NHS
Cheshire and Merseyside

Clinical Commissioning Interim Policy

CMICB_Clin115

NHS funded treatment for subfertility

Category 2 Intervention - Only routinely commissioned when specific criteria are met

Last Reviewed: May 2025
A review of this policy will be expedited upon publication of updated NICE guidance NG156.

Contents

1. Interim Policy Statement

1.1 In July 2022, NHS Cheshire and Merseyside Integrated Care Board (ICB) replaced the existing Clinical Commissioning Groups (CCGs) and began a process to review all of the existing clinical policies in order to harmonise service provision across the region and to minimise potential inequalities.

1.2 At that time, there were four "NHS funded treatment for subfertility policies" which covered the CCG areas of East Cheshire, West Cheshire, Merseyside (including Warrington) and Wirral.

1.3 The presentation of these policies followed the same format and although very similar, they do have some significant differences.

1.4 Therefore, during the latter part of 2023, the ICB convened a working group (consisting of fertility experts, commissioners, clinicians and public health) to develop a single, unified assisted conception policy.

1.5 The main objectives of this group were to harmonise the policy positions across the region and to maintain consistency with the current NICE clinical guideline (CG 156) on fertility problems.

1.6 The working group were aware that NICE are revising CG 156.

1.7 Because this represents a major revision, the ICB will need to review its policy again following publication of the revised CG 156.

1.8 For these reasons, the newly developed ICB policy is an interim one as it will undergo another revision once NICE have published their revised guidance.

2. Introduction

2.1 This policy describes circumstances in which NHS Cheshire and Merseyside Integrated Care Board (ICB) will fund Medically Assisted Reproduction (MAR)* treatments for patients with subfertility as defined in section 4.

2.2 The objective of MAR treatment for subfertility is to achieve a successful pregnancy quickly and safely with the least intervention required and the delivery of a healthy child.

2.3 The criteria set out in this policy apply irrespective of where the residents of the ICB have their treatment (local NHS hospitals, tertiary care centres or independent sector providers). A patient is defined as someone registered with a GP practice within the ICB boundary.

2.4 This policy has drawn on guidance issued by the Department of Health, Infertility Network UK and the NICE guidance (CG156) first published in February 2013 (updated in September 2017).
https://fertilitynetworkuk.org/
https://www.nice.org.uk/guidance/cg156/evidence/full-guideline-pdf-188539453

* MAR (Medically Assisted Reproduction) is now the preferred term for all medically assisted procedures for treatment of infertility and it is an umbrella term which includes ART, ovulation induction and artificial insemination, IUI and ICSI.

3. General Principles

3.1 ***[IMPORTANT]*** Management of fertility problems is a complex area. Many of the policy statements are interrelated i.e. some policy statements may be affected by other statements elsewhere in the policy document. To correctly interpret a specific statement, the whole document must be taken into consideration.

3.2 The ICB has had regard to the NICE guidance in the formulation of this policy and as such, treatments are only permitted for health-related fertility problems and in accordance with the general principles, definitions and general eligibility criteria in sections 4-10 inclusive.

3.3 The eligibility criteria set out below does not apply to clinical investigations for subfertility.

3.4 The eligibility criteria do not apply to the use of assisted conception techniques for reasons other than subfertility, for example in families with serious inherited diseases where in-vitro fertilization (IVF) is used to screen out embryos carrying the disease or to preserve fertility, for example for patients about to undergo chemotherapy, radiotherapy or other invasive treatments.

Patients in this situation are encouraged to raise the topic of their fertility with their treating physician or surgeon.

- The cancer research link covers cancer treatment related fertility.
- The inherited diseases link covers fertility problems associated with familial diseases.

3.5 The ICB respects the right of patients to be treated according to the obligations set out in the NHS Constitution and the Human Rights Act specifically with regard to age and sex discrimination.

3.6 Patients who are mid-treatment before the formal implementation of this policy will be allowed to continue on the older pathway.

3.7 Owing to the nature of clinical commissioning policies, it is necessary to refer to the biological sex of patients on occasion. When the terms ‘men’ and ‘women’ are used in this document (unless otherwise specified), this refers to biological sex. It is acknowledged that this may not necessarily be the gender to which individual patients identify.

Eligibility Criteria

4. Subfertility Definition, timing of access to treatment and age range

4.1 Fertility problems are common in the UK and it is estimated that they affect one in seven couples. Eighty four percent of women in the general population will conceive within one year if they have regular, unprotected sexual intercourse. Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate 92%). In 25% of infertility cases the cause cannot be identified.

4.2 Where a woman is of reproductive age and having regular unprotected vaginal intercourse two to three times per week, failure to conceive within twelve months should be taken as an indication for further assessment and possible treatment.

4.3 In the following circumstances an earlier assessment should be considered:

- If the woman is aged 36 or over, then such assessment should be considered after 6 months of unprotected regular intercourse or 6 cycles of artificial insemination (self-funded) since her chances of successful conception are lower and the window of opportunity for intervention is less.
- If there is a known clinical cause of infertility or a history of predisposing factors for infertility.

4.4 Women should be offered MAR treatments if they have had subfertility of at least 2 years duration (12 months for women aged 36 and over) – this includes the initial 12-month period before the initial assessment. Additional criteria apply for IVF in women aged 40–42 (see paragraph 12.6).

4.5 This policy adopts NICE guidance that access to high level treatments including IVF should be offered to women up to the age of 42 years. First treatment cycles must be commenced before the woman's 43rd birthday.

4.6 Women will be offered treatment provided their hormonal profile is satisfactory i.e. in line with NICE CG156.
https://www.nice.org.uk/guidance/cg156
https://www.nice.org.uk/guidance/cg156/evidence/full-guideline-pdf-188539453

5. Same sex couples and single women

5.1 This policy is intended, as per NICE guidance, for people who have a possible pathological problem (physical or psychological) to explain their subfertility.

5.2 Same sex couples and single women undergoing artificial insemination must have received at least 6 self-funded cycles of unstimulated, intrauterine insemination in a clinical setting before they become eligible for NHS care. The ICB will then fund a further 6 cycles of unstimulated intrauterine insemination before IVF is considered. This gives a total of 12 cycles which is considered equivalent to 2 years of unprotected vaginal intercourse.

6. Overseas Visitors

6.1 An individual ordinarily resident in the UK is eligible for NHS funded fertility treatment.

6.2 Overseas visitors coming to, or remaining in, the UK for six months or more are usually required to pay the immigration health charge (referred to as the health surcharge, or IHS) unless an exemption from paying the surcharge applies or the charge is waived.

6.3 IVF is excluded from the list of NHS treatments overseas visitors can access, even if the above surcharge is paid.

6.4 Where a non-resident wishes to access IVF, they should be charged 150% of the National NHS tariff (or locally agreed price where applicable). IVF treatment charges should be made in advance of any treatment being given.

6.5 If care is deemed an emergency by the Fertility Consultant, the provider and ICB can enter a risk share scheme and split 50% of the costs each.

6.6 Current Guidance on Overseas Visitors and Eligibility can be found using the following link https://www.gov.uk/government/publications/nhs-cost-recovery-overseas-visitors.

7. Childlessness (current or previous children)

7.1 Funding will be made available where a couple have no living children from a current or any previous relationship i.e. if there is a previous living child from a current or previous relationship, then patients are excluded from subfertility treatment.

7.2 A child adopted by a patient or adopted in a previous relationship is considered to have the same status as a biological child.

7.3 Once a patient is accepted for subfertility treatment, they will no longer be eligible for any other MAR treatment or procedures if a pregnancy leading to a live birth has occurred or the patient has adopted a child.

8. Female and Male Body Mass Index (BMI)

8.1 The woman intending to carry the pregnancy, will be required to achieve a BMI of 19-29.9 kg/m² before subfertility treatment begins. Women outside this range can still undergo investigations, but subfertility treatment will not commence until their BMI is within this range.

8.2 Men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility and they should be strongly encouraged to lose weight as this will improve their chances of a successful conception.

9. Female and Male Smoking† Status

9.1 Both partners (i.e. female and/or male) should be confirmed non-smokers in order to access any subfertility treatment and must continue to be non-smoking throughout treatment. Providers should seek evidence from referrers and confirmation from patients. Providers should also include this undertaking on the consent form and ask patients to acknowledge that smoking could result in cessation of treatment.

10. Female and Male Drugs and Alcohol intake

10.1 Both partners (i.e. female and/or male) will be asked to give an assurance that their alcohol intake is within Department of Health guidelines, and they are not using recreational drugs. Any evidence to the contrary may trigger a pause in treatment with possible referral for a welfare of the child assessment and/or further information sought from the GP.
https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence
https://www.gov.uk/government/policies/reducing-harmful-drinking

† Smoking increases the risk of infertility in women and men. Nicotine alone is known to affect development of the foetus and long-term safety data on e-cigarettes are unknown. Because of these concerns and issues, all forms of smoking (which includes cigarettes, e-cigarettes or NRT) are not permitted.

Treatment Options

11. Intra-uterine Insemination (IUI)/Donor Insemination (DI) and Intra-cytoplasmic sperm injections (ICSI)

11.1 Unstimulated intrauterine insemination is a treatment option in the following groups as an alternative to vaginal sexual intercourse:

- 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 who are using partner or donor sperm
- People with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man is HIV positive)
- People in same sex relationships (please see section 5 regarding eligibility and the need for the first 6 cycles to be self-funded).

11.2 For people in 11.1 above who have not conceived after 6 cycles of donor or partner insemination, despite evidence of normal ovulation, tubal patency and semen analysis, should be offered a further 6 cycles of unstimulated intrauterine insemination before IVF is considered.

11.3 For people with unexplained infertility, mild endometriosis or 'mild male factor infertility', who are having regular unprotected sexual intercourse, do not routinely offer intrauterine insemination, either with or without ovarian stimulation. Advise them to try to conceive for a total of 2 years (or 12 months for women aged 36 and over) as per section 4 before IVF will be considered.

11.4 Donor insemination (with IUI) may be considered for the following indications:

- obstructive azoospermia
- non-obstructive azoospermia
- severe deficits in semen quality in couples who do not wish to undergo intracytoplasmic sperm injection (ICSI).
- high risk of transmitting a genetic disorder to the offspring
- high risk of transmitting infectious disease to the offspring or woman from the man
- severe rhesus isoimmunisation

11.5 Stimulated IUI will be funded where clinically indicated, due concern must be given to the risk of multiple births in this situation and insemination abandoned if this is felt to be a possibility.

11.6 Patients who fail to achieve a pregnancy using IUI/DI will be considered for IVF.

11.7 For the sake of clarity, according to CG 156, 12 months of unprotected vaginal intercourse is considered to be equivalent to 6 cycles of artificial insemination. Further, the usual requirements for women aged ≥ 36 years are halved (in comparison to women aged <36 years) i.e. they may be required to experience a period of “watchful waiting” of 6 months (as opposed to 12 months in younger women) and/or to undergo 3 cycles of artificial insemination (as opposed to 6 cycles in younger women).

11.8 Intracytoplasmic Sperm Injection (ICSI) is routinely funded for:

- severe deficits in semen quality or
- obstructive azoospermia or
- non-obstructive azoospermia.

12. IVF

Definition

12.1 A full cycle of IVF (with or without ICSI) is defined as one episode of ovarian stimulation and the transfer of all resultant fresh and/or frozen embryo(s). If there are any remaining frozen embryos, the cycle is only deemed to have ended when all these embryos have been used up or if a pregnancy leading to a live birth occurs or the patient adopts a child (i.e. in accordance with the ICB's policy on "Childlessness").

12.2 Following ovarian stimulation, a *cancelled IVF cycle* is defined as one where an egg collection procedure is not undertaken. Should this occur, this would not count as one of the patient's "cycles" unless the reason for cancellation is thought to be due to low ovarian reserve.

Number of Cycles

12.3 For women under the age of 40 years, the maximum number of cycles permitted is 1.

12.4 When women aged 39 years or younger reach their 40th birthday, they will be allowed to complete their cycle of treatment. If this has been unsuccessful, no further cycles will be permitted irrespective of their entitlement based on their age on commencement of therapy.

12.5 For women aged 40 and up to 42, the ICB offers 1 full cycle provided:

- They have never previously had IVF (including private treatment).
- There is no evidence of low ovarian reserve.
- There has been a discussion about the implications of IVF at this age.
- The cycle must commence prior to the woman's 43rd birthday.

12.6 If patients have either funded their own IVF cycles privately, or received cycles funded by another NHS organisation, the maximum number of permitted cycles (above) will be reduced by this number.

Ovarian reserve testing

12.7 In order to predict the likely ovarian response to gonadotrophin stimulation, the principal permitted test (see below) is the anti-Müllerian hormone (**AMH**). An AMH value of less than or equal to 5.4 pmol/l is a low response (Beckman–Coulter assay: poor response defined as less than 4 oocytes or cancellation), or greater than or equal to 25.0 pmol/l for a high response (Beckman–Coulter or DSL assays: defined high response as more than or equal to 15 oocytes to more than 21 oocytes).

12.8 The AMH may be supplemented by a total antral follicle count **(AFC)** (see below). An AFC of less than or equal to 4 is a low response (follicles of less than or equal to 5 mm measured by transvaginal ultrasound on day 3 of cycle: low response was less than 4 oocytes) , and greater than 16 for a high response (follicles of 2 to 10 mm measured by transvaginal ultrasound on day 3 of cycle: high response was more than or equal to 15 oocytes or more than or equal to 20 oocytes).

12.9 The Follicle Stimulation Hormone (FSH) test is no longer recommended and is not routinely commissioned for this indication.

12.10 In the majority of cases, AMH alone will be used to assess response to ovarian stimulation. However, if the value of AMH is <5.4pmol/l, an AFC can be performed in the early follicular phase of the menstrual cycle. If the value of AFC is <4 then see section 16 – oocyte donation.

Number of Transferred Embryos

12.11 The transfer of any resultant fresh and/or frozen embryos must be transferred in line with NICE CG156 and the Human Fertilisation and Embryology Authority (HFEA). The ICB will only contract with providers who make a public commitment to comply with the HFEA single embryo transfer policy and can demonstrate significant progress towards achieving the annual target set by the HFEA with performance that is not significantly above the target.

12.12 In keeping with the Human Fertilisation and Embryology Authority's (HFEA) multiple birth reduction strategy individuals/couples will be counselled about the risks associated with multiple pregnancies and advised that they will receive a single embryo transfer (whether fresh or frozen) unless there is a clear clinical justification for not doing so (e.g. a single top-quality embryo is not available). In any event, a maximum of 2 embryos will be transferred per procedure (either fresh or frozen).

12.13 Individuals/couples with a good prognosis should be advised that a single embryo transfer, involving fresh, followed by frozen single embryo transfers, can virtually abolish the risk of a multiple pregnancy while maintaining a live birth rate which is the same as that achieved by transferring 2 fresh or frozen embryos.

12.14 Further information is available at https://www.hfea.gov.uk/about-us/our-campaign-to-reduce-multiple-births/.

13. Surrogacy

13.1 The ICB will not commission any form of fertility treatment for those in surrogacy arrangements (i.e. the use of a third party to bear a child for another couple). This is due to the numerous legal and ethical issues involved.

14. Reversal of Sterilisation

14.1 Subfertility treatment is not routinely funded where this is the result of a sterilisation procedure in either partner.

14.2 Where subfertility remains after a reversal of sterilisation, treatment is not routinely funded.

14.3 The surgical reversal of female sterilisation is not routinely funded.

15. Surgical retrieval of sperm

15.1 Surgical retrieval of sperm is routinely commissioned by NHS England (NHS-E) for male infertility if the patient satisfies the criteria outlined in the NHS-E service specification.

15.2 Before men can be referred to NHS–E, they must also qualify for treatment under the ICB's subfertility policy.

15.3 In all other cases, surgical retrieval of sperm is not routinely commissioned by the ICB.

16. Oocyte (egg) donation and sharing and embryo donation

16.1 Donor oocytes in women up to their 43rd birthday are routinely commissioned for fertility problems associated with any of the following conditions:

- premature ovarian failure
- gonadal dysgenesis, including Turner syndrome
- bilateral oophorectomy
- ovarian failure following chemotherapy or radiotherapy
- certain cases of IVF treatment failure (e.g. very poor response to ovarian stimulation)‡
- Oocyte donation may also be considered in certain cases where there is a high risk of transmitting a genetic disorder to the offspring.

16.2 Oocyte (egg) sharing or donation for any 'commercial' consideration (i.e. purchase of additional entitlements) will not be approved.

16.3 Oocyte(egg) donations will be sourced by Providers and charged separately.

16.4 Embryos donated by women according to Human Fertilisation and Embryology Authority (HFEA) regulations will be routinely commissioned for couples with female and male factor infertility.

17. Storage and cryopreservation of embryos, oocytes (eggs) and semen

17.1 Storage of embryos, oocytes or semen is routinely commissioned for eligible patients who are undergoing NHS subfertility treatment. Readers are required to interpret this section in conjunction with the ICB policy on "Childlessness."

Fertility Preservation before treatment for cancer (or other procedures which affect fertility)

17.2 Cryopreservation of embryos, oocytes or semen is routinely commissioned before treatments or procedure (e.g. for cancer or other medically essential interventions such as a surgical procedure and/or administration of medication) which are known to affect fertility. This will be performed in accordance with the Human Fertilisation and Embryology Authority (HFEA) regulations and NICE guideline CG 156.

17.3 Patients must satisfy the prevalent subfertility criteria when the time comes to use this stored material and they must have been informed of this requirement before commencing cryopreservation.

17.4 The cryopreserved material may be stored for 10 years or up to the female partner's 43rd birthday, whichever comes sooner.

Following a live birth

17.5 The ICB will fund up to 12 months' storage following the birth or adoption of a child (i.e. a "grace" period) to give the patient enough time to decide whether they wish to self-fund,

‡ See section on ovarian reserve testing

donate the stored material or consent to having any remaining gametes or embryos destroyed.

17.6 This is in accordance with the ICB's policy on "Childlessness" and beyond the "grace" period, funding for storage will no longer be available.

18. Storage of Ovarian Tissue

18.1 Storage of ovarian tissue is not routinely funded.

19. Pre-Implantation Genetic Diagnosis (PGD)

19.1 The ICB does not routinely commission PGD.

19.2 Pre-implantation genetic diagnosis (PGD) is routinely commissioned by NHS England. https://www.england.nhs.uk/wp-content/uploads/2018/07/Pre-implantation-genetic-diagnosis.pdf

19.3 Patients requiring treatment should initially be referred to the Regional Clinical Genetics Service.

20. Anti-Viral Transmission

20.1 Couples who are affected or may be affected by chronic viral infections (e.g. HIV, hepatitis B or C) should be managed according to the recommendations in NICE guideline CG 156.

Advice and Guidance

21. Aim and Objectives

21.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

21.2 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

21.3 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined.

21.4 At the time of publication, the evidence presented per procedure/treatment was the most current available.

21.5 The main objective for having healthcare commissioning policies is to ensure that:

- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

22. Core Principles

22.1 Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the ‘NHS Choice’ framework.
- Commissioning decisions will give ‘due regard’ to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

23. Individual Funding Requests (Clinical Exceptionality Funding)

23.1 If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

23.2 The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy available on the C&M ICB website: https://www.cheshireandmerseyside.nhs.uk/your-health/individual-funding-requests-ifr/

24. Monitoring and Review

24.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

24.2 This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

24.3 This policy may be subject to continued monitoring using a mix of the following approaches:

- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

24.4 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

25. Quality and Equality Analysis

25.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

Document Control

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Target audience:	All Cheshire & Merseyside ICB Staff and Provider organisations.

Version History

Version 0.1 – Draft
Amalgamation of existing CCG policies to form one draft ICB policy identifying variation for review

Version 0.2 – January 2024 - Draft
Review and update of policy reducing variation in alignment with evidence-base and commissioning priorities updating and adding clarity, specifically:

- Inclusion of an Interim policy position statement
- Introduction
- Eligibility general principles
- Definition of subfertility, timing of access to treatment and age range
- Definition of childlessness
- Same sex couples and single women eligibility criteria
- Surrogacy
- Treatment following reversal of sterilisation
- Female and Male Body Mass Index (BMI)
- Female and Male Smoking status
- Femail and Male Drugs and Alcohol intake
- Intra-uterine insemination (IUI)/Donor Insemination (DI)
- IVF definition and number of cycles
- Number of IVF cycles
- Cancelled and abandoned cycles definition
- Handling of existing frozen embryos from previously funded cycles
- Number of transferred embryos
- Ovarian reserve testing
- Surgical retrieval of sperm
- Oocyte (egg) donation
- Donor insemination/Oocyte (egg) sharing and donation
- Storage and cryopreservation of embryos, oocytes (eggs) and semen
- Pre-Implantation Genetic Diagnosis
- Anti-Viral Transmission (e.g. HIV and HEP B)
- Cryopreservation
- Check, update and correction of hyperlinks

Version 0.3 – March 2024 - Draft

- Further amendments to add clarity following local clinical engagement

Version 0.4 – January 2024 – Draft

- Further amendments to add clarity following 2nd episode of local clinical engagement
- Policy reformatted for ease of reference and in readiness for wider engagement

Version 0.5 – November 2025 – Final

- Policy approved by NHS C&M ICB Board, included detail on the number of NHS funded IVF cycles.