



*Wandsworth  
Clinical Commissioning Group*

**ASSISTED CONCEPTION POLICY  
2013-2015**

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**DOCUMENT CONTROL AND AMENDMENT RECORD**

**Assisted Conception Policy 2013-2015**

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## **1. INTRODUCTION**

### **1.1 Purpose / Rationale**

This policy defines the Assisted Conception treatments offered in Wandsworth and the eligibility criteria for these treatments.

### **1.2 Aims and Objectives**

This 2013/2015 policy updates and replaces the 2012/2013 Wandsworth Assisted Conception Policy.

### **1.3 Scope**

This policy relates to Level 3 or specialist fertility services provided by tertiary assisted conception units.

Levels 1 and 2 fertility services are commissioned and provided in primary and secondary care, and do not fall within the remit of this policy.

This policy will ensure that all patients across Wandsworth who require assisted conception will be treated in accordance with Wandsworth CCGs commissioning principles.

## **2. DEFINITION**

To access the tertiary fertility services described in this policy, preliminary advice, investigations and treatments, should have been completed at Level 1 and 2 as recommended in the NICE Pathway - Fertility overview, and NICE Pathway on the Investigation of fertility problems and management strategies.

## **3. DUTIES**

- It is the responsibility of the current providers of services to implement the Policy.
- It is the responsibility of the CCG to review the policy as appropriate and upon the stipulated review date.

## **4. ASSISTED CONCEPTION**

### **4.1 Unexplained infertility**

Women with unexplained infertility may be offered tertiary assisted conception if they have not conceived after two years of regular unprotected sexual intercourse (this can include up to one year before their fertility investigations), provided they meet all the eligibility criteria outlined in Appendix 1.

## 4.2 Types of infertility treatment

There are three main types of infertility treatment –

- medical management (such as drugs for ovulation induction),
- surgical treatment (e.g. laparoscopy for endometrial ablation)
- assisted conception

Assisted conception is a collective name for treatments designed to lead to conception by means other than sexual intercourse. 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).

## 4.3 Pathway and provider arrangements for assisted conception (IUI, IVF, ICSI)

In Vitro Fertilisation (IVF), Intra-Uterine Insemination (IUI) and Intracytoplasmic Sperm Injection (ICSI) will normally be funded only in the context of the NICE fertility care pathway . See [NICE Pathways - Fertility Overview](#).

NHS Wandsworth has a single waiting list for assisted conception managed by St Helier. Patients can opt to receive treatment at St Helier/Kings or referral to another assisted conception unit of their choice.

## 4.4 Commissioning policy

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

#### *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.

*Embryo Transfer Policy statement:*

- Wandsworth 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 CCG 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.

#### **4.5 Intrauterine insemination (IUI)**

*Definition:*

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

*Policy statement:*

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

- Obstructive and non-obstructive azoospermia (i.e. where the man has no sperm in his semen)
- Severe deficits in semen quality
- 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

#### **4.6 Pre-implantation genetic diagnosis**

*Definition:*

Pre-implantation genetic diagnosis can be used when one partner is known to have the 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.

*Policy statement:*

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

*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 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.

#### **4.7 Egg Donation**

*Definition:*

Egg donation is the process by which a fertile woman donates her eggs for use in the treatment of other women or for use in research.

*Policy statement*

Wandsworth CCG will fund one cycle of IVF/ICSI using egg/ovum donation for women with:

- Premature ovarian failure
- Gonadal dysgenesis including Turner's syndrome



- Bilateral oophorectomy
- Ovarian failure following chemotherapy or radiotherapy
- Certain cases of IVF treatment failure

Women must meet all of the criteria in Appendix 1

*Rationale:*

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

#### **4.8 Donor insemination**

*Definition:*

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

*Policy statement:*

Wandsworth CCG will fund donor insemination using IUI for the following conditions:

- Obstructive and non-obstructive azoospermia
- Severe deficits in semen quality in couples who do not wish to undergo ICSI
- 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

#### **4.9 Surrogacy**

*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.

*Policy statement*

Wandsworth CCG does not fund any element of surrogacy arrangements or associated fertility treatments and procedures.

*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 PCTs is not to fund any element of surrogacy procedures.

**4.10 Private/Self Funding Patients**

*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.
- The number of previous self-funded cycles of IVF/ICSI will be taken into account in determining a patient’s eligibility for treatment (see Appendix 1)

#### **4.11 In vitro maturation**

*Definition:*

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

*Policy statement*

In vitro maturation will only be funded in exceptional circumstances.

#### **4.12 HIV infection and sperm washing**

*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.

*Policy statement*

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

*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 for more than six months
- 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

### 4.13 Cryopreservation and cryostorage

#### *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.

#### *Policy statement*

i) Wandsworth 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. There is the potential for individuals to meet the access criteria for cryostorage and not to meet the criteria for infertility treatments at a later date.*

iii) Storage:

- May not exceed five (5) 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

### *Rationale*

Couples needing to access cryopreservation and cryostorage will 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 Wandsworth CCG. Funding for cryopreservation and cryostorage does not fall within the financial allocation for assisted conception.

#### **4.14 Surgical sperm retrieval/recovery**

##### *Definition:*

Obtain sperm from the testicles in men who cannot ejaculate or have a blockage in the flow of sperm from their testicles.

##### *Policy statement*

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

### *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.

## **5.0 DISSEMINATION AND IMPLEMENTATION**

The policy will be accessible through the CCG website and will be shared with GP practices and acute organisations who carry out the procedure.

**References:**

1. NICE Clinical Guideline CG11 on Fertility 2004 (NB replaced by CG156)
2. NICE Clinical Guideline CG156. Fertility: Assessment and treatment for people with fertility problems. February 2013
3. NHS Wolverhampton City Assisted Conception Policy
4. NHS Surrey Assisted Conception Policy 2008
5. NHS Dorset, Bournemouth and Poole Fertility-Joint Assisted Conception Policy 2010
6. NHS South Gloucestershire Policy statement on Surrogacy 2011
7. West Midlands Strategic Commissioning Group Surrogacy Policy 2012
8. NICE. Assessment and treatment for people with fertility problems Understanding NICE guidance – information for people with fertility problems, their partners and the public 2004
9. National Collaborating Centre for Women's and Children's Health Fertility: assessment and treatment for people with fertility problems (update). Commissioned by NICE May 2012

**Appendix 1: Wandsworth CCG Criteria for Access to tertiary Assisted Conception, including Intrauterine Insemination (IUI), In Vitro Fertilisation (IVF), Intracytoplasmic Sperm Injection (ICSI)**

Title	Criteria	Rationale
Duration of subfertility	<ul style="list-style-type: none"> <li>Couples will be eligible for referral for treatment if they have experienced twenty four months of unexplained infertility* (this can include up to twelve months before their fertility investigations)</li> <li>or have an identified cause of infertility</li> </ul>	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	<ul style="list-style-type: none"> <li>Woman is aged 23 – 39 years at the time of treatment</li> <li>The lower age limit will not apply to women accessing treatment due to clinical care that is likely to result in long-term infertility</li> <li>Women aged 40 – 42 who have experienced twenty four months of unexplained infertility*, where the following criteria are fulfilled:               <ul style="list-style-type: none"> <li>They have never previously had IVF treatment</li> <li>There is no evidence of low ovarian reserve</li> <li>There has been a discussion of the additional implications of IVF and pregnancy at this age</li> </ul> </li> </ul>	The likelihood of a live birth following assisted conception declines with age. Chances of live birth per IVF cycle are: <ul style="list-style-type: none"> <li>&gt;20% for women aged 23-35</li> <li>15% for women aged 36-38</li> <li>10% for women aged 39 years</li> <li>6% for women aged 40 years and over</li> </ul>
Body mass index of woman	<ul style="list-style-type: none"> <li>19 – 30 kg/m<sup>2</sup> weight to be maintained for the last 6 months prior to application.</li> </ul>	Higher body mass index reduces the probability of success associated with assisted conception techniques
Smoking status of couple	<ul style="list-style-type: none"> <li>Both partners should have been non-smokers for at least six months prior to commencement of treatment.</li> </ul>	Smoking can adversely affect the success rates of assisted reproductive techniques.
Previous cycles	<ul style="list-style-type: none"> <li>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 CCG 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</li> <li>Where couples have self-funded previous cycles, these must not exceed TWO.</li> </ul>	The probability of a live birth following the IVF is consistent for the first three cycles but effectiveness of subsequent cycles is uncertain.
Childlessness	<ul style="list-style-type: none"> <li>Neither partner must have any living children from this or previous relationships (including adopted children)</li> </ul>	As funding for assisted conception is limited, priority will be given to couples with the greatest need.
Sterilisation	<ul style="list-style-type: none"> <li>Treatments will not be available if either partner has undergone previous sterilisation.</li> </ul>	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
<u>HFEA Code of Practice</u>	Couples must comply to a <i>Welfare of the Child</i> assessment as described in the Human Fertilisation and Embryology Authority Code of Practice	<i>Human Fertilisation and Embryology (HFE) Act 1990</i> (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.
Women in same sex couples/ and women not in a partnership	<ul style="list-style-type: none"> <li>Sub fertility treatment will be funded for women in same sex couples or women not in a partnership if those seeking treatment are demonstrably sub fertile.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>Women in same sex couples and women not in a partnership should have access to professional experts in reproductive</li> </ul>	To ensure equality of access to the service.

Title	Criteria	Rationale
	medicine to obtain advice on the options available to enable them to proceed along this route if they so wish.	
FSH	FSH levels should be checked between day 1 and 4 of the menstrual cycle with an LH and 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 referral. For those with no periods the sample can be timed at any date but the same maximum levels apply	

\*women who have not conceived after 24 months of regular unprotected intercourse or 12 cycles of artificial insemination (where 6 or more are by intrauterine insemination). This period may be known as 'expectant management' or 'watchful waiting'.

The content should demonstrably comply with all relevant legal and statutory requirements, NHS guidance and policy in force at the time of writing or reviewing the document. It should include Consultation and Equality Analysis results and any required changes to the document.



