Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	8 March 2018
Officer	Helen Coombes, Transformation Programme Lead for the Adult and Community Services Forward Together Programme
Subject of Report	**Briefings for information / note**
Executive Summary	The briefings presented here are primarily for information or note, but should members have questions about the content a contact point will be available. If any briefing raises issues then it may be appropriate for this item to be considered as a separate report at a future meeting of the Committee. For the current meeting the following information briefings have been prepared: • NHS Dorset Clinical Commissioning Group: Assisted Conception Policy • NHS England: Modernising Radiotherapy Services in England.
Impact Assessment:	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Information provided by NHS Dorset Clinical Commissioning Group and NHS England.
	Budget: Not applicable.

Briefings for information

	Risk Assessment: Current Risk: LOW Residual Risk: LOW
	Other Implications: None.
Recommendation	That Members note the content of the briefing reports and consider whether they wish to scrutinise the matters highlighted in more detail at a future meeting.
Reason for Recommendation	The work of the Committee contributes to the County Council's aim to help Dorset's citizens to maintain health, safety and independence.
Appendices	1. NHS Dorset Clinical Commissioning Group: Assisted Conception Policy 2. NHS England: Modernising Radiotherapy Services in England.
Background Papers	None.
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NHS Dorset Clinical Commissioning Group

Appendix 1

Briefing note: NHS Dorset Clinical Commissioning Group

NHS Dorset CCG Fertility Assisted Conception Policy changes	**Contact name: Hannah Nettle** **Contact email: Hannah.nettle@dorsetccg.nhs.uk**

1. Purpose of this briefing

1.1 The purpose of this briefing is to advise members of the Health Scrutiny Committee of NHS Dorset Clinical Commissioning Group's (CCG) decision to make changes to the Fertility Assisted Conception policy in order to:

- Provide greater clarity and improve the experience for couples accessing assisted conception treatment/s
- Limit emotional stress for those accessing the treatment
- Improve the clarity of the description of the policy criteria

1.2 The number of fertility cycles offered to couples was not included in the review as Dorset CCG made a decision in 2015 to approve the commissioning of one cycle of treatment.

2. Background

2.1 The commissioning of assisted conception (Fertility) services has a direct and significant impact on all couples identified as meeting the criteria for assisted conception services in Dorset. National evidence based research and guidance advises that although most women fall pregnant within two years of unprotected sexual intercourse, around 10% of couples are unsuccessful. This is called infertility and there are a range of reasons why couples do not conceive, including various medical conditions in the man or the women, the woman's age, obesity and/or lifestyle factors such as smoking or drinking. There are a number of potential treatments for infertility including medical and surgical interventions. However, some couples can only conceive with the help of complex assisted conception treatments such as in-vitro fertilisation (IVF), Intracytoplasmic sperm injections (ICSI) and Intrauterine insemination (IUI).

2.2 The Criteria Based Access Protocol (CBAP) for Assisted Conception, was updated and subsequently approved in February 2015. This was to align it with the Governing Board recommendations, the Equality Act (2010-2012), best practice and NICE guidance. Key changes included:

a) Number of cycles of IVF treatment commissioned reduced from two cycles to one cycle.
b) Removal of the lower age limits for women: previously only women between age 30-35 years could access treatment.
c) Removal of the upper age limit for men: previously men had to be 55 years or under to access treatment.
d) Increased upper age limit for women, completing a treatment cycle 'by the age of 42'.
e) Same access to treatment for same sex couples as heterosexual couples.
f) BMI for female changed from 19-29 to 19-30 and for males from 35 to 30.
g) Definition and clinical indication aligned with NICE guideline 156 for IUI, IVF, ICSI.

2.3 Since the policy went live on the 1 April 2015 commissioning matters and issues relating to the policy have been raised via stakeholders; including clinicians delivering local fertility services, patients and requests to the individual patient treatment panel. As a

result of this the policy was reviewed taking these into account and a set of proposed changes were developed, and consulted which have been agreed by the CCG.

3. Proposed Changes

3.1 During August and September 2017 people with lived experience of accessing the assisted conception pathway were invited to meet with the CCG and Fertility Centre to give their views on the proposed policy changes and feedback any other areas for service improvement.

3.2 Further views were sought from those with lived experience of cancer and whose fertility might be affected by medical treatment.

3.3 Overall there was majority support for the proposed changes with one exception relating to cryostorage, fertility preservation treatment for women. Egg Oocyte cryopreservation is the freezing and storage of eggs that may be thawed for use in future in-vitro fertilisation treatment cycles. Embryo Cyrostorage is the freezing and storage of embryos that may be thawed for use in future in-vitro fertilisation treatment cycles. Nationally 2013 data (Human Fertilisation and Embryology Authority (HFEA)) states birth rate using frozen eggs was 14%, and birth rate per cycle started after frozen embryo transfer using woman's own eggs was around 25% (the success rate declines to around 17-10% from age 40-43+). The proposed change was that patients who are undertaking potential medical treatment likely to impair fertility are eligible for egg/oocyte harvesting and storage, and for couples in a three-year stable relationship they are eligible to access egg/oocyte harvesting, fertilization and embryo storage (embryo creation and storage). There was a split view that embryo creation and storage should be available to all but the majority felt that the three-year period for couples to access embryo creation and storage was too long.

3.4 The secondary care clinical staff delivering local fertility services supported all the proposed changes with exception to cryostorage and felt when a couple receive a cancer diagnosis, having criteria that stipulates that they have to have been together in a stable relationship for over three years before being able to access cryostorage could significantly restrict people's chances of having their own children in the future if the option continues to be restricted only to egg storage. The current policy does not support people who have been together for a shorter period of time, but are clear that they will be together a long time and wish to have children in the future

3.5 Following consultation, the proposed policy change for cryostorage was amended and the time period for couples to access embryo creation and storage was removed, see item 1 in the table below.

3.6 On the 20 December 2017 Dorset CCG Clinical Commissioning Group Clinical Commissioning Committee approved the proposed policy changes to be effective on the 1 January 2018.

3.7 Please see table one, for the key changes that have been agreed:

	Change in policy – effective from the 1st January 2017	**Current policy**
1	Where medical treatment will impact fertility (e.g. cancer treatments) couples have the option to discuss access to egg or embryo cryostorage, however clinical judgement will be applied to determine	No criteria apply to cryopreservation and as a result Individual Patient Treatment (IPT) requests are raised to gain clarity. This adds a further step and delay in process in an already often urgent and stressful situation.

	which option is most appropriate. Female patients have access to egg cryostorage.	
2	The length of egg/embryo storage period funded by the NHS is up to age 40 but must not exceed appropriate HFEA regulations.	10-year cryostorage period for eggs and embryos. (This storage period can be limiting for some females e.g. those who may have had cryostorage in their early 20's.)
3	Couples entitled to access 1 additional cycle of IVF or ICSI where couples have gone through a long process to reach egg collection and have unexpected failed fertilisation and do not create an embryo.	Not available.
4	Couples entitled to access 1 additional cycle of IVF or ICSI when they abandon treatment on the first cycle and do not achieve egg collection because of either a) being at risk of ovarian stimulation or b) do not stimulate (under stimulate).	Not available.
5	Patients diagnosed with absolute infertility to be entitled to immediately access NHS funded assisted conception services.	Not current policy - the two-year waiting time is inappropriate for those with absolute cause infertility as no period of trying to conceive will alter the chances of pregnancy without assisted conception treatment.
6	Patients are able to delay implantation of frozen embryo up to 12 months.	Not current policy - this has not been clear in the old policy and has caused IPT requests to be raised.
7	Couples are able to commence treatment within 3 months if clinically appropriate.	Not current policy - some patients wish to progress treatment prior to the 3 month wait time and Salisbury assisted conception service have deemed patients clinically appropriate to proceed.
8	In line with (NICE) Same Sex Female couples are able to access NHS assisted conception treatment after demonstrating infertility through 6 self-funded cycles of Donor Insemination (DI).	Current policy means same sex couples have to demonstrate unexplained infertility through 12 self-funded cycles of Donor Insemination.
9	Same sex male couples can be referred for infertility investigations after 6 cycles of DI where no pregnancy results for which the man's donated sperm has been used.	No criteria in the old policy for same sex male couples.

4. Conclusion:

4.1 Discussion at the CCG Clinical Commissioning Committee concluded:

- These are positive changes to the policy for patients that will improve access to patients going through the assisted conception pathway. It will also clarify elements of the policy that are currently unclear.
- It will improve experience of assisted conception treatments and will limit emotional distress compared to the current policy.

- The changes to the policy provide a fair and equitable offer of assisted conception treatments within the financial constraints.
- It was recognised that this policy aligns with the Equality Act, however it was noted that at any time national policies and drivers may change that could initiate further review of the policy.
- Same sex female couples access to NHS funded treatment aligns to NICE Guideline 156 for to best practice.

Definitions / Glossary of Terms

ICSI Intracytoplasmic Sperm Injection (ICSI) is a variation of in-vitro fertilisation in which a single sperm is injected into the inner cellular structure of an egg.

IUI Intrauterine Insemination (IUI) involves timed insemination of sperm into the uterus. This can be completed as part of a natural unstimulated cycle (unstimulated IUI) or following stimulation of the ovaries using oral anti- oestrogens or gonadotrophins (stimulated IUI).

IPT Where patients are outside of the criteria and clinical exceptionality exists requests for Individual Patient Treatment (IPT) can be made through the CCG IPT process.

IVF In-Vitro Fertilisation (IVF) is a technique whereby eggs are collected from a woman and fertilised with a man's sperm outside the body.

The term IVF usually refers to the full cycle of treatment, where one or two embryos which have resulted from the in-vitro fertilisation process are then transferred to the womb with the aim of starting a pregnancy.

The main procedures involved in IVF treatment are:

- pituitary down regulation: switching off the natural ovulatory cycle to facilitate controlled ovarian stimulation;
- ovarian stimulation: administration of gonadotrophins to encourage the development of several follicles followed by administration of hCG to mature eggs ready for collection;
- egg collection followed by semen production or sperm recovery;
- IVF;
- transfer of resulting embryos to the uterus;
- luteal support: administration of hormones to aid implantation of the embryos.

Appendix 2

Briefing note: NHS England – Modernising Radiotherapy Services in England

1 Background

1.1 In late December, Dorset Health Scrutiny Committee became aware (via concerned colleagues in the Isle of Wight) that NHS England had launched a consultation on radiotherapy services in October 2017. The consultation was seeking feedback on a new specification for adult radiotherapy services and, due to the level of interest, the consultation period had been extended to 24 January 2018**.**

1.2 The notification circulated by NHS England was as follows:

The development of the proposed service specification sits alongside NHS England's £130 million investment in radiotherapy equipment, which was announced last year and is aimed at delivering the vision for radiotherapy services.

Our aim is to encourage radiotherapy providers to work together in Networks to concentrate expertise and improve pathways for patients requiring radical radiotherapy for the less common and rarer cancers. This will help to increase access to more innovative radiotherapy treatments, increase clinical trial recruitment and make sure radiotherapy equipment is fully utilised, securing greater value for money. There is no intention to reduce the number of radiotherapy providers, nor is it considered to be a likely outcome of these proposals.

The specification has been developed by talking to doctors, nurses, radiographers and public and patient engagement groups and was informed by a period of stakeholder engagement in 2016. A report of this work is available.

Through the consultation, NHS England will be seeking more views on these proposals from patients, carers, members of the public, clinicians and anyone else who may have an interest in radiotherapy services.

How people can give their views
NHS England is keen to receive feedback and answer questions on the proposals for the vision of radiotherapy services across England. Feedback will help NHS England to further shape and refine proposals for the delivery of safe and effective high quality radiotherapy services that are easy for people to access and meets their needs. The consultation period, runs from 18 October 2017 to 24 January 2018.

If you have any questions or comments about the consultation, please get in touch via england.npoc-cancer@nhs.net.

1.3 NHS England (Wessex) advised that *"the proposal for our sub region suggests creating a network at Oxford for radiotherapy patients in Hampshire, Isle of Wight and Dorset."*

1.4 In response to the consultation, the Isle of Wight Council (Policy and Scrutiny Committee on Adult Social Care and Health) wrote to NHS England expressing concerns, with specific regard to travel implications for their residents in terms of distance and cost, should the specialist radiotherapy services be based at Oxford.

1.5 Recognising that Dorset's residents could be similarly affected (and therefore potentially disadvantaged), attempts were made to establish what the local impact might be, including the number of individuals involved and what travel support would be provided in future. Unfortunately no response to queries was received from NHS England or local contacts prior to the deadline. A response to the consultation was therefore submitted without the benefit of full information, but hopefully registering the key concerns.

2 Response on behalf of Dorset Health Scrutiny Committee

2.1 A response to the consultation on behalf of the Committee was submitted on 24 January 2018 via e-mail, as follows:

On behalf of the Dorset Health Scrutiny Committee, I would like to raise the following points / questions, for consideration:

- *Dorset Health Scrutiny Committee has some concerns as to what the impact will be on patients from Dorset if individuals who would normally have been treated at Poole Hospital will in future have to travel to Oxford. It is not clear from the information that has been provided how many patients are likely to be affected each year, neither is it clear whether what is being proposed is in addition to services that will continue to be provided in Poole and (in future) in Dorchester. We seek reassurances on these questions.*

- *The Committee would like to know whether any travel support will be provided (other than the usual funding available to those on low income and the NEPTS for those who qualify)? It is certainly extremely difficult to get to Oxford from parts of Dorset by public transport, and a journey by car would take well over two hours from many parts of the County. The proposals mention accommodation and that the specification will "seek to encourage" provision. The Committee would prefer a clearer approach to this concern, with a definite commitment to the provision of accommodation where required.*

- *The consultation documents state that some Networks will be introduced in April 2018. When would any changes affecting residents of Dorset be introduced?*

- *The Committee recognises the benefits of specialised treatment centres for rare and very complex conditions and understands the rationale behind their introduction. However, rural areas such as the County of Dorset, with a high number of older residents no longer able to drive or use public transport (which may in fact not exist), need particular support to ensure equity of access to Health Services. We know, from previous discussions with cancer clinicians locally, that some individuals choose not to receive treatments when access to those treatments is too onerous as a result of the distances involved. As a Committee we would not be able to support changes to services which might not be of benefit to the local population, and we would be grateful if you could respond to the concerns raised.*

3 Update from NHS England

2.1 Following submission of the response to the consultation, NHS England were contacted again to try to clarify the proposals and the potential impact for Dorset. The Lead Commissioner for radiotherapy services subsequently contacted the Health Partnerships Officer and provided the following information:

- The establishment of networks relates to strategic oversight and scrutiny to deliver consistent practice and reduce clinical variation;
- If the proposals are taken forward, the local network would link Southampton and Oxford;
- The radiotherapy concerned would be in relation to a small number of very rare cancers, and one of the first pieces of work will be to undertake a stocktake of the numbers of cases across the network;
- At the moment, the consultation is about testing principles to find out whether services that may not be sustainable can be joined and integrated across sites;
- Southampton is already a specialist centre for radiotherapy and is likely to continue to be so;
- If, following the outcome of the initial consultation, changes to local services are felt to be necessary, they will require further local consultation.

2.2 Over 11,000 responses were received in response to the current consultation and these are currently being collated. This will take at least eight weeks. In the meantime, conversations with Cancer Alliances across the county continue, alongside discussions with clinicians and other professionals involved in the delivery of radiotherapy services.

4 Update from Dorset Cancer Centre (Acting General Manger, Oncology, Poole)

4.1 In addition to the update from NHS England, the General Manager of the Oncology Centre at Poole Hospital provided the following information, which may give some reassurance to Members:

We are not really anticipating much of a change to the radiotherapy service in Dorset. We already have a good relationship with the other trusts giving radiotherapy in the Wessex region, and expect this to continue. Our paediatric patients and cranial stereotactic patients already go to Southampton as the regional specialist centre for those types of patients, and this will not change.

Looking at the clinical framework and scenarios, Poole (with Dorchester as a satellite unit of Poole) will still be treating pretty much the same cohort of patients as we are at the moment. The only difference would be some rare site work we currently do may have to go to Southampton. It is unlikely it would have to go to Oxford. These would be very small numbers of patients with sarcoma, penile cancer or rare head and neck tumours, and will have little impact on the workload in Dorset. I anticipate no impact on the satellite unit at Dorchester at all.

The aim of this proposal is for services to be more networked to provide support across regions more easily if needed, especially in areas such as radiotherapy physics where recruitment and retention is challenging. Also to have more consistency of practice, enabling better pathways for the rare tumour types.

Ideally the radiotherapy community wanted these networks to be based on the current cancer alliances, as these are already in place and work well; we have very good links across Wessex already in place for radiotherapy. In reality I can probably see Wessex working as its own network within the larger remit, with just an oversight from a regional point of view, but as yet there is no detail on how this will work, and no timescale to work with.