# Access to Infertility Treatment

# Commissioning Policy Document

## Yorkshire and Humber

## (Incorporating the Integrated Care Boards (ICBs) of

- NHS Humber and North Yorkshire ICB
- NHS South Yorkshire ICB
- NHS West Yorkshire ICB)

## April 2024 – April 2027

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| Version | Description of Amendments | Date |
|---|---|---|
| V1 | Version 1 replaces all previous CCG policies | |
| | **The on-line version is the only version that is maintained and valid. If this document has been printed or saved to another location, the reader must check that the version number matches that of the on-line version.** | 5 August 2025 |

# Contents

# Glossary

| Term | Meaning |
|---|---|
| Artificial insemination | The process by which sperm is directly placed into a female cervix, fallopian tubes or uterus. The most common method is intrauterine insemination (IUI). |
| Blastocyst | An embryo that has developed for five to six days after fertilisation. |
| Body Mass Index (BMI) | Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator which is used to screen for weight categories that may lead to health problems. |
| Donor Insemination (DI) | The introduction of donor sperm into the vagina, the cervix or womb itself. |
| Donor conception | Donor conception means having a baby using donated sperm, or donated eggs or donated embryos. |
| Embryo | A fertilised egg that has started to develop is known as an embryo until eight weeks of pregnancy, and then a foetus until birth. |
| Embryo transfer | The process of transferring embryos from the culture in which they have been developing in the lab, into the womb. |
| Female sterilisation | This is a permanent type of contraception, where the fallopian tubes are blocked or cut to stop sperm meeting an egg.<br>This is sometimes called tubal ligation. |
| Gametes | Male sperm and female eggs. |
| Gonadotrophins | Gonadotrophins are injectable hormones that are used to help stimulate the ovaries to produce eggs before cycles of IVF treatment, or to treat PCOS when Clomid hasn't worked, they are also used to stimulate the release of testosterone which |

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| | support sperm production in the testicles. |
| Human Fertilisation and Embryology Authority (HFEA). | The UK wide regulator of fertility treatment and embryo research. |
| Integrated Care Board (ICB) | Integrated care boards (ICBs) are NHS organisations responsible for planning health services for their local population. |
| Intracytoplasmic sperm injection (ICSI) | The process of injecting a single sperm into the egg. |
| Intrauterine insemination (IUI)<br>IUI | Also known as artificial insemination, involves sperm being placed directly into the womb. |
| In vitro fertilisation (IVF) | A procedure that involves removing eggs from the ovaries and fertilising them with sperm in the laboratory outside the body. The resulting embryos may then be replaced into the womb. |
| National Institute for Health and Care Excellence (NICE) | NICE provide national guidance and advice to improve health and social care. One of the ways that NICE does so is by publishing clinical guidelines, which are evidence-based recommendations on health and care in England. |
| Sperm washing | A process where sperm cells are separated from the rest of the semen fluid. |
| Surrogacy | The process of a female patient carrying a baby on behalf of another person / couple. |
| Treatment add-ons | These are optional additional treatments, also referred to as 'supplementary', 'adjuvants' or 'embryology treatments'. |
| Vasectomy | This is a surgical method of sterilisation for men. |
| Women | For the purposes of this policy document those people deemed Female at birth are referred as Female or Females. |

For other terminology that might be used when as part of fertility treatment that is not included in the glossary please see the HFEA A-Z Fertility Glossary.

# Commissioning Policy Statement:

## Commissioning

This document represents the commissioning policy of the following Integrated Care Boards:

- NHS Humber and North Yorkshire Integrated Care Board (HNYICB)
- NHS South Yorkshire Integrated Care Board (SYICB)
- NHS West Yorkshire Integrated Care Board (WYICB)

It outlines the clinical pathway which provides access to specialist fertility services. This commissioning policy has been developed in partnership with the Yorkshire and Humber Expert Fertility Panel. It is intended to provide a framework for the commissioning of services for those couples who are infertile and require infertility interventions.

The original policy was developed jointly by Clinical Commissioning Groups (CCGs) in the Yorkshire and Humber area to provide a common view of the clinical pathway and criteria for commissioning services. The policy has now been reviewed and adopted by HNYICB, SYICB and WYICB. This policy will be updated in accordance with the review period of the policy or earlier should sufficient changes in practice or evidence base require it.

## Funding

Funding decisions for health services in England are the responsibility of ICBs and are based on the clinical needs of their local population; the number of NHS funded IVF cycles is a decision of Humber and North Yorkshire ICB, South Yorkshire ICB and West Yorkshire ICB respectively and does not form part of the shared Yorkshire and Humber policy set out in the rest of this document. For more detailed information about the specific policies and funding arrangements in your area, you should refer to the relevant ICB website, where these commissioning policies are published.

This policy applies to couples: both patients should be registered with a GP within the same ICB in accordance with NHS England Who Pays? guidance (April 2024).

In general, a patient who is not ordinarily resident in the country is an overseas visitor and may not be eligible for assisted conception services funded by the ICB. The ICB will comply with government guidance regarding these patients.

## Panel Members (January – April 2024)

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James Marshall, Commissioning Manager, NHS South Yorkshire, Integrated Care Board

### References:

The following were used to inform the development of this policy:

National Institute for Health and Care Excellence (NICE), Fertility problems: assessment and treatment, Clinical guideline [CG156]
https://www.nice.org.uk/guidance/cg156

NHS website provides a guide to conditions, symptoms and treatments, including what to do and when to get help. Infertility - NHS (www.nhs.uk)

The Human Fertility and Embryology Authority (HFEA) regulates IVF/ICSI clinics, and its website contains useful information for patients: HFEA: UK fertility regulator

Guidance on NHS patients who wish to pay for additional private care
Guidance on NHS patients who wish to pay for additional private care (publishing.service.gov.uk)

Who Pays? Explains which NHS commissioner will be responsible for commissioning and paying for an individual's NHS care. NHS England » Who Pays?

HM Government. Overseas NHS Visitors: Implementing the Charging Regulations
NHS cost recovery - overseas visitors - GOV.UK (www.gov.uk)

## For further information about this policy:

### Please contact your local Integrated Care Board

- NHS Humber and North Yorkshire Integrated Care Board (HNYICB)
- NHS South Yorkshire Integrated Care Board (SYICB)
- NHS West Yorkshire Integrated Care Board (WYICB)

NHS Humber and North Yorkshire Integrated Care Board (HNYICB)
Humber and North Yorkshire Integrated Care Board (ICB)

NHS South Yorkshire Integrated Care Board (SYICB)
NHS South Yorkshire ICB - Home

NHS West Yorkshire Integrated Care Board (WYICB)
West Yorkshire Integrated Care Board :: West Yorkshire Health & Care Partnership

## 1. Aim of Paper

1.1 This document represents the commissioning policy for specialist fertility services for adults registered with an Integrated Care Board in the Yorkshire and Humber region. **This policy document represents the commissioning policy for specialist fertility services for adults registered with the NHS West Yorkshire Integrated Care Board**.

## 2. Background

2.1 On 1 April 2013, Clinical Commissioning Groups (CCGs) across the Yorkshire and the Humber regions adopted the existing Yorkshire and the Humber Fertility policy.

In February 2013 NICE published revised guidance which was reviewed and updated in 2017.

2.2 Integrated Care Boards (ICBs) replaced CCGs in the NHS in England from 1st July 2022. ICBs across the Yorkshire and Humber adopted the policy and agreed to work collaboratively to review the policy in light of any new guidance and the document review date.

2.3 **In this policy document infertility is defined as:**

The inability to conceive through regular sexual intercourse for a period of 2 years in the absence of known reproductive pathology, or less than 2 years if there is specific reproductive pathology identified. Fertility investigations can begin after one year or sooner if there is suspected pathology or there are female age considerations.

Where attempting to conceive by regular sexual intercourse is not possible (for example for disabled people with a physical disability people with psychosexual disorders or transgender and same sex couples) this will be considered as inability to conceive for the purposes of this policy.

2.4 Fertility problems are common in the UK, and it is estimated that they affect 1 in 7 couples with 80% of couples in the general population conceiving within 1 year, if:

- the female is aged under 40 years and
- they do not use contraception and have regular sexual intercourse

Of those who do not conceive in the first year about half will do so in the second year (cumulative pregnancy rate is 90%).

The remaining 10% of couples will be unable to conceive without medical intervention and are therefore considered infertile.

2.5 In 25% of infertility cases, the cause cannot be identified. However, it is thought that in the remaining couples about 30% of cases are due to the male partner being unable to produce or ejaculate sufficient normal sperm, 30% are due to problems found with the female partner such as failure to ovulate or blockage to the passage of the eggs, and 10% are due to problems with both partners.

2.6 The most recent Department of Health costing tool estimates that there are 98 attendances at a fertility clinic for every 10,000 head of population. In Yorkshire and the Humber, this could range between 4000 and 5000 attendances per year which would result in approximately 1450 couples likely to be assessed as eligible for IVF treatment.

2.7 Specialist fertility services include IUI, ICSI and IVF. They may also include the provision of donor sperm and donor eggs. The majority of treatment in the UK is statutorily regulated by the Human Fertility and Embryo Authority (HFEA). All specialist providers of fertility services must be licensed with the HFEA in order to be commissioned under this policy.

2.8 NICE Clinical Guidelines 156 (2017) covering infertility recommends:

Three full cycles of IVF be offered to eligible couples where the female is aged between 18 and 39.

One cycle for eligible couples where the female is aged 40 to 42, upto but excluding their 43rd birthday.

ICBs are required to ensure that resources are allocated equitably to address the health needs of the population. Therefore, the ICBs within Yorkshire and Humber have exercised their discretion as to the number of cycles of IVF that they will fund. **The NHS West Yorkshire Integrated Care Board will only commission/fund one cycle of IVF.**

Where a couple feel that they have exceptional circumstances that would merit consideration of an additional cycle being funded by the NHS they should speak to their doctor about submitting an individual funding request to their local ICB.

## 3. Cost Effectiveness

3.1 Evidence shows (NICE 2013) that, as the woman gets older, the chances of successful pregnancy following IVF treatment falls. In light of this, NICE has recommended that the most cost-effective treatment is for females aged 18 to 42 who have known or unknown fertility problems.

3.2 As research within this field is fast moving, new interventions and new evidence needs to be considered on an on-going basis to inform commissioning decisions.

### 3.3 Risks

Fertility treatment is not without risks. A summary of potential risks is outlined below:

- there are risks of multiple pregnancies during fertility treatment which are associated with a higher morbidity and mortality rate for female mothers and babies
- women/female who undergo fertility treatment are at slightly higher risk of ectopic pregnancy
- ovarian hyperstimulation, which is a potentially fatal condition, is also a risk. The exact incidence of this has not been determined but the suggested number is between 0.2 - 1% of all assisted reproductive cycles
- current research shows no cause for concern about the health of children born as the result of assisted reproduction
- a possible association between ovulation induction therapy and ovarian cancer in those who have undergone treatment is uncertain
- further research is needed to assess the long-term effects of ovulation induction agents

## 4. Description of the treatment

### 4.1 Principles of Care

4.1.1 Couples who experience problems in conceiving should be seen together because both partners are affected by decisions surrounding investigation and treatment.

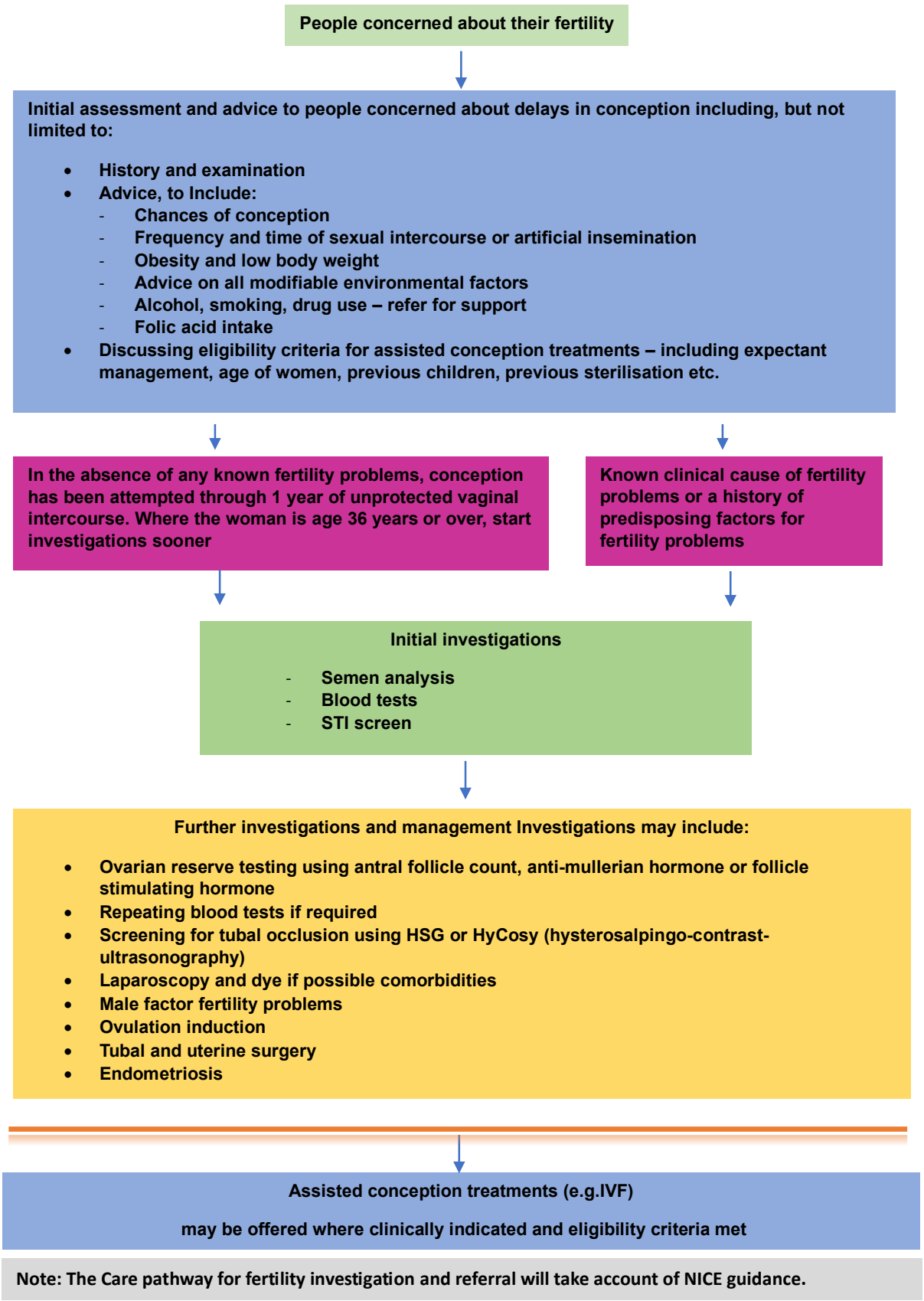
4.1.2 People should have the opportunity to make informed decisions regarding their care and treatment via access to evidence-based information. These choices should be recognised as an integral part of the decision-making process.

Information should be provided in the following formats:

- face to face and remote discussions with couples
- appointments should be face to face if clinically indicated or patients' preference.
- written information and advice
- culturally sensitive and gender inclusive
- sensitive to those with additional needs e.g. physical or cognitive, or those for whom English is not their first language
- sensitive to couples' needs and preferences

4.1.3 As infertility and infertility treatments have a number of psychosocial effects on couples, access to psychological support prior to and during treatment should be considered as integral to the care pathway.

## 4.2 The Care Pathway for fertility investigations and referral:




Note: The Care pathway for fertility investigation and referral will take account of NICE guidance.

4.2.1 Treatment for infertility problems may include counselling, lifestyle advice, drug treatments, surgery and assisted conception techniques such as IVF.

Providers of specialist fertility services are expected to:

- support appropriate interventions to promote lifestyle behaviour changes which are likely to have a positive impact on the outcome of assisted conception techniques and resulting pregnancies.
- use any appointment or meeting as an opportunity to ask couples about their general lifestyle including smoking, alcohol consumption, recreational drug use, physical activity and eating habits. If they practice unhealthy behaviours, explain how health services can support people to change behaviour and sustain a healthy lifestyle.
- offer those who would benefit a referral to local wellbeing services and / or locally commissioned lifestyle services. For those that are unable or do not want to attend support services direct them to appropriate self-help information.
- record this in the patient record or accepted local equivalent.

The care pathway begins in primary care, where the first stage of treatment is general lifestyle advice and support to increase a couple's chances of conception without the need for medical intervention.

If primary care interventions are not effective, initial assessment such as semen analysis and female hormone profile will take place. Following these initial diagnostics, it may be appropriate for the couple to be referred to secondary care services where further investigation and potential treatments will be carried out, such as hormonal therapies to stimulate ovulation. It may be appropriate at this stage for the primary care clinician to consider and discuss the care pathway and potential eligibility for IVF. It may also be appropriate for healthy lifestyle interventions to be further discussed.

If secondary care interventions are not successful and the couple fulfils the eligibility criteria, they may then be referred through to specialist care for assessment for assisted conception techniques such as IVF, DI, IUI, and ICSI.

4.2.2 IVF involves:

- controlled ovarian stimulation.
- monitoring the development of the eggs in the ovary
- ultrasound guided egg collection from the ovary
- processing of sperm
- insemination of egg with sperm or ICSI procedure
- fertilisation check / embryo culture check
- culture of embryos to blastocyst (*if clinically appropriate*)
- use of progesterone to make the uterus receptive to implantation

- transfer of selected embryo(s) (subject to multiple birth minimisation policy) and freezing of those suitable but not transferred

## 4.3 Definition of a Full Cycle

The definition of a single full treatment cycle (in accordance with NICE 2013) is one episode of ovarian stimulation with transfer of a fresh embryo and sequential replacement of ALL frozen embryos from that stimulation cycle (if clinically recommended) until either pregnancy is successful or no embryos remain, whichever comes first, providing treatment remains clinically appropriate. A pregnancy is deemed successful once a live birth has been achieved.

Adherence in this way to the NICE guidelines would encourage and not disadvantage patients agreeing to single embryo transfer.

## 4.4 Frozen Embryos

Embryos that are not used during the fresh transfer should be quality graded using the UK NEQAS embryo morphology scheme and may be frozen for subsequent use within the cycle.

All stored and viable embryos should be used before a new cycle commences. This includes embryos resulting from previously self-funded cycles.

## 4.5 Abandoned Cycles

An abandoned IVF/ICSI cycle is defined as the failure of egg retrieval, usually due to lack of response (where less than three mature follicles are present) or excessive response to gonadotrophins; failure of fertilisation and failure of cleavage of embryos. Beyond this stage, a cycle will be counted as complete whether or not a transfer is attempted.

One abandoned cycle should not affect the couple's entitlement to further IVF / ICSI (up to the maximum number of cycles funded by their ICB), providing that additional cycles are clinically appropriate. Further cycles will not be offered after a second abandoned cycle, but the clinician may submit an Individual Funding Request if there are exceptional circumstances.

## 4.6 IUI and DI

IUI and DI are separate from IVF treatment; however, the couple may then access IVF treatment if appropriate.

4.6.1 People who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem or people in same sex relationships or other specific conditions with infertility who are using partner or donor sperm (as per the

definition of infertility): up to 6 cycles of IUI may be funded where clinically appropriate, followed by further assisted conception if required. In some circumstances, IUI may be impractical or not desired and so is not a requirement to access further fertility treatment. IUI will not be funded as a treatment after IVF treatment.

4.6.2 Couples with unexplained infertility, who are having regular unprotected sexual intercourse: IUI either with or without ovarian stimulation will not be funded routinely (exceptional circumstances may include, for example, when people have social, cultural or religious objections to IVF), instead couples should try to conceive for a total of 2 years (this can include up to 1 year before their fertility investigations) before IVF will be considered, in keeping with current NICE guidance.

4.6.3 Females with anovulatory infertility: ovulation induction with gonadotrophin therapy may be funded for up to 6 cycles, followed by further assisted conception if required. In some circumstances, IUI may be impractical or not desired and so is not a requirement to access further fertility treatment. IUI will not be funded as a treatment after IVF treatment.

4.6.4 Donor Gametes including azoospermia:

Patients who require donor gametes will be placed on the waiting list for an initial period of up to 3 years, after which they will be reviewed to assess whether the fertility policy eligibility criteria are still met.

If it is anticipated that there will be difficulty finding a suitable donor and there is evidence of exceptionality the clinician may consider an IFR application to source from alternative providers.

### Donor Sperm

Where clinically indicated up to six cycles of donor insemination will be offered. The cost of donor sperm is included in the funding of treatment for which it is required, to be commissioned in accordance with this policy and the funding policy of the ICB.

Couples who request the use of a known clinically appropriate sperm donor will be responsible for all costs associated with the donor, including transportation costs. The ICB will fund the IUI / IVF / ICSI treatment at an accredited provider in line with the criteria in this policy, providing it meets the criteria defined by the HFEA.

### Donor Eggs

Patients eligible for treatment with donor eggs, in line with NICE recommendations, will be placed on the waiting list for treatment. Unfortunately, the availability of donor eggs remains severely limited in the UK. There is, therefore, no guarantee that eligible patients will be able to proceed with treatment.

Couples who request the use of a known clinically appropriate egg donor will be responsible for all costs associated with the donor, including transportation costs. The ICB will fund the associated IUI / IVF / ICSI treatment at an accredited provider in line with the criteria in this policy, providing it meets the criteria defined by the HFEA.

### 4.7 Gametes and Embryo Storage

The cost of egg and sperm storage will be included in the funding of treatment for which it is required, to be commissioned in accordance with this policy and the funding policy of the ICB. Storage will be funded by the ICB for a maximum of 3 years or until 6 months post successful live birth, whichever is the shorter. This will be explained by the provider prior to the commencement of treatment. Following this period continued storage may be self-funded.

Any embryos frozen prior to implementation of this policy will be funded by the ICB to remain frozen for a maximum period of 3 years from the date of policy adoption.

Any embryo storage funded privately prior to the implementation of this policy will remain privately funded.

### 4.8 HIV / Hep B / Hep C

People undergoing IVF treatment should be offered testing for HIV, hepatitis B and hepatitis C (NICE 2013).

People found to test positive for one or more of HIV, hepatitis B, or hepatitis C should be offered specialist advice and counselling and appropriate clinical management (NICE 2013).

### 4.9 Surrogacy

Any costs associated with the use of a surrogacy arrangement will not be covered by funding from the ICB. It will, however, fund the screening and provision of fertility treatment (IVF treatment and storage) to identified (fertile) surrogates, where this is the most suitable treatment for a couple's infertility problem and the couple meets the eligibility criteria for specialist fertility services set out in this policy.

### 4.10 Single Embryo Transfer

Please refer to the definition of a full cycle.

Multiple births are associated with greater risk to mothers and children and the HFEA therefore recommends that steps are taken by providers to minimise them. This is currently achieved by only transferring a single embryo for couples who are at high risk.

This policy supports the HFEA guidance on single embryo transfer, all providers are required to have a multiple births minimisation strategy. The

target for multiple births should now be an upper limit of 10% of all pregnancies.

Ultrasound guided embryo transfer is commissioned in line with the NICE Fertility Guideline.

### 4.11 Counselling and Psychological Support

As infertility and its treatment has a number of negative psychosocial effects, access to counselling and psychological support should be offered to the couple prior to and during treatment.

### 4.12 Sperm washing and pre-implantation diagnosis

Sperm washing and pre-implantation genetic diagnosis are not treatments for infertility and fall outside the scope of this policy. Prior approval is required.

### 4.13 Service Providers

Providers of fertility treatment must be HFEA registered and comply with any service specification drawn up by Yorkshire and the Humber ICBs.

## 5. Eligibility Criteria for treatment

Clinicians may apply to their ICB's Individual Funding Request (IFR) panel for any patient who does not meet this policy's eligibility criteria providing that there is evidence of clinical exceptionality.

### 5.1 Application of Eligibility Criteria

Eligibility criteria should apply at the point of referral to, and throughout, specialist care. Females aged between 40–42 will need further assessment within specialist care to ascertain whether they are eligible.

### 5.2 Overarching Principles

5.2.1 All clinically appropriate individuals / couples are entitled to medical advice and investigation. Couples may be referred to a secondary care clinic for further investigation.

5.2.2 Assisted conception is only funded for those couples who meet the eligibility criteria.

5.2.3 Treatment limits are per couple and per individual. Referrals should be as a couple and include demographic information for both partners in heterosexual and same-sex relationships.

## 5.3 Existing Children

Neither partner should have any living children (this includes adopted children but not fostered) from their relationship together or any previous relationship.

## 5.4 Female Age

Age as a criterion for access to fertility treatments is applied in line with the NICE Clinical Guideline on Fertility which is based on a comprehensive review of the relationship between age and the clinical effectiveness of fertility treatment.

The female intending to become pregnant must be between the ages of 18 to 42 years. Referrers should be mindful of the female's age at the point of referral and the age limit for new cycles.

Females aged 40 to 42 years who meet the eligibility criteria for infertility will receive 1 full cycle of IVF with their own eggs, with or without ICSI, provided the following criteria are fulfilled:

- they have never previously had IVF treatment
- there is no evidence of low ovarian reserve using one of the following measures AFC of less than or equal to 4, AMH of less than or equal to 5.4 pmol/l, FSH greater than 8.9 IU/l
- there has been a discussion of the additional implications of IVF and pregnancy at this age
- where IVF is the only effective treatment, females aged between 40-42 should be referred directly to a specialist team for IVF treatment

## 5.5 Pre-Referral Requirements for Specialist Care

### 5.5.1 Female BMI

The female patient's BMI should be between 19 and 30 prior to referral to specialist services and throughout treatment. In the case of same sex couples, the BMI range applies to the patient(s) intending to undergo fertility procedures. Patients with a higher BMI should be referred for healthy lifestyle interventions including weight management advice. Patients should not be re-referred to specialist services until their BMI is within the recommended range.

### 5.5.2 Smoking Status

GP should discuss smoking with couples prior to referral to secondary care and support their efforts to stop by referring to a smoking cessation programme.

Smoking adversely affects the success rate of the treatment and the pregnancy outcome. Couples must be non-smoking for 28 days to access any

fertility treatment and must continue to be non-smoking throughout treatment. Currently there is limited and uncertain evidence around the safety of vaping and nicotine products, but sole use of e-cigarettes, without the concurrent use of tobacco, is classified as non-smoking for the purposes of this policy.

If it is suspected that patients continue to smoke then carbon monoxide (CO) testing may be considered

### 5.5.3 Alcohol and Other Substances

Couples must give assurances that their alcohol intake is within current Department of Health guidelines and that they are not currently using recreational drugs.

## 5.6 Reversal of Sterilisation

The ICB will not fund IVF treatment for patients who have been sterilised, including those who have undergone reversal of sterilisation.

## 5.7 Previous Cycles

The chance of pregnancy decreases with successive cycles so all previous self-funded or NHS funded cycles will be taken into consideration when assessing a couple's ability to benefit from treatment and will count towards the total number of cycles that may be offered by the NHS. This includes where either person has had a previous cycle with a previous partner.

## 5.8 Relationship Status

Couples must have been co-habiting in a stable relationship for a minimum of 2 years at the same address.

## 5.9 Welfare of the Child

HFEA guidance concerning the welfare of the child should be followed.

# 6. Impact Analyses

## 6.1 Equality

The ICB is committed to creating an environment where everyone is treated equitably and the potential for discrimination is identified and mitigated.

As a result of preforming the screening analysis, the policy may possibly have an adverse effect on people who share protected characteristics and further actions are recommended in the equality impact assessment.

## 7. Review

This is a joint policy between the ICBs across the Yorkshire and the Humber region and will be reviewed on a 3 yearly basis, or sooner if new guidance is published.

### 7.1 Appendix one – Treatment funded and Add-Ons

| NHS Funded Contacts / Treatments |
|---|
| Outpatient visit (this includes registration, initial assessment and welfare of the child assessment and counselling where required) |
| Intrauterine insemination |
| Conventional IVF (includes drugs, scans, work up, HFEA fee and culture of blastocyst and embryo transfer where appropriate)<br>- follow up appointment for unsuccessful treatment<br>- early pregnancy scanning for successful cycles |
| ICSI supplement |
| Donor egg / embryo supplement (includes handling of gametes) |
| Donor egg supplement (includes handling of gametes) |
| Donor embryo supplement (includes handling of gametes) |
| Donor sperm supplement (includes handing of gametes) |
| Abandoned cycle |
| Frozen embryo transfer (includes blastocyst transfer where appropriate) |
| Embryo freeze (total freezing cost up to a maximum of 3 years of storage or 6 months after live birth) |
| Sperm freeze (total freezing cost for the duration of NHS funded cycles) |
| Donor insemination (total procedure cost including gametes and handing of gametes) |
| Surgical sperm recovery PESA (Including freezing where appropriate for the duration of NHS funded cycles) |
| Surgical sperm recovery TESA/E (Including freezing where appropriate for the duration of NHS funded cycles) |
| Surrogacy supplement |

Artificial oocyte activation (AOA) supplement (as referenced in ARCS / BFS guidelines)

The use of supplementary procedures often termed ‘add-ons’ is a controversial topic in the fertility sector. The HFEA (fertility regulator) have devised a traffic light system to guide patients on the efficacy of these options. Examples of such procedures include, but are not limited to the following:

- PGT-A – (checking for chromosome abnormalities in embryos)
- time-lapse imaging (an embryo selection technique)
- endometrial receptivity array (to determine when the endometrium is most receptive for implantation)
- embryo glue (hyaluronate enriched embryo culture medium to aid implantation)

These add-ons may be offered for several reasons including improving the chances of a live birth and / or reducing the chances of miscarriage. The HFEA acknowledge that the evidence for their universal application may as yet be unavailable, however it may be that for a specific subgroup of patients a red or amber rated add-on could be used after careful discussion with a clinician.

The Department of Health issued guidance in 2009 stating that patients may pay for additional private healthcare while continuing to receive care from the NHS (Department of Health Guidance on NHS patients who wish to pay for additional private care, March 2009).

The overriding rules which must be adhered to are that:

- private care must not be subsidised with public money
- patients should never be charged for their NHS care, nor be allowed to pay towards an NHS service
- no patient should lose their entitlement to the NHS care they would have otherwise received simply because they opt to purchase additional care for their condition
- all reasonable avenues for securing NHS funding must be exhausted before suggesting a patient’s only option is to pay for care privately
- the service provider should continue to provide all free of charge care that the patient would have been entitled to had they not chosen to have additional private care
- it must always be clear whether an individual procedure or treatment is privately funded, or NHS funded

**Patients deserve consistent, evidence-based treatment. Providers of specialist fertility services will only offer treatment add-ons under the following conditions:**

- where more than one high quality study demonstrates a treatment add-on to be safe and effective

- the service provider will continue to monitor success rates and long-term follow-up data and report adverse incidents. The service provider will stop offering the treatment add-on to patients if concerns are raised regarding safety or effectiveness
- patients will be provided with up-to-date information about the evidence base supporting the use of any treatment add-ons and information will include reference to the HFEA website
- it may be appropriate to charge patients for the use of a treatment add-on if it has been demonstrated to be effective for their specific patient group or were incorporating the cost of providing the treatment add-on into a standard package would significantly increase the price / cost of delivering treatment for all patients
- accurate and transparent information will be provided in the costed treatment plan

| Treatment add-ons with limited evidence |
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| For some treatment add-ons there is not enough evidence to show that they are effective at improving treatment outcomes; therefore the following will not be routinely funded as part of NHS funded treatments.<br><br>For more information: Treatment add-ons with limited evidence \| HFEA |
| Assisted hatching |
| Elective freeze all cycles (excluding freeze all for medical reasons) |
| Endometrial receptivity testing |
| Endometrial scratching |
| Hyaluronate enriched pre-transfer culture medium (e.g. EmbryoGlue) |
| Immunological tests and treatments for fertility - Intralipids |
| Immunological tests and treatments for fertility - Intravenous immunoglobulin (IVIG) |
| Immunological tests and treatments for fertility - Steroids (Glucocorticoids) |
| Intracytoplasmic morphologic sperm injection (IMSI) |
| Intrauterine culture |
| Physiological intracytoplasmic sperm injection (PICSI) – in use for patients having ICSI treatment for male factor infertility |
| Pre-implantation genetic testing for aneuploidy (PGT-A) |
| Time-lapse imaging and incubation |

DNA Fragmentation

For more information: Sperm DNA damage | HFEA
scaac-minutes-october-2018.pdf (hfea.gov.uk)