

## **The Review of Clinical Policies for Lancashire and South Cumbria Clinical Commissioning Groups (CCGs) – Frequently Asked Questions (FAQs)**

### **Supplementary FAQ's – Proposed policy for Assisted Conception Services**

These frequently asked questions are supplementary to the FAQ's already identified as part of the clinical policy review process.

#### **Why do we need an Assisted Conception policy?**

The NHS is primarily concerned with the treatment and care of patients who are ill or injured or who may have long-term physical and/or mental health needs that impact upon their general health and wellbeing. An inability to conceive or have children may or may not be clinical in origin but it is often not linked to illness or injury and does not therefore, carry the same level of urgency and priority as some other NHS services.

However, an inability to conceive can significantly impact upon the present and future general health and wellbeing of patients and, although of less a priority for NHS resources, there remain circumstances when it seems right to offer this service to patients. The assisted conception policy undertakes to determine under what circumstances and in which situations patients can expect to receive support from the NHS with conceiving and having a child/family.

#### **I've seen reference to an IVF policy and an Assisted Conception Policy – what is the difference?**

IVF (in vitro fertilisation) is a common and widely known method of assisting conception to take place, but it is not the only method available/used. IVF policies may concern IVF treatments only or they may be the name given erroneously to wider assisted conception policies.

The new draft policy in Lancashire and South Cumbria is rightly referred to as an 'Assisted Conception' policy as it relates to various methods of helping patients to conceive not just IVF. That said, much of the policy is concerned with IVF.

#### **I've seen the proposed Assisted Conception Policy and it seems to be quite technical and complex – why?**

The Assisted Conception Policy, as with all the clinical policies that CCGs adopt, are legal documents as well as guides to decision making on areas of low clinical value. As such the Assisted Conception Policy needs to be a robust document that stands up to both legal and clinical scrutiny. There are a significant number of medical/clinical techniques involved in assisted conception services and these need to be correctly referenced in terms of purpose and terminology. This can make the policy appear complex and less easy for the lay-person to understand.

**I gave feedback about a revised assisted conception policy last year. I heard nothing more. What is the link between that policy and the new draft that is on the website now?**

Some people may recall seeing or providing feedback on a revised draft assisted conception policy last year. That policy was never adopted. This is the same policy with further revisions and amendments.

Following the engagement process with patients and members of the public all the Clinical Commissioning Groups realised they could not continue with the draft policy as it stood at that time. It was felt that the policy needed further work.

A significant element of this work was around getting the best value from these services, considering that people are having children later when fertility is naturally decreasing and when assisted conception is less likely to be successful. In addition, given the current financial environment, CCGs needed to also consider what they could afford to fund in relation to assisted conception services going forward.

**What changes have been made to the proposed policy on the commissioning of assisted conception services?**

The proposed policy applies to all the CCGs in Lancashire and South Cumbria, but as the existing policies vary between each CCG, the changes needed to bring them into line also vary as a consequence. The main change that is common to all the CCGs is that the definition of a treatment cycle (now called a treatment unit) has been harmonised and the number of treatment units offered has been reduced to one treatment unit for patients between the ages of 18-42.

Another change that impacts upon all the CCGs equally is the introduction of a lower age limit of 18 and an upper age limit of 42 years of age. Previously the CCGs either had no lower age limit or had a lower age limit of 23 and an upper age limit of less 39, 40 or 43, depending upon the CCG.

For more detailed information on the level of change in your CCG area you are directed to the level of change document included as part of the consultation papers on CCG website. Alternatively, you can email [haveyoursay@lancashirecsu.nhs.uk](mailto:haveyoursay@lancashirecsu.nhs.uk) and request a copy of the level of change document or request a copy from your CCG.

**Why are you reducing the number of treatment cycles/units?**

The reason for reducing the number of treatment units is based on 2 of the 5 principles upon which all the CCG clinical policies are based. These are effectiveness and affordability.

26.5% of treatments units result in a live birth, which is just over a quarter of all treatment units. Three quarters of all treatment units are therefore, unsuccessful.

However, patients are most likely to succeed in their first attempt at IVF. This means that patients entering their second or subsequent treatment units have all failed initially and are less likely to conceive through IVF. In addition, nationally, the average age of a woman having IVF treatment is 35, after which women's fertility (naturally) declines quite rapidly. Second or subsequent attempts to conceive using IVF are therefore, more likely to take place when the patient is less able to conceive in any case.

Given the current pressure on NHS resources and the need to more adequately fund higher priority services (those which more clearly have a purpose of preserving life or of preventing grave health consequences), coupled with the decreasing effectiveness of IVF treatment units, means CCGs must make difficult choices and limit the funding available to services of this nature.

**In the proposed policy to be in an eligible family structure both partners need to be childless. In my CCG couples are eligible when only one partner is childless (as long as the other criteria are met). Why has this changed?**

Only 2 of the 8 CCGs in Lancashire and South Cumbria currently provide eligibility to couples where at least one partner is childless. The remaining 6 CCGs only offer assisted conception services to couples where both partners are childless. The proposed policy now reflects the current majority position where the eligible family structure are couples where both partners are childless.

To change the policy the other way, so that couples with at least one partner childless became the default eligible family structure, would increase the level of eligible couples significantly. This in turn would lead to an increase in funding when the affordability of assisted conception services is a concern for CCGs and will be for the foreseeable future.

**Why have you introduced a lower age limit of 18 years of age?**

We have set the age limit of 18 years as that is the age that people are legally recognised as adults in the UK and the assisted conception policy is for adults. The revised policy now makes this clear.

**Are the CCG's considering how the proposed changes will impact on different groups?**

Yes: the process of policy review undergoes assessing any impacts of proposed criteria change. This consultation feedback is important to highlight any impacts relating to different groups of people that are protected under the Equality Act 2010. All identified impacts will form part of the Equality Impact Risk Assessment in order for the CCG's to comply to Equality Legislation.