and in particular by our nearby colleagues in Croydon and Richmond CCG is expenditure on IVF and specialised fertility treatments.

2. Existing Services

Merton CCG is currently forecasting that it will spend more than £600k on IVF and specialised fertility services in the 2016-17 financial year.

Merton CCG commissions IVF and other specialised fertility treatments in limited circumstances. The rules governing access to these treatments are set out in a document shared across the South West London collaborative called the SWL Effective Commissioning Initiative (SWL ECI). This document identifies agreed thresholds for treatments for which restricted access have been agreed and has been in place in its current form since 2014.

Section 13.5 of the SWL ECI sets out the general rules surrounding access to IVF, and the detail of Merton's policy is included in Appendix G (both these sections are replicated in the Appendix to this document).

A copy of the full document is available for download on the CCG website.

3. The case for change

Specialist fertility treatments are clinically effective but the current availability needs to be reviewed in light of the CCG's current financial deficit and pressures on others areas of high priority/essential/mandated spend.

Merton CCG current spends more than £600,000 per year on these treatments and depending on the form of the final policy, could potentially re-direct a proportion of this figure in 2017-18 to other high priority areas.

By putting the existing service/ policy under review, Merton CCG will bring itself in to alignment with other CCGs in SW London, who are undertaking a wider review of commissioning priorities. This will help support the wider work ensuring parity/equality of access for all residents in SW London.

Specialist fertility treatments have been assessed as being clinically effective and cost-effective by NICE. The average live birth rate from IVF varies from 32.2% in women under 35 to 20.8% in women aged 38-39 (HFEA). Overall, the number needed to treat to achieve one live birth is about 4.

The CCGs current policy recognises the evidence-based care recommended by NICE in clinical guideline CG156 Fertility problems: assessment and treatment.

The current CCG policy is already out of alignment with this guidance; for example NICE recommends 3 cycles of IVF are offered to all women under 40 after 2 years of trying to conceive, whereas the CCG's existing policy is to only fund 1 fresh and one frozen cycle.

The number of people in the Merton population potentially affected by a change in access is relatively low: the NICE fertility guidance CG156 costing template predicts 193 women aged 18-39 in Merton would seek IVF treatment annually (0.52% of the population in that age group). No estimate is available for the other forms of treatment.

4. Outline of possible changes

Examine further restrictions in IVF – including:

- an exceptional case only policy, where only couples with exceptional clinical circumstances would be eligible for funding by application under the Individual Funding Policy, - OR

- other changes to criteria which would restrict the number or scope of treatments offered .

5. Proposed process and next steps

The requested decision is to put the service into review and to commence engagement, leading to development of a revised draft access policy and future governing body review of whether to proceed with any change

These potential changes have evidence and some precedent in support. Depending on the option which could be finally adopted, the degree of change and the potential impact could be of a scale that our Merton Oversight and Scrutiny Committee (OSC) may ask for a formal public consultation take place before the change is implemented. The governing body is therefore asked to agree to the principle

underpinning the suggested change, and to approve the commencement of pre-engagement to refine our proposals, before bringing back a formal recommendation to make any change. Assuming that the OSC agrees with our assessment that consultation is necessary and/or desirable, the governing body will then be asked formally decide to launch consultation on the implementation of the refined proposed changes.

We have informally shared our proposal to review this area of commissioning with the Council and our GP membership and have their support in principle. Nonetheless we recommend that the governing body agree to a period of stakeholder engagement to further develop proposals, and then with further refined policies, subsequently make a decision whether or not to proceed, with formal public consultation to take place if required.

Purpose of engagement and consultation
In order to undertake effective engagement and consultation a range of robust activities must be undertaken to:

- Identify patients and/or groups of patients who may be disproportionally affected by any service changes
- Assess any potentially negative (or positive) impacts on populations sharing protected characteristics (Equalities Impact Assessment - to be published to coincide with any public consultation)
- Gather and assess existing patient experience data, working closely with Healthwatch and other patient groups

This will help us to:

- Discover potential solutions and scenarios developed through processes with clinicians, patients and the public
- Set patient and public priorities for future service models of affected services in Merton, for example what would good look like?

How will we do this?
The CCG wants to ensure that members of the public, patients, carers, providers and those who have an interest in the proposals we are developing have the opportunity to inform them at an early stage. We need to talk through these proposals with local people and discuss with them how we prioritise the CCG's spend on health services to inform our resilience plans.

The CCG will utilise a range of methods for involving people which could include working closely with HealthWatch and other local voluntary or community organisations to reach into local communities as well as ensure we act on the sound and insightful local intelligence supplied by them. Existing forums such as the CCG's community involvement group and patient engagement group (PEG) network will be also used as a sounding board to ensure that if the CCG makes a decision to proceed to consultation that our plans will ensure that the patient voice is sufficiently taken into account.

As part of an equalities impact assessment we will be able to identify any potential

impacts on specific communities and groups and will work with local voluntary and community organisations to test and discuss our proposals with these communities.

If after an initial period of engagement, the governing body considers that it is appropriate to propose a significant change to the current access criteria, we will undertake a more extensive formal consultation with the local population.

Appendix 1 – Extracts from current ECI Policy on IVF

Section 13.5 IVF

See Appendix G for individual CCG variations

	Criteria	Rationale
Duration of subfertility	Couples will be eligible for referral for treatment if they have experienced thirty six months of unexplained infertility or have an identified cause of infertility	84% of women will conceive within one year of regular unprotected sexual intercourse, this increases to 92% after 2 years and 93% after 3 years
Age of woman at start of treatment cycle	The age range will be a local CCG (Borough) decision.	The likelihood of a live birth following assisted conception declines with age. Chances of live birth per IVF cycle are: >20% for women aged 23-35 15% for women aged 36-38 10% for women aged 39 years 6% for women aged 40 years and over
Body mass index of woman	19 – 30 kg/$m^{2,}$ weight to be maintained for the last 6 months prior to application.	Higher body mass index reduces the probability of success associated with assisted conception techniques
Smoking status of couple	Both partners should have been non-smokers for at least six months prior to commencement of treatment.	Smoking can adversely affect the success rates of assisted reproductive techniques.
Previous cycles	The number of NHS funded cycles including the number of frozen embryo transfers and duration of storage of frozen embryos will be a local CCG decision.	The probability of a live birth following the IVF is consistent for the first three cycles but effectiveness of subsequent cycles is uncertain.
Childlessness	Neither partner must have any living children from this or previous relationships (including adopted children)	As funding for assisted conception is limited, priority will be given to couples with the greatest need.
Sterilisation	Treatments will not be available if either partner has undergone previous sterilisation.	Sterilisation is offered as an irreversible method of contraception and individuals on the NHS are made aware of this at the time of the procedure.
HFEA Code of Practice	Couples must comply to a *Welfare of the Child* assessment	*Human Fertilisation and Embryology (HFE) Act 1990* (as amended) states: Section 13 (5): A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth. Section 2 (1) … "treatment services" means medical, surgical or obstetric services provided ... for the purpose of assisting women to carry children.
Women in same sex couples/ and women not in a partnership	Sub fertility treatment will be funded for women in same sex couples or women not in a	This section was copied from the South Central criteria to ensure equality of access to the service.

	partnership if those seeking treatment are demonstrably sub fertile. In the case of women in same sex couples in which only one partner is sub fertile, clinicians should discuss the possibility of the other partner receiving treatment before proceeding to interventions involving the sub fertile partner. NHS funding will not be available for access to insemination facilities for fertile women who are part of a same sex partnership or those not in a partnership. In circumstances in which women in a same sex partnership or individuals are eligible for sub fertility treatment, the other criteria for eligibility for sub fertility treatments will also apply. Women in same sex couples and women not in a partnership should have access to professional experts in reproductive medicine to obtain advice on the options available to enable them to proceed along this route if they so wish.	
FSH	The level of FSH would be a local CCG (Borough) decision.	

CCGs may wish to add additional criteria to this list based on local circumstances

References:

1. *National Institute for Health & Clinical Excellence (NICE) CG11Fertility: assessment and treatment for people with fertility problems, Feb 2004*

2. *National Institute for Health & Clinical Excellence (NICE) CG156 Fertility: assessment and treatment for people with fertility problems, Feb 2013*

EXTRACT FROM ECI APPENDIX G [The Merton Policy specifics]

MERTON CCG – Assisted Conception Policy 2014/2015

1. Introduction

1.1 This policy describes circumstances in which Merton CCG will fund treatment for assisted conception as defined in appendix 1.

1.2 The objective of treatment for subfertility is to achieve a successful pregnancy quickly and safely with the least intervention required and the delivery of a healthy child.

1.3 The criteria set out in this policy apply irrespective of where the residents of Merton CCG have their treatment. A Merton CCG patient is defined as someone registered with a GP practice which is part of Merton CCG

1.4 This policy has drawn on guidance issued by the Department of Health, Infertility Network UK and the revised NICE guidance (CG 156) published in February 2013.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101068.pdf

http://www.infertilitynetworkuk.com/uploadedFiles/Standardising%20Access%20Criteria%20to%20NHS%20Fertility%20Treatment%2009%2006%2009.doc

http://guidance.nice.org.uk/CG156 (summary guidance)

http://www.nice.org.uk/nicemedia/live/14078/62770/62770.pdf (full guidance)

2. Defining infertility

2.1 Infertility is a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.

3. Types of infertility treatment

3.1 There are three main types of infertility treatment –

- medical management (such as drugs for ovulation induction),
- surgical treatment (i.e. to correct a physical cause for infertility such as blocked fallopian tubes)
- assisted conception

3.2 Assisted conception is a collective name for treatments designed to lead to conception by means other than sexual intercourse where gametes are manipulated. Assisted conception techniques include intrauterine insemination (IUI), in vitro

fertilisation (IVF), donor insemination (DI), intracytoplasmic sperm injection (ICSI) and cryopreservation (of sperm, oocytes and embryos).

4. Pathway and provider arrangements for assisted conception (IUI, IVF, ICSI)

4.1 Merton CCG will have a waiting list for assisted conception at three providers:

- Epsom and St Helier University Hospitals Trust
- Guys and St Thomas NHS Foundation Trust
- Kingston Hospital NHS Foundation Trust

5. Commissioning policy

5.1 In Vitro Fertilisation (IVF) / Intracytoplasmic sperm injection (ICSI):

5.1.1 Definition:

In Vitro Fertilisation (IVF) is a technique by which eggs are collected from a woman and fertilised with a man's sperm outside the body. Usually one or two resulting embryos are then transferred to the womb. If one of them attaches successfully, it results in a pregnancy. Intracytoplasmic sperm injection (ICSI) is a variation of IVF in which a single sperm is injected into an egg.

5.1.2 Policy statement:

Merton CCG will fund **one (1) fresh cycle of IVF or ICSI for patients who meet** all of the criteria in Appendix 1.

Where the couple produces more than one good quality embryo and have an elective single embryo transfer, the PCT will fund 12 months of cryopreservation of the remaining embryos. If the initial embryo transfer does not result in a live birth, the CCG will then fund a single unstimulated frozen embryo transfer.

It is expected that the majority of patients receiving Merton CCG funded IVF/ICSI will undergo single embryo transfer. This will reduce the number of multiple pregnancies within Merton CCG and falls within HFEA guidance. The IVF providers will be expected to have in place a "Minimisation of Multiple Birth Strategy" which gives precise details of those couples who will be required to have single embryo transfer. More information is available at
www.oneatatime.org.uk

5.2 Intrauterine insemination (IUI)

5.2.1 Definition:

Intra-uterine insemination (IUI) is a technique to place sperm into a woman's womb through the cervix

5.2.2 Policy statement

Merton CCG will fund three (3) cycles of intrauterine insemination for couples undergoing insemination for the following conditions:

- Obstructive azoospermia (i.e. where the man has no sperm in his semen)
- Where there is a high risk of transmitting a genetic disorder to the offspring
- Where there is high risk of transmitting an infectious disease from the man to the woman or to the offspring
- Severe rhesus isoimmunisation

5.3 Pre-implantation genetic diagnosis

5.3.1 Definition:
Pre-implantation genetic diagnosis can be used when one partner is known to have a faulty gene. It involves having in-vitro fertilization (IVF) treatment, then genetically testing the embryo in a laboratory to see if it has the faulty gene. The embryo will only be placed inside the woman if it does not have the faulty gene.

5.3.2 Policy statement
Merton CCG will consider funding up to one fresh cycle of IVF or ICSI for couples who have had this recommended by the Pre-implantation Genetic Diagnosis (PGD) Clinical Advisory Group.

5.3.3 Rationale
The Pre-implantation Genetic Diagnosis (PGD) Clinical Advisory Group has been set up by the Genetics Consortium to consider individual requests for funding and make recommendations to commissioners of member CCGs on the clinical appropriateness to fund individual PGD cases.
Couples wishing to access PGD will therefore not be treated in the same way as couples requesting assisted conception. As such they will not be limited by the requirements of this policy (e.g. joining the centrally managed list, other aspects of the clinical criteria). However, each case will need to receive specific prior approval for funding from the CCG which will then act on the recommendations of the PGD Clinical Advisory Group. Funding for PGD does not fall within the financial allocation for assisted conception.

5.4 Egg Donation

5.4.1 Definition:
Egg donation is the process by which a fertile woman donates her eggs for use in the treatment of other women

5.4.2 Policy statement
Merton CCG will fund one cycle of IVF/ICSI using egg donation for women with:

- Premature ovarian failure
- Gonadal dysgenesis including Turner’s syndrome
- Bilateral oophorectomy
- Ovarian failure following chemotherapy of radiotherapy

Women must meet all of the criteria in Appendix 1.

Eggs must be donated through an altruistic donor, egg sharing schemes or sourcing eggs from overseas will not be funded

5.4.3 Rationale:
Some women cannot produce eggs, usually because their ovaries are not functioning, have been removed or they have a chromosomal abnormality.

5.5 Donor insemination

5.5.1 Definition:
This form of treatment involves using sperm donated anonymously by another man.

5.5.2 Policy statement
Merton CCG will fund donor insemination using IUI for the following conditions if appropriate:

- Non-obstructive azoospermia
- Where there is a high risk of transmitting a genetic disorder to the offspring
- Where there is high risk of transmitting an infectious disease from the man to the woman or to the offspring
- Severe rhesus isoimmunisation

5.6 Surrogacy

5.6.1 Definition:
Surrogacy is a way for a childless couple to become parents, with a surrogate mother carrying their child. In traditional surrogacy, the surrogate may be the child's genetic mother i.e. her egg is fertilized using sperm from the man who wishes to raise the child. In gestational surrogacy, the pregnant woman is not biologically related to the baby.

5.6.2 Policy statement
Merton CCG does not fund any element of surrogacy arrangements or associated fertility treatments and procedures.

5.6.3 Rationale:
The funding of surrogacy arrangements and associated fertility treatments raises numerous legal and ethical issues which present significant risk to commissioners. These risks arise from the complexities associated with surrogate arrangements including: issues relating to the parentage of the child; change of mind by any of the parties involved in the surrogate arrangement (including termination of pregnancy or refusal to surrender child); problems arising from “unwanted baby” or genetic or congenital defects.
Given that these are either unresolved and that the legal position on many of these aspects are presently unclear, the legal advice to CCGs is not to fund any element of surrogacy procedures.

5.7 Private/Self Funding Patients

5.7.1 Policy statement
Patients who are undergoing treatment outside of an NHS pathway will not be funded or reimbursed for drugs or additional tests incurred as a result of self-funded/private treatment.

5.8 In vitro maturation

5.8.1 Definition:
In vitro maturation involves removing immature eggs that have yet to complete their growth, and subsequently maturing these eggs in the laboratory.

5.8.2 Policy statement
In vitro maturation will only be funded in exceptional circumstances.

5.8.3 Rationale
There is limited evidence for the effectiveness of in vitro maturation of eggs

5.9 HIV infection and sperm washing

5.9.1 Definition:
Sperm washing is a process in which individual sperm are removed from the semen then used in IUI or IVF. Its use in reducing male to female HIV transmission is based on the observation that HIV is found in the seminal fluid rather than the sperm cells.

5.9.2 Policy statement
Funding of Sperm washing for the prevention of transmission HIV will be considered on an individual patient basis.

5.9.3 Rationale:
Where the man is HIV positive, the risk of HIV transmission through unprotected sexual intercourse is negligible when all of the following criteria are met:

- the man is complying with highly active antiretroviral therapy (HAART)
- the man has a plasma viral load of less than 50 copies/ml
- there are no other infections present
- unprotected intercourse is limited to the time of ovulation

If all of the criteria above are met, sperm washing may not further reduce the risk of infection and may actually reduce the likelihood of pregnancy. In addition, sperm washing reduces, but does not eliminate, the risk of HIV transmission

5.10 Cryopreservation and cryostorage

5.10.1 Definition
Cryopreservation entails freezing of eggs, sperm and/or embryos that may be thawed for use in future IVF treatment cycles. Cryostorage entails storage of frozen eggs, sperm and/or embryos that may be thawed for use in future IVF treatment cycles.

5.10.2 Policy statement
i) Merton CCG will fund sperm cryostorage, egg cryostorage and embryo cryostorage in the following circumstances:

- Medical or surgical treatment that is likely to have a permanent harmful effect on subsequent sperm or egg production. Such treatment includes radiotherapy or chemotherapy for malignant disease.
- Ongoing medical treatment that, whilst on treatment, causes harmful effects on sperm or egg production or has possible teratogenic effects, and in whom stopping treatment for a prolonged period of time to enable conception is not an option.

ii) Commencement of cryostorage does not entitle people to assisted conception treatments. In this circumstance and individual funding request can be applied

iii) Storage:

- May not exceed five (10) years.
- Will not be available where a man or woman chooses to undergo medical or surgical treatment whose primary purpose is infertility, such as sterilisation;
- Will not be available where a man or woman requests cryostorage for personal lifestyle reasons, such as wishing to delay trying to conceive

iv) Post-storage Treatment

- Funding of assisted conception treatments would be made available on the same basis as other patients who have not undergone such storage

5.11 Surgical sperm retrieval/recovery

5.11.1 Definition:
A surgical procedure to obtain sperm from the testicles in men who cannot ejaculate or have a blockage in the flow of sperm from their testicles.

5.11.2 Policy statement
Surgical sperm retrieval will be commissioned in appropriately selected patients provided the azoospermia is not the result of a sterilisation procedure or the absence of sperm and the couple meets all other criteria.

5.11.3 Rationale
Spermatozoa can be retrieved from both the epididymis and the testis using a variety of techniques with the intention of achieving pregnancies for couples where the male partner has obstructive or non-obstructive azoospermia. Sperm recovery is also used in ejaculatory failure and where only non-motile spermatozoa are present in the ejaculate. Surgically collected sperm in azoospermia are immature (because they have not traversed the epididymus) and have low fertilising ability with standard IVF. It is therefore necessary to use ICSI.

Appendix 1: Merton CCG Criteria for Access to Intrauterine Insemination (IUI), In Vitro Fertilisation (IVF), Intracytoplasmic Sperm Injection (ICSI)

Title	Criteria	Rationale
Duration of subfertility	• Couples will be eligible for referral for treatment if they have experienced twenty four months of unexplained infertility or have an identified cause of infertility	• 84% of women will conceive within one year of regular unprotected sexual intercourse, this increases to 92% after 2 years and 93% after 3 years
Age of woman at start of treatment cycle	• Woman is aged 23 – 42 at the time of treatment i.e she has not had her 43rd birthday • Couples will not be able to be referred from secondary to tertiary care where the women is aged over 42.5 years. This is because treatment must take place before her 43rd birthday and clinics will be operating an 18 week pathway The lower age limit will not apply to women accessing treatment due to clinical care that is likely to result in long-term infertility	The likelihood of a live birth following assisted conception declines with age. Chances of live birth per IVF cycle are: • >20% for women aged 23-35 • 15% for women aged 36-38 • 10% for women aged 39 years • 6% for women aged 40 years and over
Body mass index of woman	• 19 – 30 kg/m2, weight to be maintained for the last 6 months prior to application.	• Higher body mass index reduces the probability of success associated with assisted conception techniques
Smoking status of couple	• Both partners should have been non-smokers for at least six months prior to commencement of treatment.	• Smoking can adversely affect the success rates of assisted reproductive techniques.
Previous cycles	• Couples will be eligible for NHS funding of one fresh cycle of IVF or ICSI. Where the couple produces more than one good quality embryo and have an elective single embryo transfer, the PCT will fund 12 months of cryopreservation of the remaining embryos. If the initial embryo transfer does not result in a live birth, Merton CCG will then fund a single unstimulated frozen embryo transfer • Where couples have self-funded previous cycles, these must not exceed one.	• The probability of a live birth following the IVF is consistent for the first three cycles but effectiveness of subsequent cycles is uncertain.

	• Couples will not be eligible for treatment if they have received any previous NHS funded treatment • Women who are aged over 40 at the time of treatment will be entitled to one cycle of IVF/ICSI treatment provided that they have not undergone any previous self-funded or NHS IVF/ICSI treatment previously	
Childlessness	• Neither partner will have any living children from this or previous relationships (including adopted children)	• As funding for assisted conception is limited, priority will be given to couples with the greatest need.
Sterilisation	• Treatments will not be available if either partner has undergone sterilisation.	• Sterilisation is offered as an irreversible method of contraception and individuals on the NHS are made aware of this at the time of the procedure
HFEA Code of Practice	• Couples must comply to a *Welfare of the Child* assessment	• *Human Fertilisation and Embryology (HFE) Act 1990* (as amended) states: • Section 13 (5): A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth.
Same sex couples and women not in a partnership	IVF treatment will be funded for same sex couples or women not in a partnership if those seeking treatment are demonstrably subfertile and have undergone a period of expectant management. They would first need to demonstrate subfertility through 6 self-funded attempts at artificial insemination using donor sperm in a clinical setting, and undergo a period of expectant management involving up to a further 6 cycles of self or NHS-funded donor intra-uterine insemination (see policy	Same-sex couples should have access to IVF on equivalent grounds to heterosexual couples. In this respect, failure to conceive after six cycles of self-funded artificial insemination has been deemed an equivalent indicator of sub-fertility, given clinical and practical

	statement 4). Note: Men in same-sex relationships wanting a baby can either adopt or use some form of surrogacy. The CCG will not fund surrogacy arrangements. However, when a pregnancy does not occur through surrogacy after 6 cycles of self-funded intra-uterine insemination in a clinical setting there is an increased risk of some underlying problem. In those circumstances, the man whose sperm is being used and the surrogate partner would be eligible to be referred for further clinical assessment and possible treatment[4]. In the case of same sex couples where only one partner is sub fertile, clinicians should discuss the possibility of the other partner receiving treatment before proceeding to interventions involving the sub fertile partner. The other criteria for eligibility for IVF will also apply. • All same sex couples and women not in a partnership should have access to professional experts in reproductive medicine to obtain advice on the options available	considerations[3]. Further NHS-funded cycles of intra-uterine insemination (up to six) constitutes the period of expectant management required prior to being eligible for IVF, during which pregnancy may be achieved (based on NICE recommendation[3] and advice of local clinicians). •
FSH	• FSH levels should be checked between day 2 and 4 of the menstrual cycle, where day 1 is the first full day of menstrual bleeding, with Oestradiol level. Only women whose FSH has never exceeded a level of 11.9 iu/L or less when an oestradiol level checked on the same day is 249 pmol/l or less will be eligible for treatment with the sample timed within 6 months of date of treatment. For those with no periods the sample can be timed at any date but the same maximum levels apply. The clinic will be expected to repeat the FSH blood test if the level was checked more than 6 months prior to treatment and treatment will be withdrawn if the repeated level exceeds 11.9iu/L	
Investigations	• The couple must have been appropriately investigated within a recognised NHS fertility clinic in secondary care. The couple can only be referred for assisted conception once all of these investigations have been completed and a proforma referral document completed . The referring clinic will check to ensure that the couple fulfil the relevant criteria and at that point will start an 18 week clock. Couples must NOT be referred for assisted conception until all other relevant procedures have been completed and the patient discharged from secondary care.	