THRESHOLD POLICY – T34
SUBFERTILITY IN SECONDARY CARE

Policy author: Ipswich and East & West Suffolk CCGs supported by Public Health Suffolk

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Subsequent reviews August 2013
May 2014
February 2017

Next review date: February 2020

1. Policy Summary

1.1 Investigation and treatment of female subfertility is considered a low priority intervention and will only be provided by Ipswich and East Suffolk & West Suffolk CCGs in line with the criteria specified below.

2. Eligibility Criteria

2.1 Level 2 Services:

Patients should only be referred for level 2 subfertility treatment if they meet all of the following criteria:

a) Maternal BMI is greater than 19 kg/m\(^2\) and less than 30 kg/m\(^2\)

b) Maternal age is more than 23 and less than 42\(^3\)

c) Paternal BMI is less than 30 kg/m\(^3\) (NICE156, section 1.2.6.4 p.9)\(^3\)

d) Paternal age is more than 23 and less than 55\(^3\)

e) Where either or both partners smoke they have taken part and completed a recognised supportive smoking cessation programme

f) Initial investigations have been initiated in primary care (semen test, blood tests determine ovulation and lifestyle advice) for further information please refer to NICE clinical guidance 156\(^3\)

g) Neither partner has undergone sterilisation in the past

h) There are no concerns regarding the welfare of the unborn child in accordance with the Human Fertilisation and Embryology Authority (HFEA) guidance.

i) Both partners must be registered with a GP Practice within the CCG and be eligible for
NHS care for at least 12 months prior to referral from primary to secondary care.

2.2 **Level 3 services:**

For level 3 services please refer to the separate policy covering this service.

3. **Background to the Condition**

3.1 Subfertility is defined as failure to conceive after frequent unprotected intercourse for 2 years in couples of reproductive age group in the absence of known reproductive pathology. It is expected that 84% of couples in the general population having regular unprotected intercourse will conceive within one year and 92% within two years. However, a minority will be unable to conceive and may benefit from fertility treatment.

3.2 Three levels of fertility treatment services are provided:

3.3 Level 1 services, primary care – In the GP setting; assessment and investigation and referral to the next level if necessary.

3.4 Level 2 services, secondary and specialist care – provided in hospital; specialist investigations, drug treatment and monitoring at a higher level than in primary care Level 1.

3.5 Level 3 services, tertiary specialist care – All investigations, preparations and treatments are performed at a specialist centre at a higher level than in secondary care Level 2.

3.6 This policy is specific to access to Level 2 services.

4. **Rationale to the Decision**

4.1 Women with a BMI over 30 kg/m² take longer to conceive when compared with women with a lower BMI, adjusting for other factors such as menstrual irregularities. Further to this a reduction in body weight has been shown to improve ovulation and pregnancy rates.

4.2 The RCOG advises that women who have a BMI greater than 29 will take longer to conceive and that losing weight will increase the chances of conception. Further to this, NICE CG156 has the following recommendation under section 1.2.6.4 on page 9. ‘Men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility. [2004, amended 2013].’

4.3 However, women with a low BMI are also likely to have reduced fertility as weight loss over 15% for ideal body mass is associated with menstrual dysfunction and secondary amenorrhea and restoration of body weight can improve fertility. The RCOG therefore recommend that women with a BMI less than 19 should be advised that increasing body weight will increase their chances of conception. An observational study has found an inverse relationship between BMI and number of normal motile sperm. Also the RCOG advises that men with a BMI of 29 or greater are likely to have reduced fertility.

4.4 Criteria for minimum maternal and paternal age has been introduced in line with the average age of conception and cohabiting. The average age of first time mothers in 2014 ONS data was 28.5 years and a 2012 ONS short report found that people aged between 25-34 are the most likely group to be cohabiting. Further to this Cambridgeshire and Peterborough CCG
have similar criteria for minimum maternal and paternal age, which in the main has been adopted from the East of England Fertility Services Consortium policy. There is some suggestive evidence that the optimum age for conception and complications being less likely is between the ages of 23 and 31. In Suffolk the upper limit for accessing infertility services is 42 years as recommended by NICE.

4.5 There is significant association between reduced fertility and smoking in both men and women^{10,11}. Also there are risks associated with smoking and passive smoking during pregnancy^{12}. The CCGs will not commission level 2 fertility services in couple where either partner is a smoker unless they have taken part and completed a recognised supportive smoking cessation programme^{9}.

4.6 NICE clinical guidance gives advice on assessment of patients with concerns regarding fertility^{2}. Prior to referral to level 2 or 3 services all patients should have undergone initial assessment and advice as recommended by NICE, this includes semen analysis, maternal blood testing to determine ovulation and lifestyle advice.

4.7 Sterilisation is an irreversible form of contraception and this should be explained prior to sterilisation and the patient has given informed consent. As there are limited resources priority is given to those with greatest need. Again the CCGs do not offer level 2 or 3 treatments where either partner has undergone sterilisation in the past^{9}.

4.8 The Human Fertilisation and Embryology (HFE) Act 1990 clearly states that ‘A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth’^{13}.

5. References