The Office *of the*
Committee *for*
Health & Social Care

Fertility services

Policy G1029 sets out what is routinely funded by the Committee for Health & Social Care (CHSC) and the Committee for Employment & Social Security (CESS) and what is currently excluded from the care pathway for the investigation and treatment of infertility.

Policy G1029 is designed to be read in conjunction with document: The National Institute for Health and Care Excellence's Clinical Guidance 156: Fertility problems: assessment and treatment.

This amended version of Policy G1029 includes only minor adjustments to guidance as to who should order certain diagnostic tests within a normal fertility workup. The purpose of this is to correct inefficiencies and duplications as identified by clinical staff.

Lead Professional/Author	Corporate Commissioning Policy
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Committee for Health & Social Care Policy

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This is a controlled document. As a controlled document, the correct version of the document is the one available on CHSC intranet and the States of Guernsey website.

Version History

Version Number	Date	Person responsible	Prepared by	Status	Reason for Issue
1.0	Feb 2002		Policy staff	Adopted by States	Under States, Billet d'Etat II Feb 2002 IVF is excluded from State funding of health care services.
2.0	April 2017	Director of Public Health	Public Health Advisor	Adopted by CMT	This policy does not alter the States resolution. This policy sets out in more detail funding for fertility services and takes into account evidence based guidelines for the management of fertility. Its aim is also to clarify the confusion over what will and will not be funded to the investigation and fertility problems.
3.0	Jan 2019	Medical Director	Policy writer	Adopted by CMT 10 Jan 2019	This revision does not alter the States resolution. It clarifies specific tests and procedures which should occur only by request of the secondary Fertility Service.

Fertility services

1.1 This policy applies to any patient for whom Committee *for* Health & Social Care and the Committee *for* Employment & Social Security have responsibility for funding defined elements of their healthcare.

1.2 The follow elements of the fertility pathway **will be funded:**

1.2.1 **Referral to MSG**

The service will see patients who meet the definitions of infertility (which includes patients who cause of infertility is unknown or patients who present particular challenged with respect to conception) as set out in NICE CG156
Section 1.2.13.

1.2.2 **Investigations of infertility to provide a definitive diagnosis and therefore enable the couple to consider management options**

Tests which may be done in primary care prior to referral:

- Blood test to measure serum progesterone to establish fertility.
- Chlamydia testing.

Tests which should be done under supervision of the fertility clinic:

- Ovarian reserve testing in line with NICE CG156 Section 1.3.3.2.
- Blood test to measure serum gonadotrophins for women with irregular menstrual cycles.
- Investigation of suspected tubal and uterine abnormalities in line with NICE CG156 Section 1.6.
- Semen analysis
- Sperm washing only for HIV positive men who are not compliant with
- HAART or the plasma viral load is 50 copies/ml or greater.
- Hepatitis B vaccination for partners of people with Hepatitis B.

- Testing for rubella status.

1.2.3 **Medical management for male infertility**

- All medical management should be done under the supervision of the fertility clinic.
- Gonadotrophin for men with hypo-gonadotrophic hypogonadism.

1.2.4 **Medical management of ovulatory disorders**

All medical management should be done under the supervision of the fertility clinic, and fertility drugs should not be prescribed by Primary Care

- Clomifene citrate to induce ovulation.
- Gonadotrophins.
- Dopamine agonists for women with hyperprolactinaemia.

1.2.5 **Surgical management for female infertility**

- Tubal microsurgery, laparoscopic tubal surgery and tubal catherisation or cannulation.
- Surgical correction of intrauterine adhesions.

1.2.6 **Surgical management of endometriosis**

- Surgical correction of intrauterine adhesions.
- Surgical ablation in line with NICE CG156.

1.2.7 **Intrauterine insemination**

- Unstimulated intrauterine insemination where the man is HIV positive, non-compliant with HAART or has a high viral load and where sperm washing has been recommended.
- Unstimulated intrauterine insemination for couples (including same sex couples) who are unable to, or would find it very

difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem who are using partner or donor sperm.

1.2.8 **Preservation of fertility for patients undergoing cancer treatment**

- Cryopreservation of semen and oocytes for an initial period of 10 years.
- Patient's need to be informed that CHSC will not at this stage fund the use of stored gametes.

1.2.9 **Preservation of fertility for patients for other exceptional indications**

- Preservation of fertility will be considered for patient with other conditions on a case by case basis.

1.3 The follow elements of the fertility pathway **will not be funded**:

1.3.1 **Diagnostics, tests, procedures and treatments per NICE CG156 do-not-do list**:

- Post-coital testing of cervical mucus.
- Ovarian volume, ovarian blood flow, inhibin B, oestradiol (E2) for the assessment of ovarian reserve.
- Prolactin measurement.
- Thyroid function tests in the absence of any symptoms of thyroid disease.
- Endometrial biopsy in the absence of other clinical symptoms and signs.
- Routine hysteroscopy as part of the initial investigation.
- Additional cervical smear tests outside of the normal screening programme
- Anti-oestrogens, gonadotrophins, androgens, bromocriptine or kinin- enhancing drugs for the treatment of idiopathic semen abnormalities.

- Corticosteroid for the treatment of the presence of anti-sperm antibodies.
- Antibiotic treatment for men with leucocytes in their semen.
- Gonadotrophin-releasing hormone for women with polycystic ovary syndrome who are being treated with gonadotrophins.
- Adjuvant growth hormone treatment with gonadotrophin-releasing hormone agonist and/or human menopausal gonadotrophin during ovulation induction in women with polycystic ovary syndrome who do not respond to clomifene citrate.
- Pulsatile gonadotrophin-releasing hormone in women with clomifene citrate-resistant polycystic ovary syndrome.
- Medical treatment of minimal and mild endometriosis diagnosed as the cause of infertility in women.
- Medical treatment of moderate or severe endometriosis following surgical management.
- Oral ovarian stimulation agents (such as clomifene citrate, anastrozole or letrozole) to women with unexplained infertility.
- Treatments for ejaculatory failure (all currently unproven)
- Treatments for epididymal blockage

1.3.2 Any artificial means of fertilisation

This includes:

1.3.2.1 Chlamydia screening for women those undergoing IVF treatment.

1.3.2.2 Salpingectomy for women with hydro-salpinges before IVF treatment.

1.3.2.3 Intrauterine insemination including the preparation and procedure except for those indications set out in 1.2.18.

1.3.2.4 In-vitro fertilisation including: the assessment for suitability for IVF pre-treatment screening including testing

for hepatitis BSAg, hepatitis BCore, hepatitis C, HIV, syphilis, all elements of treatment (drugs, harvest, fertilisation and transfer) and hormonal monitoring during treatment.

1.3.2.5 Donor insemination including procurement, preparation and procedure.

1.3.2.6 Intracytoplasmic sperm injection (including genetic counselling, preparation and procedure).

1.3.2.7 Funding of oocyte donations.

1.3.3 Reversal of sterilisation including semen analysis following reversal

1.3.4 Surrogacy

1.4 Private fertility treatments

1.4.1 All costs associated with private infertility treatment will need to be paid for by the patient or couple. This includes for example testing for infection prior to undergoing invasive procedures and all drug costs.

1.4.2 Shared care arrangements while undergoing fertility treatment should be between the private facility in the UK and the infertility specialists on island acting in a private capacity.

1.4.3 In circumstances where the UK fertility clinic recommends off label use of a treatment under a shared care arrangement, the local private clinician is at liberty to decide whether or not they wish to accept clinical responsibility for prescribing. Ifnot all drugs will have to be prescribed and dispensed in the UK.

1.5 If a clinician considers exceptional circumstances might apply an application can be made for consideration through the Individual Funding Request process.

Guidance for referral into secondary care specialist services

People who are concerned about delays in conception despite lifestyle and other advice from their general practitioner (usually after one year of normal unprotected sex)

People who are unable to, or would find it very difficult to, have vaginal intercourse.

A woman of reproductive age who has not conceived after 1 year of unprotected vaginal sexual intercourse, in the absence of any known cause of infertility, should be offered further clinical assessment and investigation along with her partner.

A woman of reproductive age who is using artificial insemination to conceive (with either partner or donor sperm) should be offered further clinical assessment and investigation if she has not conceived after 6 cycles of treatment, in the absence of any known cause of infertility. Where this is using partner sperm, the referral for clinical assessment and investigation should include her partner.

For people for whom there is planned treatment which may result in infertility (such as treatment for cancer).

People who are concerned about their fertility and who are known to have chronic viral infections such as hepatitis B, hepatitis C or HIV.