Support for commissioning for fertility problems

Support for commissioning
Published: 23 October 2014
nice.org.uk

Overview and resources

This resource provides information on key clinical, cost and service-related issues to consider during the commissioning process for fertility services. It is underpinned by NICE's quality standard for fertility problems. Commissioners can use content from the specifying services section to populate local or regional service specifications depending on service need and local arrangements. To help with this, the specifying services section is structured to reflect Schedule 2a – The Services in the ‘Particulars’ section of the NHS standard contract 2014/15. Information can be transferred from this guide to your local service specification but it should not be used as an 'off the shelf' service specification.

We welcome your feedback on using this resource. See the feedback section for details.

More information about NICE support for commissioning

Use the NICE pathway on fertility for fast access to NICE guidance and implementation resources to support commissioning for fertility problems.

Summary of commissioning responsibilities and resource impact

- Clinical commissioning groups (CCGs) are responsible for commissioning services for the assessment and treatment of fertility problems.

- NHS England has a specific role for the direct commissioning of primary medical services through GP contracts and public health.
- CCGs may benefit from working together when commissioning services for the assessment and treatment of fertility problems. Working together will enable sharing of expert knowledge and skills, offer greater leverage with providers and minimise variation in commissioning decisions.

- CCGs should work with the providers of services for fertility problems across the whole care pathway including GPs in primary care, hospital-based secondary care and specialist fertility care services.

Table 1 Responsibilities and resource impact for achieving the quality standard for fertility problems

<table>
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<tr>
<th>Quality statement</th>
<th>Commissioner(s)</th>
<th>Providers</th>
<th>Resource impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lifestyle advice</td>
<td>NHS England area teams, CCGs, local authorities</td>
<td>GPs, primary care, fertility services, preconception advice and gynaecology services</td>
<td>No resource impact anticipated for providing lifestyle advice because this should be available as part of generic service contracts. Lifestyle changes may reduce the need for onward referrals for outpatient appointments in gynaecology (£131) and urology (£127) and fertility treatment services.</td>
</tr>
<tr>
<td>2. Referral for specialist consultation</td>
<td>NHS England area teams, CCGs</td>
<td>GPs, secondary care services</td>
<td>No significant resource impact anticipated.</td>
</tr>
<tr>
<td>3. Counselling</td>
<td>CCGs</td>
<td>Specialist fertility care services</td>
<td>There will be a resource impact where additional counsellors are recruited. The annual cost to providers of a counsellor is around £43,337. There may be financial benefits of counselling because of increased adherence to treatment.</td>
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<tr>
<td></td>
<td>4. Semen analysis</td>
<td>CCGs</td>
<td>Laboratory services</td>
</tr>
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<tr>
<td>5.</td>
<td>IVF for women under 40 years</td>
<td>CCGs</td>
<td>Specialist fertility care services</td>
</tr>
<tr>
<td>6.</td>
<td>IVF for women aged 40–42 years</td>
<td>CCGs</td>
<td>Specialist fertility care services</td>
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<td>7.</td>
<td>Intracytoplasmic sperm injection</td>
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<td>8.</td>
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<td>9.</td>
<td>Cryopreservation before cancer treatment</td>
<td>CCGs</td>
<td>Specialist fertility care services</td>
</tr>
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</table>
Key messages

- Collaborating with other CCGs and joint working on procurement and pricing would result in service contracts covering a larger population.

- Commissioning for larger populations may lead to efficiency savings and reduce variation in the costs of fertility treatment.

- Sharing expert knowledge and skills through collaborative working will also minimise variation in the decisions reached on individual funding requests and minimise the risk of litigation.

- Fertility services are subject to legislation under the Human Fertilisation and Embryology Act (2008) and sharing understanding of these complexities may minimise risks for CCGs relating to complex equity issues.

When commissioning services for fertility problems, CCGs should:

- refer to the NICE guideline on fertility and ensure that people who are having trouble conceiving receive earlier referrals to specialist services (where appropriate) and access to the most effective treatment (including IVF treatment for women aged 40–42 who meet the criteria).

- collaborate with each other, NHS England, provider organisations and people with fertility problems.

- ensure that people who are eligible for fertility services are not excluded. For more information, see the equality and diversity considerations outlined for quality statements 5, 6 and 9 in the section on treatment and management.

- plan for an increase in the number of NHS-funded cycles of treatment.

- aim to reduce the number of privately funded treatment cycles.

For more information, the Infertility Network report Assisted conception needs assisted implementation: a report into the status of NHS fertility services in England (2014) identifies CCGs who have commissioned fertility services collaboratively with one CCG taking on the role of lead commissioner.
Specifying services using the NICE quality standard for fertility problems

Commissioners can use content from this section to populate local or regional service specifications depending on service need and local arrangements. To help with this, the section is structured to reflect Schedule 2a – The Services in the 'Particulars' section of the NHS standard contract 2014/15. Information can be transferred from this guide to your local service specification but it should not be used as an 'off the shelf' service specification.

Population needs

National/local context and evidence base

Fertility problems exist when a woman cannot conceive (get pregnant) despite having regular unprotected vaginal intercourse, or artificial insemination, at and around the time of ovulation. NICE’s guideline on fertility recommends that in practice healthcare professionals should define infertility in terms of the period of time people have been trying to conceive without success after which formal investigation is justified and possible treatment implemented.

It is estimated that infertility affects 1 in 7 heterosexual couples in the UK. The main causes of infertility in the UK (with approximate prevalence given as a percentage) are:

- unexplained infertility (no identified male or female cause) (25%)
- ovulatory disorders (25%)
- tubal damage (20%)
- factors in the male causing infertility (30%)
- uterine or peritoneal disorders (10%).

In about 40% of cases, fertility disorders are found in both the man and the woman.

Outcomes

NHS Outcomes Framework

Table 2 Outcomes, overarching indicators and improvement areas from the NHS Outcomes Framework 2014/15 that the quality standard could contribute to achieving
### Domain 1: Preventing people from dying prematurely

#### Improvement area
- Reducing deaths in babies and young children
- Neonatal mortality and stillbirths

### Local defined outcomes

Clinical commissioning groups (CCGs) and NHS England should agree local outcomes based on the specific needs of their population and the quality and accessibility of current service provision. Locally defined outcomes can help drive quality improvements and help to achieve the desired outcomes for people with fertility problems.

Table 3 offers commissioners suggestions for data collection and signposts to self-assessment and clinical audit tools.

Commissioners can refer to the outcomes and quality measures in table 3 and add any reporting requirements to Schedule 6C of the 'Particulars' of the NHS standard contract.

### Table 3: Outcomes and process measures from the quality standard for fertility problems

<table>
<thead>
<tr>
<th>Quality statement 1: Lifestyle advice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome:</strong> People who are concerned that it is taking longer than expected to conceive feel informed about the impact that lifestyle can have on their chances of getting pregnant.</td>
</tr>
<tr>
<td>Use locally agreed data source. Data can be collected using the NICE <a href="#">clinical audit tool</a> for fertility: people concerned about delays in conception: audit standard 1b.</td>
</tr>
</tbody>
</table>

| **Process:** Proportion of people who are concerned that it is taking longer than expected to conceive who are given written and verbal advice on the impact that lifestyle (including body weight, smoking, alcohol and recreational drug use) can have on their chances of getting pregnant. |
| NICE's [self-assessment tool](#) developed to support the NICE guideline on weight management before, during and after pregnancy can also be used by maternity services to collect data from women about the information, advice and support they have received. |

| Quality statement 2: Referral for specialist consultation |
**Proceses:** Proportion of people (woman aged 35 years or under and men) who are referred for specialist consultation if the woman has not conceived after 1 year of intercourse or after 6 cycles of artificial insemination, when there is no known clinical cause or history of predisposing factors for infertility in the woman or man.

Use locally agreed data source.
Data can be collected using the NICE clinical audit tool for fertility: people concerned about delays in conception: audit standards 3 and 4.

Proportion of people who are referred for specialist consultation within 1 year from diagnosis of fertility problems when there is a known clinical cause in the woman or man, a history of predisposing factors for infertility or the woman is aged 36 years or older.

Use locally agreed data source.
Data can be collected using the NICE clinical audit tool for fertility: people concerned about delays in conception: audit standards 3 and 4.

### Quality statement 3: Counselling

**Outcome:** People who are having problems conceiving feel supported throughout and after investigation and treatment for their fertility problems.

Use locally agreed data source.

**Processes:** Proportion of people who are having problems conceiving and who are having investigations for fertility problems in secondary or tertiary care, who receive counselling.

Use locally agreed data source.

Proportion of people who are having problems conceiving and who are having treatment for fertility problems in secondary or tertiary care, who receive counselling.

Use locally agreed data source.

Proportion of people who are having problems conceiving and who have received treatment for fertility problems in secondary or tertiary care, who receive counselling.

Use locally agreed data source.

### Quality statement 4: Semen analysis
<table>
<thead>
<tr>
<th>Structure: Evidence of a quality assurance programme to ensure that services analysing semen samples use methods and reference values in accordance with the most recent World Health Organization laboratory manual.</th>
<th>Use locally agreed data source.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality statement 5: IVF for women under 40 years</strong>&lt;br&gt;Structure: Evidence of local arrangements to provide 3 full cycles of IVF for women aged under 40 years who meet the criteria.</td>
<td>For national data on the provision of IVF, refer to the Human Fertilisation and Embryology Authority. Use locally agreed data source.</td>
</tr>
<tr>
<td>Process: Proportion of women aged under 40 years who meet the criteria who are offered 3 full cycles of IVF.</td>
<td>For national data on the provision of IVF, refer to the Human Fertilisation and Embryology Authority. Use locally agreed data source.</td>
</tr>
<tr>
<td><strong>Quality statement 6: IVF for women aged 40–42 years</strong>&lt;br&gt;Structure: Evidence of a locally agreed policy on provision of 1 full cycle of IVF for women aged 40–42 years who meet the criteria.</td>
<td>For national data on the provision of IVF, refer to the Human Fertilisation and Embryology Authority. Use locally agreed data source.</td>
</tr>
<tr>
<td>Process: Proportion of women aged 40–42 years who meet the criteria who are offered 1 full cycle of IVF.</td>
<td>For national data on the provision of IVF, refer to the Human Fertilisation and Embryology Authority. Use locally agreed data source.</td>
</tr>
<tr>
<td><strong>Quality statement 7: Intracytoplasmic sperm injection</strong>&lt;br&gt;Structure: Evidence of local arrangements to ensure that ICSI is offered only if there are severe deficits in semen quality, obstructive azoospermia, non-obstructive azoospermia or if previous IVF treatment resulted in failed or very poor fertilisation.</td>
<td>Use locally agreed data source.</td>
</tr>
</tbody>
</table>
### Processes: Proportion of women having IVF with ICSI because of severe deficits in semen quality, obstructive azoospermia, non-obstructive azoospermia or because previous IVF treatment resulted in failed or very poor fertilisation

| Use locally agreed data source. |

### Quality statement 8: Number of embryos transferred

**Structure:** Evidence of local arrangements to implement an agreed embryo transfer strategy in which 1 or 2 embryos are transferred according to the woman’s or donor’s age, the cycle number and the quality of the embryos.

| Use locally agreed data source. Data can be collected using the NICE clinical audit tool for fertility: embryo transfer strategies: audit standards 4–7. |

### Processes: Proportion of IVF cycles in which embryo transfers are carried out in line with the NICE guideline on fertility.

| National data on elective single embryo transfers are available from the Human Fertilisation and Embryology Authority. |

### Proportion of embryo transfers that are elective single embryo transfers.

| National data on multiple pregnancy rates following IVF treatment are available from the Human Fertilisation and Embryology Authority. |

### Number of IVF treatments resulting in multiple pregnancy.

### Quality statement 9: Cryopreservation before cancer treatment

**Structure:** Evidence of local arrangements to ensure that people preparing to have treatment for cancer that is likely to result in fertility problems are offered cryopreservation.

| Use locally agreed data source. |

**Processes:** Proportion of males having treatment for cancer that is likely to result in fertility problems who receive sperm cryopreservation.

| Use locally agreed data source. |

**Processes:** Proportion of females having treatment for cancer that is likely to result in fertility problems who receive oocyte or embryo cryopreservation.

| Use locally agreed data source. |
Scope

Aims and objectives of service

Commissioners should work with service providers and service users when considering the aims and objectives of the service. Commissioners and providers seeking to address quality improvement areas may wish to refer to the NICE Into practice guide. The Into practice guide is a source of practical support for health professionals and managers. It suggests ways to improve partnership working and signposts tools that can be used to help identify where change may be needed so that the fertility quality standard can be met.

When considering objectives for fertility services commissioners may wish to note that achieving the quality standard for fertility problems should result in:

- increased rates of singleton births
- reduced rates of multiple births
- increased incidence of live births
- reduced incidence of anxiety and/or depression.

In order to achieve these objectives services should include the following components:

- lifestyle advice
- appropriate referral and investigations
- treatment and management.

Providing lifestyle advice

Quality statement 1: Lifestyle advice

People who are concerned that it is taking longer than expected to conceive are given advice on the impact that lifestyle can have on their chances of getting pregnant.

See the quality standard for the rationale for statement 1.
Commissioner and provider actions

- CCGs and NHS England area teams should work together to ensure that primary and secondary care service providers offer lifestyle advice to people who are concerned about conceiving.

- Providers of primary care, fertility, pre-conception advice and gynaecology services should demonstrate that written information and verbal advice is given on the impact that lifestyle (including smoking, alcohol, body weight and recreational drug use) can have on conception. Providers may wish to use information from NHS Choices.

Estimated resource impact

- Written and verbal lifestyle advice is available, for example from NHS Choices, and should already form part of consultations with healthcare professionals, therefore no resource impact is anticipated for this.

- Positive outcomes from lifestyle change advice and any subsequent interventions may reduce the need for onward referrals to gynaecology, urology and specialist fertility services, as well as benefitting the health of the general population and reducing longer term costs associated with lifestyle-related preventative illnesses.

- Onward referral for an outpatient appointment in gynaecology would cost £131 and in urology it would cost £127 (Payment by Results Tariff 2014/15). Costs of fertility treatment are included in the costing template for the NICE guideline on fertility.

For more information, refer to initial advice to people concerned about delays in conception in the NICE pathway on fertility.

Appropriate referral and investigations

Quality statement 2: Referral for specialist consultation

People are referred for specialist consultation if the woman has not conceived after 1 year of intercourse or after 6 cycles of artificial insemination, or earlier in certain circumstances.

See the quality standard for the rationale for statement 2.
Commissioner and provider actions

- CCGs should undertake a review of their fertility contracts and work with NHS England area teams to specify that providers of both primary and secondary care services offer people timely and appropriate referral for specialist consultation. (For a definition of specialist consultation see definitions for statement 2 in the quality standard).

- Primary and secondary service providers should demonstrate that local arrangements include referral pathways to specialist care for people if the woman has not conceived after 1 year, or after 6 cycles of artificial insemination.

- Primary and secondary service providers should demonstrate that local arrangements also include pathways for the earlier referral of women aged 36 years or over and people with a known clinical cause or history of predisposing infertility factors (before 1 year). (For a definition of predisposing infertility factors see definitions for statement 2 in the quality standard).

Estimated resource impact

- Commissioning for timely and appropriate referral of people to specialist consultation will not have a significant resource impact.

Quality statement 3: Counselling

People who are having problems conceiving are offered counselling before, during and after investigation and treatment for their fertility problems.

See the quality standard for the rationale for statement 3.

Commissioner and provider actions

- Counselling provision is already a mandatory requirement of the Human Fertilization and Embryology (HFEA) Act 1990 (see the Human Fertilization and Embryology Authority for more information). CCGs should still specify that fertility care providers in secondary and tertiary care offer counselling for people before, during and after investigation and treatment.

- Secondary and tertiary care specialist fertility care providers should demonstrate that counselling is available and offered to people who are having investigations and treatment and following treatment.
Estimated resource impact

- Where additional counselling provision is needed, commissioners and providers should work together to agree costs included within service contracts.

- The annual cost of a counsellor is estimated to be £43,337 based on 2013/14 agenda for change pay scales (assuming midpoint pay band 7) including employer's national insurance and pension contributions.

- Counselling before, during and after investigations and treatment may reduce depression or anxiety in people with fertility problems. There may also be a reduction in the number of people who fail to adhere to treatment due to anxiety and other psychological problems, which could reduce additional costs incurred from restarting treatment.

CCGs should refer to the HFEA's code of practice for further guidance on the offer and provision of counselling.

Quality statement 4: Semen analysis

Services analysing semen samples use methods and reference values in accordance with the most recent World Health Organization laboratory manual.

See the quality standard for the rationale for statement 4.

Commissioner and provider actions

- CCGs should only commission laboratory services from providers who have a quality assurance programme in place that ensures analysis is done using methods and reference values in accordance with the World Health Organization laboratory manual for the examination and processing of human semen.

- Providers of laboratory services should review and if necessary amend their processes to demonstrate that semen samples are analysed according to commissioning specifications.

Estimated resource impact

- Commissioning to meet this quality statement is not expected to have a significant resource impact.

- It may help to avoid variation in laboratory techniques and possible inappropriate treatments by improving the reliability of results.
For further information on the requirements of scientific and diagnostic services, commissioners should refer to NHS England’s Putting patients first: the NHS England business plan 2014/15 to 2015/16 and Pathology quality assurance review (January 2014).

Treatment and management

Quality statement 5: IVF for women under 40 years

Women aged under 40 years who meet the criteria are offered 3 full cycles of in vitro fertilisation (IVF).

See the quality standard for the rationale for statement 5.

Commissioner and provider actions

- CCGs should undertake a review of their commissioning contracts for fertility services and ensure that they commission 3 full cycles of IVF, with or without intracytoplasmic sperm injection (ICSI) for women aged under 40 years who have not conceived after 2 years of regular unprotected intercourse or 12 cycles of artificial insemination (where 6 or more are by intrauterine insemination). (For definitions of full cycle and ICSI see definitions for statement 5 in the quality standard).

- CCGs should also refer to recommendations 1.11.1.3 and 1.11.1.6 in the NICE guideline on fertility.

- CCGs should consider collaborating with neighbouring CCGs to reduce transaction costs, gain greater leverage with providers and minimise variation in commissioning decisions.

- CCGs should ensure that people who already have children, women in same-sex relationships and women (with or without a partner) having artificial insemination are not excluded from the provision of fertility treatment. For further information, see equality and diversity considerations.

- Secondary and tertiary specialist fertility care providers should demonstrate that 3 full cycles of IVF are offered to women aged under 40 years who are eligible.

Estimated resource impact

- CCGs should consider the clinical and cost effectiveness of fertility treatment in addition to the actual costs when reviewing their policies and commissioning specialist fertility services.
Offering less than 3 full cycles is unlikely to be cost effective in achieving the primary outcome of a live full-term birth. Additionally, the Human Fertilization and Embryology Authority gives a live birth rate of 28% per cycle (Fertility treatment 2012: trends and figures), which means that offering less than 3 cycles will significantly compromise the clinical effectiveness of the treatment.

Taking into account the live birth rate, CCGs that offer 3 cycles of IVF, are anticipated to commission an average of 2.2 cycles.

Commissioning to meet this quality statement will not have any additional resource impact to that described in the costing tools for the NICE guideline on fertility. CCGs should refer to the costing template to calculate the local resource impact by adding local policy data.

The costing template shows that, for a population of 100,000, there is an initial non-recurrent cost of around £201,000 because the length of time people are required to have been trying to conceive before receiving treatment is reduced from 3 to 2 years.

The costing template shows that the annual recurrent cost is estimated to be £129,000 for a population of 100,000 from year 3 onwards.

Collaborative commissioning would result in service contracts that cover a larger population, which may lead to efficiency savings and help to reduce variation in the costs of fertility treatment.

For more information about the provision of IVF, CCGs and specialist fertility care providers can refer to HFEA’s Fertility treatment in 2012: trends and figures.

Quality statement 6: IVF for women aged 40–42 years

Women aged 40–42 years who meet the criteria are offered 1 full cycle of in vitro fertilisation (IVF).

See the quality standard for the rationale for statement 6.

Commissioner and provider actions

- CCGs should undertake a review of their commissioning contracts for fertility services and ensure that they commission 1 full cycle of IVF, with or without ICSI for women aged 40–42 years who meet the criteria for IVF (see definitions for statement 6 in the quality standard).

- CCGs should also refer to recommendation 1.11.1.4 in the NICE guideline on fertility.
- CCGs should consider collaborating with neighbouring CCGs to reduce transaction costs, gain greater leverage with providers and minimise variation in commissioning decisions.

- CCGs should ensure that people who already have children, women in same-sex relationships and women (with or without a partner) having artificial insemination are not excluded from fertility treatment. For further information, see equality and diversity considerations.

- Secondary and tertiary specialist fertility care providers should demonstrate that 1 full cycle of IVF is offered to women aged 40–42 years to meet commissioning specifications.

**Estimated resource impact**

- The resource impact for commissioners can be calculated using the costing template for the NICE guideline on fertility. The number of women affected is anticipated to be small.

- CCGs should refer to the costing template for the NICE guideline on fertility to calculate the local resource impact by adding local policy data.

- Collaborative commissioning would mean that service contracts would cover a larger population, which may lead to efficiency savings and help to reduce variation in the cost of fertility treatment.

**Quality statement 7: Intracytoplasmic sperm injection**

| Women having in vitro fertilisation (IVF) are offered intracytoplasmic sperm injection (ICSI) only if there are severe deficits in semen quality, obstructive azoospermia, non-obstructive azoospermia or if previous IVF treatment resulted in failed or very poor fertilisation. |

See the quality standard for the rationale for statement 7.

**Commissioner and provider actions**

- CCGs should commission services from secondary and tertiary specialist fertility care providers who offer ICSI as an additional procedure only when there are recognised indications. See definitions for statement 7 in the quality standard.

- Secondary and tertiary specialist fertility care providers should demonstrate that ICSI is offered to meet commissioning specifications.
Estimated resource impact

- The costing work for the NICE guideline on fertility estimates the cost of ICSI to be around £500 in addition to the cost of IVF.

- Expert opinion suggests that achieving this quality statement would result in a decrease in the number of IVF cycles using ICSI. Potential savings will depend on current practice and should be calculated locally.

- CCGs should refer to the costing template for the NICE guideline on fertility to calculate the local resource impact by adding local policy data.

For more information, CCGs should refer to the HFEA's code of practice for further guidance on ICSI.

Quality statement 8: Number of embryos transferred

Women having in vitro fertilisation (IVF) have 1 or 2 embryos transferred according to the woman's or donor's age, the cycle number and the quality of the embryos.

See the quality standard the rationale for statement 8.

Commissioner and provider actions

- To minimise the risk of multiple pregnancies, CCGs should only commission services from secondary and tertiary specialist fertility care providers with an agreed embryo transfer strategy for 1 or 2 embryos to be transferred according to the age of the woman (or donor if donor eggs are used), the cycle number and the quality of the embryos.

- Specialist fertility care providers should ensure that their embryo transfer strategies are supportive of elective single embryo transfers.

For more information about age, cycle number and quality of embryos, CCGs and providers should refer to the table in the NICE implementation resource on the recommended number of embryos to transfer in IVF treatment.

Estimated resource impact

- Achieving this quality statement will not have any additional resource impact to that described in the costing tools for the NICE guideline on fertility.
- CCGs should refer to the costing template for the NICE guideline on fertility to calculate the local resource impact by adding local policy data.

- The costing template shows an estimated annual recurrent saving of £4000 for a population of 100,000 due to a reduction in multiple pregnancies.

CCGs and specialist fertility care providers should also refer to HFEA's:

- Code of practice for further guidance on multiple births, the use of gametes and embryos and donor-assisted conception.

- Multiple births minimisation strategy: achievements and compliance.

Quality statement 9: Cryopreservation before cancer treatment

People preparing to have treatment for cancer that is likely to result in fertility problems are offered cryopreservation.

See the quality standard the rationale for statement 9.

Commissioner and provider actions

- CCGs should commission secondary and tertiary specialist fertility care from providers who offer cryopreservation to people who are preparing to have treatment for cancer that is likely to give them fertility problems.

- CCGs should ensure that people who already have children are not excluded from the provision of cryopreservation, and that a lower age limit is not used for cryopreservation in people diagnosed with cancer. For further information, see equality and diversity considerations.

- Secondary and tertiary specialist fertility care providers should offer oocyte or embryo cryopreservation to women and sperm cryopreservation to meet commissioning specifications.

Estimated resource impact

- Commissioners are advised to review services for cryopreservation of semen, oocytes and embryos locally. The resource impact for commissioners can be calculated using the costing template for the NICE guideline on fertility.
For more information, CCGs and specialist fertility care providers can refer to the HFEA's code of practice for storage of gametes and embryos.

CCGs should refer to the NICE pathway on fertility: cryopreservation to preserve fertility in people diagnosed with cancer and may find it helpful to refer to the support for commissioning for the NICE quality standard for children and young people with cancer.

Service description/care pathway

Commissioners can refer to the NICE pathway on fertility when designing local services and should ensure that services are commissioned to include the service components described in aims and objectives in the scope section.

Commissioners should ensure that their providers adopt an integrated approach and give person-centred care.

Population covered

- People with explained or unexplained infertility.
- People preparing for cancer treatment who may wish to preserve their fertility.

In the UK in 2012, 47,422 women had a total of 62,155 cycles of IVF or ICSI and 2,265 women had a total of 4,452 cycles of donor insemination. Of these women:

- 80.9% were aged 18–39
- 13.3% were aged 40–42.

Treatment in clinics was paid for by the NHS (40%) and privately (60%).

Further information is available from Fertility treatment in 2012: trends and figures (Human Fertilisation and Embryology Authority).

CCGs are likely to receive requests for treatment for a wide range of individual circumstances and are likely to need a policy position in the following areas that are not within the scope of the NICE guideline on fertility:

- treatment following reversal of sterilisation
• surrogacy
• donor insemination
• egg sharing and donation.

Any acceptance and exclusion criteria and thresholds

The Equalities Act (effective from 1 October 2012) prohibits discrimination based on age in the commissioning of services.

For more information, commissioners may refer to the Government Equalities Office’s Age discrimination ban in services and public functions: An overview for service providers and customers.

A number of existing fertility commissioning policies restrict access on the basis of a mixture of social and clinical factors. NICE’s fertility guideline provides recommendations on clinical factors including smoking, weight and age. CCGs should consider a review of their fertility contracts where they do not comply with the NICE guideline. CCGs should ensure that restrictions for clinical reasons are supported by evidence and that any restrictions based on social value judgments are in keeping with local policies on decision-making and ethical frameworks. Engagement with services users and the public is also essential.

For more information, commissioners may refer to Assisted conception needs assisted implementation: a report into the status of NHS fertility services in England (Infertility Network UK 2014).

Interdependence with other service users and providers

• Giving lifestyle advice (see aims and objectives in the scope section) may lead to an increase in referrals to lifestyle change services such as weight management and stop smoking services.

• Where these services are not currently in place, CCGs and NHS England area teams should work with local authorities to ensure that lifestyle change services are commissioned and providers are aware of services and how to refer.

• To calculate the local resource implications of lifestyle change interventions, commissioners can refer to the NICE costing tool for the NICE guideline on weight management before, during and after pregnancy and the return on investment tools for tobacco, alcohol use and physical activity.
Services for fertility problems span different settings including primary, community, secondary, specialist fertility care and laboratory settings.

For more information about the range of providers and settings, see the section on summary of commissioning responsibilities and resource impact.

Commissioners may also find the following NICE pathways useful when defining local care pathways:

- Fertility
- Patient experience in adult NHS services
- Smoking
- Alcohol-use disorders
- Lifestyle weight management services for overweight or obese adults
- Obesity
- Diet
- Drug misuse

**Applicable service standards**

**Applicable national standards**

CCGs and NHS England area teams should work with providers to demonstrate how they are using the quality statements from the NICE quality standard for fertility problems and patient experience in adult NHS services.

Services should be commissioned from and coordinated across primary, community, secondary, specialist fertility care and laboratory settings.

**Applicable standard set out in guidance and/or issues by a competent body (for example royal colleges)**

- HM Government (1990) Human Fertilisation and Embryology Act
- Human Fertilisation and Embryology Authority. Code of practice
Applicable local standards

Clinical commissioning groups (CCGs) and NHS England should agree standards applicable for local services based on the quality and accessibility of current service provision.

Applicable quality requirements and CQUIN goals

Applicable CQUIN goals

(See schedule 4, part E of the NHS standard contract)

Commissioners may define local CQUINs. Examples could include:

- Number of elective single embryo transfers
- Number of ovarian hyperstimulation syndrome admissions
- Number of patients offered counselling.

Feedback

We welcome your feedback on using this resource, particularly if you have used it to support the commissioning process.

Please let us know how you have used it and how it was helpful. Please also let us know if you have any suggestions for improving this resource or if you would like to suggest further support that we could provide.

Send your feedback and suggestions to commissioningsupport@nice.org.uk

About this commissioning support resource

Disclaimer
This resource provides support for the local use of NICE quality standards. It does not constitute formal NICE guidance. Each resource should therefore be used in conjunction with the relevant NICE quality standard and current national guidance on commissioning.

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