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1	**What are the Principles on which the policy is based?**	No cross reference to the principles of appropriateness, effectiveness, value for money and ethics, or to any document containing those principles.	Confirms that it is based on the Principles document.	Confirms that it is based on the Statement of Principles document (which now replaces value for money with cost effectiveness and affordability).
2	**What provision does the policy make for considering cases felt to be exceptions to the policy (exceptionality)?**	"Exceptionality is taken to mean that the patient is different in their needs compared to other patients with a similar condition requiring that treatment/care." No cross reference to an exceptionality policy.	To be an exception to the policy requires 'evidence that the patient differs from the usual group of patients to which the policy applies, and this difference significantly changes how the policy is applied for this patient'.	Reference to an exceptionality policy, which interprets an exception to the policy in the same way as the 2014 Lancashire North policy.
3	**How does the policy define infertility?**	Having a diagnosed condition or the failure to conceive through two years of unprotected vaginal intercourse (section 2.3.1) or (for people not in partnerships and same sex couples only - section 2.2.1) "ten non-stimulated cycles or six cycles of clinically delivered insemination".	Diagnosed condition (list given) or failure to conceive in the absence of a treatable condition through two years of unprotected vaginal intercourse or twelve cycles of insemination (section 2.7).	A state in which "natural conception" is considered not to be possible. That may be a clinical diagnosis in which the organs are not and will not function. It may also be a failure to conceive after frequent heterosexual intercourse with the current partner for a reasonable period of time (2 years). Self-insemination is not accepted as an alternative.
4	**How many cycles are commissioned for women of different ages?**	IVF is offered only to women aged at least 23 and aged less than 40 at the start of a treatment cycle. Such women may be offered up to two cycles.	Up to two cycles of IVF may be offered to women aged under 40 (NICE CG156 suggests three). One IVF cycle may be offered to women aged 40, 41 or 42, as long as there is no evidence of having too few eggs for a reasonable chance of pregnancy (this agrees with NICE CG156).	Defines the number of cycles that may be offered to women of different ages in the same way as the 2014 Lancashire North policy.
5	**What is the definition of a treatment cycle?**	Not defined. Current practise is to consider each embryo transfer as a separate cycle, but NICE considers a cycle as one episode of ovarian stimulation (medication/drugs used to stimulate the production of mature eggs) and the transfer of any resultant fresh and frozen embryos.	Considers a cycle as one episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryos (i.e. NICE).	**EITHER** three attempts at insemination; **OR** a block or part of a block of treatment from ovarian stimulation to a single embryo transfer attempt, inclusive; **OR** the freezing storage and transfer of embryos, up to three transfer attempts; **OR** one surgical attempt to restore blocked fallopian tubes or vas deferens.
6	**Does the policy permit ICSI (intracytoplasmic sperm injection for male factor infertility – injection of sperm directly into the egg)?**	Yes.	Yes but with criteria based on clinical effectiveness, and in the case of obstructive azoospermia or ejaculatory failure it would commission only one attempt at sperm retrieval.	Yes.

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7	**What consideration does the policy give to previous cycles of IVF?**	No mention.	The limit in the number of cycles is based on effectiveness and cost effectiveness. Therefore funding will be to a maximum of two cycles regardless of whether previous cycles had been funded privately or through the NHS. Cycles funded in a previous relationship will also be taken into account unless the infertility in the previous relationship was clearly linked to the other partner.	The same as for the 2014 Lancashire North policy.
8	**Does eligibility depend on childlessness, and if so, how should this be interpreted in patients in complex family structures?**	Not commissioned if there is a living child from this or any previous relationship. An adopted child counts as a child of the adopted parents (whether the child has been adopted by the couple, or given up for adoption by the couple). No reference in the policy to the level of access to a child not living with the couple, or to issues around child with illness or disability.	Not commissioned if there is a living child from the current relationship. An adopted child counts as a child of the adopted parents (whether the child has been adopted by the couple, or given up for adoption by the couple). No reference in the policy to issues around child with illness or disability.	Eligibility requires **EITHER** at least one partner is childless, having no living biological child from this or any other relationship, irrespective of the level of contact with any such child; **OR** the only child of the couple has a diagnosed non-genetic terminal illness such that on the balance of probability that child is unlikely to live to age 18.
9	**In principle, are services commissioned for single people and/or same gender couples?**	Yes.	Yes.	The patient is defined as a couple comprising two people; thus people presenting alone are not eligible. Same sex couples are eligible only if they demonstrate clinical infertility in both partners.
10	**Are the services commissioned for single people and/or same gender couple subject to proof of clinical infertility?**	Must demonstrate clinical infertility, but there is no policy statement about the responsibility for funding insemination, to demonstrate infertility in such cases.	Must demonstrate clinical infertility and the policy is clear that the CCG will not provide the funding for any insemination attempts that may be required to deliver proof of clinical infertility.	Yes. IUI (placing sperm in the uterus) would itself count as a treatment cycle and is subject to eligibility criteria – therefore the funding of IUI to demonstrate eligibility for IVF is not relevant.
11	**In terms of discrimination, is a same sex couple considered as if they were one couple, or two single women?**	Not specific, but implies that they are considered as a couple.	Not specific, but implies that they are considered as a couple.	One couple
12	**For same sex couples, does the CCG have a view about which partner should be the biological parent of the child?**	If only one partner has infertility, the CCG should "discuss the possibility of the other partner becoming the biological parent".	No mention.	Both partners would need to have clinical infertility.
13	**Would the CCG commission services for assisted conception in patients who have no proven infertility, but for whom sexual intercourse would carry a risk of transmission of viral communicable diseases?**	No mention.	Yes.	Yes
14	**Would the CCG commission services**	The policy would allow treatment to be	Yes.	Yes, for physical or psychological reasons but

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	for assisted conception in patients who have no proven infertility, but who cannot have sexual intercourse for physical or psychosexual reasons?	commissioned 'in circumstances in which there is a diagnosed condition or inherited abnormality that would make natural conception impossible or extremely unlikely' (section 2.3.1). It is not clear whether this section would apply to difficulties with sexual intercourse, or just to conditions affecting the genital tract.		subject to specified criteria.
15	**What does the policy say about transgendered people?**	No mention.	In practice it considers transgendered people who have had the reproductive organs of their birth gender removed as having chosen sterilisation and therefore ineligible for treatment. It considers transgendered people who have retained the reproductive organs of their birth gender, to be regarded as if they retained their birth gender, thus needing to demonstrate infertility before being eligible for treatment. The policy does not recognise that such patients may be on hormone medication that may affect the function of their reproductive organs.	A transgendered person will be regarded as a person of their chosen gender and this policy will be applied in that context. However as a transgendered person is unable to produce gametes or to carry a pregnancy, it is unlikely that they would qualify for funding as assisted conception techniques cannot enable them to achieve biological parenthood.
16	**Would the CCG commission assisted conception using surrogacy?**	No.	No. Explicit that this is on the ethical grounds of risk to the surrogate.	No. Policy contains detailed explanation with legal backing.
17	**Would the CCG commission assisted conception using donated gametes (sex/germ cells), and if so would it provide any extra funding necessary to identify a donor and/or obtain donated gametes?**	Yes. No mention of the responsibility for providing any extra funding necessary to identify a donor and/or obtain donated gametes (sex cells).	Yes. No mention of the responsibility for providing any extra funding necessary to identify a donor and/or obtain donated gametes.	Yes, but would not provide extra funding for the process of finding a donor or for gamete banks.
18	**Is the age limit for eligibility based on the age of the female partner and/or the male partner and/or the egg donor?**	No mention.	No mention.	Female partner AND egg donor must both satisfy the criteria. Age criteria do not apply to the male partner
19	**Is smoking (which affects effectiveness) included in eligibility criteria?**	No mention.	Excluded if either partner is a smoker.	Yes – in accordance with NICE and applying to the relevant partner in terms of the evidence base only.
20	**Is obesity (which affects effectiveness) included in eligibility criteria?**	No mention.	Female body mass index must be in the range 19-30.	Yes – in accordance with NICE and applying to the relevant partner in terms of the evidence base only.
21	**Is alcohol consumption (which affects effectiveness) included in eligibility criteria?**	No mention.	The policy does not regard a couple in which the male partner has an "excessive alcohol intake" as having proven infertility, and therefore such a couple would not be eligible for treatment.	Yes – in accordance with NICE and applying to the relevant partner in terms of the evidence base only.

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22	**Are gametes and/or fertilised embryos stored, and if so for how long?**	No mention.	Yes, but refers to Human Fertilisation and Embryology Authority (HFEA) ten year maximum storage period.	Yes, until one of the following applies (for embryos): EITHER The female partner# reaches the age of 43; OR the embryo has been in storage for at least ten years; OR the couple have had a live birth and now have a living child who has reached the age of one year; OR the female partner# dies. Similar criteria apply for gametes. The policy requires the patient to be given 6 months' notice of the end of funding with an opportunity to fund privately thereafter.
23	**What options are considered in relation to storage of gametes (sex cells) or embryos?**	The policy does not consider whether there is a preference to store unfertilised gametes, or fertilised embryos in cases where either would be technically possible.	The policy does not consider whether there is a preference to store unfertilised gametes, or fertilised embryos in cases where either would be technically possible.	Except in the case of surplus embryos, the policy offers funding only for storage of gametes.
24	**Does the policy permit the commissioning of gamete storage for people at risk of clinical infertility as a result of early menopause?**	No mention.	No mention.	No, on grounds of clinical effectiveness. By the time clinical infertility has been demonstrated, the likelihood of success will be small.
25	**Does the policy permit the commissioning of gamete storage for people at risk of clinical infertility as a result of cancer treatment?**	No mention.	Yes, if the treatment is chemotherapy (3.7) or "treatments which are likely to result in infertility (e.g. chemotherapy or radical surgery)" (section 7.8). However technically the policy only permits storage if the treatment is likely to produce infertility. It does not consider the possibility of the treatment increasing the risk of congenital anomalies.	Gamete storage would be offered only for patients being given sex gland destroying treatment for a condition that is either life threatening or otherwise overwhelming in its severity such that it needs to be treated immediately. Therefore cancer treatment, and removal of organs to prevent the spread of disease for genetic risk above 10% in the storage period may satisfy that criterion (but treatment to prevent the spread of disease for lower risk will not)
26	**Does the policy permit the commissioning of gamete storage for people at risk of clinical infertility as a result of proposed gender reassignment?**	No mention.	No. The policy considers that patients having gender reassignment are consenting to sterilisation.	Gamete storage would be offered only for patients being given sex gland destroying treatment for a condition that is either life threatening or otherwise overwhelming in its severity such that it needs to be treated immediately. Gender reassignment is not considered to be of that level of urgency.
27	**What does the policy say about fertility investigations, and treatment not involving assisted conception?**	Funded without restriction.	Excluded from the scope of the policy.	Mostly excluded from scope but surgical procedures to restore the patency of blocked fallopian tubes or to restore the patency of a blocked vas deferens are in scope, would be funded (subject to satisfying the policy criteria)

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				and would count as a treatment cycle.
28	**Would the CCG commission reversal of sterilisation?**	No. There seems to be an intention (section 2.3.2) that the CCG would not commission IVF for people who had previously been sterilised, but that statement is unclear.	Separate policy, but this policy excludes funding for people whose infertility is the result of sterilisation. Slightly unclear whether that excludes funding for a woman whose partner has been sterilised.	Only when the only biological child of the sterilised person has died, and that death had not occurred, and could not have reasonably been anticipated, at the time of the sterilisation.
29	**What options are considered in relation to surgery or IVF?**	The policy does not consider whether IVF should be preferred to tubal surgery in cases where either would be technically possible.	The policy does not consider whether IVF should be preferred to tubal surgery in cases where either would be technically possible.	In cases in which either assisted conception services or surgical fertility services would represent a reasonable treatment option, then the CCG may take account of the probability of achieving one successful pregnancy, as well as the cost and the risk of side effects of each option in deciding which procedure to fund. The CCG may also take account of patient preference.
30	**Does the policy address pre-implantation genetic testing?**	Section 2.2 implies that preimplantation diagnostic testing will be commissioned.	Yes. Will be commissioned when this policy and a separate policy is also satisfied, and when there is no living child without the condition in question resulting from the relationship.	No. Out of scope.