

**Consultation on proposed changes to the future provision of specialist fertility  
treatment in the Cambridgeshire and Peterborough Clinical Commissioning  
Group area**

**Annex 1**

**30 August 2017**

**End of consultation report**

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## 1. PURPOSE OF THIS REPORT

This report is to inform Cambridgeshire and Peterborough Clinical Commissioning Group's (CCG) Governing Body of the responses to the consultation on proposed changes to the future provision of specialist fertility treatment in the Cambridgeshire and Peterborough Clinical Commissioning Group area.

## 2. BACKGROUND TO THE CONSULTATION

This 20-week consultation was to gather feedback on proposed changes to the future provision of specialist fertility treatment in the Cambridgeshire and Peterborough CCG area.

Originally the consultation was planned to be 13 weeks. This was to avoid the pre-election period for the local council and mayoral elections and to give enough time after these elections to hold public consultation meetings.

The consultation was then extended to 20 weeks ending on 31 July 2017 following the announcement of the General Election held on 8 June 2017. The original planned public consultation meetings were cancelled and rebooked to take place in July 2017. These new meetings were widely publicised post election.

As part of discussions about the CCG's financial challenges, GP and clinical leaders came to the difficult conclusion that, when looking at the prioritisation of funds, specialist fertility treatments were an area that should be reviewed. The CCG has finite resources to fund a whole range of health services and treatments. Currently the CCG is overspending against this resource level, with a planned deficit in 2017/18 of £15.5m, and hence must consider options to address this position.

### **The Proposal**

To stop routinely commissioning any specialist fertility services other than for two specified exceptions.

Specialist fertility services are expensive treatments. Due to financial constraints the CCG has looked at a number of areas where savings could be made. Specialist fertility services is one of those areas.

Other investigations and clinical interventions that can improve fertility for couples are widely available via NHS services before the need to access specialist fertility services. **These other services will not be affected by this proposal.**

Specialist fertility services, or IVF as these services are more commonly known, only became available on the NHS in this area in September 2005. Prior to this, patients had to pay for their own IVF treatment.

Approximately 200 people accessed IVF services in 2015/16. Although this is a small number of patients the CCG is aware that this proposal may have a significant impact on those affected by this proposed change.

The CCG's existing policy on funding for specialist fertility services, known as the Assisted Conception policy, was developed in April 2015 in collaboration with the East of England Fertility Services Consortium and amended in 2016. The CCG currently commissions the following treatments, as appropriate, for couples who meet evidence-based eligibility criteria:

- one cycle of IVF, with or without Intracytoplasmic Sperm Injection (ICSI). Intracytoplasmic Sperm Injection follows on from egg collection and involves injecting a single sperm into the centre of each mature egg to help fertilisation to occur;
- surgical sperm removal;
- up to six cycles of donor sperm insemination with Intrauterine Insemination (IUI). IUI is a form of assisted conception treatment involving the injection of prepared sperm into the womb at the time of ovulation;
- treatment using egg donation;
- egg, sperm, or embryo cryopreservation for men and women undergoing cancer treatment which is likely to cause infertility; and
- ICSI with or without sperm washing for men who have a chronic viral infection (primarily HIV) and whose female partner does not.

The current policy is specifically for those couples who are registered at a GP practice in the CCG's area and who do not have a living child from their current, or any previous, relationship(s) prior to starting NHS-funded treatment, regardless of whether or not the child resides with them. This includes any adopted child from their current or previous relationships.

**Please note:**

It is only in cases where patients' eggs and/or sperm need retrieving and laboratory fertilisation techniques are needed that there is onward referral to the specialist centres (IVF clinics).

**Services for patients with genetic disorders requiring pre-implantation diagnosis and embryo selection based on this are commissioned by NHS England and are not affected by this consultation.**

Whatever decision is made, this proposal will be reviewed at the end of the funding formula period in April 2019.

### **3. RAISING AWARENESS OF THE CONSULTATION**

As part of the pre-consultation stage for this consultation the draft documents, consultation process plan, and proposal were shared with the following groups:

- CCG Governing Body
- CCG Patient Reference Group
- Cambridgeshire Health Committee
- Peterborough Health Scrutiny Commission
- Hertfordshire Health Scrutiny Committee

- Northamptonshire Adult Care and Wellbeing Scrutiny Committee
- Healthwatch Cambridgeshire
- Healthwatch Peterborough
- Fertility Network UK

We also met with Bourn Hall to discuss the draft consultation documents. Suggestions for changes to the draft documents were considered and adopted where appropriate. Further engagement with providers was necessary before the proposals were agreed to go to formal consultation.

The consultation document was drawn up in accordance with the following requirements and guidance:

- Cabinet Office Consultation Principles July 2012
- Section 14Z2 Health and Social Care Act 2012
- Criteria for Significant Service Change
- Cambridgeshire and Peterborough CCG’s Constitution and Communications and Engagement Strategy.

#### **4. CONSULTATION**

The consultation ran for 20 weeks from 13 March 2017 to 31 July 2017.

##### **4.1 Consultation documents and other consultation materials**

The following documents were made available in hard copy and/or on the CCG website during the consultation:

- CCG Assisted Conception Policy
- The consultation document
- GP Care Pathway for Fertility Services
- IVF consultation public meeting poster
- Draft impact assessments.

##### **4.2 Consultation meetings**

The following consultation meetings were held during the consultation period:

<b>Date</b>	<b>Meeting Time</b>	<b>Venue</b>
10 July 2017	12.30–1.30pm	The Fleet, <b>Peterborough</b>
10 July 2017	6-7pm	The Fleet <b>Peterborough</b>
11 July 2017	6-7pm	The Boat House, <b>Wisbech</b>
13 July 2017	6-7pm	The library,

		<b>Huntingdon</b>
18 July 2017	6-7pm	The Cathedral Centre, <b>Ely</b>
20 July 2017	12.30-1.30 pm	Central Library <b>Cambridge</b>
20 July 2017	6-7pm	The Meadows, <b>Cambridge</b>

### 4.3 Distribution

During the consultation 9,300 hard copy consultation documents were distributed across the whole CCG area.

Consultation documents were distributed by email with hard copies being sent to the following groups, individuals, and locations:

- GP practices
- Pharmacies
- Stakeholder database including:
  - MPs
  - Local representative groups
  - Support organisations
  - Voluntary sector organisations
  - Members of the public
- Libraries
- Maternity/fertility units
- Healthwatch: Cambridgeshire, Hertfordshire, Peterborough, Northamptonshire
- Communications leads (STP Communications Cell)
- Scrutiny/Health Committees: Cambridgeshire, Hertfordshire, Peterborough, Northamptonshire
- Health and Wellbeing Boards: Cambridgeshire, Hertfordshire, Peterborough, Northamptonshire
- Social Partnership Forum
- CCG staff
- GP Members
- CCG Patient Reference Group
- CCG Governing Body
- CCG Clinical Executive Committee.

The CCG issued a press release at the beginning of the consultation period to let people know that the consultation was starting and to publicise the public meetings.

Due to the extended pre-election period for the snap General Election the planned public meetings had to be postponed and a statement was issued to let people know. A further press release was issued after the General Election to notify people of the rescheduled dates of the public meetings.

The CCG also put advertisements in the local press to advertise the new meeting dates, as follows:

- Royston Crow
- Hunts Post
- Wisbech Standard
- Cambridge Times
- Cambridge News
- Ely Standard
- Fenland Citizen
- Peterborough Telegraph.

#### 4.4 Media Coverage

The CCG issued a number of press releases which helped to publicise the start of the consultation and the public meetings. Press releases were also issued to advise that the consultation had been extended and that the public meetings had been rearranged.

The consultation had the following media coverage:

Publication	Type of coverage	Date
1. Peterborough Telegraph	Article: IVF treatment set to end for Peterborough residents in cost-cutting measure	13/03/2017
2. Ely Standard	Article: Fertility services could be cut back to basics as part of money saving measures by health bosses	13/03/2017
3. Cambridge News	Article: Dismay at proposed cuts to NHS-funded IVF treatment in Cambridgeshire	13/03/2017
4. Cambridge News	Article: Plan to cut IVF funding on NHS 'devastating'	14/03/2017
5. ITV Anglia	Broadcast: Consultation into proposed cuts to 'specialist' fertility treatments across Cambridgeshire	14/03/2017
6. ITV Online	Online: Have your say on plans to cut NHS IVF fertility treatment across Cambridgeshire	14/03/2017
7. Peterborough Telegraph	Online: 'You can't put a cost on a life' - calls for rethink on cutting IVF for Peterborough residents	15/03/2017
8. Peterborough Telegraph	Article: Speak out to save NHS IVF	16/03/2017
9. Cambs Times	Article: Fertility services targeted for cuts	17/03/2017
10. Hunts Post	Article: Plan could see cut to fertility treatments	29/03/2017
11. Cambridge News	Online: Petition launched against 'heart-breaking' proposals to cut NHS-funded IVF	04/04/2017

	treatment	
12. Cambridge News	Online: IVF cuts plan sparks petition Health	05/04/2017
13. Peterborough Telegraph	Online: Meetings on cuts to IVF service postponed	06/05/2017
14. Peterborough Telegraph	Article: Meetings on cuts to IVF service postponed	06/05/2017
15. Pulse	Online: CCG rationing continues as NHS completely scrap free fertility treatment	09/05/2017
16. Peterborough Telegraph	Article: Have say on IVF plans	29/06/2017
17. Cambridge News	Article: More than 1,500 people sign petition to keep IVF treatment on the NHS in Cambridgeshire	13/07/2017
18. BBC Radio Cambridgeshire	Broadcast: A series of public meetings is underway about plans to stop all NHS-funded IVF treatment in Cambridgeshire and Peterborough	13/07/2017
19. Cambridge News	Article: Bid to keep IVF treatment on NHS	14/07/2017
20. Cambridge News	Cambridge IVF Funding ban proposal 'infertility affects you deeply like a primal calling to have children'	26/07/2017
21. Cambridge News	Hundreds of couples to be denied chance to have baby due to IVF funding cuts	
22. Hertfordshire Mercury	Hertfordshire NHS IVF provider Bourn Hall criticises NHS consultation which could see treatment axed	28/07/2017
23. Cambridge News	Article: Campaigners hit out at proposals to cut IVF funding	28/07/2017
24. Cambridge News	Online: Campaigners hand in 1800 signature petition	31/07/2017
25. Cambridge News	Article: Petition to save IVF funding	01/08/2017
26. The Guardian	IVF cut back in 13 areas of England to save money, new data shows	06/08/2017
27. The Daily Telegraph	IVF could be restricted to women aged 35 and under	06/08/2017
28. Mail Online	More hospitals to stop offering IVF on the NHS: Further eight to consult on restricting treatment as a result of health budget cuts	06/08/2017
29. ITV	Warnings over cuts to IVF treatment on NHS in some areas	07/08/2017
30. OnMedicanet	Couples facing IVF 'postcode lottery'	07/08/2017
31. Cambridge News	Calls for NHS bosses to 'reconsider' IVF funding cuts	07/08/2017

## 4.5 CCG website and social media channels

A page dedicated to the consultation was created in the 'Get Involved' section of the CCG's website. The page could also be accessed from a link on the homepage.

Documents relating to the consultation were made available on this page in pdf format as follows:

- CCG Assisted Conception Policy
- The consultation document
- GP Care Pathway for Fertility Services
- IVF consultation public meeting poster.

A link to the consultation page on the website was publicised via the CCG's Facebook page and Twitter feed. Details about the public consultation meetings were also advertised via our social media channels.

During the consultation we publicised posts encouraging people to take part in the consultation and attend the public meetings. A summary of the data is set out below:

### Twitter

- Number of tweets: 37
- Impressions (number of times users saw the tweet on Twitter): 25,466
- Link clicks: 72
- Retweets: 55

### Facebook

- Number of Facebook posts: 40
- Reach: 19,212
- Link clicks: 90
- Shares: 71

Data shows that the web page was visited 3,884 times during the consultation. The documents were downloaded as shown in the table below:

<b>Documents and number of downloads</b>	
CCG Assisted Conception Policy	2
The consultation document	286
GP Care Pathway for Fertility Services	5
IVF consultation public meeting poster	0

#### 4.6 Response details

<b>Attendees at public meetings</b>	
Number of people attending	20
Number of people at other meetings attended during consultation	20
<b>Total</b>	<b>40</b>
<b>Enquiries received</b>	
Email	10
Phone	5
Letters from individuals	2
<b>Total</b>	<b>17</b>
<b>Consultation responses received</b>	
Formal responses (groups, statutory bodies, unions, campaign groups)	10
Completed online surveys	1245
<b>Total</b>	<b>1254</b>
<b>Overall total</b>	
	<b>1311</b>

#### 4.7 Responses from organisations

We received a number of responses from organisations, groups, and individuals. The questions and comments raised are included in Section 4.9.

We received responses from the following groups and organisations:

- Bourn Hall
- Cllr Richard Johnson, Chair of the Cambridge Local Health Partnership and Executive Councillor for Communities, Cambridge City Council
- Fertility Network UK
- Healthwatch Cambridgeshire
- Daniel Zeichner MP
- Shailesh Vara MP (Shailesh Vara MP forwarded two letters from constituents expressing their concern about these proposals. They are not published in this report due to the letters containing patient identifiable data)
- Peterborough Health Scrutiny
- Dr Alistair Brown
- Unison
- Cambridgeshire Health Committee.

## 4.8 Petition

We received a petition of 2,278 signatures from Stuart Tuckwood on behalf of the Green Party. On the petition 74.85% of signatories reported a postcode either within, or partially within, the CCG area. This was run on the 38 degrees website.

## 4.9 Themes emerging from the consultation responses

Overall the individual responses to the consultation did not support the proposal. None of the responses received from organisations supported the proposal. We have included the full copy of the responses received from organisations as Appendix B below. Where the responses contained patient identifiable information we have not included them. The issues raised have been included in the section below.

### **The CCG should not stop funding this service but look at other areas to save this money.**

Many people who responded to the consultation told us that this seemed like the wrong service to cut. People felt that the proposed savings should be found from other areas and that the CCG should look at other services to make cuts. They also felt that this service should be left as it is at one funded IVF cycle. Some people suggested that pharmacy or medicines management could be an area where savings could be found. Others suggested that services for people who chose unhealthy lifestyles could be looked at.

Healthwatch Cambridgeshire and Cambridgeshire Health Committee have suggested that a prioritisation exercise should be undertaken to look at which services should be considered for cost savings. Peterborough Scrutiny Committee commented that the savings did not justify the loss of this service.

### **CCG response**

The CCG has significant financial pressures. Cambridgeshire and Peterborough has been identified as one of England's 11 most financially challenged health economies. It has a growing population which is ageing, diverse, and has significant inequalities. We have a limited budget and a growing demand for all types of healthcare services, as well as a financial deficit that needs to be cleared. Against this backdrop the CCG has to evaluate services that it commissions to see if they offer good quality, good outcomes, and good value for money, as well as whether it is an effective and equitable way of allocating our resources for the benefit of the whole population. If the CCG Governing Body decides in favour of the proposal the CCG is forecasting a saving of £700,000 per annum recurrently.

### **The CCG should stop funding services for people who have conditions that are brought on by their lifestyle choices such as drug and alcohol**

### **addictions or obesity.**

Many people suggested that people who chose unhealthy lifestyles or who became addicted to drugs or alcohol should not receive services. They should manage their own addictions or lifestyle and not have funded services on the NHS. People felt it was unfair to pay for those services but not fund IVF. We were told that people who are going through infertility investigations are often advised to eat healthily and maintain a healthy weight in order to maximise their chance of conception.

### **CCG response**

The NHS gives advice to patients on weight loss prior to certain treatments and surgeries in order for the patient to achieve the best recovery they can. The NHS supports people with drug and alcohol addictions through mental health services to understand what has caused the addiction. Smoking cessation services are funded through public health, as smoking related illnesses are much more expensive to treat than supporting people to stop smoking before the illnesses develop.

Supporting people to live healthy lifestyles is an everyday part of the health service and is delivered by public health, community services, GPs and practice staff working together to prevent illness and improve health of the local population. We have looked at a number of service areas for reducing availability. For example, we are reviewing referral access for all acute hospital specialities. The CCG has also been reviewing the clinical thresholds policies and restricting access to other procedures to only include patients who will receive sufficient health gain; as well as reducing prescribing of medicines that can be bought over the counter without prescription.

### **NICE guidance states that people should receive three cycles of IVF for women under 40 years of age and one cycle for women aged 40-42 years of age.**

People who responded to the consultation felt that the CCG should be adhering to the national NICE guidance. Healthwatch Cambridgeshire commented that the NHS Constitution enshrines the rights of patients to have access to NICE approved treatments.

Many of the organisations who responded to the consultation quoted this NICE guidance.

### **CCG response**

The CCG makes decisions about how to commission or buy health services for the local population in this area. NICE guidance is national guidance, it is not mandatory. The CCG understands that this proposal is difficult for people who are impacted individually. However we need to balance where we spend

our money to ensure that we can meet the needs of our population when they are ill or need lifesaving treatment.

### **What happens to people already in the system? What will happen to people who already have frozen embryos?**

People expressed concerns about those who had already been referred for IVF treatment but were waiting for their first appointment or to start their course of treatment. Concerns were also raised about people who, as part of their NHS funded IVF treatment, had their embryos frozen. People were concerned about what would happen to those embryos.

#### **CCG response**

People who have already been referred to the specialist fertility treatment service from their secondary care specialist will continue to receive the one cycle of IVF as part of the July 2016 policy. People who have had the one cycle of IVF treatment but still have frozen embryos will still go ahead with that implantation as it is considered to be part of the same cycle of IVF. One cycle of IVF includes one fresh embryo implantation and one frozen embryo implantation.

If the decision is to adopt the proposals then people who have not yet been referred from the secondary care specialist for specialist fertility treatment will be affected. The Governing Body decision is due to be taken on 5 September 2017.

### **How did you decide on the two exceptions?**

People wanted to know why the CCG had decided on these very specific exceptions. People told us that they felt the exceptions were too limited and that other long-term conditions should be considered. Healthwatch Cambridgeshire wanted to know which diseases or conditions would be included in these exceptions.

#### **CCG response**

The proposal has two exceptions outlined:

- fertility preservation will be offered to patients undergoing cancer treatment, or who have a disease or a condition requiring medical or surgical treatment, that has a significant likelihood of making them infertile. The specialist fertility treatment that will still be available for people who may be having treatment that can cause infertility is for those patients to have their eggs or sperm frozen, not access to IVF once the treatment is complete.
- sperm washing will be provided to men who have a chronic viral infection (primarily HIV) and whose female partner does not, where intrauterine insemination is being considered. This is a risk reduction measure to limit the transmission of a serious, pre-

existing viral condition such as HIV to the woman and therefore, potentially, her unborn baby.

The first exception is to support people who otherwise would not have any fertility issues. The treatment they will receive for other causes will result in them becoming infertile.

The second is to protect the unborn children and female partners of men with HIV. HIV can be contracted in a number of ways.

**Infertility caused by treatment being treated differently to infertility caused by a long-term condition such as PCOS (polycystic ovary syndrome), endometriosis, hypogonadism, cystic fibrosis etc.**

Many respondents queried why people who had a diagnosed condition that caused infertility would be treated differently to those whose treatment had caused the infertility. People felt this was unfair as the anxiety and distress was the same however the infertility was caused. Fertility Network UK pointed out that the World Health Organisation classes infertility as a disease. They quoted Simon Stevens, Chief Executive of NHS England, as publicly stating that ultimately the basis on which people get care on the NHS should be their ability to benefit from treatment. This point was also raised by Bourn Hall and Unison.

**CCG response**

Specialist fertility treatment that will still be available for people who may be having treatment that can cause infertility is for those patients to have their eggs or sperm frozen. They will not have access to IVF once the treatment is complete. These patients, as well as any other patients, can apply for funding under an Individual Funding Request. In order to be successful in applying for this funding they must demonstrate that their case is an exception to others in a similar position.

**The CCG should consider the costs of not funding IVF on the NHS.**

People felt that there would be increased costs for mental health support for those people who cannot afford to pay for their IVF treatment privately. This point was also raised by Cambridgeshire Health Committee, Healthwatch Cambridgeshire, and Unison. There could also be increased costs associated with multiple births. If people go abroad for IVF treatment because it is cheaper than in the UK, they will be given multiple implantations which can result in multiple births. The extra costs for multiple birth pregnancies and care would then have to be met by the NHS. Bourn Hall, one of the CCG's current providers for IVF, mentioned that their single embryo transfer policy has minimised the likelihood of multiple births. Bourn Hall also raised the issue of safety and standards of clinics not in the UK. They state in their response that the level of legal or regulatory standards of clinics overseas

varies greatly and not all countries have organisations equivalent to the Human Fertilisation and Embryology Authority (HFEA). Some places have no specific laws or regulations relating to assisted reproductive services. Also, multiple births are 17 times more likely to be pre-term, requiring caesarean section and ongoing care due to complications.

Fertility Network UK quoted The Impact of Fertility Problems 2016 from Fertility Network UK with Middlesex University London which highlighted:

- 90% of respondents reported feeling depressed; 42% suicidal; nearly 50% of respondents reported on average feeling sad, out of control, frustrated, helpless, fearful, and worried nearly all of the time
- 70% reported some detrimental effect on their relationship with their partner.

### **CCG response**

These issues will be part of the consideration by the Governing Body when it discusses the feedback from this consultation and makes a decision about the future of specialist fertility services.

Any increase in costs that may be incurred would mainly be in the area of multiple births and it is recommended that this is kept under review. The number of patients receiving IVF – approximately 200 per annum - is very small compared to the total number of people who develop mental health conditions each year. If individuals did find themselves experiencing some mental health problems, even if that was every patient, the cost pressure would not be significant. However, we do recognise that for these 200 patients there would be a considerable personal cost.

The CCG commissions a wide range of mental health services from GP-centred care, community wellbeing services, and community mental health services through a wide range to inpatient and cluster care for a range of mental health conditions.

As a snapshot to give an idea of the numbers of people who may require access to mild to moderate psychological therapies, the CCG has provided IAPT (increased access to psychological therapies) for 15,781 people in 2016/17. This is set to increase year-on-year in line with national targets, based on calculated prevalence of people with mild to moderate anxiety and depression.

The CCG has contacted other CCGs who have already adopted the proposed policy to ask whether there has been an increase in mental health costs associated with patients impacted by the inability to access specialist fertility

services. Each CCG that responded told the CCG that no direct correlation has been seen at this stage.

### **The costs of IVF per cycle.**

Both Healthwatch and Cambridgeshire City Council raised the issue of how much the CCG pays per cycle for NHS patients. Healthwatch quoted between £5-7000 per patient and Cambridgeshire City Council quoted between £4-8000 per cycle. Healthwatch felt the cost per cycle was high compared to other CCGs. Cambridgeshire City Council raised this issue that this amount of money would be difficult for people on low incomes if they were not eligible for NHS funded IVF treatment.

### **CCG response**

It is difficult to quote a cost per cycle for IVF treatment. Each case is individual and has different cost due to the differing drugs and treatments needed by the patient to make this as successful as possible. These costs can vary enormously. However the average cost per patient is £3000 per cycle. Please note that is on NHS tariffs and is not comparable to privately funded care.

### **Why isn't this a national decision?**

People understood that in some areas in the UK you can still receive three cycles of NHS-funded IVF and challenged why there should be disparity across the country. People felt that this should be a national decision.

### **CCG response**

Each CCG receives a budget from the Department of Health to provide health services for its area. In this area we have a patient population of approximately 950,000 which is diverse, ageing, and has significant inequalities. We manage a budget of around £1.1 billion to spend on healthcare for the whole population of this area, which is just over £1,000 per person. The amount each CCG receives is different and the population and health needs of each CCG area are different. It is the responsibility of the CCG working in collaboration with Public Health and health providers to understand the health needs of its population and to manage the budget to provide the appropriate services to meet those needs.

### **The CCG should consider making this a means tested service.**

People should be given the opportunity to part fund their treatment if they can afford to do so rather than cutting the funding altogether. This was also suggested by Cambridgeshire Health Committee and by Dr Alistair Brown.

### **CCG response**

The NHS is not able to means test for services. The services need to be provided for all, or only for specified people with strict eligibility criteria.

### **The CCG should tighten the eligibility criteria.**

It was suggested that reducing the age range, or making the eligibility criteria much more strict, would make some savings rather than cutting funding altogether.

#### **CCG response**

The consultation on this proposal was undertaken to gather views and hear suggestions from members of the public. The feedback will be considered as an option by the Governing Body before making a decision.

### **The consultation process**

People asked the CCG where the consultation was publicised.

#### **CCG response**

The CCG sent copies of the consultation document to all GP practices, pharmacies, and libraries in the area. We also emailed the document to all our current infertility treatment providers and key stakeholders. It was publicised on the CCG website and social media outlets as well as being highlighted by stakeholder groups across the area. There have been a number of media interviews promoting the consultation and we placed advertisements in the local media for all the public meeting dates following the General Election.

### **People asked the CCG why the consultation was extended.**

They also asked why we had to cancel the originally planned public meetings and rearrange them. Healthwatch Cambridgeshire also commented on this, although they understood the need to cancel the planned public meetings.

#### **CCG response**

The consultation started on 13 March 2017 and was initially to end on 12 June 2017. The closing date was extended to 31 July 2017 after the General Election was called to allow time to hold public meetings once the election result had been announced. The CCG is not permitted to hold consultation meetings during the run up to council or general elections. Due to the snap election being announced we had to cancel the original public meeting dates and rearrange them for after the General Election. The consultation was extended from 12 June 2017 to 31 July 2017 in order to allow enough time for us to rearrange public meetings and publicise them. The consultation ran for a total of 20 weeks. The rearranged public meetings were widely publicised via paid advertisements in all of the local newspapers across the CCG area as well as online and via email. Details of the rearranged meetings were sent to all GP practices in the area and key stakeholder groups.

### **People commented on why we were holding the consultation.**

They felt that the proposal was very clear and that if the CCG needed to save this money then we would go ahead and do it anyway.

### **CCG response**

The CCG genuinely wanted to hear people's views and suggestions on this proposal. The CCG is a financially challenged organisation but it is important to us to ensure that the services we provide meet the needs of our population. All responses to this consultation, including the views expressed at the public meetings, will be reported to the Governing Body. The Governing Body needs to consider all the feedback before it makes a decision. No decisions have been made; this is still a proposal at this stage.

### **Inequity**

People responding to the consultation, as well as Healthwatch Cambridgeshire and Cambridge Local Health Partnership, felt that the proposal would not only create a postcode lottery of where you can and cannot receive IVF services and the number of IVF cycles offered, but was also creating inequalities. People felt that it was unfair to those on low incomes who may not be able to raise the money to pay for privately funded IVF services. This would create inequity for those facing infertility. Healthwatch Cambridgeshire and Cambridge Local Health Partnership asked about our equality impact assessments.

### **CCG response**

The CCG completed a suite of impact assessments before starting the consultation on these proposals. All of these impact assessments will be updated to incorporate responses to the consultation and will form part of the documents presented to the Governing Body to assist in the decision-making process. They are listed at the end of this report at Appendix D.

### **The consultation process highlighted a number of themes. These are set out below:**

- Infertility is a medical treatment that deserves NHS funding.
- This should be a national decision not a local one.
- This sets up a postcode lottery where you can get three cycles of NHS-funded IVF if you live in some parts of the country, two or one in others, but nothing here.
- This is discrimination - both sector and gender.
- Those on lower incomes will be the most affected
- If the decision is taken to cut IVF funding it will be devastating for couples. It will cause enormous distress for couples and the implications to other aspects of the health service will be greater than the money you are trying to save.
- You are stopping life evolving.
- The NHS should save lives not create them.
- It should not be about the money it should be about the people.

- The NICE guidelines say each eligible patient should get three cycles of NHS funded IVF, how can you ignore that guidance?
- The NHS should be able to means-test for services. Those who can afford to pay should do so, but those who can't afford to pay should receive NHS-funded IVF.
- There is too much administration and bureaucracy in the NHS. You should cut money from those areas before you start cutting services.
- The NHS should publish a price list for services, then people would understand how much NHS services cost. They would think twice about how they used NHS services if that was the case.
- There would seem to be little point in offering investigations into infertility if you are offering no hope of treatment.
- What happens to people already in the system?
- What will happen to people who have frozen embryos from a cycle of IVF?
- Why not tighten the eligibility criteria? You could restrict the age range or use success criteria as eligibility. That would reduce the costs while still giving some people a chance.
- The exceptions are too limiting.
- The exceptions seem reasonable.
- This seems like a reasonable proposal.
- Unfortunately the NHS needs to be focussed on treatments and services that are life-saving only; this doesn't fall into that category.
- Will other services be cut? Is this the thin end of the wedge?

## 5. Recommendation

The Governing Body is asked to approve the proposals outlined in the consultation but, in doing so, to review and consider all the comments and feedback from the public, and the consultation process. The Governing Body is also asked to consider the revised impact assessments when making the following decisions:

- To suspend, until April 2019, routinely commissioning any specialist fertility services other than for two specified exceptions which are:
  - Fertility preservation will be offered to patients undergoing cancer treatment, or who have a disease or a condition requiring medical or surgical treatment, that has a significant likelihood of making them infertile. The specialist fertility treatment that will still be available for people who may be having treatment that can cause infertility is for those patients to have their eggs or sperm frozen, not access to IVF once the treatment is complete.
  - Sperm washing will be provided to men who have a chronic viral infection (primarily HIV) and whose female partner does not, where intrauterine insemination is being considered. This is a risk reduction measure to limit the transmission of a serious, pre-existing viral condition such as HIV to the woman and therefore, potentially, her unborn baby.

- Agree that all other investigations and clinical interventions that can improve fertility for couples are widely available via NHS services before the need to access specialist fertility services.
- Agree to review the proposal, irrespective of the Governing Body's decision, at the end of the funding formula period in April 2019. The review of the provision of specialist fertility services (IVF) will be made in April 2019, if necessary, and will include an assessment of the CCG's financial position, including the impact of the withdrawal of the service on multiple birth levels and any impact experienced by mental health services.

In response to the feedback to the consultation it is also recommended that the CCG:

- Monitors through contracts with providers, where contractually possible, multiple births via first round of IVF that have taken place abroad and any associated complications.
- Reviews the decision with recommendations to the Governing Body at the end of the funding formula period in April 2019. The review of the provision of specialist fertility services (IVF) will be made in April 2019, if necessary, and will include an assessment of the CCG's financial position, including the impact of the withdrawal of the service on multiple birth levels and any impact experienced by mental health services.
- Recommends that the CCG writes to providers to ask them to monitor the following wherever possible
  - Any significant increase in multiple births from IVF patients
  - Any significant increase in mental health referrals from patients who are unable to receive IVF treatment as a direct result of the decision to cease funding this service

## APPENDICES

### Appendix A – Statistical responses to the survey

#### Statistical responses to date

The following are the numbers of responses we have had to the main questions in the consultation survey:

**Question 1:** Do you understand why the CCG has proposed to stop the routine commissioning of any specialist fertility services other than two specified exceptions as described below?

Exceptions to the proposal:

Under the proposal, specialist fertility services would no longer be commissioned except for the following two exceptions listed below:

- i. fertility preservation will be offered to patients undergoing cancer treatment, or who have a disease or a condition requiring medical or surgical treatment, that has a significant likelihood of making them infertile; and
- ii. sperm washing will be provided to men who have a chronic viral infection (primarily HIV) and whose female partner does not where intrauterine insemination is being considered. This is a risk reduction measure to limit the transmission of a serious, pre-existing viral condition such as HIV to the woman and therefore, potentially, her unborn baby.

Answer Choices–	Responses–
– <b>Yes, I understand ceasing specialist fertility services would save approximately £700,000 per annum, investigations would still be available and there would be two exceptions as outlined above.</b>	<b>82.78%</b> 798
– <b>No, I do not understand</b>	<b>14.73%</b> 142
– <b>I need more information</b>	<b>2.49%</b> 24
Total	964
<a href="#">Comments(226)</a>	

**Question 2:** Do you agree with the proposal to stop the routine commissioning of specialist fertility services other than two specified exceptions as described below?

Exceptions to the proposal:

Under the proposal, specialist fertility services would no longer be commissioned except for the following two exceptions listed below:

- i. fertility preservation will be offered to patients undergoing cancer treatment, or who have a disease or a condition requiring medical or surgical treatment, that has a significant likelihood of making them infertile; and
- ii. sperm washing will be provided to men who have a chronic viral infection (primarily HIV) and whose female partner does not where intrauterine insemination is being considered. This is a risk reduction measure to limit the transmission of a serious, pre-existing viral condition such as HIV to the woman and therefore, potentially, her unborn baby.

Answer Choices	Responses
<input type="radio"/> Yes, I agree	<b>16.36%</b> 159
<input type="radio"/> No, I do not agree	<b>82.00%</b> 797
<input type="radio"/> Undecided	<b>1.65%</b> 16
Total	972
<a href="#">Comments(365)</a>	

**Question 3:** Do you agree that the two exceptions proposed, as described below in this consultation document are appropriate?

Exceptions to the proposal:

Under the proposal, specialist fertility services would no longer be commissioned except for the following two exceptions listed below:

- i. fertility preservation will be offered to patients undergoing cancer treatment, or who have a disease or a condition requiring medical or surgical treatment, that has a significant likelihood of making them infertile; and
- ii. sperm washing will be provided to men who have a chronic viral infection (primarily HIV) and whose female partner does not where intrauterine insemination is being considered. This is a risk reduction measure to limit the transmission of a serious, pre-existing viral condition such as HIV to the woman and therefore, potentially, her unborn baby.

<b>Answer Choices</b>	<b>Responses</b>
– <b>Yes, I agree with the two exceptions</b>	<b>26.84%</b> 259
– <b>No, I do not agree with the two exceptions</b>	<b>64.56%</b> 623
– <b>Undecided</b>	<b>8.60%</b> 83
Total	965
<a href="#">Comments(348)</a>	

**Appendix B – Organisation responses to the consultation**

**Bourn Hall**  
FERTILITY CLINIC

Submission to the Cambridge and  
Peterborough CCG consultation on  
Specialist Fertility Treatment  
July 2017



## What NICE say - Clear National Guidance

Dr Gill Leng, Deputy Chief Executive, NICE,

- "Infertility is a medical condition that can cause significant distress for those trying to have a baby. This distress can have a real impact on people's lives, potentially leading to depression and the break-down of relationships. However, in many cases infertility can be treated effectively - there are thousands of babies and happy parents thanks to NHS fertility treatment - which is why the NHS provides services and why NICE produces guidance on the topic.

NICE Recommended provision

- In women aged under 40 years who have not conceived after 2 years of regular unprotected intercourse offer **3 full cycles of IVF, with or without ICSI and up to 3 cycles of frozen embryo transfer**
  - If the woman reaches the age of 40 during treatment, complete the current full cycle but do not offer further full cycles.
- In women aged 40–42 years who have not conceived after 2 years of regular unprotected intercourse offer **1 full cycle of IVF, with or without ICSI and 1 frozen embryo transfer**

## What Bourn Hall says - View from the provider

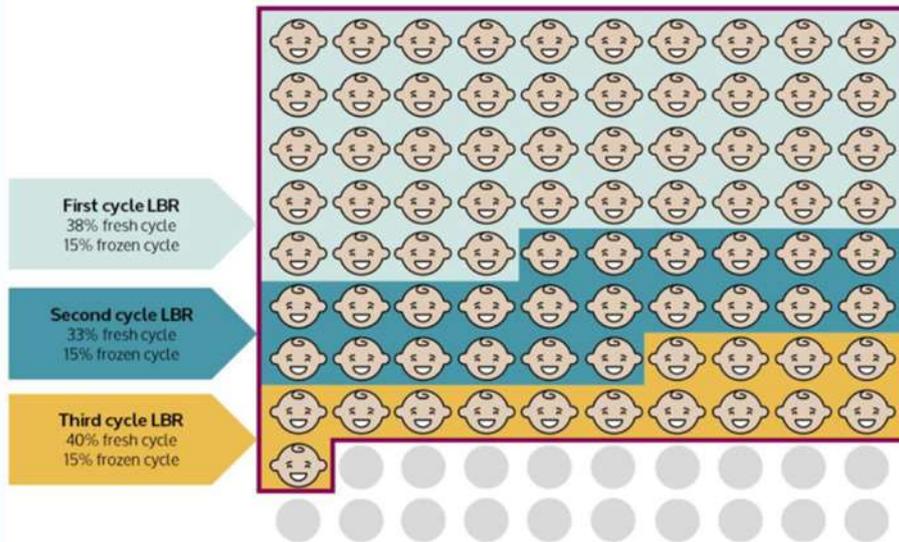
We believe to remove the tertiary care element of this pathway would be a retrograde and discriminatory step which will leave a significant number of Cambridge and Peterborough residents with no hope. We believe the likely impact of withdrawal of NHS entitlement will be an increase in cost to the NHS greater than any savings, as patients will seek low cost treatment abroad returning to NHS care with higher order multiple pregnancies and other complications of unregulated IVF.

- Infertility is a painful medical condition affecting one in six couples
- Data shows that 40% of those with fertility problems suffer clinical depression and anxiety because of their inability to have children. Other studies show fertility patients have similar stress levels to those with cancer. Infertility is a "disease" and those afflicted need treatment.
- On average 120 couples per year are referred to Bourn Hall from Cambridge and Peterborough CCG catchment
  - Close to 40% of these couples become parents on the first attempt and a further 35% on the second attempt – all singleton births
- Our single embryo transfer policy has minimised the likelihood of multiple births in these patients while maintaining world class success rates
- **Standards and Safety abroad**

The level of legal or regulatory standards of clinics overseas varies greatly and not all countries have organisations equivalent to the HFEA. Some places have no specific laws or regulations relating to assisted reproductive services.
- Multiple births are 17 times more likely to be pre-term, requiring caesarean section and ongoing care due to complications
- A twin pregnancy costs at least six times more than a singleton and a triplet 18 times more for the delivery and first year of life
- See links here for report and data:  
<http://www.irishtimes.com/opinion/why-fertility-treatment-deserves-state-funding-1.2355721>

Diagram showing how many Cambridge and Peterborough patients became mothers – part of Press release (Appendix A)

**8 out of 10 women undergoing up to three cycles of IVF (per NICE guidelines) become mothers**





## Appendix A press release Bourn Hall

### 8 OUT OF 10 CAMBRIDGE NHS PATIENTS HAVE A BABY WITH 3 IVF CYCLES

Bourn Hall suggests that a more integrated approach is taken to fertility treatment

“Infertility does affect you deeply; it is like a primal calling to have children. I would have really struggled if I had not been able to have a baby,” says Laura Foley, from Fulbourn, devoted mum to IVF baby Alfie. She feels a deep sense of sadness that others may not have the chance that she was given. Plans are being discussed to remove all NHS funding for specialist fertility treatment in Cambridgeshire.

Laura, who works with disabled adults, understands how difficult the funding landscape has become and says that she and husband Michael feel “really blessed” that their treatment was funded.

“Who knows? If we had left it another year we might not have been able to have NHS- funded treatment.”

Laura and her husband had treatment at Bourn Hall, the world’s first IVF clinic established almost 40 years ago, which provides treatment to NHS and self-funded patients..

Dr Mike Macnamee CEO of Bourn Hall says success rates have continually improved. When Cambridge implemented the NICE recommendations of 3 cycles of treatment 8 out of 10 couples became pregnant and had a baby (see diagram)

Dr Macnamee comments: "Infertility is a medical condition, that causes severe mental distress and it deserves better diagnosis at an earlier stage.

"Recent cuts in funding have signalled that this area of medicine is not a priority and as a result the causes of infertility are also not being properly investigated. The risk is that even couples who might conceive naturally will miss out on having a baby as they are not being given relevant advice or medication."

"We have proposed a more integrated approach that would involve GPs and fertility specialists working more closely together would streamline the system, create better outcomes and be more cost-effective for the CCGs."

Multiple births increase the chances of complications and premature babies. The policy of single embryo transfer for NHS funded patients has resulted in a reduction in the number of multiple births from 25% to 6% in the last three years.

Dr Macnamee warns: "Withdrawal of funding will encourage people to go abroad for treatment where clinics are not closely regulated and a few returning with multiple pregnancies will wipe out any saving from cutting IVF funding."

90 percent of CCGs fund one or more cycle of IVF - if Cambridge cuts all funding it will be one of only 5 CCG's across England to do so.

-ENDS-

Enquiries  
to: Richard  
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Executive Councillor for  
Communities Mobile: 07712  
129529  
E: Richard.Johnson@cambridge.gov.uk



Dr Gary Howsam  
Cambridgeshire and Peterborough  
CCG Lockton House  
Clarendon  
Road  
Cambridge  
CB2 8FH  
30 July 2017

Dear Gary,

**Consultation on proposed changes to the future provision of specialist fertility treatment in Cambridgeshire and Peterborough**

I write to you in my capacity as Chair of the Cambridge Local Health Partnership, where this matter was recently discussed. I would like to bring to your attention the considered views expressed at the meeting, and some of those subsequently provided to me as an elected representative, that I hope you will take into account as part of this consultation.

Firstly I appreciate your frankness in the consultation document in stating that this proposal, to stop routinely commissioning any specialist fertility services, is about helping to reduce costs within a local health care economy that is in crisis, one that is facing increasing demand for services and chronic underfunding. I understand you are having to face a number of tough decisions about prioritising funds within the context of a continually difficult financial situation for the CCG. I also appreciate your efforts and those of the Governing Body in trying to win a fairer funding formula from NHS England that better reflects our local circumstances.

I'm sure that in different circumstances the CCG might take a different stance in removing a service that offers clinical value at a cost that is relatively small, at £700k, in terms of the overall £1.4 billion budget that the CCG has its disposal. I can see that if the decision to proceed with the proposal is taken you will seek to review it at the end of the current funding formula period in April 2019 – perhaps when more money is available. This indicates to me that this might be rather a marginal decision.

I would argue that whilst you are not clinically obligated to provide this service, infertility is a disease, and women and men who cannot become parents without medical help are as deserving of healthcare as people with other medical conditions. The Cambridge Local Health Partnership agreed that the guidance from the National Institute of Health and Clinical Excellence that states that the provision of three full cycles of IVF is both clinically and cost effective for women under 40, should be accepted and implemented locally. This is something that a number of CCGs have done, albeit they may not be facing the same degree of financial challenge.

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PO Box 700, Cambridge, CB1 0JH [www.cambridge.gov.uk](http://www.cambridge.gov.uk) • Switchboard: 01223 457000

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The existing level of service, consisting of one cycle of IVF, is already at a minimum acceptable level in my opinion, and according to the campaigning group Fertility Fairness the disparity in services now available across the country is marked, leading to what they describe as an “IVF post code lottery”. For example, if a Cambridge resident was to live in Luton, an hour’s drive away, they would have access to three cycles of treatment.<sup>1</sup>

I would be saddened if we were to exacerbate this “post code lottery” problem and put local people at such a disadvantage. I understand that Fertility Fairness is also calling for the standardisation of eligibility criteria across England and the development of a national tariff for fertility services. I hope that you would be able to support this work in the future.

Your consultation document acknowledges that whilst we are fortunate to enjoy relative prosperity in our area, there are substantial inequalities present, both between different geographical areas and within communities. Starting a family is believed to be almost a fundamental right for couples, and fertility problems can have serious and lasting impacts on those affected. If treatment is denied couples are likely to want to continue their journey towards parenthood and seek treatment elsewhere. I understand that the cost of IVF treatment in the UK can range between £4,000 and £8,000 per IVF treatment cycle, including consultations and prescription charges. For many people living on a low income this is simply unaffordable and is a reminder of the reality of the health divide between the “haves and the have-nots”.

This is an emotive and a very personal issue for people currently affected by fertility problems and I can understand any reluctance in local people coming forward to contribute to this consultation. I would be interested in how you have reached out to those who are likely to be impacted the greatest by this proposal both in the near and more distant future, particularly those people living on low incomes or who have other attributes, such as a mental illness, that might make it more difficult to engage with. My first reading of the consultation document was that it wasn’t easy to understand and that it might deter some people from responding.

I didn’t see an Equalities Impact Assessment on your web-pages, so haven’t really got a feel for your approach but I trust that some of the issues that became apparent during the consultation about the relocation of the “Out of Hours Service” in Cambridge, such talking to people who might be most affected by the change, have been taken on board. For our part we have tried to raise the profile of the consultation with the groups of people in our community that might be most affected  
– encouraging people to participate in this consultation.

I would therefore urge you to stick with the existing minimal position of offering one cycle of IVF rather than to stop offering specialist fertility services altogether (other

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<sup>1</sup> Admittedly, the definition of what is a cycle of treatment is, is different between these two CCG areas. But the disparity is clear.

than for the two exceptions) on the grounds that local people of all means can maintain the hope of success from this treatment, which strikes at the core of fairness and equality in our National Health Service.

As this subject is of particular importance, I am releasing this letter into the public domain.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Richard Johnson', with a long horizontal flourish extending to the right.

Councillor Richard Johnson  
Chair of the Cambridge Local Health Partnership and Executive  
Councillor for Communities, Cambridge City Council



fertilitynetworkuk

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25<sup>th</sup> July 2017

Cambridgeshire and Peterborough CCG  
Lockton House  
Clarendon Road  
Cambridge  
CB2 8FH

Dear Sirs,

I would like to respond to Cambridgeshire and Peterborough CCG's consultation to stop routinely funding the provision of IVF services other than for two specified exceptions. This decommissioning of specialist fertility services goes completely against the national recommendations for this treatment which have been deemed as being both cost and clinically effective. On behalf of patients, Fertility Network UK would like to ask you not to proceed with proposals to cut a service which already falls below the national recommendations.

The World Health Organisation classes infertility as a disease which, as with any other medical condition, is deserving of treatment. Recently Simon Stevens, Chief Executive of NHS England, publicly stated that ultimately the basis on which people get care on the NHS should be their ability to benefit from treatment.<sup>1</sup> In addition, the new Health Minister, Nicola Blackwood, responding to proposals to cut services by another CCG stated in a letter to a patient that '*Although the provision of local services is a matter for CCGs, we expect them to commission services, including fertility services, in line with NICE guidelines*'.

The NICE guideline on fertility which has been updated and re-validated is clear that three full cycles of IVF or ICSI should be provided to those in need.

I would particularly like to highlight the following points:

- Restricting access to IVF treatment completely would mark a drastic departure from the NICE guidelines, and further exacerbate the postcode lottery of fertility services

The NICE guideline, issued in 2004 and updated in 2013, recommends that all eligible couples should receive up to three full cycles of IVF or ICSI where the woman is aged under 40. This figure was arrived at on the basis of what was deemed to be a reasonable cost and clinical effective use of NHS resources.

<sup>1</sup> [http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/31\\_05\\_15\\_simon\\_stevens.pdf](http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/31_05_15_simon_stevens.pdf)

- **Evidence for consultation**

Your consultation document states

Specialist fertility services are expensive treatments. There is a real need to consider the value of funding this treatment at the current time compared with all other NHS treatments and services

I would like to question why Cambridgeshire and Peterborough CCG has classified fertility treatment as less deserving of funding compared to any other non-life threatening condition. Infertility is often caused by disease, is classified as a disease and results in disease. Its patient group warrants NHS treatment. People struggling with its consequences, through depression anxiety and other associated conditions, are more likely to present to their GPs many more times a year than other patients and thus are more expensive to the system. Patients often struggle to hold down jobs whilst dealing with infertility, and face an increased rate of marriage breakdown. There is therefore real value in continuing to fund this treatment.

I would also like to refer to key findings of The Impact of Fertility Problems 2016 from Fertility Network UK with Middlesex University London<sup>2</sup> which highlighted:

- 90 per cent of respondents reported feeling depressed; 42% suicidal; nearly 50% of respondents reported on average feeling sad, out of control, frustrated, helpless, fearful and worried nearly all of the time
- 70% reported some detrimental effect on their relationship with their partner

- **Long term costs associated with decommissioning fertility services**

In recent years, fertility treatment abroad has become an increasingly affordable option for UK patients unable to access IVF on the NHS, and evidence suggests that the demand is increasing exponentially.

However, whilst this treatment might represent a more affordable option for patients, it carries hidden costs to the NHS. The Human Fertilisation & Embryology Authority (HFEA) has always strictly regulated the number of embryo that can be transferred during IVF treatment to reduce the chance of multiple pregnancies. However, in some other European countries, and outside of the EU, there is often no statutory limit to the number of embryos transferred. One ESHRE study examining 225,507 IVF cycles across Europe found that the majority of clinics questioned were not only conducting two embryo transfers, but that 22% were using three embryo transfers, and a further 3% were using four embryo transfers.<sup>3</sup>

The UK has pursued strict strategies to restrict multiple embryo transfers because of the complications for mothers and babies and high costs that arise out of multiple pregnancies. At least half of twins are born before 37 weeks (making them pre-term) with low birth weights, which puts them at a high risk of serious health problems. Over 90% of triplets are born before 37 weeks, and many are born sufficiently prematurely that they are at high risk of long-lasting serious health problems and death.<sup>4</sup> By stopping funding, Cambridgeshire and Peterborough CCG will increase the risk that more patients will receive treatment abroad which is highly likely to drive up the number of multiple births the CCG sees

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<sup>2</sup> <http://fertilitynetworkuk.org/survey-on-the-impact-of-fertility-problems/>

<sup>3</sup> ESHRE 2016, "Long-term prognosis of live birth after ART, intrauterine insemination and spontaneous conceptions in women initiating treatment with homologous gametes: A Danish national cohort study" Malchau S et al; Abstract O-250.

<sup>4</sup> [http://www.hfea.gov.uk/docs/Multiple\\_Births\\_Report\\_2015.pdf](http://www.hfea.gov.uk/docs/Multiple_Births_Report_2015.pdf)



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I would be happy to discuss any of these issues further.

Yours sincerely,

Susan Seenan  
Chief Executive Fertility Network UK

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## Proposed changes to NHS funded IVF provision

### - Consultation Response -

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This response is based on evidence from National Institute for Health and Care Excellence (NICE) clinical guidelines, our observations from attending four consultation meetings, Healthwatch Cambridgeshire and Peterborough's knowledge of the local health economy and through listening to the views of people on this matter.

#### The consultation process

We are pleased that there was a significantly longer consultation period than required. However, some misunderstandings were caused by the postponement of the consultation meetings, due to a General Election being called. We accept that this was the correct procedure and beyond the CCG's control, however it may have contributed to the very low attendance at the re-arranged meetings.

It is not clear in the consultation papers which diseases and conditions are included in: 'a disease or a condition requiring medical or surgical treatment, that has a significant likelihood of making them infertile'. This lack of clarity in the consultation has meant that local people have been unable to comment on this key point and that the Governing Body decision will not take into account those views.

Feedback has been received that people did not find the questionnaire easy to complete. Some local people expressed frustration that the questions in the consultation did not match the dilemma for the CCG. This consultation mixes issues about clinical effectiveness and affordability of one part of a clinical pathway to support fertility problems vs shortage of money to pay for all CCG funded services in the Cambridgeshire and Peterborough areas.

Healthwatch regrets that this consultation was not part of a broader public discussion about the values underpinning cost-cutting. Consideration of this service area is not to our knowledge mentioned in the Sustainability and Transformation Plan nor its associated workstreams, which have at least attempted to raise the profile of the financial, service quality and access gaps in the public consciousness. People will be concerned about what treatment or service is considered for cuts next, and what the rationale for this choice of treatment or service is.

We are disappointed that a health economic analysis was not included in the consultation document, nor is there any indication that prioritisation or ethical frameworks are being used to inform decision-making.

#### **An important distinction between reducing what is known to be a cost-effective treatment, and the cost of delivering that service to local people effectively**

NICE guidance states that in instances where IVF is clinically considered as the best treatment, three cycles is most cost-effective. In 2016 Cambridgeshire and

Peterborough CCG reduced the available cycles from three to one. We understand that the local success rate for one cycle is relatively high. This appears to be a good outcome for the limited intervention compared to other parts of the country. The cost per cycle in our CCG area is £5-7,500. In other CCG areas we understand it can be much lower. This suggests there is scope to review the commissioning of services locally to achieve greater efficiencies. It is our view that these efficiencies should be given priority over reducing choice and access to a clinical intervention which is proven to be cost effective both locally and nationally. By reducing from the current policy of one cycle to none, the service is essentially deleted to local people.

#### **Expectations about the use of NICE guidance**

We note that the existing policy of one cycle already takes away from clinicians their ability to follow NICE guidance for clinically suitable patients. By specifying zero cycles, this further constricts the treatment options for patients and the ability of clinicians to consider effective use of health service resources along-side evidence of clinical effectiveness, which is considered a professional duty.

The NHS Constitution enshrines the rights of patients to have access to NICE approved treatments. Whilst the CCG could reasonably defend a planned process of service improvement over time, to fully comply with NICE guidelines, a further reduction in the number of cycles may be hard to defend. In the light of this point, it is welcomed that the CCG propose to review the decision in 2019, should it press through with the proposed changes at this point.

There is lack of clarity in the consultation document regarding what might constitute a case for exceptional funding. It is our understanding that the impact of infertility on someone's mental health could be seen as an exception by some doctors. It is possible that a range of exceptions could be argued in this complex area of treatment and care, to the point where the proposed new more restrictive policy may lose its credibility. Transparency about the exceptions process is important and it would need careful consultation and construction to avoid inconsistent effects and an inequitable service.

#### **Impact on local people**

The impact of the proposed change will primarily impact upon people on lower incomes, as people with greater income will be able to pursue private treatment. The numbers of people accessing private IVF treatment varies considerably across the country. Healthwatch asked the CCG to look into these statistics to understand the extent of public reliance on NHS services in this locality, and thereby better appreciate the economic impacts. The economic impacts and other considerations should be analysed thoroughly in the equality impact assessment.

It is accepted that this policy change will affect small numbers of people, however the impact on those people will be significant. For example, during the consultation meetings we heard from people who had been through fertility treatment. We also heard that infertile couples are more likely to experience depression.

Removing access to NHS funded IVF will make it more likely that people will go abroad for treatment. Less guidance and regulation of treatments abroad means that multiple births are far more likely. Multiple births have cost implications for the NHS, especially where newborn children need extra support.

We welcome the CCG's expressed intention to contact other CCGs to look at the impact on people's mental health and increases in multiple births since ending IVF in order to

understand associated costs.

### **Summary**

Whilst understanding the CCG's need to make very large savings to its overall budget, we have observed that this consultation in isolation of a more systematic discussion on cost savings has been confusing to some people.

It is worrying that these proposals place further local policy restrictions on clinicians' ability to refer and provide a cost-effective treatment that is in line with current national guidance.

It appears that removing NHS funded IVF may not save the money calculated because of the potential offset by increased multiple births and demand for mental health services. There may be cheaper ways of delivering it rather than cutting IVF completely.

Finally, we stress the inequitable impact of this policy change on the basis of people's ability to pay. We suggest that more information is gathered about who may be most affected by these changes and how they can be supported.

We ask that all the factors above are considered as far as possible in making the current decision. If the decision is taken to remove NHS funded IVF we ask that the growing base of information on the impacts of this policy are used to inform the review in 2019.

**Sandie Smith CEO (Cambridgeshire)**

**Healthwatch Cambridgeshire and Peterborough**

**31 July 2017**



House of Commons  
London SW1A 0AA

Cambridgeshire and Peterborough CCG  
Lockton House  
Clarendon Road  
Cambridge  
CB2 8FH

6 July 2017

Dear Communications and Engagement Team,

Thank you for sending the recent consultation document to me regarding the state of specialist IVF treatment.

From my understanding, you are proposing to heavily cut the specialist IVF treatment that the NHS provides. Whilst I sympathise that NHS funding is very stretched and the number of people who will be affected is relatively small, these changes may be met more comfortably if they were slightly more lenient. For example, even if the offer of one cycle of IVF per couple was maintained, this would save couples up to £5000 and increase the number of cycles they are able to afford.

IVF is deeply important issue for those concerned and I hope that we truly listen in the consultation to the views of people who have taken the time to respond.

Yours sincerely,

Daniel Zeichner  
Member of Parliament for Cambridge

*DANIEL ZEICHNER*  
*Member of Parliament for Cambridge*

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17 May 2017

Dear Jessica

#### **Formal Response to IVF Consultation**

I am writing to you on behalf of the Health Scrutiny Committee to inform you of our formal response to the IVF Consultation, which you presented to the Committee at its meeting on 14 March 2017. Having considered and debated the consultation proposal it was felt that the Health Scrutiny Committee could not support the proposal to withdraw IVF services as it was felt that the potential savings did not justify the loss of the service.

Yours sincerely

pp. *P Ford*

On behalf of:  
Councillor Cav Marco Cereste OMRI OSSI  
Chairman, Health Scrutiny Committee

Dr Alistair Brown

I feel very strongly that this is wrong and would propose some alternatives: 1. Decommission oncology drugs which prolong life for less than four months. Add a line in this survey asking the public where to making savings. 2. Public health campaign making it clear to the public that your GP can only refer you when they are concerned about the diagnosis or need a specialist opinion, and not on demand, thus making it easier for GPs to say no to referrals 3. Add another exception, that a psychiatrist can put a patient forward when their infertility is causing undue psychological distress (akin to the ruling with Viagra). Have a fund of £150k to pay for this and let the exceptional case panel decide the most deserving cases 4. Make it obligatory that any couple contemplating IVF first meet with adoption services 5. Introduce means testing, even if this requires a change of law. There has to be a way around this. I am happy to be involved in further discussion if that's helpful Dr Alistair Brown



Cambridge Hospitals

## **UNISON Cambridge Hospitals response to Cambridgeshire and Peterborough CCG Consultation on specialist fertility services**

The branch representing UNISON healthcare workers at Addenbrooke's Hospital and the Rosie is calling on the Clinical Commissioning Group for Cambridgeshire and Peterborough to drop plans to end routine NHS funding for IVF treatment in the region.

UNISON believes in a comprehensive, publicly owned and funded national health service. We do not wish to see further fragmentation and disintegration of services that meet the healthcare needs of the population. As such we wish to see Cambridgeshire and Peterborough CCG;

- Drop plans to entirely decommission funding for IVF on the NHS
- Meet the standards set by NICE and offer three funded cycles of IVF with NHS funding

UNISON Cambridge Acute Hospitals would also like the CCG to note, as part of the consultation, the following facts and points;

- The Governing Body of Bedfordshire CCG, following an extensive consultation last year, decided **unanimously** to retain funding for routine IVF treatment. Feedback indicated they did not believe cutting specialist fertility funding would lead to savings for the CCG.
- Infertility is a medical condition and it is against the spirit of the comprehensive, universal nature of the NHS to end public access to a treatment such as IVF. The outgoing health minister Jane Ellison has said that 'blanket restrictions on procedures that do not take account of the individual healthcare needs of patients are **unacceptable**.' Recent Health Minister Nicola Blackwood has indicated to CCG's that they are expected to commission services, including fertility services, in line with guidance from NICE.
- UNISON believes, and would like it noted as part of the consultation response, that is both **immoral and incompetent** to contemplate cutting a vital service for the sake of saving £700,000, when the costs of

marketization and the NHS internal market continue to grow. UNISON notes that the drawing up of cost cutting STP plans across the UK cost the NHS more than £17.6 million in management consultant fees last year.

- Infertility and associated costs place a heavy burden on people and often leads to poor mental health. A study by Middlesex University London last year noted that 90% of those with infertility problems reported feeling depressed and 42% experienced suicidal thoughts. This has been reiterated by couples and individuals in the CCG area locally who have attended public meetings. It is highly likely there will be high costs to the local NHS of treating mental health problems if the only available option for IVF treatment is removed. These costs may well outstrip any potential savings to be made.
- The post-consultation report by Bedfordshire CCG noted evidence indicating the much higher costs to the NHS of treating families who have had twins or triplets post IVF. This was a key factor in their decision to retain IVF funding. If NHS access is ended in Cambridgeshire it is highly likely it will mean higher long term costs for local services as couples seek less well regulated IVF treatment abroad.

The officers of UNISON Cambridge Acute Hospitals would like our comments to be officially noted as part of the consultation response. We cannot support proposals that further fragment the local health service and restrict public access to treatment.

**Officers**

**Cambridge Acute Hospitals Branch**

**Abington House, Addenbrooke's Campus, Cambridge**

## **HEALTH COMMITTEE: MINUTES**

**Date:** Thursday 16th March 2017

**Time:** 2.00pm to 5.25pm

**Present:** Councillors L Dupre, L Harford, P Hudson, D Jenkins (Chairman), G Kenney, R Mandley (substituting for Cllr Clapp), T Orgee (Vice- Chairman), M Smith, P Topping, A Walsh (substituting for Cllr Moghadas) and S van de Ven District Councillors M Abbott (Cambridge City), S Ellington (South Cambridgeshire), J Tavener (Huntingdonshire)

**Apologies:** County Councillor P Clapp District Councillor M Cornwell (Fenland)

**Also in attendance:** Councillor J Scutt

Extract from published minutes:

### **316. CONSULTATION ON PROPOSED CHANGES TO THE FUTURE PROVISION OF SPECIALIST FERTILITY TREATMENT IN THE CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP AREA**

At its meeting on 15 December 2016, the Committee had considered a report on the CCG's plans to conduct a consultation on its proposal to stop routinely commissioning any specialist fertility services other than for two specified exceptions. The Committee now received a report presenting the consultation document and inviting it to make a response to the consultation.

In attendance from the Cambridgeshire and Peterborough Clinical Commissioning Group to present the report and respond to members' questions and comments were:

- Jessica Bawden, Director of Corporate Affairs
- Tracy Dowling, Chief Officer
- Dr Richard Spiers, Clinical Lead for Prescribing and Clinical Policies.

Members were reminded that the proposal had arisen as a response to the CCG's serious financial deficit; it was an area that the CCG would prefer not to have to consider, but budget requirements were such that it was necessary to examine rigorously what could and could not be funded in the CCG's present circumstances.

The consultation had now started. The document had space for additional comment; attendees at the first public meeting had put forward various other ideas for savings.

Discussing the Committee's response, individual members

- acknowledged the need to set boundaries on NHS expenditure; it might be necessary to ask people to pay for IVF treatment as the price for getting the best cancer care
- suggested that, rather than the CCG picking services to cut, the approach used by the Oregon experiment should be tried, when the population had been asked what healthcare it did and did not want to fund
- expressed discomfort at cutting the service, so that only those who could afford to pay would receive any cycles of IVF

- said that IVF should not be regarded as an optional extra; there were links between infertility and mental ill health
- suggested that it might be more acceptable if there could be an element of means testing when requiring somebody to pay, and if the system could be sensitive to who could and could not handle the disappointment of not receiving the service. It was explained that neither means-testing nor co-payment were possible.

In further discussion, members noted that the CCG had not made this proposal without examining all other areas of its expenditure. IVF was a cost-effective intervention based on good data; once finances permitted, it would be one of the first interventions that had been reduced to be restored.

The Committee agreed in response to the consultation that

- a) It recognised that this was an extremely difficult decision
- b) It noted that specialist fertility treatment would be one of the first treatments to be restored once the CCG's financial position permitted
- c) It was not in a position to make any recommendation for or against the proposed changes.

## **Patient Reference Group (PRG)**

The Patient Reference Group provided input into the consultation documentation and process plan at its meeting in March 2017, prior to the launch of the IVF consultation.

Updates on the consultation were provided at each PRG meeting between March and July 2017. At its meeting in May 2017 the PRG asked about the distribution of posters to advise people about the cancellation of the original set of public meetings. At the meeting in July 2017 the PRG raised points about whether respondees to the consultation were directly affected, as well as the potential impact on other NHS services, such as mental health, if the proposal was to be agreed.

The PRG was given the opportunity to see a draft interim report of the themes from the consultation responses at its meeting in August 2017.

It is noted that the PRG agreed the process and understood the rationale for the consultation but there was no consensus within the group about whether the PRG agreed with the proposals.

## Appendix C – Public meeting and other meeting notes

- **10 July, Peterborough – No attendees**
- **10 July, Peterborough – No attendees**
- **13 July, Huntingdon – Healthwatch Cambridgeshire: short informal discussion about the meetings as Healthwatch also attended other meetings**

### Notes from IVF public meeting

**Time and date:** 6pm-7pm, Tuesday 11 July

**Venue:** Wisbech

**Presenter:** Sue Watkinson, Dr David Irwin

**CCG staff:** Jo Hobson, Adam Miller

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Q. What is the success rate of the 200 people that were referred for IVF treatment in 2015/16?

Q. If proposals are agreed you have said you would still be able to apply through exceptional cases – is there criteria you can share?

Q. Statistics show that many couples fall pregnant in the second year of trying to conceive. Currently people get referred for tests after one year – would you consider referring people after two years as this would mean smaller numbers being referred and, in turn, less cost?

Q. Aware new NICE guidance on IVF is due later this year – shouldn't you wait until this is available before you make a decision?

Q. What are the timescales if the proposals are agreed?

Q. Can the full list of conditions that are exempt be shared?

## Notes from IVF public meeting

**Time and date:** 6pm-7pm, Tuesday 18 July

**Venue:** Ely Cathedral Conference Centre, Palace Green, Ely

**Presenter:** Tracy Dowling

**CCG staff:** Sarah Prentice, Hazel Thomson

**Number of attendees:** 7

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### Questions and comments

**Q = question**

**C = comment**

Q. One cycle of IVF is funded at the moment? If the recommendations go ahead no cycles will be funded? Why is the CCG going against NICE guidelines to fund three cycles of IVF for couples under 42?

Q. Is there any budgetary information available about what services will be prioritised over IVF?

Q. Will the exceptional funding route be open for IVF patients? Or is it just for cancer patients/couples where the man has HIV and needs sperm washing?

Q. Do you have a ballpark date when this would take effect?

Q. What date in September would this be?

Q. Have you thought about the mental impact and the cost to the NHS of this? And the cost of counselling? My sister in law has a child but knows that she can't have anymore without IVF – she's suffering mentally.

Q. Has it all been quantified and costed?

Q. Will the report to the Governing Body be public?

Q. What about endometriosis, PCOS, fibrosis – some people are told that pregnancy can cure these conditions. What about the cost of IVF compared to the cost of drugs for these conditions?

C. The drugs for endometriosis are the same as those for cancer. Treatment can be a hysterectomy or ovary removal, meaning that people with this condition couldn't have children.

Q. How do people apply for exceptional funding for IVF?

Q. Is there any guidance on what would be considered 'exceptional'?

Q. Would partial funding for the service be considered?

C. You referred to a £504million deficit earlier in the year. It's been in previous presentations but it isn't in this one.

Q. How do you get yourself into a deficit of £25.6million?

Q. Once the deficit is cleared will IVF be funded again?

Q. How will that affect people who are going through the process now with their GP? Will they get IVF if you fund it again following the 2019 Spending Review? Will they have to start going through the process with their GP/secondary care again?

Q. After this meeting is there anything else we can do to make our views known? I can't have time off to attend a Governing Body meeting during the day.

Q. Where and how was the consultation advertised? I found it hard to find any information about it.

C. Social media is probably the only thing that people under 40 look at.

C. You could advertise the consultation on local selling pages. People don't necessarily read local papers or look on your website.

C. If people didn't have to have IVF they wouldn't put themselves through it. Why not stop funding things like smoking cessation and obesity – things that people have a choice or control over. It all comes from the healthcare budget.

C. You can't cost smoking over having a child.

Q. If you cut the service how much would the average person have to spend on IVF?

C. It's a lot of money to expect people to have to pay out.

Q. Does the CCG fund gastric band surgery?

Q. It's a postcode lottery. Is there not a risk of pushing the problem to other parts of the country?

Q. Which other counties have done this and what impact has it had? Have they seen a financial gain?

Q. What other cuts did Bedford make? Could we learn from Bedford and Essex? When did Essex make their decision?

Q. What's the situation in Thetford?

Q. Has anyone spoken to Bourn Hall and the impact on them?

## Notes from IVF public meeting

**Time and date:** 12.30pm-1.30pm, Thursday 20 July

**Venue:** Cambridge Library, Cambridge

**Presenter:** Dr Gary Howsam

**CCG staff:** Helen McPherson (notes), Hazel Thomson

**Number of attendees:** 5

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### Questions and comments

**Q = question**

**C = comment**

Q. How is value measured?

Q. Will the responses to the consultation mediate the decision?

Q. The policy that you're changing, how does that compare to other CCGs? Is it on a par?

Q. Have you been directed by NHSE as a service (IVF) to cut?

Q. Health impact assessment has not been published, the impact on local families. Will it be published?

Q. Have you contacted any advocacy groups and other people interested in this?

Q. Were people put off this consultation by the out of hours consultation? People felt like 'what's the point in taking part' as they won't be listened to?

C. Out of hours consultation was very poorly done, but this consultation is much improved. Understand people's cynicism about this.

Q. Know you're under direction from NHSE but if 80% of people say don't do it, will you then not go ahead?

Q. Will there be a cost of not providing IVF? Will you have that cost to present to the Governing Body?

C. This consultation is an emotive subject to a specific age range. You're in danger of getting everyone who is personally affected by it responding to it.

Q. Exceptions: chromosome abnormality - is that covered? Would sperm selection be included?

C. Find it hard to believe that once this service is stopped, that it might be restarted in the future. There will always be more funding problems and cuts.

Q. Why IVF?

C. Feels like a soft option

C. £700k is a not a large saving

Q. Do you have a prioritisation framework to make decisions? Is this a public document?

C. Other CCGs have chosen to retain IVF and found another service to cut.

C. NHSE gives this area an unfair allocation.

C. The Government has ruined us financially.

Q. How do you include (communicate) with those who might be affected?

Q. When will this go back to the Scrutiny/Health Committee?

## Notes from IVF public meeting

**Time and date:** 6pm–7pm, Thursday 20 July

**Venue:** Meadows Community Centre, Cambridge

**Presenter:** Tracy Dowling and Dr Gary Howsam

**CCG staff:** Melanie Kynaston (notes), Hazel Thomson

**Number of attendees:** 5

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### Questions and comments

**Q = question**

**C = comment**

Q: Can you say something about how much each IVF cycle costs and what savings you hope to make?

Q: Do you have detail about how much is spent each year?

C: Need to think of mental health financial impact as well as IVF financial costs.

Q: Has there been a projection of the cost of the implications for mental health through stopping IVF?

Q: Are you asking people that have personal experience?

Q: A CCG that stopped IVF is now £11k in the black. Shouldn't they then be able to look at funding IVF again now they are balanced?

Q: How much does the CCG pay for IVF?

C: Attendee stated that he paid £6.2k privately.

Q: Did the CCG look at reducing the amount it pays for each patient?

Q: Why doesn't the NHS keep it in house?

Q: The CCG should be commanding a better deal.

Q: Can you delegate the consultation to Jeremy Hunt?

C: Tracy explained that if the CCG decided to stop funding IVF it would be a temporary decision and would be reviewed if the CCG got back in the black.

Q: What happens if you don't balance the books?

Q: Could the CCG still look for efficiencies in other parts of the system?

Q: People will go abroad where it is cheaper. This will still cost the NHS in the long run with the possibility of multiple births. There will also be the added cost to mental health.

C: Has the CCG spoken to Bedford CCG? Bedford CCG decided to halt its decision to stop funding IVF; it still funds one cycle of IVF per patient. When asked what the driver was the CCG said it was mental health and additional multiple birth costs.

Q: WHO (World Health Organisation) referenced IVF as a disease – are there any other diseases that the CCG is stopping treating?

C: The consultation is to stop 'routinely' funding IVF. The CCG always has a route whereby people can be referred by a clinician through the exceptional cases panel.

Q: Are there any other areas where you don't adhere to NICE guidelines?

Q: How influential is feedback from the consultation?

Q: How many members are there on the Governing Body?

Q: If not IVF where will you save the money?

Q: (To Tracy) Is it your decision?

A: No. It is a decision of the Governing Body. Decisions regarding consultations are made in the proper way. The Governing Body must respond to the points that people have made.

Q: What is the date of the meeting where the decision will be made?

A: 5 September – it is a meeting in public.

Q: Why have a Q&A session when the decision has already been made?

A: It is to be courteous to people so they don't have to sit through the whole meeting. It is for people to see the decision being made.

Q: What can we do about the allocation that the CCG receives?

A: You can write to your MP.

Q: What can we do other than write to our MPs if we feel that our MP isn't supportive of the NHS? If we write to ask why our CCG is not getting its fair share.

A: They really do want to help. It is not a waste of time.

## **Cambridge – Friends Meeting House invited by the Green Party but open to the public**

Tuesday 25 July 2017 7pm

Presenter: Tracy Dowling

Notes: Sue Last

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The Green Party advised that it had started the petition.

In attendance were Tracy Dowling, CCG, Fertility Fairness, and Jackie, a counsellor who is currently working with couples with infertility.

Tracy provided the group with the IVF presentation.

Tracy also provided information that this would be reviewed by the Governing Body and that it would make a decision at its meeting on 5 September which is taking place at Peterborough Football Club from 3.30pm-6pm.

We would take a note of people's views and record them to reflect this in the final paper.

Q. Are we the only CCG that is an outlier on this? Are we the minority for IVF?

Q. How will couples stand who are already in the system?

Q. If you save this target of £50million where will the saving be spent?

A. The money is not ours to spend. We are expected to break even.

Q. You state that this will make cost savings. Have you considered the cost of the other services if this doesn't go ahead, such as mental health or multiple births from people going abroad for treatment?

Q. Do you have a measure of the people going abroad for treatment? It does not seem right for those that can afford it. What about those people that cannot afford it?

Q. Who sets the price for IVF? Why is it cheaper to go abroad?

Q. Will your withdrawal destabilise the services?

Q. Have you considered the mental pressure for a woman when she cannot conceive? Have you thought how this affects the whole relationship and the mental issues this brings?

Q. I have a genetic disorder, but no one helps us. How much do you pay for plastic surgery, gastric bands, boob jobs, and other such things? Medical conditions should be added to the exceptions.

Q. Will people get what they have been referred for when you stop?

Q. Have you looked at all your administrative costs? This is a minuscule amount.

Q. What other alternatives have you looked at other than IVF?

Q. Whose job is it to say our allocation of spending per head is not enough?

Q. Could you consider means testing or part funding?

Q. You stated that you had no plan B so you must have made the decision.

A. No, the decision will be made by the Governing Body on 5 September. We are constantly reviewing our plans so we will need to look at other things.

**Statement**

If you stop this you are stopping things evolving. You are stopping re-creation of life and this is putting a strain on everyone's life. This puts pressure on men too. It can destroy marriages. This should not be about the money, it should be about the people. These are not savings – these are cuts to services. This is discrimination of a sector of the population i.e. young families, gender, and sector.

## Appendix D – Impact assessments

### Appendix D1 - Equality Impact Assessment

<b>Name of Proposal</b>	<p>Proposal to stop routinely commissioning any specialist fertility services other than for two specified exceptions.</p> <p>Note: Infertility investigations provided at secondary care level will continue to be funded by Cambridgeshire and Peterborough CCG and will be available to all patients.</p>
Those involved in assessment:	<p>Julie Istead Clinical Policies and Exceptional Cases Team Manager</p> <p>Jane Coulson Communications and Engagement Manager</p> <p>Dr Fiona Head Consultant in Public Health Medicine</p>
Is this a new proposal?	Yes
Date of Initial Screening:	8 November 2016 – prior to consultation
Date of Review:	16 August 2017
What are the aims, objectives?	<p>Under the new proposal, specialist fertility services will no longer be commissioned except for the following two exceptions:</p> <ul style="list-style-type: none"> <li>• Fertility preservation will be offered to patients undergoing cancer treatment, or who have a disease or a condition requiring medical or surgical treatment, that has a significant likelihood of making them infertile.</li> <li>• Sperm washing will be provided to men who have a chronic viral infection (primarily HIV) and whose female partner does not where intrauterine insemination is being considered. This is a risk reduction measure to limit the transmission of a serious, pre-existing viral condition such as HIV to the woman and, therefore, potentially her unborn baby.</li> </ul>

Who are the main stakeholders?	<ul style="list-style-type: none"> <li>• Patients</li> <li>• GP practices</li> <li>• Dentists</li> <li>• Pharmacies</li> <li>• MPs</li> <li>• Councils for Voluntary Services (Peterborough and Cambridgeshire)</li> <li>• Health Scrutiny Commissions/Health Committee: Cambridgeshire, Peterborough, Hertfordshire, Northamptonshire, Norfolk</li> <li>• Health and Wellbeing Boards: Cambridgeshire, Peterborough, Hertfordshire, Northamptonshire, Norfolk</li> <li>• Local Health Partnerships, Fenland, South Cambs, East Cambs, Cambridge City, North East Northants, Hunts</li> </ul>
Who are the main stakeholders? cont'd	<ul style="list-style-type: none"> <li>• CCG Patient Reference Group</li> <li>• Patient Forum Groups</li> <li>• Healthwatch organisations: Peterborough, Cambridgeshire, Northamptonshire, Hertfordshire, Norfolk</li> <li>• Libraries</li> <li>• Cambridgeshire Community Services NHS Trust</li> <li>• Cambridge University Hospitals NHS Foundation Trust, Maternity Unit, IVF unit</li> <li>• Cambridgeshire and Peterborough NHS Foundation Trust</li> <li>• East of England Ambulance Service NHS Trust</li> <li>• North West Anglia NHS Foundation Trust (Hinchingbrooke Hospital and Peterborough City Hospital Maternity, IVF unit)</li> <li>• Queen Elizabeth Hospital Kings Lynn NHS Trust</li> <li>• Bourn Hall Clinic (current provider of services)</li> <li>• Unions</li> <li>• NHS England Area Team</li> <li>• Herts Urgent Care</li> <li>• Lincolnshire Community Health Services NHS Trust/Peterborough Minor Illness and Injury Unit</li> <li>• BICA (British Infertility Counselling Association)</li> <li>• Cambridge IVF</li> </ul>
What are the desired outcomes?	Specialist fertility services will no longer be commissioned except for the two exceptions listed above.
What factors could detract from the desired outcomes?	Public opinion against the proposal during the consultation.
What factors could contribute to the desired outcomes?	<p>Evidenced case that this change allows resources to be used to greater overall population health benefit.</p> <p>Public support for the proposal.</p>
Who is responsible?	Sue Watkinson, SRO.

Have you consulted on the proposal? If so with whom? If not why not?	The public consultation ran for 20 weeks from 13 March 2017 to 31 July 2017.
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Which protected characteristics could be affected and be disadvantaged by this proposal (Please tick )		Yes	No
Age	<u>Consider:</u> Elderly, or young people -	Yes - women of childbearing age and adult men.	
Disability	<u>Consider:</u> Physical, visual, aural impairment, mental or learning difficulties		No
Gender Reassignment	<u>Consider:</u> Transsexual people who propose to, are doing, or have undergone a process of having their sex reassigned		No
Marriage and Civil Partnership	<u>Consider:</u> Impact relevant to employment and/or training		No
Pregnancy and maternity	<u>Consider:</u> Pregnancy related matter/illness or maternity leave related mater	Yes	
Race	<u>Consider:</u> Language and cultural factors, include Gypsy and Traveller groups		No
Religion and Belief	<u>Consider:</u> Practices of worship, religious or cultural observance, include non-belief		No
Sex /Gender	<u>Consider:</u> Male and Female	Yes	
Sexual Orientation	<u>Consider:</u> Know or perceived orientation	Yes	

What information and evidence do you have about the groups that you have selected above?

Engagement with various groups took place before the consultation and the consultation itself was open to the general public.
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**How might your proposal impact on the groups identified?**

If the proposal is accepted following public consultation then women up to the age of 42

who meet the clinical threshold for specialist fertility treatment will no longer be able to access this service on the NHS in the Cambridgeshire and Peterborough Clinical Commissioning Group area, apart from for the two detailed exceptions.

This affects both women of childbearing age and also their male partner.

Currently, same-sex couples are entitled to treatment on the NHS following six cycles of self-funded intrauterine insemination, unless they are couples with a diagnosed cause of absolute infertility which precludes any possibility of natural conception, and who meet other eligibility criteria, who have immediate access to NHS-funded assisted reproduction services.

This proposal applies equally to both male-female couples and same-sex couples who are seeking NHS-funded assisted conception.

In the event that the outcome of the consultation results in the stopping of routinely commissioned specialist fertility services, in line with the CCG's Exceptional and Individual Funding Request Policy for treatments that are not normally funded on the NHS, a couple, supported by their clinician (primary or secondary care), may apply to the CCG's Exceptional and Individual Funding Request Panel to request NHS-funded IVF.

<b>Summary</b>	
<p>Positive impacts (note the groups affected)</p> <p>Fertility preservation will be offered to patients undergoing cancer treatment, or who have a disease or a condition requiring medical or surgical treatment, that has a significant likelihood of making them infertile.</p> <p>Sperm washing will be provided to men who have a chronic viral infection (primarily HIV) and whose female partner does not where intrauterine insemination is being considered. This is a risk reduction measure to limit the transmission of a serious, pre-existing viral conditions such as HIV to the woman and, therefore, potentially her unborn baby)</p>	<p>Negative impacts</p> <p>If the proposal is accepted, following public consultation, then women up to the age of 42 who meet the clinical threshold for specialist fertility treatment will no longer be able to access this service on the NHS in the Cambridgeshire and Peterborough Clinical Commissioning Group area, apart for the two detailed exceptions.</p>

What consultation has taken place or is planned with each of the identified groups?

Consultation took place from 13 March 2017 to 31 July 2017

What was the outcome of the consultation undertaken?

Will not be known until after the CCG Governing Body meeting on 5 September 2017.

What changes or actions do you propose to make or take as a result of research and/or consultation?

If the proposal is approved by the Governing Body following the consultation the CCG will no longer commission IVF services for new patients. Patients currently in the IVF process will continue to receive their IVF cycle(s).

Access to gynaecology clinics at local hospitals will continue to be available for:

- The standard investigation of causes of infertility.
- Non-specialist treatments such as physical and hormonal therapy.
- Management of ovulatory disorders.
- Management of tubal and uterine abnormalities.
- Medical and surgical management of endometriosis.
- Medical and surgical management of male infertility.
- Management of ejaculatory failure.

If the service restriction is implemented couples will still have access to fertility preservation for patients undergoing treatments that are likely to make them infertile and sperm washing for men who have a chronic viral infection, whose partner does not, and where intrauterine insemination is being considered – these services are provided by a specialist provider.

Will the planned changes to the proposal:

Please State  
Yes or No

Lower the negative impact?	No
Ensure that the negative impact is legal under anti-discriminatory law?	Yes
Provide an opportunity to promote equality, equal opportunity, and improve relations i.e. a positive impact?	No

Taking into account the views of the groups consulted and the available evidence, please clearly state the risks associated with the proposal, weighed against the benefits.

From the consultation people clearly felt that there would be increased costs for mental health support and there may be an increase in multiple births if people go abroad for IVF treatment. From personal communications with CCGs who have ceased to provide IVF on the NHS they have not seen an increased demand in mental health services or observed an increase in multiple births.

To mitigate, it is important that those patients who cannot afford private IVF treatment and are suffering symptoms of psychological distress are referred to the appropriate psychological support services (i.e. Psychological Wellbeing Service).

Guidance should be issued to relevant clinical colleagues about the importance of referral in such instances. Such symptoms may be mitigated by targeted publicity of the treatment options for subfertility that are still available to those who are unlikely to be able to afford IVF privately.

There is a range of services available to people who need help with fertility issues, both in

primary care and in our local hospitals.

Subject to the decision of the Governing Body to stop NHS funded IVF, the CCG will monitor multiple births.

What monitoring/evaluation/review systems have been put in place?

Dependent on the decision by the Governing Body:

Ongoing monitoring of the adherence to the policy and requests for exceptional case funding for IVF will be used to monitor the effects of this proposal on equality.

Annual monitoring of referral to psychological wellbeing services for fertility-related matters.

When will it be reviewed?

Dependent on the outcome of the decision of the CCG Governing Body when considering the outcome of the consultation.

<b>Date completed:</b>	9 November 2016
<b>Date review completed</b>	16 August 2017
<b>Signature:</b>	Julie Istead, Clinical Policies Manager
<b>Approved by:</b>	Soomitra Kawal, Equality and Diversity System Adviser
<b>Date approved:</b>	11 November 2016
<b>Date review approved</b>	

## Evidence

**1. What evidence have you considered to determine what health inequalities exist in relation to your work?** List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses. If there are gaps in evidence, state what you will do to mitigate them in the Evidence based decision making section on the last page of this template.

**Answer:**

Local data on the rate of access to IVF services across the CCG from April 2014 to October 2016 shows that:

1. An average of 142 women per year accessed NHS-funded IVF between April 2014 and October 2016 out of a Cambridgeshire and Peterborough population of over 940,000. In the year 2015/16 200 people accessed this treatment as reported in the consultation document.
2. No local area has an access rate that is significantly different from the Clinical Commissioning Group (CCG) average.
3. Greater Peterborough has an access rate significantly lower than the previous CATCH practices and Huntingdonshire practices.
4. The rate of IVF access does not vary with index of deprivation of the referring GP (see table below).

Index of Multiple Deprivation quintile of referring GP practice	Rate per 10,000 women aged 15-49
1- most deprived	5.97
2	6.05
3	6.57
4	6.20
5- least deprived	7.70
<b>Total</b>	<b>6.48</b>

Data from CCG Business Intelligence for April 2014 to October 2016

The evidence on IVF, including its effectiveness, is comprehensive and has been recently summarised in a Cochrane Review (Farquhar et al 2015).

Pandian, et al (2013) reviewed the outcomes of single versus multiple embryo transfers as part of IVF.

The decision to fund IVF and the number of cycles funded is made by CCGs. The picture changes regularly as CCGs consult on changes. The Fertility Fairness website shows current IVF provision across England.

The Human Fertilisation and Embryology Authority reported in 2015 on multiple births and IVF.

The responses to the public consultation have informed this revised document.

**References:**

Farquhar C, Rishworth J R, Brown J, Nelen W L D M, Marjoribanks J. Assisted reproductive technology: an overview of Cochrane Reviews. Cochrane Database of Systematic Reviews 2015, Issue 7

Fertility Fairness website  
<http://www.fertilityfairness.co.uk/nhs-fertility-services/ivf-provision-in-england/>  
Accessed on 14 August 2017

Human Fertilisation and Embryology Authority (2015)  
Improving outcomes for fertility patients: multiple births 2015

Pandian Z, Marjoribanks J, Ozturk O, Serour G, Bhattacharya S. Number of embryos for transfer following in vitro fertilisation or intra-cytoplasmic sperm injection. Cochrane Database of Systematic Reviews 2013, Issue 7.

**Impact**

**2. What is the potential impact of your work on health inequalities?** Can you demonstrate through evidence based consideration how the health outcomes, experience and access to health care services differ across the population group and in different geographical locations that your work applies to?

**Answer:**

At an individual level the impact of this proposal on couples with women who would otherwise have been offered IVF paid for by the NHS is high.

However, the change affects a relatively small number of people in the Cambridgeshire and Peterborough CCG population. An average of 142 women per year accessed NHS-funded IVF between April 2014 and October 2016 out of a Cambridgeshire and Peterborough population of over 940,000. In the year 2015/16 200 people accessed this treatment as reported in the consultation document.

As no local area has a current rate of access to IVF that is different from the CCG average, at a CCG level there will be no significant difference in the impact by geographical area.

**3. Will this work produce any specific changes in inequalities in access?**

**Answer:**

Under this proposal IVF will no longer be available on the NHS for the whole Cambridgeshire and Peterborough CCG population, regardless of pre-existing inequalities. So from a service perspective this work will not increase inequalities in access to NHS services at the level of the CCG geography.

However, from a wider population perspective those who can afford to pay may still access the service privately and this may produce an inequality in access.

The Fertility Fairness website (accessed on 14 August 2017) notes that:

34 CCGs fund three cycles of IVF

46 CCGs fund two cycles

125 CCGs fund one cycle

4 CCGs do not fund IVF

This shows a geographical inequality in access to NHS-funded IVF provision across England.

**4. Will this work produce any specific changes in inequalities in health outcome?**

**Answer:**

Under this proposal IVF will no longer be available on the NHS for the whole Cambridgeshire and Peterborough CCG population, regardless of pre-existing inequalities. So from a service perspective this work will not increase inequalities in outcomes from NHS services.

However, from a wider population perspective those who can afford to pay may still access the service privately and this may produce an inequality in outcomes related to IVF.

**5. How can you make sure that your work has the best chance of reducing health inequalities?**

**Answer:**

Any inequality will be mitigated by targeted publicity of the treatment options for subfertility that are still available to those who are unlikely to be able to afford IVF privately.

There is a range of services available to people who need help with fertility issues, both in primary care and in our local hospitals.

Services provided by the gynaecology clinics in the local hospitals include:

- The standard investigation of causes of infertility.
- Non-specialist treatments such as physical and hormonal therapy.
- Management of ovulatory disorders.
- Management of tubal and uterine abnormalities.
- Medical and surgical management of endometriosis.
- Medical and surgical management of male infertility.
- Management of ejaculatory failure.

The care pathway for fertility services can be found on the website:

<http://www.cambsphn.nhs.uk/CCPF/PHPolicies.aspx>

**6. Would providing this service in an integrated way, either integrated within health service or integrated with social care, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved?**

**Answer:**

No

**If yes please briefly state the plan for this integration:**

### **Risks**

**7. Are the risks to health inequalities clearly identified and part of your project risk register?**

Yes.

### **Monitor and Evaluation**

**8. How will you monitor and evaluate the effect of your work on health inequalities?**

**Answer:**

Ongoing monitoring of the adherence to the policy and requests for exceptional case funding for IVF will be used to monitor the effects of this proposal on inequality.

### **For your records**

**Name of person(s) who carried out these analyses:**

Dr Fiona Head, Consultant in Public Health Medicine

Julie Istead, Clinical Policies and Exceptional Cases Team Manager

**Name of Sponsor Director in November 2016:**

Jill Houghton, Director of Quality

**Name of Sponsor Director in August 2017:**

Sue Watkinson, Director of Transformation and Delivery: Planned and Primary Care

**Date analyses were completed:**

24 November 2016

**Date analyses reviewed to take into account consultation responses**

17 August 2017

## **Appendix D3 - Health Impact Assessment Tool**

### **Background**

An impact is any effect of implementing a proposal (whether this is a project, service, or wider programme change) on an individual or group.

Impacts can be positive or negative; intended or accidental.

### **Reason for undertaking impact assessments**

We assess impacts before proposals are implemented so that we:

- Identify benefits
- Plan to mitigate dis-benefits
- Guide evaluation
- Fulfill statutory requirements

All impact assessments need:

- A clear description of the proposal  
In particular the assessment needs to define how the proposal will change the current service
- Definition of the group of people that will be affected and understanding of the characteristics of these groups
- Identification of the stakeholders of the proposal

This form covers the Health Outcome Impact Assessment.  
It has the same fields as those found on the “wave” system.

## Health Outcome Impact Assessment

<b>Lead assessor completing form:</b>	Julie Istead	<b>Reviewer</b>	<b>Initial Reviewer</b> Alexandra Faragher, Research Office <b>Revised document reviewed by</b> Dr Fiona Head
<b>Position</b>	Clinical Policies and Exceptional Cases Team Manager	<b>Position</b>	Associate Director Clinical Outcomes and Population Health Strategy
<b>Date assessment completed</b>	Initially completed 14 February 2017 Revised after consultation on 17 August 2017	<b>Date assessment reviewed</b>	Initially reviewed on 14 February 2017 Revised version reviewed 17 August 2017

### Step (1) Define the change and who will be affected

<b>Title of project</b>	<b>Service restriction to stop routinely commissioning any specialist fertility services</b>
<b>Brief description</b>	<p>The CCG Governing Body is considering a proposal to stop the routine commissioning of specialist fertility services that are currently provided to NHS patients registered at a GP practice in the CCG's area.</p> <p>Specialist fertility services are currently commissioned via a consortium arrangement lead by East and North Herts CCG on behalf of a number of CCGs within the East of England (known as the East of England Fertility Consortia). Couples referred from secondary care infertility investigation clinics have the option to be referred to one of five specialist providers contracted to provide the service.</p> <p>If this service restriction is implemented couples will still have access to:</p>

	<ul style="list-style-type: none"> <li>• Fertility preservation for patients undergoing treatments that are likely to make them infertile such as certain cancer treatments.</li> <li>• Sperm washing for men who have a chronic viral infection, whose partner does not, and where intrauterine insemination is being considered.</li> </ul> <p>Secondary care fertility investigations will continue to be funded.</p>
<p><b>Change that the project will bring about</b>  <b>What will be different in terms of structures and processes as a result of this project?</b></p>	<p>The proposal is that the CCG will no longer commission IVF services for new patients. This will apply to all new referrals following implementation of the service restriction.</p> <p>Patients currently in the IVF process will continue to receive their IVF cycle(s).</p>
<p><b>Intended improvement:</b>  <b>Please be precise about the improvement that this project will bring about, i.e. what are the results of the change described above?</b></p>	<p>The Cambridgeshire and Peterborough health system is currently spending more money providing healthcare than it has in its total budget, therefore the total budget for the CCG needs to prioritise what services are commissioned.</p> <p>If the CCG Governing Body decides in favour of the proposal the CCG is forecasting a recurring saving of £700,000.</p>

**Step (2) Specify the people affected by this change (patients)**

<p><b>How many people will be affected by this change?</b></p>	<p>The people affected by this change will be all couples registered with a Cambridgeshire and Peterborough CCG GP if they are diagnosed with unexplained infertility and wishing to access specialist IVF services to help them conceive a child.</p> <p>Based on data between April 2014 and October 2016, 142 couples each year will be affected by this change. In the year 2015/16 200 people accessed this treatment as reported in the consultation document. The above figure is an average figure over a number of years.</p>
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<p><b>What is their age range?</b></p>	<p>Women aged 23 years up to and including 42 years of age (at which point the current IVF service provision ends). Men aged 23 years up to and including 55 years of age (at which point the current provision ends).</p>
<p><b>Where are they living? (locality or geographical area)</b></p>	<p>The patients are living in the practice areas of GP practices which are members of NHS Cambridgeshire and Peterborough CCG.</p>
<p><b>Any other features that help define the population who are affected by this change?</b></p>	<p>All couples registered with a Cambridgeshire and Peterborough CCG GP requiring help from specialist IVF services to conceive who fulfil the residency requirement of the current Assisted Conception Policy.</p>
<p><b>Are there any significant inequalities already <u>between</u> this group of people overall and other groups either within Cambridgeshire and Peterborough or elsewhere?</b> <i>Please give reasons for thinking this is the case.</i></p>	<p>This group will be characterised by a particular age range (30-39 years) as the majority of IVF patients fall within this range.</p>
<p><b>Are there any significant inequalities already within this group of people?</b> <i>Please give reasons for thinking this is the case.</i></p>	<p>Data has been analysed for the time period April 2014 to October 2016. No local area has a current rate of access to IVF that is different from the CCG average.</p> <p>The rate of IVF access does not vary with index of deprivation of the referring GP. However, Greater Peterborough has an access rate significantly lower than some areas of Cambridgeshire (the previous CATCH practices) and Huntingdonshire.</p> <p>This change will affect those who are unable to afford to pay privately for IVF treatment. It can reasonably be assumed that those who are unable to pay privately for IVF are more likely to have lower incomes.</p>
<p><b>Please describe the number and type of groups of people affected by the change who are either vulnerable or already subject to inequality.</b></p>	<p>Couples on a low income may not be able to pay for private IVF treatment.</p> <p>There are no direct measures of the income of couples seeking IVF. The index of multiple deprivation of the patient's GP practice is the closest proxy. Approximately 50 couples each year seek IVF from the practices in the CCG in the two lowest quintiles of relative deprivation.</p>

**Step (3) Please identify and list the individual the population health outcomes from the CCG Improvement and Assessment Framework that could be affected by this change (Health outcome impact assessment)**

<https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/technical-annex.pdf>

CCG Improvement and assessment framework outcome	Brief rationale for link between the change and the population outcome	Positive/ Negative/ Neutral Impact	Risk identified
<b>105d. People with long term conditions feel supported to manage their condition</b>	<p>Conditions such as cancer, endometriosis, and pelvic inflammatory disease can cause fibrotic obstruction to the fallopian tube and the uterus that cannot be normally repaired or the treatment of which damages the integrity of cells and therefore significantly impair fertility. Patients with these conditions may feel unsupported in managing the consequences of their long term condition if they cannot afford to pay for private IVF treatment.</p> <p>It was not possible to acquire objective data relating to reason for infertility amongst the patient population currently accessing IVF. However, advice from our Clinical Lead indicates that this population does not constitute a significant proportion of those in receipt of IVF treatment at present.</p>	Negative	<p>This is a potential negative impact.</p> <p>In mitigation there is a process through the Exceptional Case Panel through which such exceptional cases can be heard.</p> <p>Clinical Lead opinion is that the numbers of people in this situation are not likely to constitute a significant proportion of those in receipt of IVF treatment at present.</p>
<b>122d. Cancer Patient Experience</b>	As above for people with long term conditions.	Negative	As above.
<b>141 a Financial Plan</b>	<p>In the year 2015/16 the CCG spent £1,037,000 on specialist fertility treatment. This includes those who were eligible for more than one cycle prior to the existing changes. If the CCG Governing Body decides in favour of the proposal the CCG is forecasting a recurring saving of £700,000.</p>	Positive	
<b>141 b In year financial performance</b>	In-year financial performance for 2017/18 will	Neutral/	

	not be as significant as outlined above as those patients in receipt of IVF will not be restricted.	Positive	
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**Step (4) List any other population health outcomes that could be affected by this change**

<b>Population health outcome</b>	<b>Brief rationale for link between the change and the population outcome</b>	<b>Positive/ Negative/ Neutral Impact</b>	<b>Risk identified</b>
<b>Self-reported well-being</b>	Evidence suggests that infertility can cause anxiety and depression for many couples. This service restriction may cause some couples, especially those who are unable to pay for private IVF treatment, significant anxiety and depression.	Negative	<p>Symptoms of anxiety and/or depression amongst couples affected by this service restriction, especially those unable to pay for private IVF treatment.</p> <p>Possible increased impact on mental health and counselling services.</p> <p>Please note that other CCGs in the East of England that have ceased to commission IVF report anecdotally that they have not seen an increase in demand for mental health services. This is expected as the numbers accessing IVF are very small in comparison to the total numbers referred each year for mental health services.</p>
<b>Increase in multiple pregnancies and subsequent increase in adverse obstetric and neonatal outcomes</b>	<p>All clinics offering IVF in the UK, whatever the funding route, are by law regulated by the Human Fertilisation and Embryology Authority (HFEA).</p> <p>The HFEA has worked with providers of IVF to decrease multiple embryo transfer.</p>	Neutral at a population level.	<p>Current IVF policy is for NHS-funded IVF patients to receive one embryo per transfer (current policy if the woman is aged 23 to 39 years).</p> <p>HFEA statistics accompanying the 2015 Multiple Births report show that the multiple birth rate for elective single</p>

	<p>The result is that in the UK elective transfer of single embryos has increased and multiple pregnancy rates have fallen over the last decade. (HFEA 2015 Report on Multiple Births)</p> <p>If women pay privately for IVF there is a risk that they may use international providers who do not provide a service of the same quality as the current NHS service and be more likely to have multiple embryos transferred. This could result in more multiple pregnancies and these are known to have poorer obstetric and neonatal health outcomes.</p> <p>In European clinics the rate of single embryo transfer is increasing and the rate of multiple pregnancy is falling. See for example: <a href="https://www.eshre2017.eu/Media/ESHRE-2017-Press-releases/CalhazJorge.aspx">https://www.eshre2017.eu/Media/ESHRE-2017-Press-releases/CalhazJorge.aspx</a></p> <p>An estimated twin pregnancy rate following IVF across European clinics is 17%. This excludes UK data:</p> <ul style="list-style-type: none"> <li>• Assuming a pregnancy rate of approximately 40% (see Bourn Hall consultation response) for one cycle of NHS-funded IVF</li> <li>• And that no NHS-funded women would have a multiple pregnancy</li> </ul> <p>If all women who would otherwise have had one cycle of NHS-funded IVF went overseas for this one cycle the multiple pregnancy</p>		<p>embryo transfer is 1.7%.</p> <p>Locally Bourn Hall reports a very low multiple pregnancy rate (see Bourn Hall response to consultation).</p>
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	<p>numbers might be expected to increase by <math>150 \times 0.4 \times 0.17 = 10</math> per annum</p> <p>There were 218 multiple births in in 2016/17 across Cambridgeshire and Peterborough CCG resident population. So we are unlikely to detect any increase in multiple pregnancies secondary to ceasing to fund one cycle of IVF.</p> <p>Personal communications from CCGs in our area who have ceased to provide IVF on the NHS are that they have not observed an increase in the number of multiple births.</p>		
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**Step (5) Assess where the impacts will fall**

	<b>Positive/ Negative/ Neutral Impact</b>	<b>Brief rationale for link between the change and the population outcome</b>	<b>Risk identified</b>
<b>What type of impact will the proposal have on health, mental health, and wellbeing?</b>	Negative	<p>Evidence suggests that infertility can cause anxiety and depression for many couples. This service restriction may cause some couples, especially those who are unable to pay for private IVF treatment, significant anxiety and depression.</p> <p>Couples unable to pay for their own IVF treatment may require counselling for symptoms of depression and/or anxiety.</p> <p>If women pay privately for IVF there is a</p>	<p>Symptoms of anxiety and/or depression amongst couples affected by this service restriction, especially those unable to pay for private IVF treatment.</p> <p>Possible increased impact on counselling services.</p> <p>Please note that other CCGs in the East of England that have ceased to commission IVF report anecdotally that they have not seen an increase in</p>

		<p>risk that they may use providers who do not provide a service of the same quality as the current NHS service.</p> <p>If overseas private providers are used then there may be an increase in multiple birth rates with associated negative obstetric and neonatal outcomes. The numbers affected would be small. Please see note under section (4) above.</p>	<p>demand for mental health services. This is expected as the numbers accessing IVF are very small in comparison to the total numbers referred each year for mental health services.</p> <p>Personal communications from CCGs in our area who have ceased to provide IVF on the NHS are that they have not observed an increase in the number of multiple births.</p>
<b>Will the impact on an individual's ability to improve their own health and wellbeing be positive/neutral or negative?</b>	Negative	<p>Couples who can afford to pay for IVF will be able to address their own health and wellbeing if it is affected by this service restriction.</p> <p>Couples who cannot afford to pay for IVF may suffer symptoms of anxiety and depression which impede their ability to improve their own wellbeing and health.</p>	<p>Symptoms of anxiety and/or depression amongst couples affected by this service restriction, especially those unable to pay for private IVF treatment.</p> <p>Possible increased impact on psychological wellbeing services, although as above this effect is expected to be too small to detect at the population level.</p>
<b>Will the impact on social, economic and environmental conditions that could affect health be positive/neutral/negative?</b>	Negative	<p>Couples may over-extend themselves financially in order to pay for private IVF treatment. This additional financial stress may have implications on each individual's health.</p>	<p>Couples may suffer financial stressors as a result of acquiring private IVF treatment.</p> <p>Increased impact on health outcomes as a result of stress.</p>
<b>Will the impact in the demand for or access to health and social services be positive/neutral or negative?</b>	Neutral	<p><b>1) Demand for fertility services:</b> Couples will continue to access investigative procedures for fertility with no change in service. A relatively small number of couples compared to the</p>	

		<p>number in the whole population are currently referred to tertiary services to try to achieve a pregnancy.</p> <p>If IVF is no longer available the demand on these investigative services may go up. Alternatively the demand for access to investigative NHS fertility services could be expected to fall once no cycles of NHS funded IVF are available so this has been assessed as neutral.</p> <p><b>2) Demand for mental health services:</b> The numbers currently receiving NHS-funded IVF are very small compared to the number referred to mental health services each year.</p> <p><b>3) Services related to multiple pregnancies</b> Estimates (see above) show that if all people currently receiving one cycle of NHS-funded IVF went overseas for treatment then the increase in the number of multiple births could be up to 10 per annum in Cambridgeshire and Peterborough.</p> <p>Personal communications from CCGs in our area who have ceased to provide IVF on the NHS are that they have not observed an increase in the number of multiple births.</p>	
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		There were 218 multiple births in 2016/17 across Cambridgeshire and Peterborough CCG's resident population	
<b>Will the proposal's impact on global health be positive/ neutral or negative?</b>	Neutral	There are no foreseeable significant impacts on global health.	

		<b>Brief rationale for link between the change and the population outcome</b>	<b>Risk identified</b>
<b>Will the health impacts affect the whole population or will there be differential impacts within the population?</b>	Differential impacts	This service restriction will affect a relatively small number of couples who are mainly in the 30-39 year old age range and are unable to conceive a child naturally and are unable to afford to pay for private IVF treatment.	
<b>Do each of the negative health impacts have a mitigation in place?</b>	Yes	Couples can pay for IVF themselves or may apply through the CCG individual funding request (exceptional cases) process.  There is clear information on the NHS Choices website about choice of a private IVF provider.	

Appendix D4 Sustainability Impact Assessment

**Sustainability Impact Assessment**

<b>Lead assessor completing form:</b>	Julie Istead	<b>Reviewer:</b>	Sharon Fox
<b>Position:</b>	Exceptional Cases and Clinical Policies Manager	<b>Position:</b>	Associate Director of Corporate Affairs (CCG Secretary)
<b>Date assessment completed:</b>	7 February 2017	<b>Date assessment reviewed:</b>	14 February 2017
<b>Date assessment review completed</b>	16 August 2017	<b>Date assessment reviewed</b>	
<b>Signature:</b>		<b>Signature:</b>	

**Stage 1: Screening questions**

**Step 1 Specify the people who are affected by this change (patients)**

<b>How many people will be affected by this change?</b>	All couples registered with a Cambridgeshire and Peterborough GP in the CCG geographical area diagnosed with unexplained infertility and wishing to access specialised IVF services to help them conceive a child.
<b>What is their age range?</b>	Women aged 23 years up to and including 42nd year. Men aged 23 years up to and including 55th year.
<b>Where are they living? (locality or geographical area)</b>	Covers patients that are registered with a Cambridgeshire and Peterborough GP in the CCG geographic area.
<b>Any other features that help define the population who are affected by this change?</b>	All couples registered with a GP in Cambridgeshire and Peterborough CCG's geographical area, requiring help from specialist IVF services to conceive – not two week wait or urgents.
<b>Are there any significant inequalities already <u>between</u> this group of people overall and other groups either within Cambridgeshire and Peterborough or elsewhere?</b> <i>Please give reasons for thinking this is the case.</i>	Some couples will be unable to afford to pay for IVF – there is a higher cost to couples seeking to pay privately for treatment.

<p><b>Are there any significant inequalities already <u>within</u> this group of people?</b>  <b><i>Please give reasons for thinking this is the case.</i></b></p>	<p>This will be reflected in the more deprived and less affluent areas of the CCG's area. This will result in inequity amongst couples who can pay and those who cannot.</p>
<p><b>Please describe the number and type of groups of people affected by the change who are either vulnerable or already subject to inequality.</b></p>	<p>Couples on low incomes.</p>

**Sustainability impact assessment**

**Please consider whether the change will do any of the following:**

Help in filling out this section is available from: tbc

Area for assessment	Key points	Positive/ Negative/ Neutral Impact	Risk identified
<b>Leadership, Engagement and Development</b>			
Provide employment opportunities for local people?	N/A		
Offer employment opportunities to disadvantaged groups?	N/A		
Promote and encourage a sustainable local economy?	This change will allow resources to be used to greater overall population benefit.	Positive	
<b>Sustainable clinical and care models</b>			
Minimise 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes?	N/A		
Promote prevention of, and improve self-management of, long term conditions?	N/A		
Provide evidence-based, personalised care that achieves the best possible outcomes with the resources available?	<p>Patients will continue to be offered CCG-funded infertility investigations provided at secondary care level.</p> <p>Fertility preservation to patients undergoing</p>	Positive	

	<p>treatments that are likely to make them infertile.</p> <p>Sperm washing provided to men who have a chronic viral infection and whose partner does not where intrauterine insemination is being considered.</p>		
Deliver integrated care that co-ordinates different elements of care more effectively and remove duplication?	N/A		
<b>Carbon hotspots</b>			
Support the CCG's objectives to reduce carbon emissions and become more sustainable?	Reduce travel to specialist IVF clinics.	Positive	
Affect the use of energy or water? Affect pollution to air, land, or water?	Reduce travel to specialist IVF clinics, reducing pollution.	Positive	
<b>Commissioning and Procurement</b>			
Will specific social, economic, and environmental outcomes to be accounted for in procurement (if applicable) and delivery?	<p>Possible issues around increased demand for counselling for couples unable to afford private treatment.</p> <p>The number of patients receiving IVF (approximately 200 per annum) is very small compared to the total number of people who develop mental health conditions each year. If individuals did find themselves experiencing some mental health problems, even if that was every patient, the cost pressure would not be significant. However we do recognise that for these 200 patients there would be a considerable personal cost.</p> <p>The CCG commissions a wide range of mental health services from GP-centred care, community wellbeing services, and community mental health services through a wide range to inpatient and cluster care for a range of mental</p>	Negative	Symptoms of anxiety and/or depression amongst couples affected by this service restriction, especially those unable to pay for private IVF treatment.

	<p>health conditions.</p> <p>As a snapshot to give an idea of the numbers of people who may require access to mild to moderate psychological therapies, the CCG has provided the IAPT (increased access to psychological therapies) service for 15,781 people in 2016/17. This is set to increase year-on-year in line with national targets, based on calculated prevalence of people with mild to moderate anxiety and depression.</p>		
Will the change stimulate innovation among providers of services related to the delivery of the organisations' social, economic, and environmental objectives?	N/A		
Will implementation promote ethical purchasing of goods or services and promote sustainable procurement e.g. the purchase of materials from sustainable sources?	N/A		
Will implementation promote greater efficiency of resource use?	Savings identified will be reinvested back into the health economy.	Positive	
Will implementation obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)?	N/A		
Will implementation support local or regional supply chains?	N/A		
Will implementation make current activities more efficient or alter service delivery models?	N/A		
<b>Overall Corporate Vision: transport</b>			
Provide / improve / promote alternatives to car based transport?	N/A		
Support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)?	N/A		
Promote active travel (cycling, walking)?	N/A		

Affect vehicle use, mileage or other transport or travel activity?	N/A		
<b>Overall Corporate Vision: buildings</b>			
Improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)?	N/A		
Increase safety and security in new buildings and developments?	N/A		
Reduce greenhouse gas emissions from transport (choice of mode of transport, reducing need to travel)?	N/A		
Provide sympathetic and appropriate landscaping around new development?	N/A		
<b>Overall Corporate Vision: buildings: adaptation</b>			
Support adaptation to the likely effects of climate change (e.g. identifying vulnerable groups; contingency planning for flood, heat wave and other weather extremes)?	N/A		

## Stage 2 – Assessment of Risk

To be completed for any areas where a negative impact has been identified

Area of impact	Risk (as identified in stage 1)	Risk score	Mitigating actions	Mitigated risk score	Monitoring arrangements	Timescale for review	Responsibility for managing risk
Commissioning and Procurement	Possible issues around increased demand for counselling for couples unable to afford private treatment.	6	<p>It is important that those patients who cannot afford private IVF treatment and are suffering symptoms of psychological distress are referred to the appropriate psychological support services (i.e. Psychological Wellbeing Service).</p> <p>Guidance should be issued to relevant clinical colleagues about the importance of referral in such instance.</p> <p>Such symptoms may be mitigated by targeted publicity of the treatment options for subfertility that are still available to those who are unlikely to be able to afford IVF privately.</p>	4	<p>Annual monitoring of referral to Psychological Wellbeing Service for fertility-related matters. Data gathered from referring clinicians or Psychological Wellbeing Service, if possible.</p> <p>As numbers are small, this is not expected to be detectable at the population level. The number of patients receiving IVF (approximately 200 per annum) is very small compared to the total number of people who develop mental health conditions each year. If individuals did find themselves experiencing some mental health problems, even if that</p>	Annually	Associate Director for Planned Care

			<p>There is a range of services available to people who need help with fertility issues, both in primary care and in our local hospitals.</p>		<p>was every patient, the cost pressure would not be significant. However we do recognise that for these 200 patients there would be a considerable personal cost.</p> <p>The CCG commissions a wide range of mental health services from GP-centred care, community wellbeing services, and community mental health services through a wide range to inpatient and cluster care for a range of mental health conditions.</p> <p>As snapshot to give an idea of the numbers of people who may require access to mild to moderate psychological therapies, the CCG has provided the IAPT (increased access to psychological</p>	
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					therapies) service for 15,781 people in 2016/17. This is set to increase year-on-year in line with national targets, based on calculated prevalence of people with mild to moderate anxiety and depression.		
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**Notes:**

1. All areas of risk scoring greater than eight must be escalated in line with the CCG risk management process.
2. Monitoring arrangements can include review of complaints, incidents, serious incidents, use of clinical audit, observation, and patient feedback.

**Examples for Quality Impact Assessment Section:**

	<b>Risk</b>	<b>Mitigating action</b>
<b>Examples</b>	<b>Patient Experience</b>	
	Patients do not find the location or timings of the treatment easily accessible	Ensure appropriate patient involvement in project development
	Patients have not been involved in or consulted about the change	Ensure appropriate patient involvement in project development
	<b>Patient Safety</b>	
	Staffing levels have not been adequately calculated	Ensure robust workforce review completed
	Staff concerns lead to increased turnover and sickness	Ensure all relevant staff are kept informed and involved about change
	There is not an appropriate location that meets required integrated prevention and control and other quality standards to carry out the proposed treatment	Review possible locations, current use and possible availability
	Similar services, either locally or nationally, have recorded safety concerns, identified by incident reporting	Review similar services locally or across the country
	<b>Clinical Effectiveness</b>	
	There are not appropriate clinicians available with relevant qualifications, training and clinical supervision arrangements	Ensure robust workforce review completed
	The treatment proposed does not meet best practice e.g. NICE or Royal College guidance	Ensure requirements of guidance are reviewed and met, and included in quality indicators for evaluation
	Referral criteria is not clear, robust and evidence based	Ensure referral criteria is based on best practice and agreed by all stakeholders

**Appendix D5      Quality Impact assessment**

<b>Title of project</b>	Proposal to stop routinely commissioning any specialist fertility services other than for two specified exceptions.
<b>Brief description</b>	Consultation on a service restriction to stop funding NHS-funded IVF services provided by contracted tertiary/specialised providers
<b>Project Lead</b>	Rob Murphy, Associate Director Transformation and Delivery – Planned Care
<b>Intended Improvement</b>	N/A

<b>Lead assessor</b>	Julie Istead	<b>Reviewer</b>	Jill Houghton
<b>Position</b>	Clinical Policies and Exceptional Cases Team Manager	<b>Position</b>	Director of Quality, Safety and Patient experience
<b>Date assessment completed</b>	27 September 2016	<b>Date assessment reviewed</b>	29 September 2016
<b>Date of post consultation review</b>	16 August 2017	<b>Date of post consultation assessment review</b>	
<b>Signature</b>		<b>Signature</b>	

**Stage 1 – Assessment of Impact**

Discussion should consider the domains of the NHS Outcomes Framework - could the proposal impact positively or negatively on the delivery of the five domains:

- Preventing people from dying prematurely
- Enhancing quality of life
- Helping people recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

Area for discussion	Key points of discussion	P / N impact	Risk identified
<b>Patient Experience</b> Could the proposal impact positively or negatively on any of the following:			
Patient Choice	If the service restriction is applied, patients will no longer have the opportunity to apply for NHS-funded IVF and will have to provide their own funding.	N	Not all patients will be able to afford to pay for privately funded IVF and this may adversely affect their wellbeing.
Accessibility of services	Details of private providers are available from the HFEA.	P	
Range of services	Reduces the range of services.	N	End of NHS-funded access to specialist IVF services preventing infertile couples from having a means/opportunity of achieving pregnancy without specialised clinical assistance.
Timing of services	N/A		
Patient involvement in service development	There is patient forum membership and/or lay membership on the Clinical Policies Forum and SCPG. The consultation paper has also been to the CCG's Patient Reference Group. Fertility UK and any other patient groups will also be engaged.	P	

Area for discussion	Key points of discussion	P / N impact	Risk identified
<b>Patient Safety</b>			
Could the proposal impact positively or negatively on any of the following:			
Safeguarding of children	N/A		
Safeguarding of adults at risk	N/A		
Staff engagement with changes in service	N/A		
Appropriately trained and qualified staff providing service	Details of private providers of infertility services licensed by the HFEA are available to couples. Details are also available on the NHS Choices website: <a href="http://www.nhs.uk/Conditions/IVF/Pages/Availability.aspx">http://www.nhs.uk/Conditions/IVF/Pages/Availability.aspx</a>	P	
Safe clean environment	N/A		
Safe clean equipment	N/A		
Possible Serious Incidents or Never Events (as recorded by similar services)	N/A		
<b>Effectiveness</b>			
Could the proposal impact positively or negatively on any of the following:			
Provision of evidence-based service.	Reduces the range of services.	N	End of NHS-funded access to specialised IVF services preventing infertile couples from having a means/opportunity of achieving pregnancy without specialised clinical assistance.
Appropriate equipment for service	N/A		
Clinical outcomes	Reduces the clinical outcome of “pregnancy in infertile couples”.	N	End of NHS-funded access to specialised IVF services preventing infertile couples from having a means/opportunity of achieving pregnancy without specialised clinical assistance.
Interface with other services, including referrals to and from the service	N/A		
Mortality (as recorded by similar services)	N/A		

<b>Other quality issues identified in review</b>			
Include any additional areas identified that could impact positively or negatively:			
Private provider implanting multiple embryos	Current NHS policy restricts multiple embryo implants.	N	Risk to mother and child. Additional knock-on health costs to the NHS.
Counselling costs for couples unable to afford private treatment	Additional IAPT costs.	N	Additional knock-on health cost to the NHS.

**Stage 2 – Assessment of Risk**  
**To be completed for any areas where a negative impact has been identified**

<b>Risk (as identified in stage 1)</b>	<b>Risk score</b>	<b>Mitigating actions</b>	<b>Mitigated risk score</b>	<b>Monitoring arrangements</b>	<b>Timescale for review</b>	<b>Responsibility</b>
Inability to afford private IVF treatment may adversely affect couples' wellbeing.	3x3	Consultation on introducing this will assist in managing expectations.	3x2	If implemented we will not be able to monitor this.	Annually	Associate Director Transformation and Delivery – Planned Care
Risk of multiple pregnancies due to private provider implantation of multiple embryo causing potential health problems to mothers and babies and increasing the financial burden to the NHS.	3x3	Communicating risks to our population. Good antenatal and post natal care mitigates the risk – all of our maternity units are well equipped to manage the risks.	3x2	If policy implemented a monitoring mechanism will be established via the maternity dashboard.	Annually	Associate Director Transformation and Delivery – Planned Care
Reduction in range of services.	3x3	Couples may go down the exceptional/individual funding request route or fund their own treatment.	3x2	Monitor funding requests.	Annually	Associate Director Transformation and Delivery – Planned Care

Reduction in provision of evidence-based service.	3x3	Couples may go down the exceptional/individual funding request route or fund their own treatment.	3x2	Monitor funding requests.	Annually	Associate Director Transformation and Delivery – Planned Care
Reduction in clinical outcomes of pregnancy in infertile couples.	3x3	Couples may go down the exceptional/individual funding request route or fund their own treatment.	3x2	Monitor funding requests.	Annually	Associate Director Transformation and Delivery – Planned Care

**Notes:**

3. All areas of risk scoring greater than eight must be escalated in line with the CCG risk management process.
4. Monitoring arrangements can include review of complaints, incidents, serious incidents, use of clinical audit, observation, and patient feedback.