SUPPLEMENTARY AGENDA

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 26 November 2021, 10:00 a.m.
MS Teams

Contact: Fiona Rae / Robert Mack

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Councillors: Alison Cornelius and Linda Freedman (Barnet Council), Larraine Revah and Paul Tomlinson (Camden Council), Tolga Aramaz and Derek Levy (Enfield Council), Pippa Connor **(Chair)** and Khaled Moyeed (Haringey Council), Tricia Clarke **(Vice-Chair)** and Osh Gantly (Islington Council).

Support Officers: Tracy Scollin, Sola Odusina, Claire Johnson, Robert Mack, and Peter Moore.

Quorum: 4 (with 1 member from at least 4 of the 5 boroughs)

AGENDA

7. FERTILITY REVIEW (PAGES 1 - 78)

To receive an update on the fertility review.

8. ELECTIVE SERVICES RECOVERY (PAGES 79 - 106)

To receive an update on elective services recovery in North Central London.

9. WINTER PRESSURES (PAGES 107 - 128)

To receive an update on winter pressures.

Robert Mack, Principal Scrutiny Officer / Fiona Rae, Principal Committee Co-ordinator
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Monday, 22 November 2021

NHS
North Central London
Clinical Commissioning Group

Developing a Fertility Policy for North Central London

Joint Health & Overview Scrutiny Committee

26 November 2021

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Setting the scene

Introduction

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- In 2020, the clinical commissioning groups in Barnet, Camden, Enfield, Haringey and Islington joined to become the North Central London Clinical Commissioning Group (NCL CCG). Each CCG had an individual Fertility Policy and these are still being used.
- To inform the development of a new, single Fertility Policy the CCG undertook a Review – seeking views of patients, residents, clinicians and examining clinical evidence, national guidance etc. From this, a set of recommendations were produced to inform development of a new policy.
- A draft single policy has now been produced. We are seeking views on this, and the feedback we receive will be used to finalise the Policy.
- The engagement window is open for 12 weeks (22 November 2021 to 13 February 2022), and you can feed in views in a range of different ways (see slides 16-20).

What have you seen before

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- JHOSC Chair, HOSC Chairs and Cllr leads for Adult and Social Care Services have received communications throughout the engagement window during stage 1 (the Review) informing members of:
  - opening and length of the engagement window (10 May to 9 July 2021).
  - how to have your say (for example, completing the survey, inviting CCG staff to a meeting to discuss the review and having the opportunity to attend the public meetings that were held during the first engagement period).

- A Joint Health Oversight and Scrutiny Committee (JHOSC) Briefing Paper sent to the JHOSC Chair and members (dated 20 September) setting the scene following the engagement window, summarising themes of public feedback received and providing information on the Review Recommendations*.

* The 20 September briefing paper is attached to the draft fertility policy for information

What is a fertility policy?

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Every CCG in England has a fertility policy. Typically, a CCG fertility policy sets out:

- Assisted conception treatments (e.g. IVF, intrauterine insemination) and other services (e.g. sperm washing for men living with HIV, freezing of eggs, sperm or embryos for people undergoing treatment that may affect fertility) that are available to patients in that area
- The eligibility criteria patients must meet to receive these fertility treatments (e.g. age, smoking status)
- It is not possible for a fertility policy to anticipate every possible individual circumstance. Therefore, GPs can submit Individual Funding Requests for patients who have exceptional clinical circumstances

What help is available to people wanting to conceive?

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- There are a range of medicines and treatments available that can help people to conceive, and many of these are available through the NHS
- Everyone's fertility 'journey' will differ depending on personal circumstances – for example, whether you are in a heterosexual couple, LGBT+ people or you are an individual who wants to conceive independently
- Many people start by speaking to their GP – who may undertake, or refer a person or couple for, initial investigations. These can include blood tests, sperm-testing and scans
- People may then be referred by their GP to a specialist clinic (at a local hospital) that can prescribe fertility medicines and offer a range of different treatments
- One of the most widely known treatments is in-vitro fertilisation (IVF) but, in fact, not all of people who have difficulty conceiving will need a treatment such as IVF

What do our current NCL fertility policies cover?

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- In vitro fertilization (IVF) with or without intracytoplasmic sperm injection (ICSI)
- Intrauterine insemination (IUI)
- Assisted conception treatments (for example, IVF or IUI) using donated oocytes or sperm
- Fertility preservation for patients who are about to have medical treatment such as chemotherapy that will affect their future fertility (egg, embryo or sperm storage)
- Surgical sperm retrieval in four of the five boroughs
- Sperm washing (for people with blood born viruses such as HIV) in four of the five boroughs
- Assisted conception treatments involving surrogates

Reflecting the aims of the NCL Integrated Care System in policy development

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- The main aims of an Integrated Care System are to:
  - improve outcomes in population health and healthcare
  - tackle inequalities in outcomes, experience and access
  - enhance productivity and value for money
  - help the NHS to support broader social and economic development.
- Each ICS has a responsibility to coordinate services and plan health and care in a way that improves population health and reduces inequalities between different groups.
- NCL CCG prioritised the development of a new Fertility Policy, recognising the current inequity of access to specialist fertility services across our boroughs (through five different policies)
- The draft policy would increase spending on NHS-funded treatment as it increases access to treatment in a number of boroughs. We carefully considered affordability alongside evidenced-based and equitable access to treatment, with the aim of maximising the opportunity of successful outcomes for people undergoing treatment within available funding.

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Draft single Fertility Policy

Considerations in producing the draft policy

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- The development of the draft policy was informed by:
  - The recommendations from the Review stage* (incorporating feedback from local residents and stakeholders**)
  - National guidance (including NICE guidelines)
  - Input from a group of specialist fertility clinicians & CCG clinical leaders
  - Data on current use of specialist fertility services, and NHS spending on these
  - A review of potential equality, equity and quality issues

- The CCG sought to adopt NICE guidance wherever feasible, but also considered other relevant factors including affordability. In a limited number of areas, the draft policy therefore varies from the full recommendations made by NICE***.

*The full set of recommendations produced from the Review can be read here.
** The findings from the stage 1 engagement window can be read here.
*** National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. NICE guidelines are evidence-based recommendations for health and care in England.

How we have applied our recommendations

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In response to feedback received from clinicians and the public the Review Recommendations have been collated into three groups and we have applied our recommendations a number of way. For example;

Policy	Policy Communication and Implementation	Support the application of the policy and pathway
• Drafted a draft single fertility policy across NCL that avoids variation between boroughs • Working to address inequalities and ensure equality of access • Established an NCL readers panel (a reading panel with community representation from across NCL to test the draft policy for ease of readability, as well as provide views on policy implementation plans).	• Communications will be targeted at the three core audiences: residents, primary care and secondary care, ensuring that staff and communities have the opportunity to have their say • The NCL Readers Panel/Healthwatch will meet with CCG staff throughout the engagement window to advise on activity and to ensure our communications are clear and easy to understand • To assist the communication of the policy the public leaflet will be made available in easy read and will be available in other languages when requested.	• GP update/education sessions will be delivered in NCL to support the awareness of the new policy and its implications. • Education events for secondary care clinicians (and their service management teams) who provide fertility treatments to be held across NCL to raise awareness about the new NCL fertility policy, ensuring that all providers understand and adhere to the requirements of the policy.

Draft single fertility policy – the benefits for our local communities

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- Implementing a single policy will offer residents and clinicians greater clarity and consistency on the provision and funding of specialist fertility treatments.
- The draft policy represents a significant improvement for most of our population as it expands the provision of NHS-funded fertility treatment in a number of boroughs.
- By offering more equitable and consistent access to treatments, we envisage this will improve patients' experience and reduce inequity between residents.
- We have carefully considered the equality impact of the draft policy – on age, race, religion, sexual orientation, disability and other protected characteristics. Overall, the draft policy has a positive impact for most protected characteristic groups.
- The draft policy is more closely aligned to the main national guidance (NICE) than our current five policies.

Comparison table: draft NCL policy, national guidance and current policies

			Current local policies				
Policy aspect	**Draft new policy**	**NICE recommendations**	**Barnet**	**Camden**	**Enfield**	**Haringey**	**Islington**
No. IVF cycles in eligible women <40	6 embryo transfers from a max of 3 fresh cycles (all good quality frozen embryos should be transferred before starting next fresh cycle)	3 full cycles*	1 fresh + 1 frozen	3 fresh + 3 frozen	1 fresh + 1 frozen	1 fresh + 1 frozen	2 embryo transfers
IUI for eligible same sex couples	Up to 6 cycles funded for patients who have not got pregnant following 6 cycles of self-funded IUI	6 cycles for patients who have not got pregnant following 6 cycles of artificial insemination	Not funded	Not funded	Funded for patients who have not got pregnant following 6 cycles of self-funded IUI	Funded	Not funded
IVF and IUI using donor sperm	IVF and IUI and donor sperm funded for NICE recommended indications	Recommended for specific indications	IVF and IUI funded where donor sperm funded by patient	Not funded	IVF and IUI funded where donor sperm funded by patient	IVF and IUI funded where donor sperm funded by patient	IVF and IUI funded where donor sperm funded by patient
IVF using donor egg	IVF and donor egg funded for NICE recommended indications	Recommended for specific indications	IVF funded where donor egg funded by patient	Not funded	IVF funded where donor egg funded by patient	Not funded	IVF funded where donor egg funded by patient
Duration of trying to conceive by sexual intercourse **	2 years: applies to women of all ages	2 years; applies to women of all ages	Aged <36: 2 years Aged ≥36: 1 year	Aged <36: 2 years Aged ≥36: 1 year	Aged <36: 2 years Aged ≥36: 1 year	Aged <36: 2 years Aged ≥36: 1 year	Aged <36: 2 years Aged ≥36: 1 year
Ovarian reserve criterion	Applies to women of all ages	Applies to women aged 40-42	Applies to women of all ages	Applies to women of all ages	Applies to women of all ages	Applies to women of all ages	Applies to women of all ages

*Full cycle = 1 episode of ovarian stimulation plus transfer of any resultant fresh and frozen embryos.
**Does not apply if there is a known cause of infertility where patients should be referred for IVF without delay

Equality considerations

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The draft policy:

- Is inclusive of individuals with HIV, a physical disability, psychosexual problems, people undergoing cancer treatment, and undergoing gender reassignment.
- Accommodates couples with unexplained infertility, mild endometriosis or mild male factor infertility who have social, cultural or religious objections to undergoing IVF.
- Follows NICE guidance on preserving donor gametes (e.g. eggs or sperm) where a person is about to undergo a procedure that could harm their gametes. This could include procedures such as chemotherapy or gender reassignment.
- Supports patients from different socio-economic backgrounds to access NHS fertility treatments by not requiring patients to pay for donor eggs or sperm to be used in their NHS treatment.
- Includes single women on the same basis as female same sex couples.
- Follows NICE guidance on age of the woman, body mass index and no smoking eligibility criteria to access fertility treatment.

However, the draft policy:

- Does not fund treatment involving surrogates for any patient groups*. This may impact on male same sex couples, single men and those with a disability that means they cannot carry a pregnancy.
- Only funds fertility treatment for people who do not already have a child (for those in a couple, at least one partner should not have a child), to prioritise those with the most need.

*A surrogate is available only to those with means and, by parity of reasoning with the prohibition on mixing NHS and private care in one episode of care, ACT involving surrogates is not funded

The Financial Context

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- We are operating in a system under significant pressure and facing financial challenges, therefore we need to consider how we ensure our resources are deployed as effectively as possible:
    - The NCL health system is amongst the most financially challenged systems across London (both pre & post pandemic)
    - The national message as we move into the second half of the 2021/22 financial year is for systems to focus on restoration and recovery of services and recovering finances back to a sustainable footing
    - NHS England have been clear that the funding for the second half of the 2021/22 financial year includes an increased efficiency requirement which will continue to increase into 2022/23
    - The CCG and future Integrated Care System (ICS) will need to carefully consider the impact of any investment decisions or patient pathway changes on the aforementioned efficiency requirements and the need to return the NCL system to financial balance.
- The draft policy would increase spending on NHS-funded treatment as it increases access to treatment in a number of boroughs. We carefully considered affordability alongside evidenced-based and equitable access to treatment, with the aim of maximising the opportunity of successful outcomes for people undergoing treatment within available funding.

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Stage 2 engagement: Sharing your views on the draft single Fertility Policy

Engagement on the draft policy

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- The engagement window will run from 22 November 2021 to 13 February 2022 (12 week period)
- We will use a variety of different mediums and formats, and will include key stakeholder groups such as our service users, residents, general practice, secondary care clinicians, Healthwatch*, VSC partners, and special interest groups.
- We will be running a number of public events at which the CCG will share information about the development of the single fertility policy and seek views on the proposed single policy.
- Online events will be held for Barnet, Camden, Enfield, Haringey and Islington (one per borough). An NCL-wide online public meeting will also be held during the engagement window.
- We are planning to hold a pan-NCL event face-to-face in January, although this will be subject to COVID-19 guidance at the time.
- The CCG is happy to come along to discuss the draft fertility policy at any meetings or events happening across North Central London, for example, local Fertility Support Groups or GP Patient Participation Groups.

* Meetings with local Healthwatch groups will be held throughout the engagement window to focus on engagement activity and where the communications should be targeted if responses from certain communities are low.

How to give your views

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How local residents can contribute their views and experiences in the following ways:

- By attending one of our public meetings
- By inviting us to a meeting
- By completing the online questionnaire (hard copies are available upon request)

Residents will also be able to access the opportunities via our website or you can contact us by:

Email: nclccg.fertility-development@nhs.net

Telephone: 020 3688 2038

The views shared will be carefully considered by the CCG as we finalise the single policy, and will inform planning for how we promote the policy when it is in place.

What are your views on the draft single Fertility Policy?

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We are seeking feedback from residents, fertility services and clinicians on the draft single policy. We would welcome your feedback:

- What are your views on the single draft policy?
- Do you have any specific concerns about any areas of the policy?
- Are there specific actions / changes you can suggest which would address your concerns?
- Is there anything else you would like to tell us about these proposals?

You may also want to share any experience of being referred for, or undergoing, fertility treatment under the NHS in North Central London.

What are your views on the draft single Fertility Policy?

North Central London Clinical Commissioning Group

In providing feedback, you may want to consider what the draft policy says on:

- Eligibility criteria for access to NHS treatment
- Assisted Conception Treatments (IVF and IUI)
- Assisted Conception Treatments using donated sperm and eggs
- Other Assisted Conception Treatments (surgical sperm retrieval, IUI and IVF involving surrogates)
- Assisted Conception Treatments for people with conditions other than infertility (people with HIV and conditions that may impact on future fertility)

We would be interested in your views on:

- How easy or difficult the Fertility Policy is to understand?
- How we can make sure local residents are aware of the approved Fertility Policy?

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Additional information:

- Stage 1: engagement activity overview
- Reports from stage 1 of the policy review work
- Stage 2 public meeting dates

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Engagement during stage 1

Stage 1: engagement activity overview

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Engagement activity – public and stakeholder engagement ran from 10 May for eight weeks

- ✓ People with lived experience focus group (in collaboration with Fertility Network UK)
- ✓ Focus groups with representatives from diverse communities (LGBT – BAME – people who live in the UK whose country of origin is not the UK)
- ✓ Three public meetings
- ✓ Online survey
- ✓ In-depth interviews with individuals from the African Health Forum, Hopscotch Asian Women's Centre and LGBT networks
- ✓ Discussions with local voluntary and community groups
- ✓ Webinar with The LGBT Mummies Tribe (posted on Facebook, Instagram and public websites)
- ✓ Webinar with Programme and Clinical Lead (posted on public website and Twitter)
- ✓ Attending borough GP events
- ✓ NCL CCG Governing Body GPs and Clinical Leads meeting
- ✓ Ongoing communications to promote survey and public meetings (e.g. social media promotion, CCG resident newsletters, NCL GP Bulletin, inclusion on agendas for BAU borough MP and Councillor meetings)

Themes from stage 1 engagement: policy

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Development of a **single policy is welcomed**

Outdated terminology is used in policies (**more inclusive language needed** for LGBTQ+ community)

Clarity provided on **donor assisted conception**

New policy should consider including **surrogacy**

There is strong feeling the future policy should **follow NICE guidance / level up, not down** (e.g. 3 full cycles offered)

The new policy eligibility criteria should reconsider:
- **Previous child policy**
- **Exclusions of young women with low AMH levels**
- **BMI** in some circumstances (e.g. for African women**)**

Clarity is needed around the policy, **inclusion / exclusion criteria**, **permissible add-ins**, and the **treatment journey**

Question asked **honouring commitments to treatment**: will people on waiting list / part way through treatment be assured that they will get what they were expecting when policy changes?

Respondents aware of **differences in the policies across the five boroughs**, which was often described as "…a bit of a **postcode lottery**"

There should be **equality of access for all**, including **same sex couples and single women**

IUI should be **offered before IVF** if women prefer for unexplained fertility

Themes from stage 1 engagement: service experience

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Fertility treatment is considered a luxury, **distress is not fully taken into account**

The **whole process needs streamlining**, from referrals to waiting times, to **reduce the delay**

Access to **psychological support** should be available

Impact of the pandemic: delays to access treatment, inability of partners to attend appointments

Mental health support (counselling) **for women from BAME communities** could be better due to the pressures (from within the extended family) placed on them to conceive

Timescales and delays a common theme, including:

- Going through primary care to get a referral
- Timescales to qualify for referral (incl. referral time for male partners)
- Waiting times to get appointments
- Timescales between each stage of the fertility journey from referral to treatment

Mental health is a concern for people even prior to their first engagement with a GP, and throughout the whole process

Male partners should be **referred for tests** beyond a sperm count **earlier**. There were long wait times for appointments, and referrals were only made when female partners were quite some way into the process

Distress around operational elements – waiting rooms shared with maternity services (distressing when attending for fertility diagnostics, scans for miscarriage etc.)

Adhoc approach to male investigations. Infections not excluded

Themes from stage 1 engagement: other points

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Improve training for GPs and others so they understand the new policy

Is there **ethnicity differences in fertility** in women?

Risk that **people from BAME communities** who live in NCL think the National Health Service is similar to the health provision in their country of origin which means they **miss out on fertility support**.

Requirement to have **three miscarriages before investigations** undertaken (distressing and delays timings for treatment)

Lack of knowledge from healthcare professionals (including GPs) about the details of existing policies:

- **Patients need to educate GPs** about policies, tests, and treatments.
- **GPs either did not know / misinterpreted details** of their borough policy

Fertility treatment is not a necessity and **shouldn't be NHS funded**. There are limited resources available for health care in general and huge backlogs for NHS treatment for life threatening and life changing conditions.

Reports from the Fertility Policies Review (stage 1)

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- If you want to know more about the first stage of work (the Fertility Policies Review) the following two reports set the scene:
    - NCL CCG Fertility Policies Review: Recommendations Report - the Recommendations Report will inform you of the findings of the review, including feedback received during a period of public and wider stakeholder engagement; and the recommendations of the review to inform the subsequent development of a single NCL Fertility Policy.
    - NCL CCG Fertility Policies Review: Engagement Report - this document reports the findings from the stage 1 public engagement window (10 May to 9 July 2021).
- You can also access all our archived information used during the review stage here.

Stage 2 public meeting dates

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Public online meetings	Date
Barnet (Barnet residents only)	Thursday 9 Dec (15:00 – 16:30)
Camden (Camden residents only)	Tuesday 14 Dec (10:30 – 12:00)
Enfield (Enfield residents only)	Thursday 16 Dec (15:00 – 16:30)
Haringey (Haringey residents only)	Wednesday 12 Jan (10:00 – 11:30)
Islington (Islington residents only)	Monday 17 Jan (15:00 – 16:30)
NCL wide (open to all residents across North Central London)	Saturday 29 Jan (11:30 – 13:00)

Face to Face public meeting	Date
NCL wide (open to all residents across North Central London)	Thursday 20 Jan (17:30 – 19:00) To be held in Islington (venue to be confirmed)

It is important to note that the CCG will be actively promoting the draft fertility policy to residents through local community groups, local authorities and NHS providers. In the communications local people will also have the opportunity to invite CCG staff to group and committee meetings to discuss the draft single policy.

DRAFT

North Central London CCG Fertility Policy

22 November 2021

This policy will, if implemented, replace the legacy policies of the previous Barnet CCG, Camden CCG, Enfield CCG, Haringey CCG and Islington CCG.

Contents

Glossary

Abandoned IVF cycle	Defined as an IVF cycle where an egg collection procedure has not been undertaken. Usually occurs due to a lack of response (where fewer than three mature follicles are present) or conversely if there has been an excessive response to ovarian stimulation and the patient is at risk of severe ovarian hyperstimulation syndrome (OHSS). May also be referred to as a 'cancelled cycle'.
Artificial insemination (AI)	AI is the introduction of sperm into cervix or uterine cavity. Intrauterine insemination (IUI) is a type of AI undertaken at a fertility clinic where sperm is filtered to produce a concentrated 'healthy' sample which is placed directly into the uterus. AI undertaken at home would normally be intra-cervical insemination (ICI).
Assisted conception treatment (ACT)	The collective name for treatments designed to lead to conception by means other than sexual intercourse. Includes: intrauterine insemination (IUI), in vitro fertilisation (IVF), intracytoplasmic sperm injection (ICSI) and donor insemination (DI).
Azoospermia	Where there are no sperm in the ejaculate.
Cryopreservation	The freezing and storage of embryos, sperm or eggs for future use in IVF treatment cycles.
Donor insemination (DI)	DI is a type of fertility treatment in which high quality donor sperm is injected directly into the womb (IUI) or cervix (ICI). DI is commonly used when either the male partner has no sperm or for lesbian couples/ single women.
Egg (oocyte) donation	The process by which a fertile woman donates her eggs to be used in the treatment of others.
Embryo transfer	The procedure in which one or more embryos are placed in the uterus.
Embryo transfer strategies	Defines the number of embryos that should be transferred in an embryo transfer procedure, depending on factors such as the age of the woman and the quality of the embryos.
Endometriosis	A condition where tissue similar to the lining of the womb starts to grow in other places, such as the ovaries and fallopian tubes.
Fertilisation	The union of an egg and sperm.
Fertility policies	CCGs are responsible for commissioning most fertility treatments; most therefore have policies in place specifying which interventions are funded and eligibility criteria for access to these. These policies typically explain when the CCG will fund fertility treatments for people experiencing infertility and assisted conception treatments for patients who require interventions for other reasons e.g. fertility preservation for patients due to undergo a gonadotoxic treatment.
Fertility preservation (FP)	Fertility preservation involves freezing eggs, sperm, embryos or reproductive tissue with the aim of having biological children in the future.
Fresh IVF cycle	Comprises an episode of ovarian stimulation and the transfer of embryos created that have not previously been frozen.
Frozen embryo transfer (FET)	Where an excess of embryos is available following a fresh cycle, these embryos may be frozen for future use. Once thawed, these embryos may be transferred to the patient as a 'frozen embryo transfer'. Also known as a 'frozen IVF cycle'.
Full IVF cycle	Defined by NICE as one episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryo(s).
Gonadal dysgenesis	Abnormal development of a gonad (ovary or testicle).
Gonadotoxic treatment	Treatments that can cause infertility such as some chemotherapies.

Infertility	Infertility is the period of time people have been trying to get pregnant (conceive) without success after which formal investigation is justified and possibly treatment implemented.
In vitro fertilisation (IVF)	IVF involves ovarian stimulation and then collection of a woman's eggs. They are then fertilised with sperm in a lab. If fertilisation is successful, the embryo is allowed to develop for between two and six days and is then transferred back to the woman's womb to hopefully continue to a pregnancy. Ideally one embryo is transferred to minimise the risk of multiple pregnancy. In older women, or those with poor quality embryos, two may be transferred. It is best practice to freeze any remaining good quality embryos to use later on in a frozen embryo transfer if the first transfer is unsuccessful.
Intracytoplasmic sperm injection (ICSI)	IVF with ICSI treatment is similar to standard IVF. However, instead of mixing the sperm with the eggs and leaving them to fertilise in a dish, an embryologist will inject a single sperm into each mature egg. This maximises the chance of fertilisation as it bypasses any potential problems the sperm may have in penetrating the egg.
Intrauterine insemination (IUI)	IUI is a type of fertility treatment in which the best quality sperm are separated from sperm that are sluggish or non-motile. This sperm is then placed directly in the womb. This can either be performed with the woman's partner's sperm or donor sperm (known as donor insemination or DI). Sometimes ovarian stimulation is used in conjunction with IUI.
Male factor infertility	Problems with male fertility are related to sperm, sperm production and the reproductive tract.
Men/ male	Due to the nature of policies on assisted reproductive technologies, it is necessary to refer to the sex of patients on occasion. This document therefore refers to 'men' and 'male'. When these terms are used in this document, unless otherwise specified, this refers to sex defined by biological anatomy. It is acknowledged that this may not necessarily be the gender to which individual patients identify.
Natural cycle IVF	An IVF procedure in which one or more oocytes are collected from the ovaries during a spontaneous menstrual cycle without any drug use.
NICE	National Institute for Health and Care Excellence. NICE provide national guidance and advice to improve health and social care. NICE guidelines are evidence-based recommendations for health and care in England. Organisations commissioning and delivering services are expected to take the recommendations contained within NICE clinical guidelines into account when planning and delivering services. NICE has published a Clinical Guideline (CG 156) on fertility problems.
Oophorectomy	An operation to remove one or both ovaries.
Ovarian Hyper-Stimulation Syndrome (OHSS)	A condition in which the ovarian response to stimulation results in clinical problems, including abdominal distension, dehydration and potentially serious complications due to thrombosis and lung and kidney dysfunction. It is more likely in women who are excessively sensitive to medicines used for ovarian stimulation.
Ovarian reserve	A woman's fertility is related to the number of eggs remaining in her ovaries, referred to as 'ovarian reserve', which influences the chance of becoming pregnant.
Ovarian stimulation	Stimulation of the ovary to achieve growth and development of ovarian follicles with the aim of increasing the number of eggs released.
Ovarian tissue cryopreservation	Involves removing and freezing ovarian tissue from a girl or woman. At a later date, the ovarian tissue strips can be thawed and either re-implanted into the ovary, to allow them to try to conceive naturally, or the eggs can be retrieved and fertilised in vitro and the embryo implanted in the uterus.
Pathological problem	One that relates to medical conditions/ diseases (physical or psychological).
Pre-implantation	A technique used to identify inherited genetic defects in embryos created through

genetic diagnosis	IVF. Only embryos with a low genetic risk for the condition are then transferred back to the woman's uterus. Any resulting pregnancy should be unaffected by the condition for which the diagnosis is performed.
Premature ovarian failure	When a woman's periods stop before the age of 45. Also known as primary ovarian insufficiency or early menopause.
Rhesus (Rh) isoimmunisation	A condition where antibodies in a pregnant woman's blood destroy her baby's blood cells. Also known as rhesus disease.
Sperm donation	The process by which a fertile man donates his sperm to be used it the treatment of others. The HFEA regulates sperm donation undertaken at UK fertility clinics.
Sperm washing	Sperm washing is used to reduce the viral load (for example, of HIV) in prepared sperm to a very low or undetectable level. The washed sperm can then be transferred to the women using IUI or used to fertilise eggs in IVF or ICSI.
Supernumerary embryos	Un-transferred embryos created from a fresh IVF cycle.
Surgical sperm retrieval (SSR)	Surgical sperm retrieval means extracting sperm by a surgical procedure. Types of SSR include: percutaneous epididymal sperm aspiration (PESA), microsurgical epididymal sperm aspiration (MESA), testicular sperm aspiration (TESA), testicular sperm extraction (TESE) and microscope-assisted testicular sperm extraction (MicroTESE).
Surrogacy	Surrogacy is where a woman carries and gives birth to a baby for another person or couple. This may involve the eggs of the surrogate, the intended mother or a donor.
Unsuccessful cycle of IVF/ ICSI	Includes failure of fertilisation, failure of development of embryos and failure to conceive following transfer of embryos.
Women/ female	Due to the nature of policies on assisted reproductive technologies, it is necessary to refer to the sex of patients on occasion. This document therefore refers to 'women' and 'female'. When these terms are used in this document, unless otherwise specified, this refers to sex defined by biological anatomy. It is acknowledged that this may not necessarily be the gender to which individual patients identify.

Background

It is estimated that infertility affects about one in seven heterosexual couples in the UK. About 84% of couples will conceive naturally within a year if they have regular unprotected sex (every 2 or 3 days).

NHS fertility treatment is available for eligible individuals and couples who want to become parents but who have a possible pathological problem (physical or psychological) leading to them being infertile.

People concerned about their fertility are normally referred for clinical assessment and investigation where:

- there is a known clinical cause of infertility or a history of predisposing factors for infertility, or
- the individual or couple has been trying to conceive through either 1 year of unprotected vaginal sexual intercourse or 6 cycles of artificial insemination.

The treatment options offered will often depend on what the cause of the fertility problems are. Fertility treatments may include:

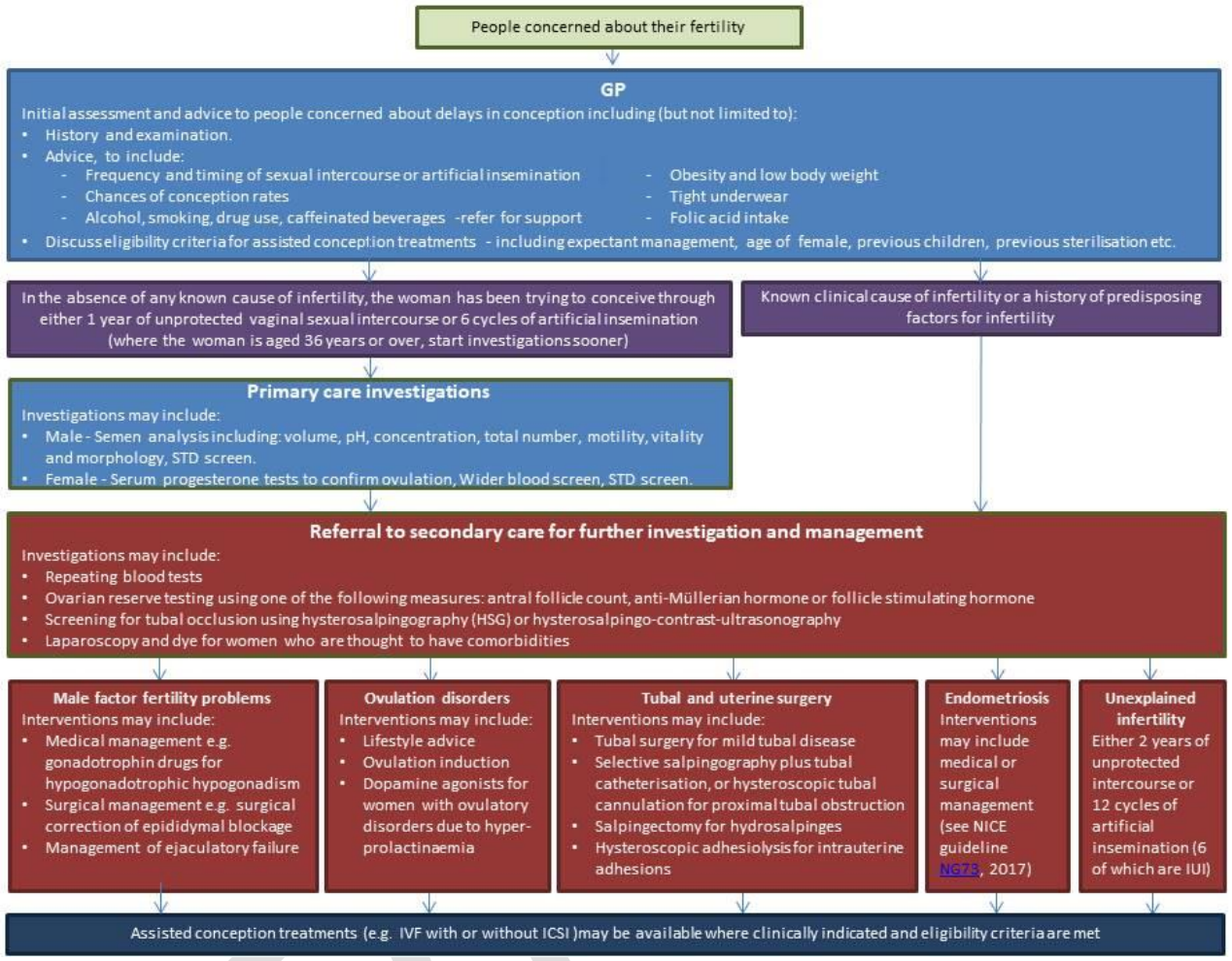
- medical treatment such as ovulation induction for ovulation disorders (no periods or irregular periods).
- surgical procedures such as those used to treat endometriosis or tubal obstruction.
- assisted conception such as intrauterine insemination (IUI) or in vitro fertilisation (IVF)

Not all patients who have fertility problems will require assisted conception treatments like IVF. This policy document sets out the criteria patients must meet in order to access assisted conception treatments funded by NCL CCG.

Figure 1 outlines a summary of the NICE pathway for people who are concerned about their fertility.

The eligibility criteria outlined in this policy document only apply to assisted conception treatments. Patients do not have to meet the eligibility criteria outlined in this document to access NHS funded investigations or medical or surgical treatment for fertility problems which do not fall within the definition of assisted conception treatments.

Figure 1 – Summary of NICE pathway for patients concerned about their fertility



Note: The above pathway does not apply to all patient groups, for example, where treatment is planned that might result in infertility (such as treatment for cancer) or where people are known to have chronic viral infections (e.g. HIV) and are concerned about their fertility; in such cases other pathways will be followed.

Purpose of this document

North Central London Clinical Commissioning Group (CCG) is responsible for commissioning a range of health services including hospital, mental health and community services for the local population. The CCG has a statutory duty to maintain financial balance. When exercising its discretion to determine what service it will commission it must make judgements about which services are appropriate and affordable for its local population.

Across the country most, if not all, CCGs have a policy or set of fertility policies addressing funding of assisted conception treatments such as in vitro fertilisation (IVF) and intrauterine insemination (IUI). This policy document describes the circumstances where NCL CCG will fund these treatments.

This policy has been developed following:

- Consideration of NICE Clinical Guideline (CG) 156, other national guidance and the current evidence base
- Discussions with stakeholders including specialist clinicians, service users and residents
- Identification and consideration of potential equality and equity issues

In developing this policy, the CCG has sought to adopt NICE guidance wherever feasible. However, it has also taken into account wider system factors such as service demand and population health needs. Consequently some sections of the policy vary from the full recommendations made by NICE.

This policy cannot anticipate every possible individual clinical presentation. Clinicians may submit Individual Funding Requests (IFR) to the CCG for patients who they consider to have exceptional clinical circumstances falling within the CCG's IFR policy and whose needs are not fully addressed by this policy. The CCG will consider such requests in accordance with its policy on Individual Funding Requests; you can read about this on the NCL CCG website.

Scope of this document

The scope of the NCL CCG fertility policy is limited to setting the criteria for CCG funding for treatment for patients for whom it is the responsibility of NCL CCG to pay for the provision of healthcare services as outlined in *Who pays?* guidance (NHS England, 2020)[1].

The following groups of patients are excluded from the scope of the policy:

- Members of the Armed Forces, their families or veterans; NHS England commission assisted conception services for these groups
- Patients who pay the immigration surcharge; assisted conception services are not included in the scope of services available for free for these patients

The following interventions are excluded from the scope of the policy:

- Interventions which do not fall within the scope of assisted conception treatments (for example: investigations of conditions causing infertility, and medical or surgical treatments to restore fertility)
- Pre-implantation genetic diagnosis (PGD), which is the commissioning responsibility of NHS England
- Surgical sperm retrieval, which is the commissioning responsibility of NHS England
- Treatment add-ons with limited evidence (as outlined on the HFEA website), which are not funded by NCL CCG

NCL CCG will follow Department of Health Guidance on the interface between NHS and private care, Principles of which include the following:

- The NHS provides a comprehensive service, available to all; access to NHS services is based on clinical need, not an individual's ability to pay
- Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves
- The NHS should never subsidise private care with public money, which would breach core NHS principles
- Patients should never be charged for their NHS care, or be allowed to pay towards an NHS service (except where specific legislation is in place to allow this) as this would contravene the founding principles and legislation of the NHS.

[1] The individual who will be undergoing the fertility procedure will need to be of NCL CCG responsibility. It is not necessary for their partner (if they have one) to also be of NCL CCG responsibility.

Policies: Assisted conception treatments (ACTs)

1. IVF, with or without ICSI

1.1 In order to access NHS funded IVF, with or without ICSI, patients are required to fulfil relevant eligibility criteria set out in Section 9.

1.2 For eligible patients requiring IVF where the woman is aged under 40, the CCG will fund up to six embryo transfers from a maximum of three fresh cycles. All good quality frozen embryos should be transferred before starting the next NHS funded fresh cycle.

1.3 For eligible patients requiring IVF where the woman is aged 40–42, the CCG will fund up to two embryo transfers from one fresh cycle.

1.4 One abandoned cycle (defined as a cycle where an egg collection procedure has not been undertaken) does not count towards the number of commissioned cycles.

1.5 Cryopreservation of supernumerary embryos will be funded for a maximum of two years following each fresh cycle[2,3]

1.6 Embryo transfer strategies outlined in NICE CG156 should be followed in order to minimise the number of multiple births.

1.7 Natural cycle IVF is not funded by NCL CCG.

[2] Patients will have the opportunity to fund continued storage of any unused embryos for future self-funded frozen embryo transfer after the NHS funded storage period concludes.
[3] Cryopreservation of embryos for fertility preservation for patients receiving gonadotoxic treatment is addressed by a separate policy (see Section 8).

2. IUI using partner sperm

2.1 In order to access NHS funded IUI using partner sperm, patients are required to fulfil relevant eligibility criteria set out in Section 9.

2.2 Up to six cycles of unstimulated IUI using partner sperm is funded where there is evidence of normal ovulation, tubal patency and semen analysis for:

(a) 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 and have not conceived after six cycles of [self-funded] IUI, or

(b) people who are clinically indicated to receive IUI following a successful sperm washing procedure where the man is HIV positive (access to NHS funded sperm washing is addressed in a separate policy – see Section 7)

2.3 IUI is not routinely funded for people with unexplained infertility, mild endometriosis or mild male factor infertility[4] except in the following circumstances:

- Up to six cycles of unstimulated IUI using partner sperm is funded in exceptional circumstances for people with unexplained infertility, mild endometriosis or mild male factor infertility who have social, cultural or religious objections to IVF [note: this would be an alternative to receiving IVF treatment and therefore IVF would not subsequently be funded for patients accessing IUI in these circumstances]

[4] Defined by NICE as: Two or more semen analyses that have one or more variables which fall below the 5th centile as defined by WHO, 2010, and where the effect on the chance of pregnancy occurring naturally through vaginal intercourse within a period of 24 months would then be similar to people with unexplained infertility or mild endometriosis.

Policies: ACTs using donated genetic materials

3. ACT (IUI and IVF) using donor sperm

3.1 In order to access NHS funded ACT using donor sperm, patients are required to fulfil relevant eligibility criteria set out in Section 9.

3.2 Up to six cycles of unstimulated IUI using donor sperm is funded where either criteria A, B or C are met:

A. The patient has fertility problems associated with one of the following conditions:

- obstructive azoospermia
- non-obstructive azoospermia
- severe deficits in semen quality in couples who do not wish to undergo intra-cytoplasmic sperm injection (ICSI)

B. Where one of the following have been confirmed/ diagnosed by an appropriate specialist:

- there is a high risk of transmitting a genetic disorder to the offspring
- there is a high risk of transmitting infectious disease to the offspring or woman from the man
- severe rhesus isoimmunisation

C. Same-sex couples or single people who have evidence of normal ovulation and tubal patency, but who have not conceived after six cycles of [self-funded] IUI.

3.3 IVF using donated sperm will be funded for eligible patients as per the IVF/ICSI policy (see Section 1) in either one of the following circumstances:

1. Patients fulfil one of the criteria A, B or C outlined above AND investigations show IVF is the only effective treatment option
2. Patients fulfil one of the criteria A, B or C outlined above AND have not conceived after 12 cycles of IUI

3.4 The CCG will fund the cost of the IUI and/ or IVF and the donor sperm where required.

3.5 The CCG will only fund assisted conception treatment using donor sperm at UK clinics subject to HFEA regulations.

4. IVF using donor eggs

4.1 In order to access NHS funded IVF using donated eggs, patients are required to fulfil relevant eligibility criteria set out in Section 9. Women accessing IVF using donor eggs will not be required to fulfil the ovarian reserve criterion.

4.2 IVF using donated eggs will only be funded for eligible patients as per the IVF policy (see Section 1) where either criteria A or B are met:

A. The patient has fertility problems associated with one of the following:
   - premature ovarian failure
   - gonadal dysgenesis including Turner syndrome[5]
   - bilateral oophorectomy
   - ovarian failure following chemotherapy or radiotherapy

B. Where it has been confirmed by an appropriate specialist that there is a high risk of transmitting a genetic disorder to the offspring.

4.3 The CCG will fund the cost of the IVF and the donor egg where required. Patients may be able to provide an egg donor[6]. Alternatively the patient can be placed on a waiting list until a donor becomes available. If, during their time on the waiting list, patients waiting for a donor egg no longer fulfil the eligibility criteria, NHS funding will not be available.

4.4 The CCG will only fund IVF using donor eggs at UK clinics subject to HFEA regulations.

[5] Pre-treatment screening should have excluded phenotypic manifestations of Turner syndrome that might jeopardise successful pregnancy, including aortic dilation and cardiac lesions.
[6] Known donors will need to meet and follow HFEA regulations for donating eggs.

Policies: Other ACT interventions

5. Surgical sperm retrieval

Surgical sperm retrieval

5.1 Surgical sperm retrieval (SSR) is the commissioning responsibility of NHS England and will not be funded by NCL CCG

5.2 NHS England state they will only fund SSR where the patient meets eligibility criteria and has confirmed funding for subsequent stages of the pathway (i.e. cryopreservation and/ or ICSI treatment), as set out in the NHS England Clinical Commissioning Policy: Surgical sperm retrieval for male infertility (2016). The responsible clinician should therefore ensure the patient meets the relevant eligibility criteria prior to undertaking SSR (see 5.4 and 5.6 below).

Cryopreservation and storage of surgically retrieved sperm

5.3 Where a man with azoospermia has undergone successful surgical sperm retrieval funded by NHS England, cryopreservation and storage will be funded by the CCG for a maximum of two years[7].

5.4 In order to access cryopreservation of surgically retrieved sperm, men are required to fulfil relevant eligibility criteria set out in Section 9.

IVF with ICSI using surgically retrieved sperm

5.5 Eligible couples, where the man has undergone successful surgical sperm retrieval funded by NHS England, will have ICSI funded as per the IVF/ICSI policy[7] (see Section 1).

5.6 In order to access ICSI using surgically retrieved sperm, couples are required to fulfil relevant eligibility criteria set out in Section 9.

6. Assisted conception treatments involving surrogates

6.1 Assisted conception treatments involving surrogates are not routinely funded by NCL CCG for any patient group

[7] Cryopreservation of sperm for fertility preservation and subsequent assisted conception treatments for patients receiving gonadotoxic treatment is addressed by a separate policy (see Section 8).

Policies: ACTs for people with conditions other than infertility

7.	Sperm washing
7.1	In order to access NHS funded sperm washing and subsequent assisted conception treatments, patients are required to fulfil relevant eligibility criteria set out in Section 9.
7.2	Sperm washing will be funded for couples where the man is HIV positive and the female partner is HIV negative and either: • the man is not compliant with antiretroviral treatment, or • his plasma viral load is 50 copies/ml or greater
7.3	Where a man has undergone successful sperm washing procedure, cryopreservation and storage of washed sperm will be funded for a maximum of two years.
7.4	Where the procedure is successful, couples may access IVF/ICSI or IUI, depending on their clinical circumstances, in line with the relevant policy (see Section 1 and Section 2 respectively)

8. Cryopreservation of gametes for fertility preservation

8.1 Cryopreservation of sperm, eggs or embryos will be funded for eligible patients (as defined in paragraphs 8.2 and 8.3 below) who are not currently infertile but meet one of the following criteria:

- The patient is under the care of a specialist clinician who confirms they are due to undergo a gonadotoxic treatment; this may include patients undergoing interventions for gender reassignment
- The patient is under the care of a specialist clinician who has confirmed they have a medical condition that, in their case, is likely to progress such that it will lead to infertility in the future

8.2 Cryopreservation of sperm will be funded for fertility preservation for men if they fall within 8.1 above

8.3 Cryopreservation of eggs or embryos will be funded for fertility preservation for women if they fall within 8.1 above and fulfil all of the following criteria:

- They are aged under 43 years
- They are well enough to undergo ovarian stimulation and egg collection, and this will not worsen their condition
- Enough time is available before the start of their gonadotoxic treatment.

8.4 Ovarian tissue cryopreservation is not routinely funded for adult women.

8.5 Other than those listed in paragraphs 8.1–8.3 above, patients are not required to meet any additional eligibility criteria in order to access cryopreservation of sperm, eggs or embryos

8.6 Storage of sperm, embryos and eggs will be funded for up to ten years after cryopreservation[8]. NHS funding of storage will cease either after ten years or sooner where:

- Patents are no longer eligible for NHS fertility treatment, or
- The patient dies and no written consent has been left permitting posthumous use

[8] Patients will have the opportunity to fund continued cryopreservation of any unused sperm, embryos or eggs for future self-funded assisted conception treatment after the NHS funded storage period concludes.

8.7	In order to access assisted conception treatments using cryopreserved materials, fertility preservation patients will be required to fulfil the same eligibility criteria as other patients with infertility (Section 9). An exception to this is the criterion for ovarian reserve, which women who have accessed NHS funded fertility preservation will not be required to fulfil.

Eligibility criteria

9. Eligibility criteria

See matrix of which eligibility criteria apply to which policies on page 20 of this document.

Demonstrating infertility for eligibility of IVF

9.1 In order to be eligible for IVF, infertility must be demonstrated in one of the following ways:

- Investigations show there is no chance of pregnancy with expectant management and IVF is the only effective treatment, OR
- Patients have not conceived after either 2 years of regular unprotected intercourse[9] OR 12 cycles of IUI.

Age of the women

9.2 The woman receiving fertility treatment must be aged under 43 years. Women undergoing IVF must start medication with the provider before their 43rd birthday. Women must only be referred to fertility clinics if there is adequate time to complete work up.

9.3 If the woman reaches the age of 40 during treatment, the current full cycle will be completed but no further full cycles will be available. A full cycle of IVF treatment, with or without ICSI, should comprise one episode of ovarian stimulation and the transfer of resultant fresh and frozen embryo(s), in line with the IVF policy (see Section 1).

Previous IVF cycles

9.4 Treatment will not be funded for women aged under 40 years if three previous fresh cycles of IVF have been received, irrespective of how these were funded.

9.5 Treatment will not be funded for women aged 40–42 years if they have undergone any previous IVF treatment, irrespective of how this was funded.

9.6 One abandoned cycle (defined as a cycle where an egg collection procedure has not been undertaken) does not count towards the number of 'previous' IVF cycles.

Body mass index (BMI)

9.7 Women undergoing treatment must have a BMI within the range 19–30 kg/m^2.

[9] Defined by NICE as unprotected vaginal intercourse every 2 to 3 days.

Smoking

9.8 Treatment will not be funded if the woman undergoing treatment smokes[10].

9.9 Treatment will not be funded if the man undergoing treatment or providing sperm for treatment smokes[10].

Ovarian reserve

9.10 There should be no evidence of low ovarian reserve in women undergoing treatment. Low ovarian reserve is defined as:

- antral follicle count (AFC) of less than or equal to 4
- anti-Müllerian hormone (AMH) of less than or equal to 5.4 pmol/l
- follicle-stimulating hormone (FSH) greater than 8.9 IU/l

Previous children

9.11 Couples: At least one partner in a couple should not have a living child from their relationship or any previous relationship.

Single persons: Individuals should not have a living child.

9.12 An adopted child is considered to have the same status as a biological child. Foster children are excluded from the scope of this criterion. 'Child' refers to a living son or daughter irrespective of their age or place of residence.

Previous sterilisation

9.13 Couples: Neither individual in a couple should have undergone sterilisation.

Single persons: Individuals should not have undergone sterilisation.

9.14 The above criteria still apply where sterilisation reversal has unsuccessfully been attempted.

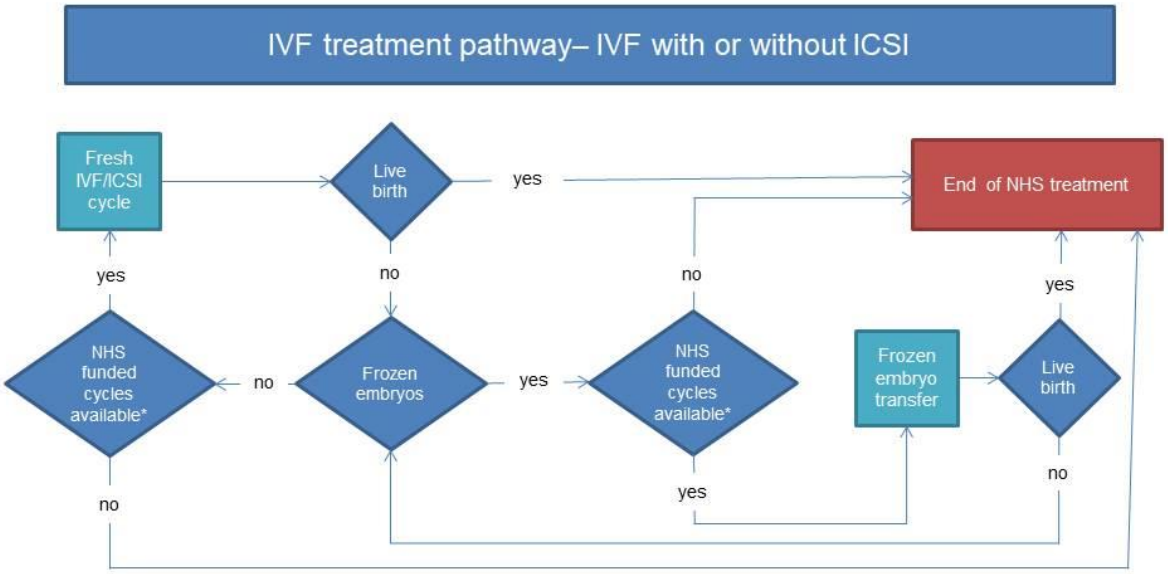
[10] Vaping is not included within the definition of smoking.

Matrix of which eligibility criteria apply to which policies

Eligibility criteria (see Section 9 for details)	Policy*										
	1. IVF/ICSI	2. IUI using partner sperm	3. IUI using donor sperm	3. IVF using donor sperm	4. IVF using donor eggs	5. Cryopreservation of surgically retrieved sperm**	5. ICSI using surgically retrieved sperm	7. Sperm washing	8. Cryopreservation of sperm for FP	8. Cryopreservation of embryos or eggs for FP	8. ACT using sperm cryopreserved for FP	8. ACT using embryos or eggs cryopreserved for FP
Demonstrating sub-fertility (prior to IVF)	✔			✔		✔	✔				✔	✔
Age of woman	✔	✔	✔	✔	✔		✔	✔		✔	✔	
Previous IVF cycles	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔
Body mass index (BMI)	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔
Smoking	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔
Ovarian reserve	✔	✔	✔	✔			✔	✔			✔	
Previous children	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔
Previous sterilisation	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔

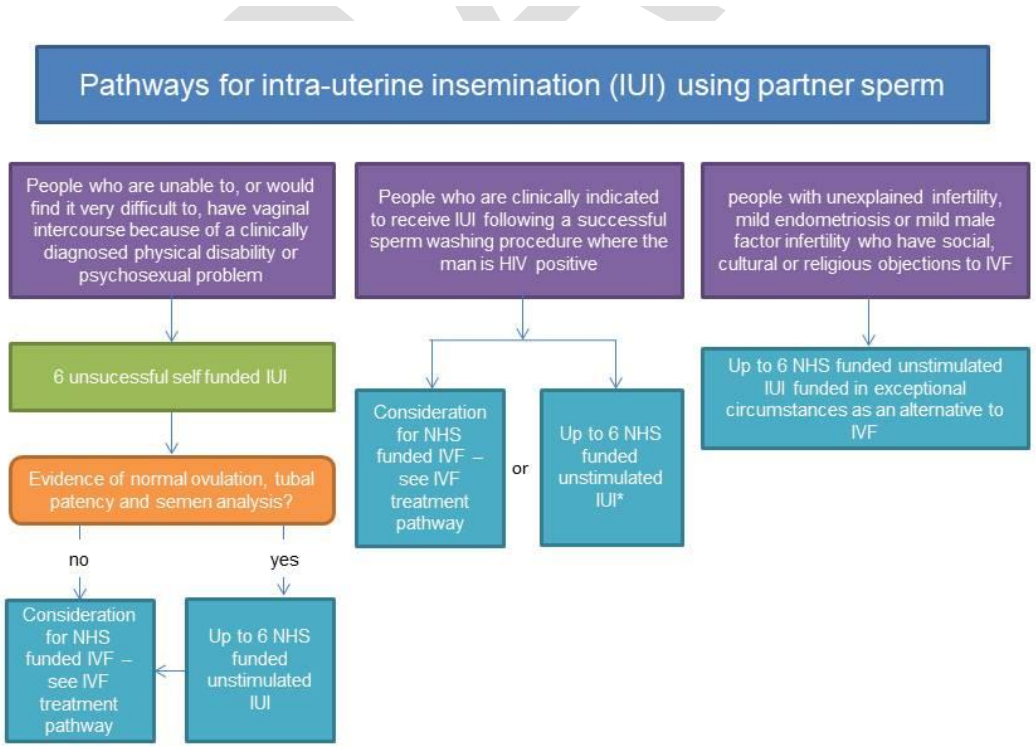
*ACT = Assisted conception treatment; FP = Fertility preservation; *Additional criteria apply – see relevant policy for details.*

Flow charts of pathways for fertility treatments



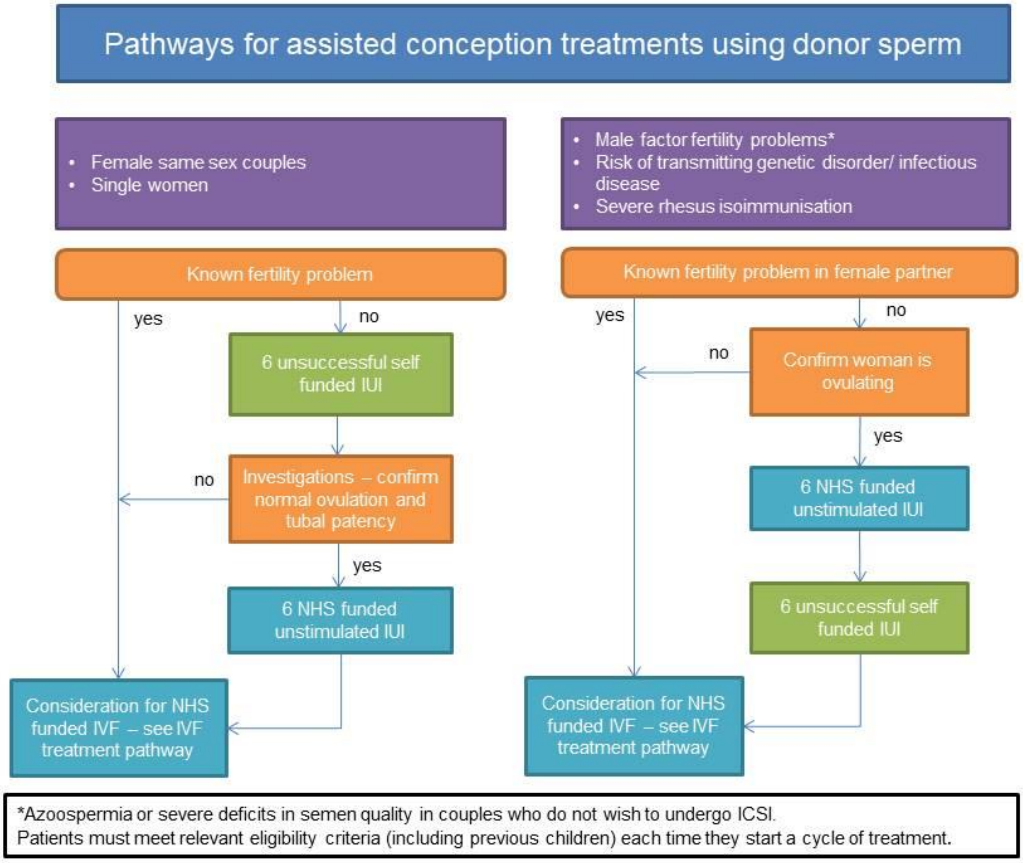
*For women aged under 40, the CCG will fund up to 6 embryo transfers from a maximum of 3 fresh cycles. For eligible patients requiring IVF where the woman is aged 40–42, the CCG will fund up to two embryo transfers from one fresh cycle.

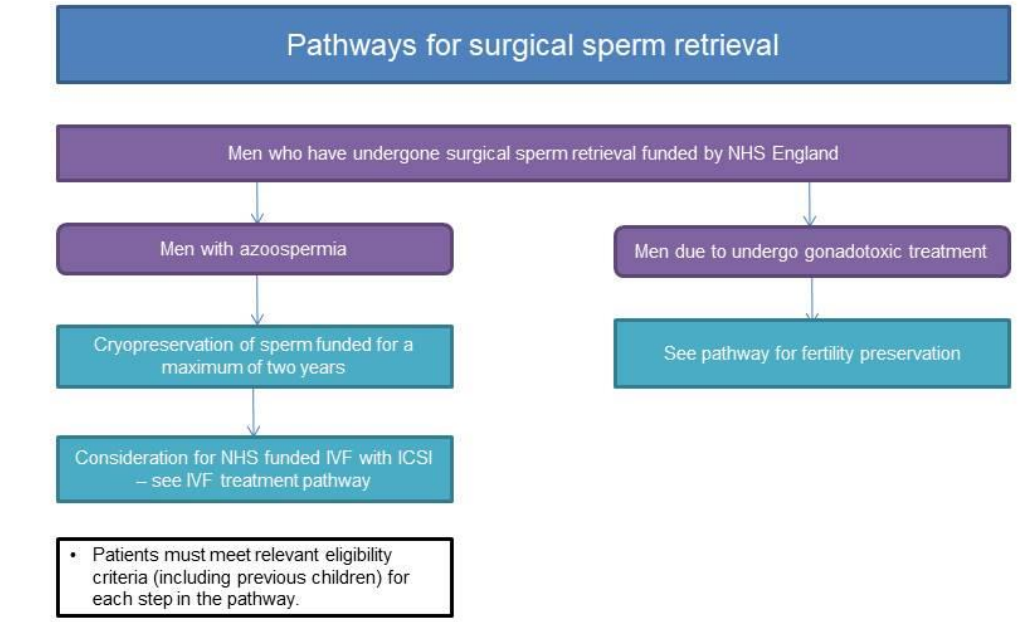
- All good quality frozen embryos should be transferred before starting the next NHS funded fresh cycle.
- Patients must meet relevant eligibility criteria (including previous children) each time they start a cycle of treatment.
- Storage of frozen embryos will be funded for a maximum of two years for each fresh cycle.
- In order to undergo FET frozen embryos must be deemed by the clinician suitable for implantation.

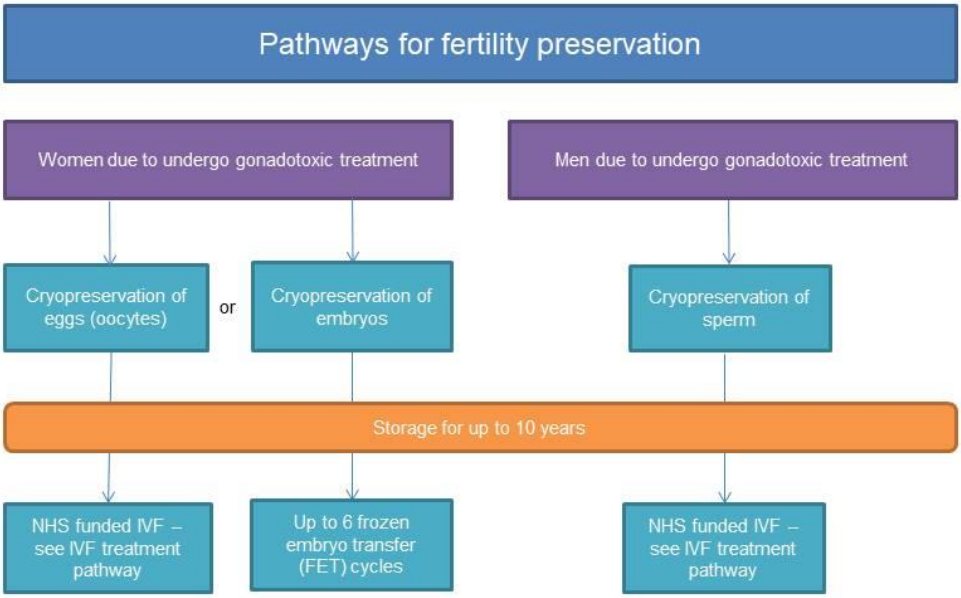


- Patients must meet relevant eligibility criteria (including previous children) each time they start a cycle of treatment.

*Where there is evidence of normal ovulation, tubal patency and semen analysis.


Pathways for assisted conception treatments using donor sperm
Female same sex couples
Single women
Male factor fertility problems*
Risk of transmitting genetic disorder/ infectious disease
Severe rhesus isoimmunisation
Known fertility problem
yes
no
6 unsuccessful self funded IUI
no
Investigations – confirm normal ovulation and tubal patency
yes
6 NHS funded unstimulated IUI
Consideration for NHS funded IVF – see IVF treatment pathway
Known fertility problem in female partner
yes
no
no
Confirm woman is ovulating
yes
6 NHS funded unstimulated IUI
6 unsuccessful self funded IUI
Consideration for NHS funded IVF – see IVF treatment pathway
*Azoospermia or severe deficits in semen quality in couples who do not wish to undergo ICSI.
Patients must meet relevant eligibility criteria (including previous children) each time they start a cycle of treatment.


Pathways for surgical sperm retrieval
Men who have undergone surgical sperm retrieval funded by NHS England
Men with azoospermia
Men due to undergo gonadotoxic treatment
Cryopreservation of sperm funded for a maximum of two years
See pathway for fertility preservation
Consideration for NHS funded IVF with ICSI – see IVF treatment pathway
Patients must meet relevant eligibility criteria (including previous children) for each step in the pathway.



- Patients do not need to fulfil the same eligibility criteria as patients with infertility in order to access cryopreservation of eggs, embryos or sperm for fertility preservation. See policy in Chapter 8 for more information.
- However, in order to access assisted conception treatments (IVF or IUI) using cryopreserved materials, fertility preservation patients will be required to fulfil the same eligibility criteria as other patients with infertility. An exception to this is the criterion for ovarian reserve, which women who have accessed NHS funded fertility preservation will not be required to fulfil.

North Central London
Clinical Commissioning Group

EQUALITY ANALYSIS
(Equality Impact Assessment)

Service/Policy title	**Draft NCL Fertility Policy**
Service/Policy type	
Author	
Lead Director	**Penny Mitchell**
Email	**penny.mitchell3@nhs.net**
Date approved	**October 2021**
Review date	**October 2024 (or earlier if the policy is updated before this date)**

Before completing the Equality Analysis (EQIA) please read the guidance on the intranet.

For further help and advice please contact Emdad Haque at emdad.haque@nhs.net
Tel: 07753836900

Brief description of the policy/service

Please provide only a brief description covering what this policy/service aims to achieve and which groups it will benefit.

North Central London Clinical Commissioning Group (NCL CCG) was formed in April 2020, with the merger of the five North Central London CCGs: Barnet, Camden, Enfield, Haringey and Islington. Each borough had its own fertility policy and with the formation of a single clinical commissioning group, NCL CCG has been working to develop a new, single policy, which will cover all five boroughs. North Central London has a population of over 1.5m residents. The population is relatively young with Camden, Haringey and Islington having more adults under the age of 30 than other NCL areas. Haringey, Islington and Enfield have on average, higher rates of deprivation compared to London, although pockets of deprivation are dispersed across NCL[1]. More than half of NCL residents are White, with around 20% Asian and 20% Black. Barnet and Camden have larger Asian communities, whereas Haringey and Enfield have larger Black communities.[2]

It is estimated that infertility affects about one in seven heterosexual couples in the UK. About 84% of couples will conceive naturally within a year if they have regular unprotected sex (every 2 or 3 days). NHS fertility treatment is available for eligible individuals and couples who want to become parents but who have a possible pathological problem (physical or psychological) leading to them being infertile. Not all patients who have fertility problems will require assisted conception treatments such as in vitro fertilisation (IVF). In NCL, an estimated 700 people received NHS funded IVF each year.

The draft fertility policy covers a small group of specialised treatments, including In Vitro Fertilisation (IVF), Intra Uterine Insemination (IUI) and fertility preservation, which may be used to support people who are experiencing some forms of sub-fertility. The draft policy document sets out the criteria that NCL GP registered patients must meet, in order to access assisted conception treatments funded by NCL CCG. The eligibility criteria outlined in the draft NCL fertility policy document only apply to assisted conception treatments. Patients do not have to meet the eligibility criteria outlined in the draft policy to access NHS funded investigations or other medical or surgical treatment for fertility problems.

The CCG has a statutory duty to maintain financial balance, which means that it must make judgements about the affordability of any proposed service for local patients. In developing this draft policy, the CCG has sought to adopt NICE guidance wherever feasible. However, the need to balance service access demands with affordability has meant that in some sections the draft policy may vary from the full recommendations made by NICE.

Engagement with patients and stakeholders

Please provide a brief summary about engagement with patients, clinical leads, voluntary organisations Healthwatch- and the outcomes. If no engagement has been carried out then please explain why.

[1] NCL CCG Diversity and inclusion strategy 2021-2023

[2] GLA 2018, Housing led population projections

In developing this policy, NCL CCG has carried out engagement activities to support the review stage (consisting of pre-engagement, engagement and review recommendations) and to influence the policy development stage of the programme.

A pre-engagement stage was carried out ahead of the start of the engagement window for the Fertility Policies Review. We wrote to a core list of 75 key stakeholders, which included 38 groups representing protected characteristics, across North Central London offering the opportunity to discuss our approach and seek their early views. We also wrote to national special interest groups to collate views (for example, Fertility Network UK and The LGBT Mummies Tribe) as well as local Healthwatch leads and the Chairs of the Joint HOSC and HOSC committees. Responses received in the pre-engagement period were logged, and where relevant, used to inform our engagement approaches.

The first stage was a Review to develop recommendations to inform the subsequent development of the future single policy. A key strand of the Review had been to seek the views of our residents, service users, voluntary and community (VCS) organisations, fertility groups and wider stakeholder audiences, both on the current fertility policies and also what the CCG should consider when developing the future policy. The Review engagement window for this work ran from 10 May to 9 July 2021. Proactive communications and engagement activities were undertaken throughout the engagement window to promote awareness of the Review, including social media content across a number of channels, detailed information on our website, with an online questionnaire (also available as a hard copy (and easy read) on request), articles featured in our stakeholder and residents newsletters. A range of approaches were taken to reach out to groups and individuals from different ethnic backgrounds and communities across our five boroughs. It should be noted that the Review took place during the COVID-19 pandemic, which restricted engagement interactions to online and telephone methods. Wherever possible mitigations were put in place to enable and encourage people to take part; for example, by working with VCS groups to reach ethnic minority communities whose first languages are not English, and by providing interpreters at online events.

In addition to the groups that we engaged with, the Steering Group that led the policy review also included on member of Fertility Network UK to fulfil the Community Member 'expert' role and one of the CCG's existing Community Members, acting as the NCL 'citizen' Community member on the group. These members have also contributed to the development of the policy, and in particular to equality considerations, through the Steering Group itself.

NCL CCG was committed to being flexible in how we heard from residents, service users and groups, and welcomed 1:1 conversations as well as the opportunity to attend existing events and meetings to discuss the Review. Written comments were welcomed and processed through a single document management system and a consistent analysis framework. The core engagement methods implemented by the CCG are detailed in Appendix 1.

Good and detailed qualitative insights and data were collected. For the information about the themes of the engagement, you can read the NCL CCG Fertility Policies Review: Engagement Report here. The majority of people who engaged during the Review stage were past or present service users, and were well-informed about policies and treatments available. NCL CCG has been committed to using these insights to support the development of this policy at local, borough and system level to improve service provision.

The views of specialist clinicians were obtained during the course of the NCL Fertility Policies Review in the following ways:

- Establishing a Clinical Reference Group (CRG) of fertility specialists from across NCL and its partners to provide clinical 'check and challenge' to the methods and outputs of relevant activities being undertaken by the Review.
- Collating responses to questionnaires to obtain the views of fertility specialists (and other specialist clinicians who see patients who might require fertility treatments) on the interventions and eligibility criteria included within the scope of the fertility policies review.
- Considering findings of interviews with specialist clinicians who provide ovarian tissue cryopreservation[3].

You can read the NCL CCG Fertility Policies Review: Engagement Report here.
This document reports the findings from the stage 1 public engagement window (10 May to 9 July 2021)

Following on from Phase 1 of our engagement process, we then commenced the Policy Development Phase. With input from our Clinical Reference Group and expert clinicians on the CCG Governing Body, we have developed a draft Policy and we are now due to go out to 12 weeks of engagement on the draft policy from 22 November 2021 to 13 February 2022.

Input from governing body clinicians fed into the second stage of Policy Development with the formation of a Readers' Advisory Panel made up of six NCL Community members to provide advice and observations on the phrasing and 'readability' of the draft NCL fertility policy from the perspective of readers and local residents. The Policy Development engagement window for this work is anticipated to run from 22 November 2021 to 13 February 2022. During the engagement window, local residents will be able to contribute their views and experiences in the following ways:

- By attending one of our online public meetings (N=5)
- By attending a face-to-face public meeting
- By inviting CCG staff to attend a meeting or event, for example Fertility Support Groups, or GP Patient Participation Groups
- By completing the online questionnaire (hard copies will be available upon request (also in easy read))

Residents will be able to find out about the engagement opportunities via our website and the Fertility Policy Development team will be contactable by email nclccg.fertility-development@nhs.net and by telephone: 020 3688 2038

The communications and engagement team will be proactively raising awareness of the draft single policy and how to give feedback through our public website, social media and key stakeholder public-facing channels (e.g. The LGBT Mummies Tribe, Fertility Network UK, Healthwatch, NHS providers, local authority and local voluntary and community sector groups (focusing on seldom-heard communities).

The EQIA currently reflects that draft policy, and will be updated as and when the Policy itself is updated. We will collect responses from this second engagement phase and will then report back to the S&C Committee and will take this feedback into account in finalising the Policy. Once we have a finalised Policy, we will update the EQIA accordingly.

[3] Note, these interviews were undertaken as part of a different policy review for a group of CCGs based in the south east in October 2020.

Impact analysis

This section should be used to analyse the likely impact of the policy/service on protected and disadvantaged groups. It should be noted that the CCG's default policy intent is to maximise opportunity (positive impact) for all groups by removing barriers so that they can access the service they need and enjoy good outcomes.

<table>
<tr><th>Protected Group/Strands</th><th>Level of impact
Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.</th><th>Likely impact
See the keys at the end of the form</th><th>Recommendation /mitigating action
Please reference by entering the number from the list on the next page.</th></tr>
<tr><td>Age</td><td>ONS data indicates there are an estimated 329,400 women aged between 18-45 in NCL.

The draft NCL CCG policy specifies assisted conception treatments (ACT) will be funded for eligible women aged under 43. NCL women aged 43 and over will not routinely have NHS funded ACT available to them.

ONS mid 2020 female population estimates by age.
<table>
<tr><th>Age</th><th>Barnet</th><th>Camden</th><th>Enfield</th><th>Haringey</th><th>Islington</th><th>Total</th></tr>
<tr><td>43</td><td>2,799.00</td><td>1,708.00</td><td>2,484.00</td><td>1,941.00</td><td>1,323.00</td><td>10,255.00</td></tr>
<tr><td>44</td><td>2,851.00</td><td>1,844.00</td><td>2,372.00</td><td>1,976.00</td><td>1,302.00</td><td>10,345.00</td></tr>
<tr><td>45</td><td>2,773.00</td><td>1,706.00</td><td>2,250.00</td><td>1,942.00</td><td>1,292.00</td><td>9,963.00</td></tr>
<tr><td>46</td><td>2,709.00</td><td>1,912.00</td><td>2,185.00</td><td>1,770.00</td><td>1,430.00</td><td>10,006.00</td></tr>
<tr><td>47</td><td>2,665.00</td><td>1,773.00</td><td>2,277.00</td><td>1,871.00</td><td>1,258.00</td><td>9,844.00</td></tr>
<tr><td>48</td><td>2,787.00</td><td>1,653.00</td><td>2,304.00</td><td>1,820.00</td><td>1,282.00</td><td>9,846.00</td></tr>
</table></td><td>Positive</td><td>The NCL CCG draft policy specifies ACT will be funded for eligible women aged under 43 years. The rationale for this is:
• NICE Clinical Guideline (CG) 156 and Quality Standard (QS) 73 recommend funding of IVF for women aged up to 42 (inclusive).
• The NICE CG156 full guideline states that IVF is not cost effective for women aged 43 years or older.
• The NICE CG156 full guidelines states: 'The clinical and health economic evidence was overwhelming in indicating that IVF should not be offered to women aged 43 years or older'
• HFEA data on all fertility treatments undertaken in the UK shows the success rates decrease as the woman's age increases for IVF and other ACT including donor insemination, IUI and IVF using thawed eggs.</td></tr>
</table>

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
	49 2,810.00 1,706.00 2,369.00 1,890.00 1,304.00 10,079.00 50 2,816.00 1,690.00 2,329.00 1,812.00 1,238.00 9,885.00 51 2,830.00 1,677.00 2,418.00 1,831.00 1,336.00 10,092.00 **Total 25,040.00 15,669.00 20,988.00 16,853.00 11,765.00 90,315.00** N.B. the above details female population estimates by age not those who may require fertility treatment. Average age of menopause for women in UK is 51. A woman's age is an initial predictor of her overall chance of success through natural conception.[4] Fertility decreases as women age.[5] Success rates for fertility treatments decrease as women age (with the exception of IVF using donor eggs)[6] Service users commented that NCL women aged 40-45 years are in a position to start a family due to good career/ life balance.		The NCL CCG will promote the policy to all eligible age groups and ensure equity in access. Recommendation / mitigating action (1)
	The draft NCL CCG policy specifies that, unless investigations show IVF is the only treatment option (in which case eligible patients can be referred directly for IVF), patients must	Positive	The rationale for requiring women to try to conceive for 2 years prior to accessing NHS funded intercourse is:

[4] NICE CG156 (2013)
[5] Infertility - NHS (www.nhs.uk)
[6] HFEA data

<table>
<tr><th>Protected Group/Strands</th><th>Level of impact
Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.</th><th>Likely impact
See the keys at the end of the form</th><th>Recommendation /mitigating action
Please reference by entering the number from the list on the next page.</th></tr>
<tr><td></td><td>demonstrate their infertility by trying to conceive for either 2 years of regular unprotected intercourse or 12 cycles of IUI in order to be eligible for NHS funded IVF.

Older women may be over the age threshold if they have to undergo 2 years of unprotected intercourse before they are eligible for IVF.</td><td></td><td>• This is recommended in NICE CG156 for all ages of women accessing IVF
• NICE noted data from Dunson (2004 – see Table below) when making their recommendations
<table><tr><th>Age (years)</th><th>Pregnant after 1 year</th><th>Pregnant after 2 years</th></tr><tr><td>19-26</td><td>92%</td><td>98%</td></tr><tr><td>27-29</td><td>87%</td><td>95%</td></tr><tr><td>30-34</td><td>86%</td><td>94%</td></tr><tr><td>35-39</td><td>82%</td><td>90%</td></tr></table>• Removing this criterion may mean woman who would have otherwise conceived naturally are treated with IVF
• Where investigations show IVF is the only treatment option, patients can be referred directly for IVF
• Implementation planning and support will schedule engagement and guidance to primary care and secondary care to support implementation of the new policy. Our aim being that as people enquire, they can find info easily via our website and be well supported by their GP or other treating clinician.</td></tr>
</table>

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
	The draft NCL CCG policy requires women undergoing ACT to have a BMI within the range 19-30 kg/m^2. Feedback from the engagement exercise was that older people and people with medical conditions may find it more difficult to lose weight than younger people.	Negative	The BMI criteria are in place for the following reasons: • NICE CG156 states that a female BMI outside this range is likely to reduce the success of assisted reproduction procedures • NICE CG156 recommends women should be informed BMI should ideally be in the range 19-30 before commencing assisted reproduction • HFEA Commissioning Guide for Fertility Treatment states: Women should have a BMI of 19-30 kg/m^2 before commencing assisted reproduction.
	The COVID-19 pandemic may have delayed access to NHS funded fertility treatment for some patients, which may have led to some patients no longer being eligible (e.g. if they are now too old to meet the age criteria).	Negative	• Ensure people can get support and information about the draft policy in a timely way to make informed decisions about when they want to attempt to have a baby. • National response to Covid-19 pandemic in operation to reduce waiting times.
Disability	Based on the 2011 Census, 8.6% of men and 9.3% of women in London have an illness or disability that limited a lot of their daily activities.	Positive	The draft NCL CCG policy is broadly consistent with NICE CG156 in funding ACT to eligible patients with physical disability/ psychosexual problems.

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
	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. The draft NCL CCG policy specifies that up to 6 cycles of IUI using partner sperm is funded for these patient groups if they have not conceived after 6 cycles of self-funded IUI. These patients may also be eligible for IVF if they undergo a total of 12 unsuccessful IUI cycles.		This group of patients have been covered in the policy. Recommendation / mitigation (2) Recommendation / mitigation (3)
	In 2018, Public Health England estimated that the prevalence rate for HIV was 5.7 per 1,000 people in London. This equates to an estimated 1,778 men aged 18-42 in NCL who are HIV+. The draft NCL CCG policy specifies sperm washing may be funded for eligible men who are HIV+ and have a HIV- female partner.	Positive	The draft NCL CCG policy is consistent with NICE CG156 in funding sperm washing to eligible patients who are HIV+. This group of patients have been covered in the policy
	Data from Public Health England Cancer Registry indicates around 1,900 NCL women and 1,500 NCL men aged 15-44 are likely to be diagnosed each year with cancer which may be treated with a potentially gonadotoxic treatment. The draft NCL CCG policy specifies that fertility preservation interventions (cryopreservation of sperm, eggs and embryos) is funded for eligible patients who are either due to undergo a	Positive	The draft NCL CCG policy is broadly consistent with NICE CG156 in funding fertility preservation for patients due to undergo a gonadotoxic treatment.

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
	gonadotoxic treatment or have a medical condition which is likely to progress such that it will lead to infertility in the future. This applies to patients with conditions including cancer.		
	The draft NCL CCG policy indicates that IVF/ ICSI using donor eggs will be funded for eligible patients who have undergone bilateral oophorectomy or who have ovarian failure following chemotherapy or radiotherapy. This applies to patients with conditions including cancer.	Positive	The draft NCL CCG policy is consistent with NICE CG156 in funding IVF/ ICSU using donor eggs for eligible patients who have undergone bilateral oophorectomy or ovarian failure following chemotherapy or radiotherapy.
	People with HIV who require fertility treatment need to be referred to clinics licensed to treat them.[7]	Positive	The draft NCL CCG policy is inclusive of those with HIV.
	The draft NCL CCG policy states that assisted conception treatments involving surrogates are not routinely funded by NCL CCG for any patient group. This has potential an impact on people who would not be able carry a pregnancy to term due to a disability.	Negative	The rationale for this is: a surrogate is available only to those with means and, by parity of reasoning with the prohibition on mixing NHS and private care in one episode of care, ACT involving surrogates is not funded. NICE does not make recommendations on ACT involving surrogates.
Gender	NCL Demographics (April 2019/20) estimate population of 809,362 males (49%) and 838,675 females (51%)	Positive	"Gender" in itself is not the critical factor. The point of the policy is to deal with pathological issues to do with an individual's sexual reproductive system

[7] HFEA

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
	Some fertility treatments are specific to either men or women and as such require different considerations when developing policy (e.g. surgical sperm retrieval is specific to man and oocyte cryopreservation is specific to women).		Due to the nature of policies on assisted reproductive technologies, it is necessary to refer to the sex of patients on occasion. This document therefore refers to 'men' and 'women', and 'male' and 'female'. When these terms are used in this document, unless otherwise specified, this refers to sex defined by biological anatomy. It is acknowledged that this may not necessarily be the gender to which individual patients identify.
	NICE CG156 makes specific recommendations regarding the woman's age; no equivalent recommendations are made regarding the man's age. The draft NCL CCG policy has retained the upper age limit for women but has removed the upper age limit for men.	Positive	The draft NCL CCG policy is consistent with NICE CG156 guidance with regard to the age of women undergoing IVF. The upper age limit for women has been retained because of the strong evidence outlined above that IVF birth rates decrease as the women's age increases. The upper age limit for men has been removed because this was based on previous HFEA regulations which have now been changed (previously sperm could not be stored after a man reached the age of 55 years; this has now been changed so sperm cannot be stored for more than 55 years duration).

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
	The draft NCL CCG policy specifies IUI and IVF are funded for eligible single women and female same sex couples. No assisted conception treatments are funded for single men or male same sex couples because ACT involving surrogacy are not funded for any patient groups.	Negative	The draft NCL CCG policy specifies IUI and IVF are funded for eligible female same sex couples broadly consistent with NICE CG156 recommendations. NICE CG156 does not address surrogacy. The rationale for not funding ACT involving surrogacy for any patient groups is as follows: a surrogate is available only to those with means and, by parity of reasoning with the prohibition on mixing NHS and private care in one episode of care, ACT involving surrogates is not funded.
Gender reassignment	NHS admissions data indicates that in 2018/19, just under 100 NCL patients were admitted to secondary care with a primary diagnosis of gender dysphoria. People undergoing gender reassignment interventions such as hormone therapy or surgery may wish to cryopreserve their genetic materials to preserve their fertility. Although admissions data may give an indication of the numbers of patients undergoing gender reassignment interventions on the NHS, there is likely to be a significant number of transgender patients accessing gender reassignment interventions privately thereby underestimating the number who require fertility preservation.	Positive	The draft NCL CCG policy states that fertility preservation may be offered to eligible patients under the care of a specialist clinician who confirms they are due to undergo a gonadotoxic treatment, including those who are due to undergo interventions for gender reassignment

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
	NHS England and NHS Improvement issued guidance for CCGs on formation of clinical commissioning policies for fertility preservation which stated: 'CCGs must not determine which patient groups might be offered fertility preservation service on a basis which discriminates against those patients because of a protected characteristic, including gender reassignment'	Positive	The draft NCL CCG policy states that fertility preservation may be offered to eligible patients under the care of a specialist clinician who confirms they are due to undergo a gonadotoxic treatment, including those who are due to undergo interventions for gender reassignment.
	Due to the nature of policies on assisted reproductive technologies, it is necessary to refer to the sex of patients as defined by their biological anatomy on occasion. This may not necessarily be the gender to which individual patients identify.	Positive	This has been acknowledged in the draft NCL CCG fertility policy.
Marriage and civil partnership[8]	Assisted Conception Treatment (ACT) for single women and those who are not married or in a civil partnership.	Positive	The draft NCL CCG policy specifies IUI and IVF is funded for eligible single women on the same basis as it is available for female same sex couples.
	Couples in a 'stable relationship' for a specified period of time.[9]	Positive	The draft NCL CCG policy does not stipulate this a requirement for service users to be in a "stable relationship" for a specified period of time.
	Access for single women compared to couples for fertility services.	Positive	The draft NCL CCG policy specifies IUI and IVF are funded for eligible single women on the same basis as it is available for female same sex couples.

[8] https://www.ons.gov.uk/file?uri=%2fpeoplepopulationandcommunity%2fbirthsdeathsandmarriages%2flivebirths%2fdatasets%2fbirthsbyparentscharacteristics%2f2019/parentscharacteristics201912112020134413.xls

[9] NCL CCG Fertility Policy Review Recommendations report

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
Pregnancy and maternity	The NCL CCG Policy is to support those with a pathological issue to help them become pregnant. Multiple births are the single greatest risk of fertility treatment.[10] People entering fertility services with the aim of a single live birth may be impacted.	Positive / unknown	The policy states that embryo transfer strategies outlined in NICE CG156 should be followed in order to minimise the number of multiple births.
	The draft NCL CCG policy specifies that couples who already have a child together, including those with secondary infertility are currently excluded from NHS funded fertility treatment due to the 'previous child' criterion.	Negative	The CCG has a statutory duty to maintain financial balance. The CCG needs to focus resources on patients in most need. Investigations and other (medical/ surgical) treatments for infertility are not covered by the policy and may therefore be available for couples who already have a child together. Recommendation / mitigation (1)
	Some CCGs do not fund fertility treatments for couples where one individual in a couple has a child from a previous relationship.[11]	Negative	The draft NCL CCG policy specifies that ACT will be funded for eligible patients where at least one partner does not have a living child. Recommendation / mitigation (1)

[10] HFEA

[11] NCL CCG Fertility Policy Review Recommendations report

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
Race/ethnicity[12] [13]	Mid 2019 estimates NCL demography and diversity of have 63% White and 37% BAME.[14] Local specialists noted that age-related decline in fertility may occur sooner for Asian/ Chinese women compared to Caucasian and African women (Gleicher, 2012).	Positive / unknown	The NCL CCG policy on eligibility is inclusive of all race / ethnicities. The age related criteria is not specific to race / ethnicity.
	It has been suggested by service users that ethnicity impacts on BMI and should be taken into account in relation to the BMI eligibility criterion for women.	Positive / unknown	The BMI criterion outlined in the proposed policy is consistent with NICE CG156 recommendations and the HFEA Commissioning Guide for Fertility Services.
Religion/belief	There are a number of religions that prohibit fertility treatments or aspects of fertility treatments (e.g. Muslim patients may not accept donor gametes; Catholic patients may not wish to create embryos that risk being discarded; orthodox Jewish men may not have surgical sperm retrieval).	Positive	Fertility clinics confirmed they are able to accommodate for patients with religious beliefs (e.g. creating 1 embryo at a time, electro ejaculation for those not allowed to masturbate). The NCL CCG draft policy states that up to six cycles of unstimulated IUI using partner sperm is funded for people with unexplained infertility, mild endometriosis or mild male factor infertility who have social, cultural or religious objections to IVF

[12] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/parentscountryofbirthenglandandwales/2019

[13] https://www.ons.gov.uk/file?uri=%2fpeoplepopulationandcommunity%2fbirthsdeathsandmarriages%2flivebirths%2fdatasets%2fparentscountryofbirth%2f2019/parentscountryofbirth2019.xlsx

[14] https://intranet.northcentrallondonccg.nhs.uk/downloads/Governing%20Body/Meeting/Diversity%20%20Equality%20and%20Inclusion.pptx

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
Sexual orientation	People in same sex relationships who wish to have their own biological children will need fertility treatment to achieve this (donor insemination for women and assisted conception treatments involving surrogates for men). The draft NCL CCG policy specifies that assisted conception treatments involving surrogates are not funded for any patient groups. This excludes male same sex couples from accessing NHS funded fertility treatments.	Negative / unknown	The draft NCL CCG policy specifies IUI and IVF is funded for eligible female same sex couples broadly consistent with NICE CG156 recommendations. NICE CG156 does not address surrogacy. The rationale for not funding ACT involving surrogacy for any patient groups is as follows: a surrogate is available only to those with means and, by parity of reasoning with the prohibition on mixing NHS and private care in one episode of care, ACT involving surrogates is not funded. NICE CG156 does not address surrogacy.
	NICE CG156 recommends IUI for eligible people in same sex relationships.	Positive	The draft NCL CCG policy specifies IUI and IVF is funded for eligible female same sex couples broadly consistent with NICE CG156 recommendations.
	Heterosexual couples are required to try to conceive through unprotected intercourse for 1 year before accessing NHS investigations and 2 years before accessing NHS funded IVF. Survey respondents noted equitable equivalent criteria need to be determined for same sex couples, which take into account the cost of IUI in a clinical setting.	Positive	The draft NCL CCG policy criteria on demonstrating infertility for eligibility for IVF are broadly consistent with NICE CG156 recommendations. In determining their recommendations on this topic, the NICE GDG discussed ethical and practical issues relating to 'equivalence' including time, financial cost, availability of donor sperm and practical difficulties.

Protected Group/Strands	Level of impact Describe how the policy/service will impact the protected and disadvantaged groups based on the data available from local/NHS/national sources + the latest COVID 19 information. It's important that the relevant data is used in the analysis and referenced for robustness and relevance. If the policy/service is not relevant to a group/strand then say 'N/R'.	Likely impact See the keys at the end of the form	Recommendation /mitigating action Please reference by entering the number from the list on the next page.
			Investigations are outside of the scope of the draft policy.
Disadvantaged groups [homeless, unemployed, single parents, asylum seekers, victim of domestic violence]	Some patients who have frozen embryos from NHS funded cycles available may not be able to afford treatment using these.	Negative	Recommendation / mitigation (1)
	The draft policy states treatment will not be funded for women aged under 40 years if they have undergone 3 previous IVF cycles. For women aged 40-42 treatment is not funded if they have undergone any previous IVF cycles. Patients who have previously undergone private treatment but can no longer afford this may therefore be ineligible for NHS funded treatment.	Negative / unknown	The draft policy is consistent with NICE CG156 recommendations.
Human Rights [how the policy/service will impact Human Rights of patients]	The development of the draft NCL Fertility policy builds on the opportunity for improving and promoting equality and human rights of our population.	Positive	The draft policy will have a positive impact on human rights, particularly Article 8: Right to respect for private and family life; Article 12: Right to marry and found a family.

Recommendations/mitigating actions

No	Recommendation/mitigating action	Which protected group/ strand does this cover	Lead Person and Organisation	Deadline/ Review date
1	Across the country most, if not all, CCGs have a set of fertility policies addressing funding of assisted conception treatments such as in vitro fertilisation (IVF) and intrauterine insemination (IUI). The CCG has a statutory duty to maintain financial balance, which means that it must make judgements about the affordability of any proposed service for local patients. In developing this policy, the CCG has sought to adopt NICE guidance wherever feasible. However, the need to balance service access demands with affordability has meant that in some sections the policy may vary from the full recommendations made by NICE.	Age Pregnancy / maternity Disadvantaged groups	NCL CCG	October 2024
2	Other related speciality pathways (not specifically detailed in the policy), for example, where treatment is planned that might result in infertility (such as treatment for cancer) or where people are known to have chronic viral infections (e.g. HIV) and are concerned about their fertility are to be followed. Recommendations are that these services are aware of the new policy in order to reduce unwarranted variation.	Disability	NCL ICS	October 2024
3	This policy cannot anticipate every possible individual clinical presentation. Clinicians may submit Individual Funding Requests for patients who they consider to have exceptional clinical circumstances and whose needs are not fully addressed by this policy. The CCG will consider such requests in accordance with its policy on Individual Funding Requests.	All (where relevant as per case by case basis).	Individual Funding Request Panel	October 2024

Please send a copy of the EqIA with the original business case or policy for review to Emdad Haque at emdad.haque@nhs.net

Keys explaining the impact-

- Positive- Evidence including the policy/service objectives indicate that this protected group/strand will benefit equally like their counterparts. It should be noted that the default policy intent of the CCG is to maximise opportunity for all groups.
- Negative- Evidence including the policy/service objectives indicate that this protected group/strand may not benefit and experience disadvantage compared to their counterparts.
- Positive/unknown- The policy/service intent is clear about the equality in access and outcomes in its objectives/goals – and evidence is required to demonstrate the actual positive impact.
- Negative/unknown- There is no hard evidence of likely negative impact but anecdotes and engagement outcomes suggest the likelihood of negative impact.
- Not relevant- The policy/service is not relevant to equality or this protected group/strand. The general rule of thumb is that all patient facing services are equality relevant.

Appendix 1: Core Engagement Methods

- Review Questionnaire (hard copy available upon request, easy read version also available on request).
- Online version hosted on our website
- Shared with our key stakeholder database, which included Healthwatches, VCS groups, special interest groups, local authorities and local hospital patient/membership groups.
- Distributed to the North Central London Residents Panel – a group of nearly 1,000 local residents with an interest in health and care services
- Distributed via Next Door (online neighbourhood network) with close to 9,000 impressions across North Central London resident online timelines.
- Promoted via CCG public channels, notably social media, newsletters (to the wider NCL system and also our residents newsletter), news articles on our public-facing website and our intranet (recognising that our staff may wish to share their views).
- Information was shared by Provider organisations (not only those part of the North Central London system, but also those out of area who provide fertility services to our population), Healthwatches, local VCS, local authorities and other key partners through the Review period
- Shared with local general practice teams (both GPs and via Practice Managers and PPG Groups) across our boroughs via NCL CCG GP website and newsletter Public and service user-focused activity:
- Three open-access online events were run for members of the public. These events were spread throughout the engagement period and were run at different times of the day, with one held at the weekend in order to allow the greatest accessibility for attendees with differing responsibilities
- A service user focus group, supported by Fertility Network UK
- A resident focus group with LGBT men
- A resident focus group, hosted in collaboration with the Enfield Racial Equality Council, which particularly welcomed people from local ethnic minority communities and those with lived experience from across the five NCL boroughs
- A resident focus group held with residents whose country of origin was not the UK 12
- Outreach via fertility group social media channels, including a pre-recorded Instagram Live event with The LGBT Mummies Tribe, which had over 350 views
- A pre-recorded question and answer session with the Clinical Responsible Officer and Programme Director, which was shared on the CCG's YouTube channel and via social media platforms in collaboration with The LGBT Mummies Tribe
- In-depth interviews held with residents from local BAME and LGBT communities Wider stakeholder-focused activity:
- 1:1 briefings for key stakeholders and representative organisations
- Meetings with local organisations, including online groups, discussion sessions with groups
- In-depth interviews conducted with individuals with protected characteristics
- Attending/presenting at meetings organised by others, such as Healthwatch and local community groups, VCS organisations, PPG network meetings and local authorities
- Information shared with our communications counterparts in local authorities and Trusts General Practice-focused activity
- Presentation by CRO and Programme Director to webinar for all NCL Governing Body GPs and clinical leads. This webinar is held weekly and chaired by the Chair of the CCG's Governing Body.

- Presentations to Borough-based GP Forums in Barnet and Islington During the pre-engagement phase seventy eight organisations were contacted and invited to take part in the Review, as well as a wide range of stakeholders. During the engagement phase:
- 52 people completed the survey
- 44 people were involved in group discussions, public online sessions and interviews
- 350+ people viewing a Mummies' Tribe Instagram Q&A session
- From the FPR public website you can see the number of times documents were downloaded by visitors to the webpage.
  - NCL Fertility Review Questionnaire – 103 downloads
  - Patient Leaflet – 131 downloads
  - NCL FPR Variations slide deck – 149 downloads
  - Barnet Fertility Policy – 111 downloads
  - Camden Fertility Policy – 106 downloads
  - Enfield Fertility Policy – 89 downloads
  - Haringey Fertility Policy – 113 downloads
  - Islington Fertility Policy – 84 downloads
  - NCL CCG Fertility Policies Review FAQs – 104 downloads
  - North Central London Fertility Policies Review - Easy Read Leaflet – 122 downloads
- 31 Tweets were sent from the NCL CCG's account which had 27,954 impressions on local stakeholder and resident twitter accounts raising awareness of the Fertility Policies Review.

North Central London
Clinical Commissioning Group

North Central London Clinical Commissioning Group Fertility Policies Development

Joint Health Oversight and Scrutiny Committee (JHOSC) Briefing Paper

Sarah Mansuralli
Executive Director for Strategic Commissioning

20 September 2021

V0.01

Contents

1. Introduction

North Central London Clinical Commissioning Group (NCL CCG) was established in April 2020. Prior to this, each of the five North Central London Clinical Commissioning Groups (NCL CCGs) had their own fertility policies, and this has continued into the present day as a legacy of the separate CCGs.

Since we are now a single organisation, there is no longer a reason for having five separate policies. Reducing health inequalities and ensuring fair access to treatments across North Central London (NCL) is a strategic priority for the CCG, and so our Governing Body has commissioned a review into the five legacy fertility policies to make recommendations on the way forward.

Initial work began in September 2020, but elements of the project were paused as a result of the COVID-19 pandemic. Full work recommenced in April 2021 and is being done in two stages. The first stage was a Review, with the aim of producing a set of principles and recommendations to inform the development of the future single policy. No decisions on the future policy were made in the Review stage.

This briefing paper relates to the first stage, informing the JHOSC of the reasons for the review, the methodology undertaken, a summary of the public feedback, recommendations and next steps.

The review is led by NCL Fertility Policy Steering Group, which reports into the Strategy and Commissioning Committee. The Steering Group is led by a Clinical Responsible Officer nominated by the Governing Body and includes a number of relevant subject matter experts, including an independent fertility expert from the University of Southampton who is not associated with any of the provider organisations in NCL.

The methodology undertaken for the review included the following key stages:

- Review our current policies and understand how they differ from each other, as well as understanding our care pathways and how many procedures of each type we undertake each year, in each borough.

- Review the scientific evidence and understand how it might influence policy development, ensuring that our policies are based on the latest evidence available. We have only focused on areas where our policies depart from the National Institute for Health and Care Excellence (NICE) guidelines, as NICE has its own system to ensure that its policies are based on the latest evidence.

- Engagement to seek the views of our residents, service users, voluntary and community organisations, fertility groups and wider stakeholder audiences, both on our current fertility policies and also what the CCG should consider when developing the future policy. A set of recommendations will be made for the way in which future policy is to be developed.

Throughout the review, the impact of equality issues needs to be fully understood and taken into account as part of any change in future policy.

2. Setting the scene (public feedback)

A key strand of the Review stage has been to seek the views of our residents, service users, voluntary and community (VCS) organisations, fertility groups and wider stakeholder audiences, both on our currentfertility policies and also what the CCG should consider when developing the future policy. The engagement window for this work ran from 10 May to 9 July 2021; this briefing paper highlights a summary of the findings from the feedback received.

We sought views from as many people and groups as possible and our methodology was rigorously designed to support this aim. Proactive communications and engagement activities were undertaken throughout the engagement window to promote awareness of the Review, including social media content across a number of channels, detailed information on our website, an online questionnaire (also available as a hard copy (and easy read) on request), and articles featured in our stakeholder and residents newsletters. A range of approaches were taken to reach out to groups andindividuals from different ethnic backgrounds and communities across our five boroughs.

It should be noted that the Review took place during the COVID-19 pandemic, which restricted engagement interactions to online and telephone methods. Wherever possible, mitigations were put in place to enable and encourage people to take part; for example, by working with VCS groups to reach ethnic minority communities whose first languages are not English, and by providing interpreters at online events.

The numbers of people who took part in the engagement were relatively small, likely reflecting not only the challenges presented by the pandemic, but also the small numbers of people for whom this topic is relevant. Also important to note is that some stakeholders, such as local Healthwatch and local VCS groups, felt that it would be easier for residents and service users to provide feedback when the draft single policy is available. We also received feedback from groups that residents and members had engagement 'fatigue' due to both local (NHS and Local Authorities) and national (central Government departments) undertaking a wide range of engagement through the pandemic period.

However, good and detailed qualitative insights and data were collected. The majority of people who engaged during the Review stage were past or present service users, and were well-informed about policies and treatments available. Every opportunity was given to hear views from across the board and the survey did draw a very small number of comments from people who thought that fertility treatment should not be available on the NHS.

As well as sharing views on current and future policy, many participants also shared information about their own experiences of accessing local services, which are detailed below. NCL CCG is committed to using these insights, working collaboratively with our Providers and residents, to improve local commissioning decisions and service provision.

The following summary of findings draws out the themes from engagement activity undertaken in respect of the Fertility Policies Review. The key headlines are categorised under policy, service experience and other points.

Policy:

- Development of a single policy is welcomed and there is strong feeling the future policy should follow NICE guidance / level up, not down (for example, three full cycles offered and Intrauterine Insemination (IUI) support offered across all boroughs)
- Outdated terminology is used in policies (more inclusive language needed for LGBTQ+ community)
- The new policy eligibility criteria should consider:
    - previous child policy
    - exclusions of young women with low AMH levels
    - BMI in some circumstances (e.g. for African women)
    - clarity on donor assisted conception
- Clarity is needed around the policy, inclusion and exclusion criteria, permissible add-ins, and the treatment journey
- There should be equality of access for all, including same sex couples and single women
- The new policy should consider including surrogacy
- Questions were asked around honouring commitments to treatment: will people on

waiting list or part way through treatment be assured that they will get what they were expecting when policy changes?
- IUI should be offered for unexplained fertility before IVF, if women prefer

Service experience:
- Fertility treatment is considered a luxury, distress is not fully taken into account
- Ad hoc approach to male investigations. Male partners should be referred for tests beyond a sperm count earlier. There were long wait times for appointments, and referrals were only made when female partners were quite some way into the process
- The whole process needs streamlining, from referrals to waiting times, to reduce the delay
- Timescales and delays a common theme, including:
    - going through primary care to get a referral
    - timescales to qualify for referral (incl. referral time for male partners)
    - waiting times to get appointments
    - timescales between each stage of the fertility journey from referral to treatment
- Distress around operational elements – waiting rooms shared with maternity services (distressing when attending for fertility diagnostics, scans for miscarriage etc.)
- Access to psychological support should be available – mental health is a concern for people even prior to their first engagement with a GP, and throughout the whole process.
- Feedback was also received on mental health support (counselling) for women from Black, Asian and minority ethnic communities could be improved, related to pressures (from extended family) to conceive
- Impact of the pandemic: delays to access treatment, inability of partners to attend appointments

Other points:
- Improve training for GPs and others so they understand and communicate the new policy
- Are there ethnicity differences in fertility in women?
- A perceived lack of knowledge among healthcare professionals (including GPs) about the details of existing policies:
    - patients need to educate GPs about policies, tests, and treatments
    - GPs either did not know / misinterpreted details of their borough policy
- Risk that people from ethnic minority communities who live in NCL think the NHS is similar to the health provision in their country of origin, which means they could miss out on fertility support
- Requirement to have three miscarriages before investigations undertaken (distressing and delays timings for treatment)
- Fertility treatment is not a necessity and shouldn't be NHS funded. There are limited resourcesavailable for health care in general and huge backlogs for NHS treatment for life threatening and life changing conditions.

The views shared with the CCG through the engagement work as part of this Review were used to inform the development of recommendations for the future policy, which can be found in the Recommendations Report. Please note that a detailed set of recommendations are outlined on page 33 of the report. Learnings from this stage will also be used to develop and refine the Communications and Engagement Strategy for the next stage, commencing later this year. We anticipate that the engagement period for the second phase will begin in the autumn 2021.

It is important to note that a key success of the engagement undertaken to date has been the establishment of relationships with both local communities across NCL and colleagues at NHS providers and local authorities who can assist us in promoting the draft single fertility policy.

3. Review Recommendations

In summary the recommendations focus both on the policy itself, and on the way that it is communicated and disseminated to the key stakeholders, which include service users and clinicians.

Given that we are now a single CCG across NCL, and that we should be providing fair and equal access to treatments across the whole of our area, the review has reached the conclusion that a single fertility policy should be developed and adopted across NCL CCG.

The policy should be aligned to national considerations such as NICE guidelines and recommendations wherever this is feasible, to encourage consistency with the national approach, unless there are clear reasons why our population's needs are different. It is recommended the policy should address inequalities and issues of access to different population groups and to ensure there is fair access, based on the ability to benefit from the treatments offered.

The policy should be clearly written in language that is unambiguous to service users, clearly articulating the fertility pathway. A reading panel should be established to review the policy once it is drafted to support the policy's "readability".

In order to ensure the policy remains current, there should be regular review with clear timeframes established at the start.

The review found raising awareness and understanding of the future policy with residents is key, and there should be a robust communications plan around publication.

Equally important are primary care-facing communications and materials for acute hospital clinicians, with accompanying education sessions to raise awareness. In this way, all clinicians should be able to give a consistent message when communicating with residents who seek their advice.

Finally, the report acknowledges that cost will need to be taken into account when setting policy. It notes that investment in one area could redirect resources away from other areas, and therefore levels of funding do need to be balanced against those other areas and against the general resource envelope. Further modelling is taking place to understand the financial implications of changes to the policy under different scenarios.

4. Next Steps

Finally, the report acknowledges that cost will need to be taken into account when setting policy. It notes that investment in one area could redirect resources away from other areas, and therefore levels of funding do need to be balanced against those other areas and against the general resource envelope. Further modelling is taking place to understand the financial implications of changes to the policy under different scenarios.

The next steps, which are currently underway or in planning, are:

- Policy drafting
- Engagement on the single draft Policy
- Equality Impact Assessment
- Draft Single Policy to be presented at the November JHOSC meeting

The final output will be the single NCL Fertility Policy, with accompanying plans and materials to support the successful launch and implementation of the new policy. It is currently estimated that the single NCL Fertility Policy will be published in 2022.

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NCL Elective Recovery

JHOSC – November 2021

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Summary

During 2020 and 2021, the NHS has been put under unprecedented pressure, operating within a national level four or three incident, due to the pandemic. The health and care system in north central London (NCL) had to respond rapidly to this very challenging situation.

The second surge of the COVID-19 pandemic in winter 2020/21 was 25% higher than the first wave in April 2020 and, at its height, led to double the baseline number of critical care beds being used in North Central London (NCL). This again placed health and care services under significant pressure

For elective (planned) care has this meant that during some periods in the last eighteen months, we could only provide the most urgent elective care to patients. Throughout, we have worked collaboratively across NCL to ensure that we are providing elective care fairly and equitably, based upon clinical need and using available capacity as efficiently as possible.

As a result, we have experienced substantial increases to our waiting lists, with a large number of patients waiting more than 52 weeks for treatment. Robust plans are now in place support recovery of routine elective care across North Central London. Plans have been developed jointly by NCL's health and care organisations and we are using all available resources to reduce waiting times as quickly and as fairly as possible.

This report provides an overview of the approach employed by NCL system partners to recover elective care, explains how system partners worked together, developed innovative system solutions and key achievements that have been delivered as a result.

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Introduction

- Since the start of the Covid-19 pandemic, NCL like all other ICSs in England has faced considerable pressures on its elective services. At the time of writing this report, NCL acute and specialist providers have over 233,274 patients on their waiting lists, of which 11,938 patients have been waiting over 52 weeks and 416 over 104 weeks.
- The variability of covid hospitalisations coupled with other significant non-elective pressures and the efficiency loss from Infection, Prevention and Control (IPC) measures has meant that elective capacity has fluctuated from 40% to 95% of pre-pandemic levels.
- Under these challenging circumstances, NCL has still performed very well and has consistently been amongst the highest performing ICSs in London and nationally for elective performance. In addition, some other key successes from the past year have been:

North Central London
233,274 patient waits
416 104+ week waits
11,938 52+ week waits
28 weeks clearance time

The Royal Free
94,408 (40%) patient waits
335 (81%) 104+ week waits
8,931 (75%) 52+ week waits
76 weeks clearance time

UCLH
56,137 (24%) patient waits
63 (15%) 104+ week waits
1,969 (16%) 52+ week waits
23 weeks clearance time

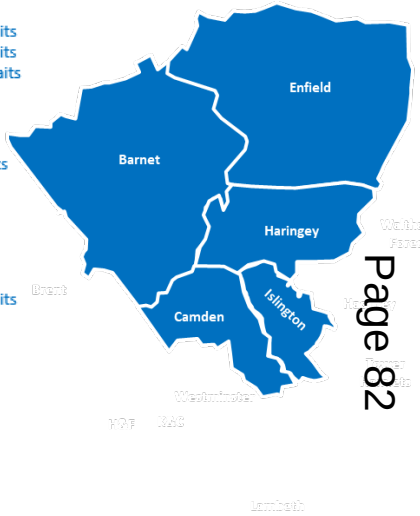
The Whittington
17,570 (8%) patient waits
0 (0%) 104+ week waits
576 (5%) 52+ week waits
17 weeks clearance time

NMUH
15,801 (7%) patient waits
8 (2%) 104+ week waits
77 (1%) 52+ week waits
16 weeks clearance time

Moorfields
35,723 (15%) patient waits
0 (0%) 104+ week waits
7 (0%) 52+ week waits
20 weeks clearance time

GOSH
7,069 (3%) patient waits
8 (2%) 104+ week waits
206 (2%) 52+ week waits
21 weeks clearance time

RNOH
6,566 (3%) patient waits
2 (0%) 104+ week waits
172 (1%) 52+ week waits
21 weeks clearance time



- Rapidly forming an effective governance structure to develop and oversee the elective recovery plan – allowing NCL to be the first ICS in London to restart all elective services following the first pandemic wave.
- Formulating six clinical networks for priority surgical specialities – with all six then implementing a consolidated surgical hub model for high volume / lower complexity procedures. Including opening of the new Grafton Way Building as a green elective site.
- Being nominated as one of the national 'Accelerator Systems' for elective recovery, bringing in significant investment to further bolster our recovery efforts.
- Development of a 'One System' patient tracking list (PTL) to allow a joined up view from across our system on the size, shape and characteristics of our waiting list – allowing better management of patients.

As we approach the end of H1, it is now the optimal time to consolidate our learning from the last year (both through the recovery programme and initial accelerator phase) to inform our medium to longer term elective recovery and transformation strategy.

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Our elective recovery mission and aims

Our mission is to treat as many patients in need of elective care, in the most expeditious time, safely, working together across our system adopting innovative models of care.

- We will achieve this mission through five inter-linking aims:

1	Support elective referrals to return to an 'optimised' level following significant suppression during the pandemic
2	Reduce the hidden level of clinical risk, inequality and inequity in our waiting lists
3	Maximise and optimise capacity to ensure cumulative backlogs for cancer, admitted/non-admitted cases and diagnostics decline
4	Reverse the trend in the number of 52 week / long waiters
5	Empowering Clinical Networks to drive change and allocate specialty accountability across the system

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Planning horizons for our strategy

- Our elective recovery and transformation strategy can be broken down into three planning horizons:

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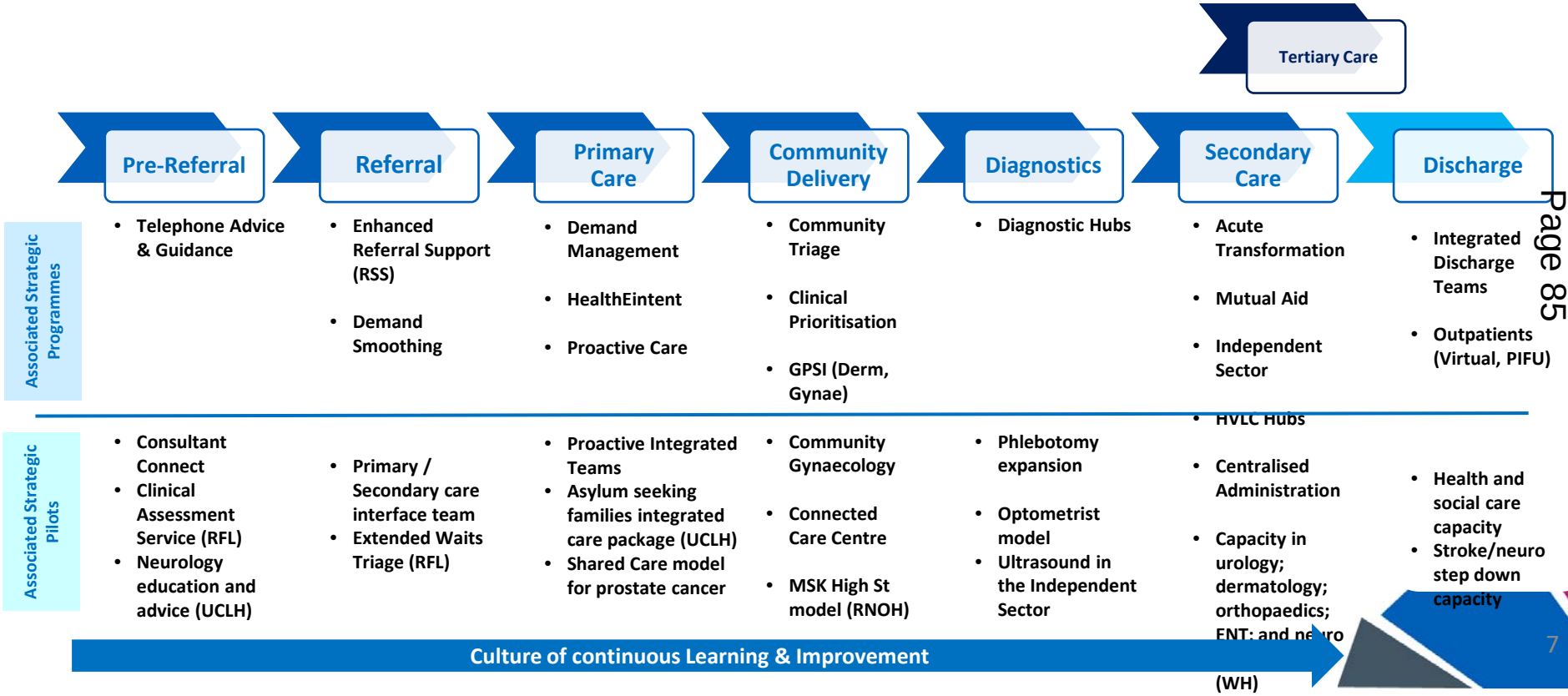
Strategic Pathway Mapping

The following diagram demonstrates how each stage of the patient pathway has a strategic programme or initiative aligned to deliver elective recovery supported by a continuous culture of learning and improvement;



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Strategic Recovery Programme Alignment

1. Support elective referrals to return to an 'optimised' level following significant suppression during the pandemic

- Telephone Advice & Guidance
- Enhanced Referral Support (RSS)
- Demand Smoothing
- Primary / Secondary care interface team
- Demand Management

2. Reduce the hidden level of clinical risk, inequality and inequity in our waiting lists

- HealthEintent
- Proactive Care
- Triage
- Prioritisation
- GPSI (Gynae, Derm)
- Community Gynaecology
- Connected Care Centre
- MSK High St model (RNOH)

3. Maximise and optimise capacity to ensure cumulative backlogs for cancer, admitted/non-admitted cases and diagnostics decline

- Diagnostic Hubs
- Phlebotomy expansion
- Ophthalmology referrals
- Mutual Aid
- Independent Sector
- Outpatients (Virtual, PIFU)

4. Reverse the trend in the number of 52 week / long waiters

- Acute Transformation
- HVLC Hubs
- Accelerator Pilot Programmes
- Centralised Administration Team

5. Empowering Clinical Networks to drive change and allocate specialty accountability across the system

- Additional Administration support
- Chief Exec Leadership
- OD Programme Development
- Integrated Discharge Teams

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System working and governance

In NCL we rapidly forming an effective governance structure to develop and oversee the elective recovery plan – allowing NCL to be the first ICS in London to restart all elective services following the first pandemic wave.
established cross system governance structures and ways of working that have allowed us to respond to changing demands and ensure we are able to recover as much elective capacity as possible.

Collaborative groups with representation across NCL's health and care system include:

- Senior leadership provided by **Clinical Advisory Group** (CAG) and **Operational Implementation Group** with representation from all acute NHS providers, both reporting into **NCL System Recovery Executive**
- **Clinical Prioritisation Group** – working to ensure prioritisation is fair and equal across NCL so that those with the most urgent needs are seen first
- Formulating **six clinical networks** for priority surgical specialities – ophthalmology, general surgery, urology, gynaecology, dermatology and Ear, Nose, Throat – with all six looking to implement a consolidated surgical hub model for high volume, lower complexity procedures.
- **NCL Cancer Alliance** – working to ensure urgent cancer treatments are prioritised fairly and equitably
- **Independent Sector oversight** – to maximise capacity within the independent sector
- **Elective Strategy Group** – established in summer 2021 to ensure a plan for short, medium and longer term elective recovery in NCL.

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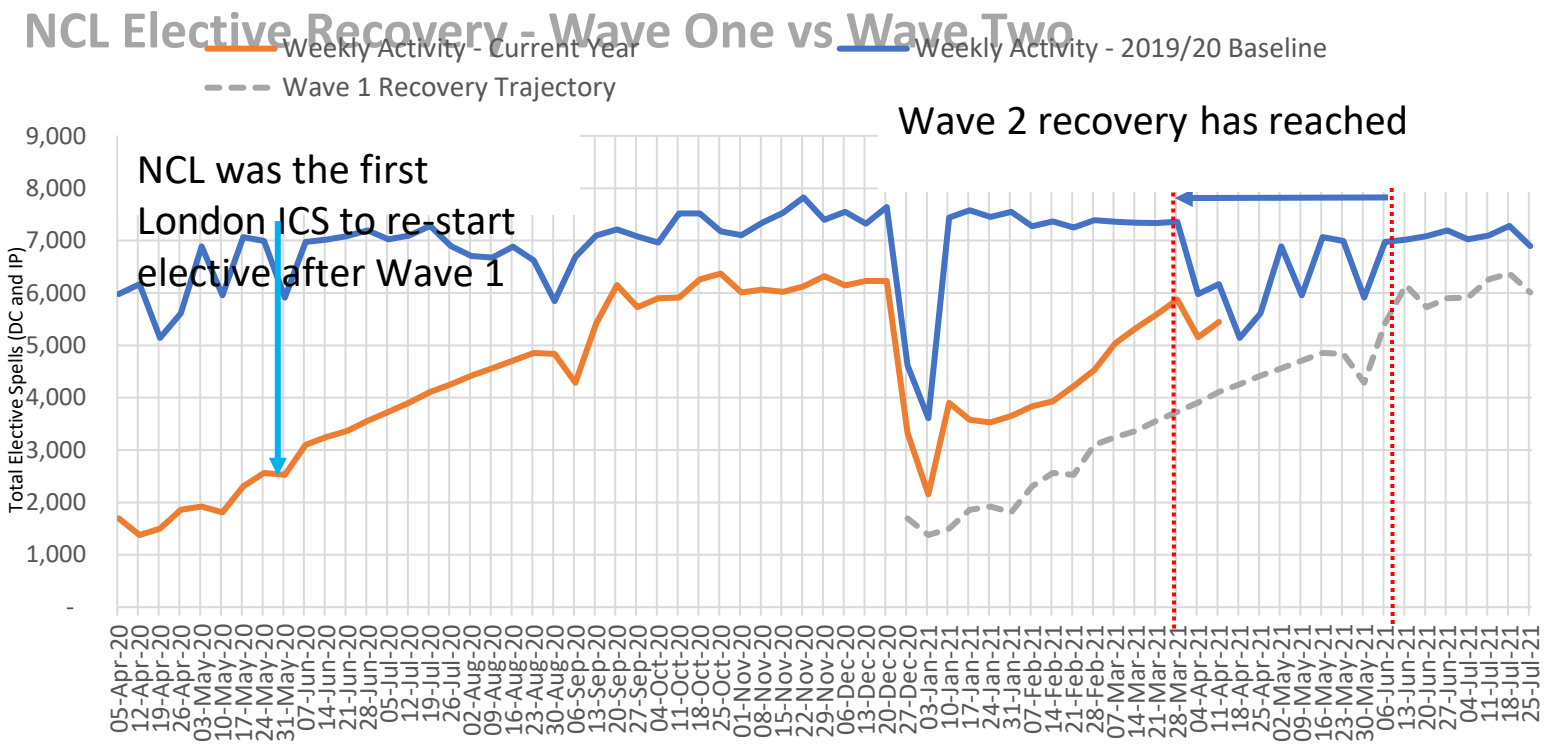
Recovery progress to date

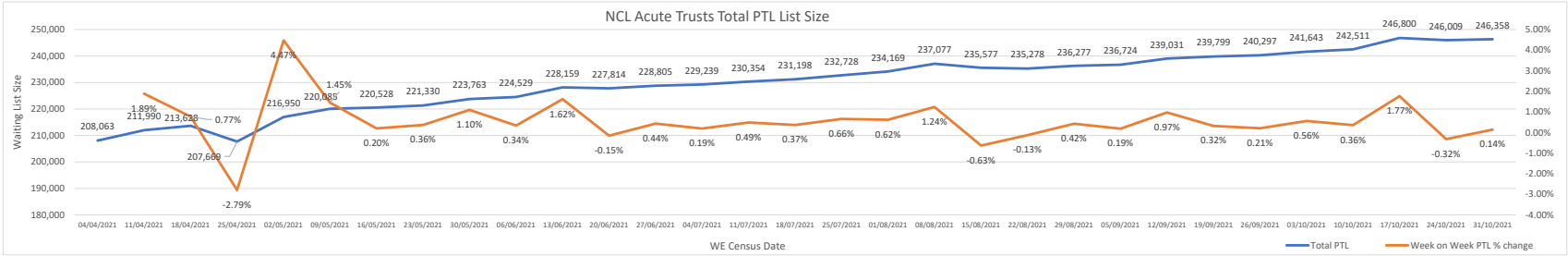


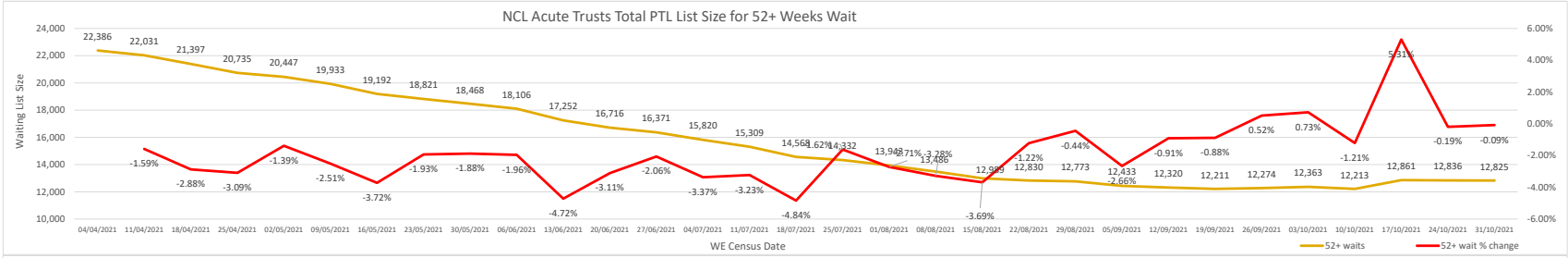
During the first wave of this pandemic, NCL proactively and rapidly set up an elective recovery programme built on the **principles of system wide collaboration, data driven decision making and addressing variation in care**.

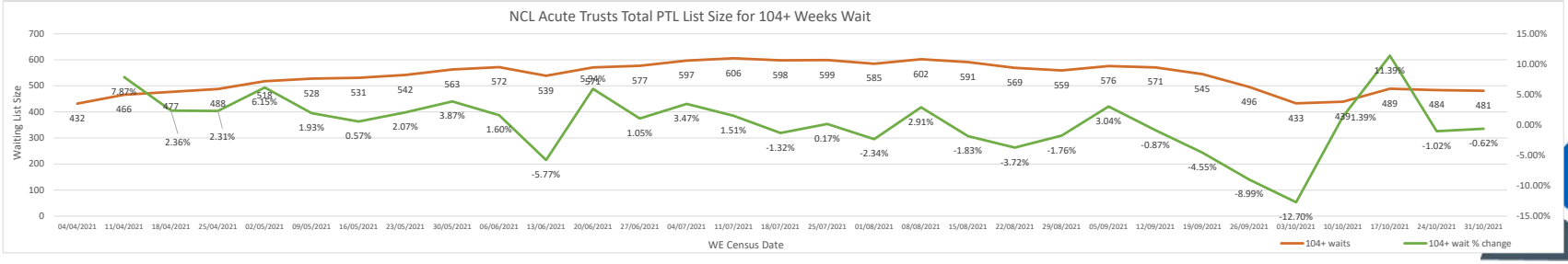
Our robust and thorough planning led to NCL being approved as the **first London ICS to restart elective work**.

Through our recovery programme and **mantra of continuous improvement** we applied a number of learnings from wave 1 recovery to our current recovery plan leading to a **10 weeks improvement in recovery pace**.

NCL RTT Waiting List Long Waits Trend







- Data is taken from the NCL RTT dataset as a weekly unvalidated snapshot and is subject to change.

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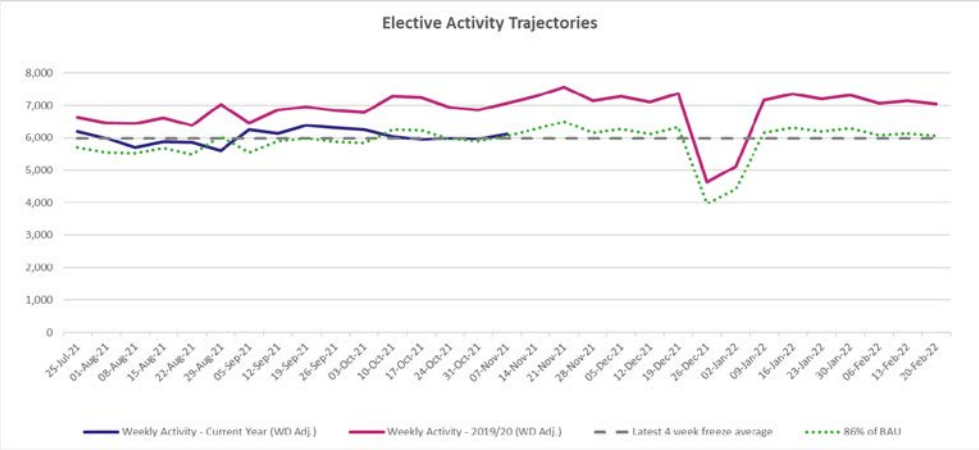
Recovery Trajectory – Elective inpatients

- Total Elective Inpatients

W/E	25-Jul-21	01-Aug-21	08-Aug-21	15-Aug-21	22-Aug-21	29-Aug-21	05-Sep-21	12-Sep-21	19-Sep-21	26-Sep-21	03-Oct-21	10-Oct-21	17-Oct-21	24-Oct-21	31-Oct-21	*flex* 07-Nov-21
Week No.	Wk_30	Wk_31	Wk_32	Wk_33	Wk_34	Wk_35	Wk_36	Wk_37	Wk_38	Wk_39	Wk_40	Wk_41	Wk_42	Wk_43	Wk_44	Wk_45
Weekly Activity - Current Year (WD Adj.)	6,200	5,979	5,698	5,880	5,847	5,601	6,253	6,144	6,378	6,305	6,250	6,039	5,946	5,991	5,976	6,117
Weekly Activity - 2019/20 (WD Adj.)	6,627	6,459	6,440	6,618	6,382	7,020	6,456	6,859	6,952	6,836	6,774	7,275	7,238	6,941	6,855	7,059
% of Baseline Year (2019/20)	**94%**	**93%**	**88%**	**89%**	**92%**	**80%**	**97%**	**90%**	**92%**	**92%**	**92%**	**83%**	**82%**	**86%**	**87%**	**87%**



- Elective activity recovered to an average of ***87%*** in the latest 4 weeks excluding the current flex position.
- The latest flex position shows a recovery of ***87%.***
- The latest freeze position, week 42, also is at ***87%*** of BAU.

*Public holidays have been adjusted for so that activity levels are more comparative for the current and baseline year 2019/20.
*RFL, no submission for the last 6 weeks, due to PAS/EPR upgrade. Assumptions applied from Weeks 40 onwards

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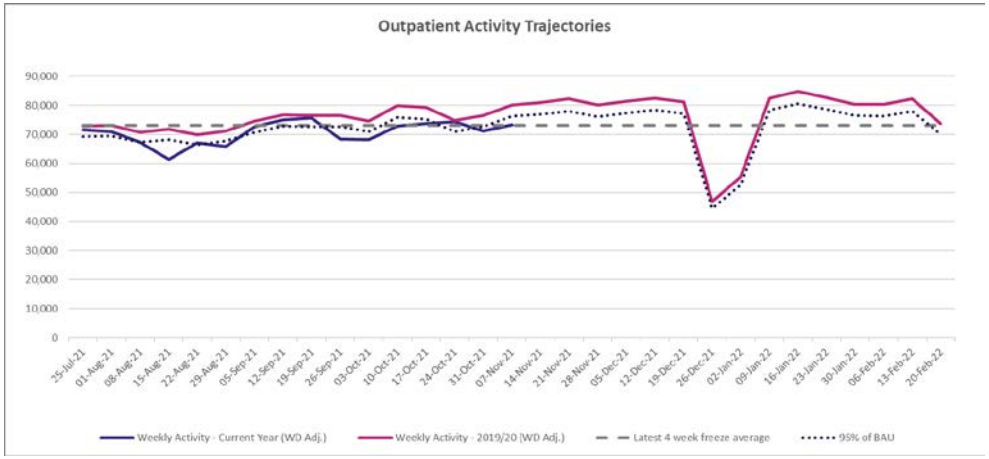
Recovery Trajectory – Outpatients

- Total Outpatients

W/E	25-Jul-21	01-Aug-21	08-Aug-21	15-Aug-21	22-Aug-21	29-Aug-21	05-Sep-21	12-Sep-21	19-Sep-21	26-Sep-21	03-Oct-21	10-Oct-21	17-Oct-21	24-Oct-21	31-Oct-21	*flex* 07-Nov-21
Week No.	Wk_30	Wk_31	Wk_32	Wk_33	Wk_34	Wk_35	Wk_36	Wk_37	Wk_38	Wk_39	Wk_40	Wk_41	Wk_42	Wk_43	Wk_44	Wk_45
Weekly Activity - Current Year (WD Adj.)	71,592	70,908	67,392	61,308	67,148	65,879	72,623	75,022	75,693	68,430	68,242	72,957	73,687	74,406	71,172	73,404
Weekly Activity - 2019/20 (WD Adj.)	72,797	73,196	70,838	71,843	69,914	71,240	74,570	76,758	76,527	76,515	74,645	79,860	79,255	74,762	76,527	80,219
% of Baseline Year (2019/20)	**98%**	**97%**	**95%**	**85%**	**96%**	**92%**	**97%**	**98%**	**99%**	**89%**	**91%**	**91%**	**93%**	**100%**	**93%**	**92%**



- Outpatient activity recovered to an average of ***94%*** in the latest 4 freeze weeks.
- The latest flex position shows a recovery of ***92%***.
- The latest freeze position, which is at ***93%***, is ***3% above*** the 4 week average activity levels.

*Public holidays have been adjusted for so that activity levels are more comparative for the current and baseline year 2019/20.

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Total Weekly Activity by Provider

Elective	25-Jul-21	01-Aug-21	08-Aug-21	15-Aug-21	22-Aug-21	29-Aug-21	05-Sep-21	12-Sep-21	19-Sep-21	26-Sep-21	03-Oct-21	10-Oct-21	17-Oct-21	24-Oct-21	31-Oct-21	*flex* 07-Nov-21	Vol as % of baseline year (2019/20) (4wks rolling excl. flex)		
Provider	Wk_30	Wk_31	Wk_32	Wk_33	Wk_34	Wk_35	Wk_36	Wk_37	Wk_38	Wk_39	Wk_40	Wk_41	Wk_42	Wk_43	Wk_44	Wk_45	Current Week	Prior Week	Change
GOSH	673	718	654	685	726	734	584	663	723	686	639	733	698	659	757	735	95%	93%	▲
MEH	633	604	524	562	527	576	460	649	619	667	636	612	635	675	695	677	89%	88%	▲
NMUH	496	500	485	425	478	469	479	578	646	624	684	674	599	611	611	638	84%	86%	▼
RFL	1,438	1,410	1,310	1,352	1,253	1,140	1,025	1,359	1,371	1,073	1,073	1,073	1,073	1,073	1,073	1,025	66%	65%	▲
RNOH	254	246	263	221	228	200	208	241	271	234	236	243	222	194	248	236	73%	71%	▲
UCLH	2,265	2,090	1,997	2,192	2,198	2,037	1,879	2,198	2,300	2,593	2,542	2,276	2,289	2,330	2,172	2,457	92%	98%	▼
WH	441	411	465	443	437	445	367	456	448	428	440	428	430	449	420	349	94%	94%	▼
Grand Total	**6,200**	**5,979**	**5,698**	**5,880**	**5,847**	**5,601**	**5,002**	**6,144**	**6,378**	**6,305**	**6,250**	**6,039**	**5,946**	**5,991**	**5,976**	**6,117**	**85%**	**86%**	▼

Outpatient	25-Jul-21	01-Aug-21	08-Aug-21	15-Aug-21	22-Aug-21	29-Aug-21	05-Sep-21	12-Sep-21	19-Sep-21	26-Sep-21	03-Oct-21	10-Oct-21	17-Oct-21	24-Oct-21	31-Oct-21	*flex* 07-Nov-21	Vol as % of baseline year (2019/20) (4wks rolling excl. flex)		
Provider	Wk_30	Wk_31	Wk_32	Wk_33	Wk_34	Wk_35	Wk_36	Wk_37	Wk_38	Wk_39	Wk_40	Wk_41	Wk_42	Wk_43	Wk_44	Wk_45	Current Week	Prior Week	Change
GOSH	3,559	3,182	3,350	3,208	3,201	3,313	2,808	3,650	3,834	3,637	3,564	3,871	4,101	3,506	3,626	3,807	112%	112%	▲
MEH	10,783	10,660	9,651	10,311	9,823	9,970	8,459	10,939	11,143	11,265	11,010	11,028	11,245	11,483	11,707	11,649	91%	91%	▲
NMUH	7,495	8,111	7,914	6,554	7,041	7,427	6,568	8,572	8,931	8,480	8,578	8,549	7,479	8,260	7,229	8,408	107%	111%	▼
RFL	17,329	16,605	16,086	16,525	15,962	15,022	13,380	17,735	17,910	15,498	15,498	15,498	15,498	15,498	15,498	14,808	73%	73%	▲
RNOH	1,814	1,819	1,674	1,822	1,729	1,619	1,549	1,914	1,687	1,946	1,772	2,000	1,934	1,829	1,762	1,539	85%	88%	▼
UCLH	25,537	25,176	23,709	17,472	24,187	23,489	20,874	26,409	26,131	22,001	21,759	25,952	27,997	27,788	25,495	27,929	108%	106%	▲
WH	5,075	5,355	5,008	5,416	5,205	5,039	4,460	5,803	6,057	5,603	6,061	6,059	5,433	6,042	5,855	5,264	93%	93%	▼
Grand Total	**71,592**	**70,908**	**67,392**	**61,308**	**67,148**	**65,879**	**58,098**	**75,022**	**75,693**	**68,430**	**68,242**	**72,957**	**73,687**	**74,406**	**71,172**	**73,404**	**94%**	**94%**	▲

- Total elective activity has ***decreased*** by ***1%*** in the current 4 week rolling average compared to the previous 4 weeks .
- Elective 4 week rolling average ***decreased*** by ***5%*** at UCLH and by ***2%*** at NMUH in the current week.
- Total outpatient activity 4 week rolling average ***increased*** by ***0.4%***.
- UCLH outpatient activity increased ***2.5%,*** NMUH decreased ***4.8%*** and RNOH also decreased ***2.8%*** against the previous 4 weeks.

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Total weekly elective and day case activity by specialty

	25-Jul-21	01-Aug-21	08-Aug-21	15-Aug-21	22-Aug-21	29-Aug-21	05-Sep-21	12-Sep-21	19-Sep-21	26-Sep-21	03-Oct-21	10-Oct-21	17-Oct-21	24-Oct-21	31-Oct-21	*flex* 07-Nov-21	Vol as % of baseline year (2019/20) (4wks rolling excl. flex)		
Specialty	Wk_30	Wk_31	Wk_32	Wk_33	Wk_34	Wk_35	Wk_36	Wk_37	Wk_38	Wk_39	Wk_40	Wk_41	Wk_42	Wk_43	Wk_44	Wk_45	**Current Week**	**Prior Week**	**Change**
ENT	114	100	102	115	100	93	60	112	80	96	103	108	115	108	98	96	80%	81%	▼
General Surgery	104	126	102	100	96	84	81	96	106	88	90	96	91	96	84	66	64%	65%	▼
Gynaecology	162	130	102	119	125	110	96	131	152	97	103	107	103	101	104	91	69%	67%	▲
Ophthalmology	791	722	668	711	672	716	551	783	772	823	766	770	770	811	855	828	85%	83%	▲
Trauma & Orthopaedics	407	360	377	340	353	318	343	397	437	362	401	380	384	329	368	370	89%	89%	▼
Urology	284	267	233	273	265	232	200	288	324	326	329	295	320	325	323	273	97%	94%	▲
Cardiology	78	79	57	59	56	50	61	83	88	74	82	75	101	75	76	82	119%	130%	▼
Clinical Haematology	647	635	675	659	675	630	557	669	667	789	742	632	686	691	665	729	91%	93%	▼
Clinical Oncology	114	127	109	116	139	129	130	141	163	148	136	149	142	139	150	143	91%	90%	▲
Colorectal Surgery	182	175	185	177	152	155	115	184	181	123	119	125	121	119	120	113	54%	57%	▼
Gastroenterology	708	734	718	755	703	686	683	748	813	754	753	721	732	689	647	707	80%	83%	▼
General Medicine	11	7	13	10	10	7	6	11	12	4	4	4	3	3	4	3	58%	54%	▲
Medical Oncology	423	368	411	399	375	357	328	389	403	455	428	434	370	431	405	355	124%	123%	▲
Neurology	280	209	183	243	293	245	245	305	303	312	267	262	235	258	202	331	120%	122%	▼
Neurosurgery	36	26	32	20	35	23	28	18	41	36	49	36	40	32	37	47	95%	103%	▼
All Paediatric TFCs	171	174	159	147	157	133	136	166	165	143	176	179	142	165	174	180	73%	75%	▼
All Other	1,688	1,740	1,572	1,637	1,641	1,633	1,382	1,623	1,671	1,675	1,702	1,666	1,591	1,619	1,664	1,703	77%	80%	▼
HVLC Total	***1,862***	***1,705***	***1,584***	***1,658***	***1,611***	***1,553***	***1,331***	***1,807***	***1,871***	***1,792***	***1,792***	***1,756***	***1,783***	***1,770***	***1,832***	***1,724***	*85%*	*83%*	▲
Grand Total	**6,200**	**5,979**	**5,698**	**5,880**	**5,847**	**5,601**	**5,002**	**6,144**	**6,378**	**6,305**	**6,250**	**6,039**	**5,946**	**5,991**	**5,976**	**6,117**	**85%**	**86%**	▼

- Majority of the specialties have decreased in elective activity on the 4 week rolling averages.
- Cardiology **decreased** by ***11%***.
- Neurosurgery decreased by ***7%.***
- Paediatric TFCs ***decreased*** by a total of ***1.4%***.
- HVLC specialities as a whole ***increased*** outpatient activity by ***1%***.

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Strategic Pilots – Accelerator Schemes

- NCL launched the Accelerated Elective Recovery (AER) Programme in June 2021. £20m was available to fund schemes that could increase the volume and efficiency of elective activity in NCL. 46 bids were approved and aligned to the key aims of elective recovery. Highlights include:

Consultant Connect: Expanding the telephone advice and guidance service for GPs to cover all of NCL. Initial activity in Barnet and Enfield led to a 60% reduction in referrals or admissions. Latest data showing similar levels of outcomes.

Community Gynae: 3 community gynae providers in NCL triaging non-admitted gynae patients, communicating with patients and transferring care where appropriate.

Day Case Hub: This has been developed in Whittington Hospital and supporting capacity across NCL. In 8 weeks it has improved theatre utilisation by 6% and increased overall elective activity to 104% of baseline.

Interface Programme: 7 workstreams developed to tackle interface issues between primary and secondary care including secondary care links to community pharmacy; developing the NCL Referral Support Service; and regular communication on changes.

Phlebotomy Expansion: Over 13k bleeds/week were being delivered through increased community provision of phlebotomy services before the blood bottle shortage.

Waiting List Dashboard: Creation of a public facing dashboard incorporating a range of waiting time metrics to enable patients to make informed choices.

Triage Bids: 3 programmes being piloted to review non-admitted patients: Extended Waits will review 6000 ENT patients at RFL; Connected Care will provide a dedicated 'one team' multidisciplinary personalised initial management centre; Proactive Integration Teams will offer MDT support in the community

Transforming Admin: RFL and NHS SBS developing a centre of excellence model for admin, from referral to outcome. Creating a 20% improvement in capacity through decreased first to follow up; reducing DNAs; reducing cancellations and improving clinic utilisation.

IDT Capacity: Additional capacity for the collaborative approach to discharge delivering a sustained reduction in overall Length of Stay and Stranded Patients at hospital. Currently delivering 52% same day discharges.

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Communication on elective recovery

- Developing communications materials with clinical networks to reassure patients on waiting list. For example all orthopaedic patients on waiting lists across NCL sent a letter apologising for wait, explaining what patients can do in the meantime to manage their condition, signposting helpful resources and providing a contact should they need to talk to their surgical team
- We have provided information for referrers (GPs and other health and care professionals), including information on indicative waiting times for first appointments, so that they can have informed conversations with patients both when making a referral and when a patient has questions about their care
- When we offer patients the option of attending a different location to receive care to reduce waiting times, patients are either contacted by letter or by phone. A standard telephone script is used when contacting patients, and this provides information and explains why a different location may be offered. The aim is to provide as much information as possible so that patients can make an informed decision about their care
- We provide regular information on elective recovery with our senior stakeholders through NCL's system update. We have also shared information via NCL's residents' newsletter which goes to a large list of voluntary and community sector organisations to share with their contacts.
- We have worked with trusts to share some proactive media stories – The Times (September), The Guardian (September), BBC News (September)

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Single waiting list – using Healtheintent to assess equity and equal access

All analysis is either for NCL's 'responsible population' (patients who are GP registered in NCL) or the whole Patient Treatment List (PTL - patients on NCL providers waiting lists)

Are people receiving equal access to care for equal need once they are on the waiting list?	Is there equal access to elective care in the first place (NCL only)?
Population denominator = people on the PTL / open pathways	Population denominator = NCL GP registered population

Median waiting times (days)
% of pathways 18+, 52+, 78+ weeks
By gender, age, deprivation, ethnicity
Also serious mental health illness, learning disabilities, dementia and long term conditions

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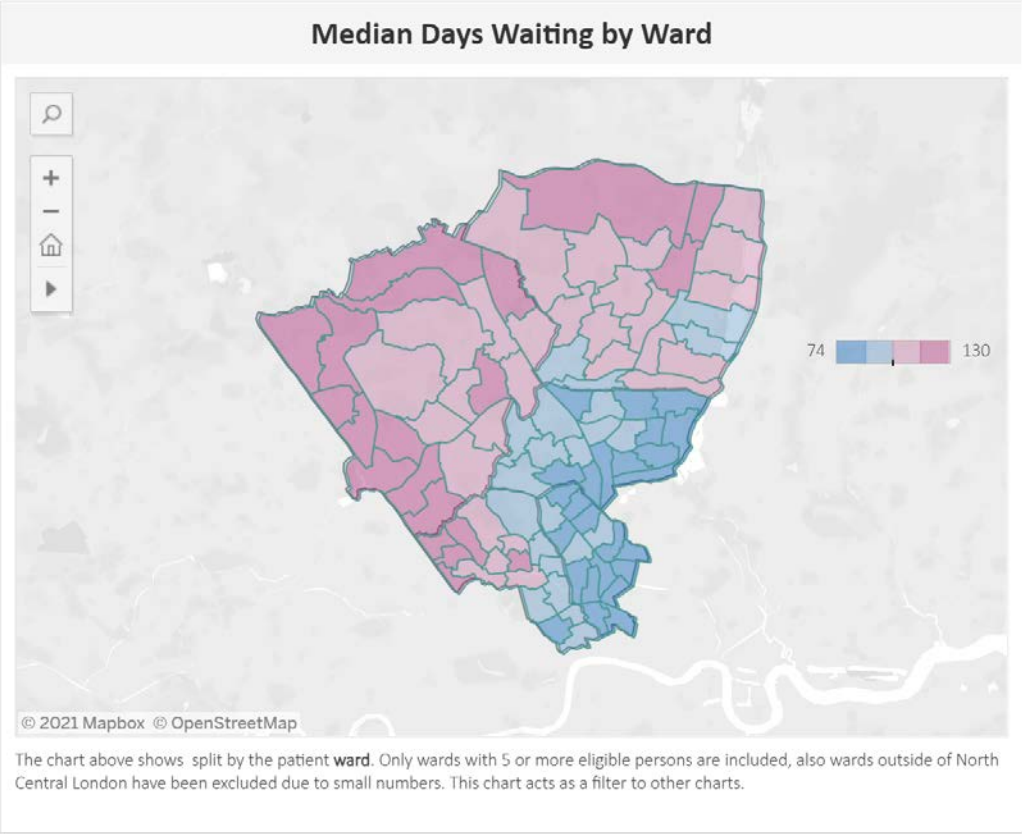
ON THE PTL (NCL pop'n): there are differences by deprivation in waiting times: those living in the *least* deprived areas wait 15 days longer on average for care



More people from most deprived communities on the PTL (22,000 vs. 10,000 least deprived).

Median wait
Most deprived = 99 days
Least deprived = 114 days

At ward level there is 50 day difference, on average, in waiting times between some areas.

Royal Free longer waiting times will be skewing the gradient – longer waits (133 days) compared to providers who have more deprived populations (North Mids 71 days), and because 55% of waiting list (NCL pop'n, 42% whole PTL) at RF.

People with SMI – average wait is 110 days
People with LD – average wait is 104 days

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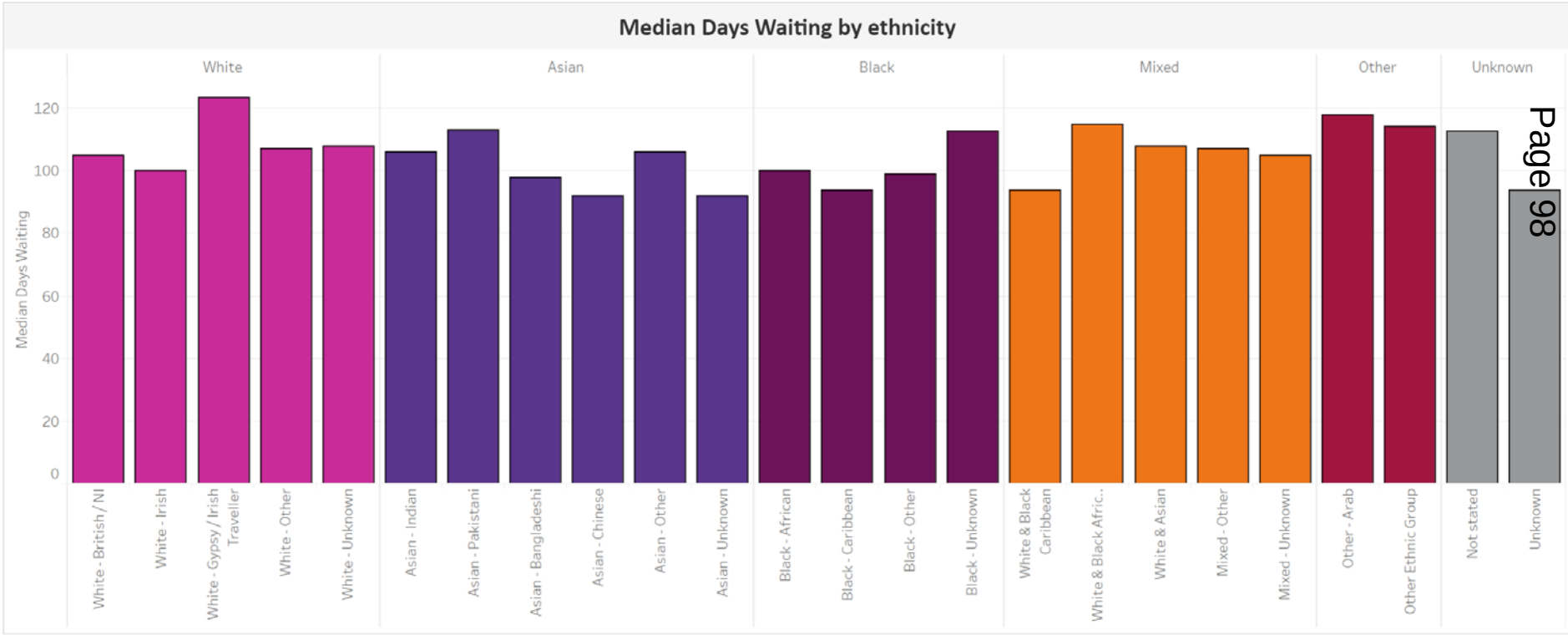
ON THE PTL (whole PTL): there is no difference in the length of time that Black, Asian or minority ethnic groups (101 days) wait compared to the average (101 days). The White Gypsy, Irish Traveller community consistently waits longer, but numbers are small.



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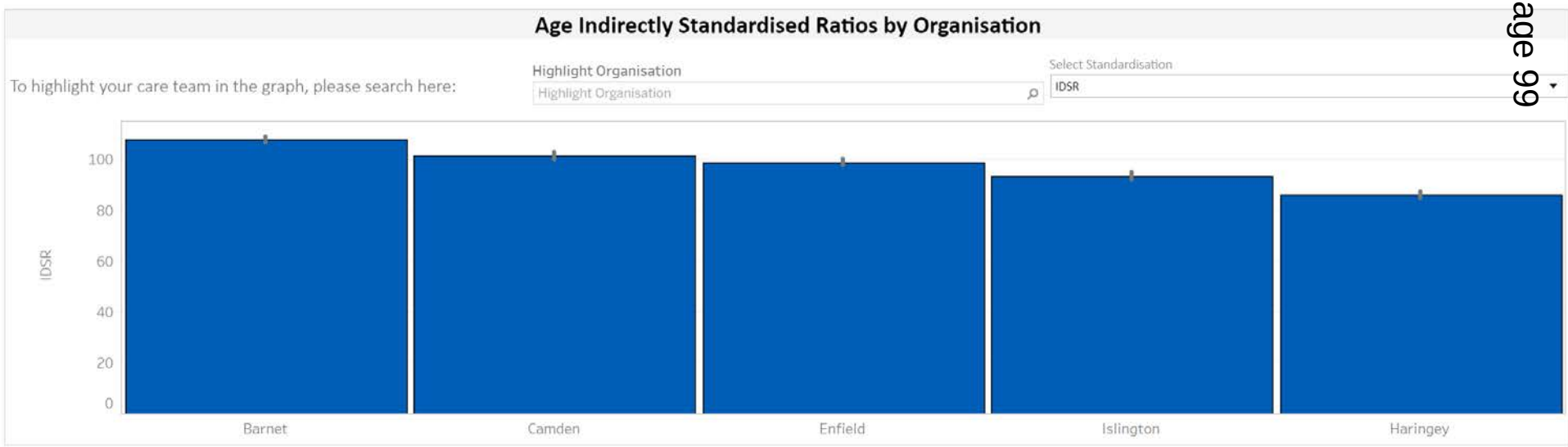
GETTING ON TO THE PTL: there are fewer patients than expected on the PTL from the more deprived boroughs in NCL, and more from Barnet. Needs to be interpreted alongside emergency care too.

% more people on the PTL than expected:
Barnet: +8%, Camden no difference, Enfield -1%, Islington -7%, Haringey -14%



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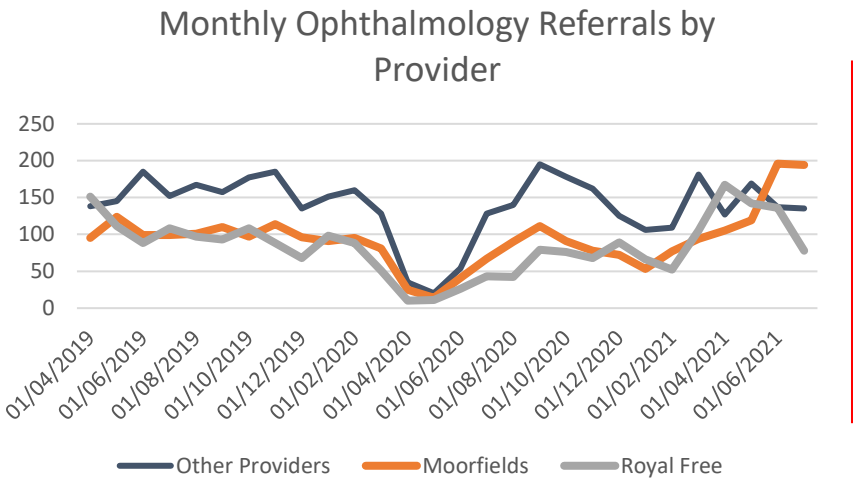
Single waiting list – findings

- At a system level, on average and aside from the differences in waits by provider, the median day wait on waiting lists appear to be reasonably equitable (i.e. equal access for equal need). There are no clear patterns in waits by ethnicity or deprivation by specialty, provider or borough that are not explainable by underlying populations and patient complexity. Any differences in medians are relatively small – are they materially different?
- All analysis is impacted by the longer waits and larger numbers of people at Royal Free.
- As providers work to reducing waiting times, inequities by ethnicity and deprivation may arise so NCL will monitor trends in HealtheIntent.
- There may be some inequities in who gets onto the waiting list in the first place with the most deprived boroughs having a lower than expected percentage of patients on the waiting list. This will be impacted by the Royal Free. Understanding whether there are issues with access to elective care needs to be done within a wider context of demographics, burden of ill health, primary and community care, and emergency care within different communities.
- **It is difficult to make any clear recommendations for action on equity by ethnicity and deprivation on the waiting list in NCL. Inequities in other parts of the health and care system and associated outcomes are far larger, and NCL is already focussing on or building up programmes of work to reduce these.**

What have we achieved to date?

Ophthalmology

- We first introduced a demand smoothing for Ophthalmology in May 21; as well as starting a mutual aid programme between RFL and Moorfields for 500 cataract patients. We also supported RFL in putting on more capacity at its Edgware HVLC hub.
- These interventions have had a significant impact with the RFL admitted clearance time almost halving over the summer and coming into line with the sector average.
- However we are now looking to go further with the non-admitted backlog given the recent rise in overall referrals – and are looking at ways MEH can support the sector to work through the backlog faster.
- From when demand smoothing went live we have seen RFL referrals halve and Moorfields referrals almost double which has supported the balancing of waiting lists across our sector.



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What have we achieved to date?

Gynecology

- **Community gynae service –** now mobilised to work through acute non-admitted backlog with a target reduction of 25% of our gynae P4s across the sector. Looking to embed this as more substantive part of gynae provision across NCL

- **High volumne, low complexity hub piloted**– first pilot session run successfully on 18 September at Chase Farm and saw around 80 patients – now looking to regularly schedule lists in and improve throughput. Patient feedback largely positive:

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What have we achieved to date?

Orthopaedics

- Mutual aid from RFL sending ~100 hand and wrist referrals of patients that have not yet been seen to UCLH/Whittington Health
- Capacity alert to be implemented on foot and ankle services highlighting long waits given volume of patients +52 weeks
- Re-direction of some of hip and knee referrals that have not yet been seen to other providers in the sector
- Implement capacity alert highlighting long wait times for RFL shoulder and elbow service
- Capacity alert placed on RFL paediatric service directing patients towards RNOH
- Opening of the new Grafton Way Building as a green elective site with more orthopaedic capacity

Ear, Nose Throat

- **Insourcing**: RFL and WH started July (>150 per week); UCLH to start September; review fortnightly via ops sub group
- **Outsourcing:** Oral Surgery to Wellington allows ENT parallel lists in GWB; General ENT @ Wellington too
- **Staffing**: Four new staff at RFL; UCLH recruiting a further 4 Consultants and 4 ENT Doctors (ERF); staff to be flexed across NCL, and utilise sessions @ Wellington
- **Mutual Aid:** GOSH to support Paediatric patients
- **Community & Primary Care**: tele-otology up and running in Enfield; RFL to work with Barnet (Oct/Nov start); other boroughs to follow
- **Triaging:** RFL working with Islington GP federation on establishing a local service to review >1000 ENT referrals

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What have we achieved to date?

Community Diagnostic Centres

Additional diagnostic capacity has been established at Finchley Memorial Hospital, hosted by Royal Free London, as one of London's flagship Community Diagnostic Centres. Additional facilities are also planned at Wood Green Shopping Centre, hosted by Whittington Health NHS Trust, and due to open in Spring 2022.

The new centres will be available for all residents in north central London, and aim to:

- contribute to improvements in population health outcomes
- increase overall diagnostic capacity
- improve productivity and efficiency, whilst helping to relieve pressure on outpatient referrals and attendances at acute hospitals
- contribute to reducing health inequalities
- support easier access closer to home for residents and a better, more personalised patient experience
- support integration of care across primary, community and secondary care

For some patients this may mean diagnostic tests may be delivered in different places to where they may have had them before. Where this is the case we will ensure that invite letters contain clear information and contact details.

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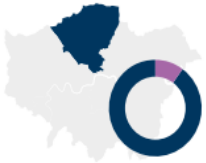
North Central London's Accelerated Elective Recovery Programme

Learning summary, October 2021

Background

In early 2021, North Central London (NCL) Integrated Care System (ICS) was appointed as one of the national Accelerator Systems for elective recovery, which aims to address the backlog of patients on the waitlist as a result of services closed or reduced in the early waves of the COVID-19 pandemic.



In May 2021 there were 211,756 patients waiting for elective care in NCL.

20,259 had waited more than 52 weeks.

The ICS set an ambitious trajectory to increase capacity 110% of baseline delivery by the end of July 2021, through the delivery of 5 interventions:

1. **Extended hours**
2. **Outsourcing within the NHS**
3. **Use of the Independent Sector**
4. **Demand management capabilities**
5. **One system Patient Tracking List (PTL)**

UCLPartners worked as a learning partner to the NCL team, adopting a learning health system methodology. Activities included:

Site visits | **Interviews** | **Data analysis**

UCLPartners

Findings

Recommendations

Patient perspectives

Reflections on the impact of the programme on patient experience.

- Efforts were made to support patients to make **informed decisions** around their treatment options, such as alternative treatment centres, independent sector, or delaying care
- There was **hesitancy to change** hospital provider once patients were on the secondary care pathway
- **Continuity of care** is an important consideration

- **Continuity of care** – Consider the wider impact on patients of moving between providers on pathway of care
- **Communications strategy** – Increase the consistency of communication content and channels used
- **Embed patient feedback** – Collect more data on patient experience, directly from patients and their families, through multiple channels

Staff perspectives

Reflections on staff experience, the benefits and challenges of new ways of working.

- Aligning around a **common goal** created commitment
- Staff exhaustion is highly prevalent in certain staff groups, managers are attempting to **prioritise staff wellbeing**
- There was increased **burden on administrative staff**

- **Staff wellbeing** – How to address sustainability and **burn out concerns**, informed by embedded insights from staff and job plan review
- **Administrative support** – Potential solutions highlighted include: a centralised administration team within the ICS, digital solutions to streamline processes, development of common tools and approaches
- **Communications strategy** – To widen awareness of the programme, increase engagement and levels of buy in for the different interventions

New ways of working

Reflections on processes and pathways put in place or adapted to support the programme.

- **Collaboration within and between organisations**
- The **complexity of cases and patient choice** impacted the utilisation of the independent sector
- The **tight timescale** of the programme added pressure to the system and staff

- **Whole system response** – Ensure organisations are willing and able to ask for help, automate thresholds at which demand smoothing or mutual aid will be required and actioned
- **Best use of data** – Develop a clear plan for different stakeholders' use of the data (PTL) platform, use whole system metrics to reinforce common goals
- **Service consolidation** – Identify opportunities for service consolidation where centralising on one site can bring operational and outcomes benefit
- **Independent Sector utilisation** – Understand where they can have greatest value

Wider Refelections

How should the programme best mitigate widening **inequalities** of access and in post referral management?

Implementation within the context of the **whole pathway** – What impact does increasing capacity have on follow ups, rehabilitation and follow on care?

Produced in collaboration with: North London Partners • Great Ormond Street Hospital for Children NHS Foundation Trust • Highgate Hospital • Moorfields eye Hospital NHS Foundation Trust • North Middlesex University Hospital NHS Trust • Royal Free London NHS Foundation Trust • Royal National Orthopaedic Hospital NHS Trust University College London Hospitals NHS Foundation Trust • Whittington Health NHS Trust. • UCLPartners

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Findings - internal audit on recovery, Nov 21

Positive Controls were found in:

- NHSE Planning Guidance alignment
- Setting out a Spring Elective Recovery Plan
- Process for clinical prioritisation of waits
- Process for clinical harm reviews
- Ensuring Equality as part of Waiting Lists
- Oversight and Assurance of Waiting Lists
- Undertaking Provider waiting list validations
- Transformation to services and implementing long-term change
- Implementing good practice

Two management actions were recommended:

- A comms and engagement plan will be developed to manage the anxiety of patients on the elective waiting list who may convert into urgent care attendances and communicate progress to wider stakeholders.
- The CCG will increase awareness of the HealtheIntent system and promote the system capabilities across NCL to help with data sharing.

In response NCL has set plans bi-weekly meetings have been initiated with NCL communication leads to develop and communicate key messages on elective recovery. The CCG is starting to publish waiting time data on the GP Website to support GPs with their referral discussions with patients. An NCL Accelerator bid is developing real time data on elective waiting times on a public facing website to manage expectations and help with comms and engagement.

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NCL Winter Plan 2021/22
Joint Health Overview and Scrutiny Committee
Friday 26 November 2021

Agenda Item 9

Introduction

Our plans for winter 2021/22 are set in the context of:

- Current levels of hospitalisation (due to COVID-19) expected to continue until the end of December 2021. In acute hospitals, Covid-positive patients occupying 2 to 3 wards and one-third of ICU beds.
- Development and use of robust mutual aid plans (including for the elective recovery programme and supporting escalation triggers in response to the pandemic) will support the response to winter planning.
- Service developments during the year have provided additional winter capacity.
- Particular focus on areas with poor patient experience including plans to reduce ambulance handover delays and reduce long waits for mental health patients in acute emergency care pathways.
- Continuation of the Think 111 First programme to stream non-urgent patients away from urgent care to more appropriate care settings – supported by national campaign and significant local activity.
- Pressures on urgent and emergency care (UEC) systems in primary and secondary care – with primary care appointments and emergency department (ED) attendances above pre-pandemic levels. The NCL system has agreed a series of actions to address these pressures including supporting Children & Young People (CYP) through:
    - early clinical triage and remote monitoring to help reduce emergency department attendances
    - boosting ED front door triage and refreshing streaming/redirection models.
- Capacity will be supported by mutual use of 239 community beds across NCL and the admission avoidance schemes in place including rapid response.

Service developments to support Winter 2021/22

New additional measures will be in place to help mitigate pressures in the system.

- Expanding the Rapid Response team to support achievement of the 2-hour Urgent Crisis Response minimum standard.
- Investment in Enhanced Health and Care Homes (targeted in priority areas) to reduce inequity in service provision. All care homes in Barnet and Enfield will receive community in-reach for the first time.
- Integrated Discharge Teams (IDT) now established at each acute hospital to help improve the flow of patients out of hospital beds and maintain bed capacity across the system. These will remain in place throughout winter.
- To support the IDT function, there is a well-developed weekly NCL-wide Multi Agency Discharge Event (MADE). The group helps with expediting discharges and simplify complex discharge processes. These will be utilised throughout winter to help resolve complex discharge issues.
- Well developed mutual aid plans with escalation triggers agreed by providers in response to the COVID-19 pandemic and to balance managing winter pressures.
- Refined Governance structure, surge plans and capacity escalation process to oversee and support the system. System oversight through UEC Operational Group.

Mental Health Winter Actions

Alternatives to A&E

- Service for those without a medical need now available across NCL.
- 24 hour crisis line for all ages.
- Five crisis cafes across NCL providing easy access 7 days a week outside of core hours of mental health services offering a range of support both digitally and face-to-face.
- Direct walk-in access with known patients, improve timeliness of conveyance from EDs to Mental Health Clinical Assessment Service (MHCAS) and ensure all non-medical/mental health LAS conveyances are directed to MHCAS.
- Development of an NCL Crisis-Single Point of Access and linking with 111 work and perhaps the MH Ambulance.
- Crisis response times are 1hr emergency, 4hrs urgent, 24hrs routine.
- A Paediatric MH Liaison provision in all acutes mainly focused on wards.
- NCL CAMHS Crisis Service is available to see CYP who present with urgent and emergency mental health needs in the five NCL A&E sites in a timely and defined manner between 12pm and midnight daily. Out of hours psychiatry is available to respond 5pm – 9am.
- Crisis Hubs offers support and assessment for CYP outside of A&E departments 9am-midnight, 7 days per week.

Mental Health Winter Actions

Accelerated Discharge

- With engagement from social care so that there are no delays to discharging mental health patients.
- All Patient Flow initiatives will continue to maintain focus on reducing length of stay, Pre- Delayed Transfer of Care, Delayed Transfer of Care and maintaining prevention of admission activity.
- Multi Agency Discharge Event (MADE) and Super MADE (expanded MADE that includes LA and commissioning partners) continue to impact positively on the number of occupied bed days for patients with complex needs.
- Social care is delivered by Camden and Islington NHS Foundation Trust via s75 arrangements with both Camden and Islington local authorities.
- Investment in support workers for accommodation pathways is enabling a more efficient movement out of hospital for homeless patients and foreign nationals returning to home countries.
- Multidisciplinary team working to improve flow and free capacity locally for our patients and avoid delays, by working with system partners via scheduled weekly Delayed Transfer of Care, and daily monitoring of medically fit for discharge patients with Executive and Senior Management support via ‘Grand Rounds’.

Mental Health Winter Actions

Accelerated Discharge (continued)

- Additional funding used to secure capacity; 2 x step-down beds. Work underway to agree Floating Enablement Support with the Local Authorities, as well as Discharge to Assess pathway pilot to expedite discharge pathways which can be bolstered should this be required.
- Discharge Facilitation Team, closely aligned to bed management team and staffed with one senior social worker per borough and third sector partners to expedite accommodation pathway issues.

Surge Planning

- To ensure bed modelling is being carried out locally, considering impact of any increased demand and surge plans are in place – commissioning from private sector, opening closed wards or managing through enhanced community input

Primary Care Capacity – Actions to Support Winter

- All practices complete fortnightly survey (SITREP) to provide feedback on:
  - current demand and capacity
  - specific pressures or emerging trends in increased patient presentations
  - whether doors are open, with planned follow up of targeted primary-care specific infection prevention and control (IPC), for any practices with concerns relating to provision of face-to-face care
  - long and short term support required to continue to deliver business as usual primary care.
- Practices that request support are contacted by a CCG clinical lead to discuss their needs and system-wide response to support primary care identified.
- Follow-up support is offered to any practices who identify that they are not able to offer sufficient capacity in any area, including provision of face-to-face appointments. Our primary care dashboard allows us to understand variation between practices, and offer support where required.
- Development of a primary care activity dashboard to bring together primary care datasets (including workforce), into a single place to allow both a strategic “at a glance” view of primary care demand, capacity and activity, and practice-level data to allow CCG teams to offer proactive support to practices where this would be useful.

Primary Care Capacity – Actions to Support Winter

- Latest appointment data shows that capacity in routine primary care is now above pre-pandemic levels (2021 compared to 2019 data). Aggregated to NCL CCG level, 50% of appointments are face-to-face.
- Primary care dashboard will shortly provide this data at practice level. Reduction in capacity or critical gaps will be identified and acted on early through the SITREP process.
- Work underway to develop primary care-specific comms, to provide information on accessing services to patients. Initial discussions have taken place with Healthwatch to scope deliberative enquiry piece with members of the public on the model of primary care, particularly given current and anticipated system pressures and use of Total Triage.

London Ambulance Service winter pressures

- London Ambulance Service has been experiencing significant demand and pressures on our 111 and 999 services this year.
- For LAS our winter has arrived early, with June, July, August, September and October being some of the busiest months we have ever experienced in our history.
- Since the start of the summer LAS has been consistently receiving more than 6,000 999 calls every day, and on some busier days that has risen to more than 7,000 calls. Before the pandemic, a usual busy day would be around 5,500 calls.
- We are anticipating this winter to be our most challenging yet, which is why we are developing a plan to maintain service delivery through the period of peak winter pressures and to ensure that we can provide high quality care to patients when they need us.
- We are planning to respond to and manage demand this winter in a variety of ways. This includes measures to secure 999 and 111 call answering resilience and resource availability, and to mobilise additional patient facing resources. We are also making a sustained effort to support our staff and volunteers during these busy times.
- As we approach what will be a busy winter while we are already experiencing high demand, we're asking Londoners to use us wisely and help us to help them.

Reducing delays for ambulance patient handovers

- Reduction in delays to ambulance handover of patients is an area of focus in relation to poor patient experience and remains a high priority for this winter. Some measures are outlined below:
  - All Emergency Departments (EDs) have agreed handover plans that include clarification of the clinician responsible for the patients waiting to be handed over within the Trust, after the ambulance has arrived.
  - ED teams have reviewed escalation triggers and strengthened escalation responses for winter 2021/22
  - Ambulance cascade – enhanced intelligence triggering change of location for defined patient groups to sites with capacity within NCL.
  - Refinement of Rapid Assessment Teams (RAT) to facilitate safer and more timely handover of patients.
  - Refurbishment of resuscitation area to provide isolation capacity which enables Majors cubicles currently used for infected patients to revert back to rapid assessment space for ambulance conveyed patients (UCLH).
  - Ongoing promotion of other services (NHS 111, 2-hour Rapid Response) as alternatives to ED for non-urgent issues.

Next steps

Our winter planning for 2021/22 will be further developed through:

- Further consideration on workforce resilience.
- Building LAS expected demand into plans with some ability to flex what LAS is forecasting for this winter.
- Further development of system oversight and assurance processes including any response to forthcoming national guidance.
- Ongoing evaluation on system pressures and response.

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Winter resilience

Comms and engagement plan
Autumn/Winter 2021/22

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Campaign overview

- Our ICS strategic vision is to provide high quality health and care services to support local people to ‘Start well, live well, age well and work well’. As we prepare for what is likely to be another challenging winter, there remains significant pressure on NCL services, alongside a need to maintain elective care, continue to vaccinate local people against Covid and flu and provide routine and emergency care.
- We will deliver an integrated communications and engagement programme to support residents, patients and health and care workers stay well and to access care in the right place at the right time.
- National campaigns (Winter, vaccine) will be tailored for North Central London. Building on the success of the Covid-19 vaccine work to date, a partnership delivery model is envisaged - with the CCG, NHS provider and Council communications and engagement teams working collaboratively.
- The system-wide public winter resilience communications and engagement campaign will be delivered over the next three – six months with collaboration and support across NCL’s partner organisations.
- The campaign will align a range of messages relating to winter preparedness including: building confidence and trust in the NHS, and that services are open; helping people know how to access services appropriately for different types of needs; flu and Covid vaccination promotion; providing reassurance and information on self-care and how to manage long term conditions; encouraging respect for staff and message of zero tolerance on staff abuse.

Campaign focus

Building confidence in NHS services; 'NHS is Open' and NHS staff ready to care for you (including 'Respect' messaging)

Immunisation as best protection; promote flu and Covid vax (build confidence, drive uptake)

Stay well this winter: Reduce health anxiety and promote **self management and self-care** where possible with positive health and wellbeing messaging winter

Right care, right place; promote appropriate point of access – encourage everyone to seek the right care

- Clear offer for alternatives to A&E/UTC –111, Extended Access Hubs, SDEC, WICs
- Prioritise frequent attenders – parents, respiratory, mental health service users.
- Manage expectations/timing when A&E particularly busy – plan for escalation/incidents
- Encourage people to seek care when needed – e.g. cancer, paediatric conditions.

Recovery narrative; provide reassurance and remind of work to maintain elective care, reduce waiting lists and times and increase capacity

Encourage **longer term behaviour change** through using digital, where appropriate, (NHS 111, 111 online, telephone and video appointments).

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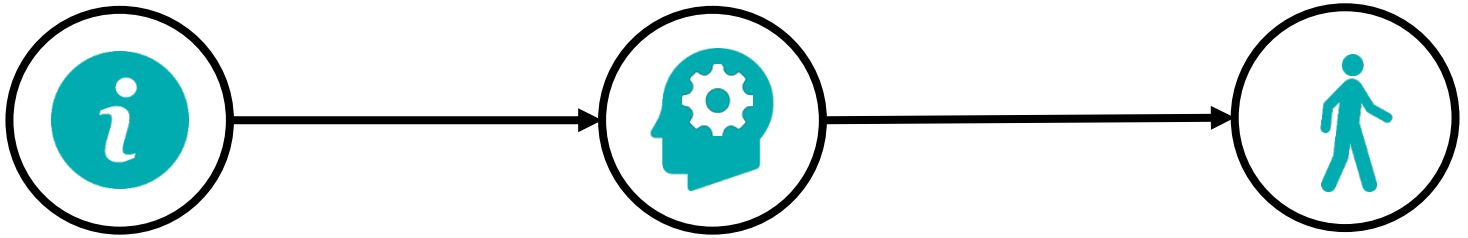
Approach: informing and influencing patients



AWARENESS STAGE

- Clear and flexible access offer
- Use simple, consistent and positive messaging
- Information accessible and available in variety of formats.
- Reaching all communities particularly those at risk of health inequalities.
- Align with national campaigns
- Staff supported and empowered to signpost help.

CONSIDERATION STAGE

- Easy to find information on the most appropriate services
- Reassurance on self-care and how to stay well.
- Understanding different options available to suit needs.
- Confidence and trust in primary care, NHS 111, hospitals to help.
- Reassurance to reduce anxiety.
- Advice available via NHS 111/ 111 online

DECISION STAGE

- It is easy to make the right choice.
- Confidence that advice or care will be provided in a timely way.
- Chosen access point is easy to access in a variety of ways.
- Reassurance about when to seek help and when to self-care.
- Clear advice about when to escalate
- The right choice won't be the same each time.
- Confidence in decision

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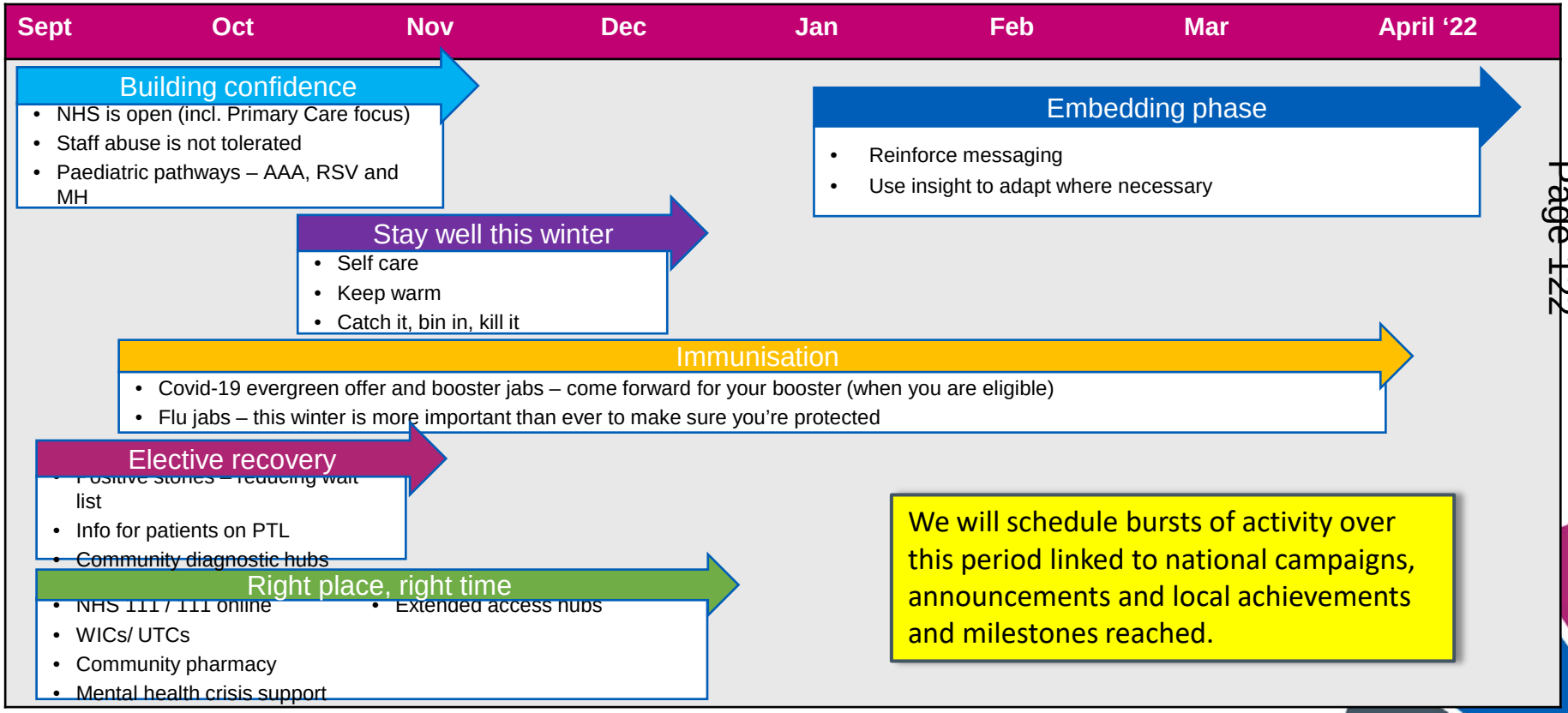
Approach: phasing activity



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Target audiences

- Building confidence
  - Staff as an important advocates for health and care, and local residents and healthcare users
  - Partners including councils and local voluntary and community organisations
- Immunisation:
  - Evergreen offer to cohorts 16 + (particular focus on 16-30 years)
  - 12-15 year olds
  - Priority cohorts for boosters
  - Priority cohorts – pregnant women, over 65s, adults 50-64 years, clinical risk groups (aged 6 months-49 years), unpaid carers, children aged 2-16
- Staying well this winter
  - Parents with young children
  - Mental health service users
  - Elderly and residents with long term conditions and co/multiple morbidities
- Right care, right place
  - Frequent attendees – in particular for primary care and A&E (paediatric and mental health)
  - Focus on north of patch, geographical areas around North Mid/Barnet Hosp, as busiest
- Elective recovery
  - Residents on PTL, patient rep organisations
  - Referrers including GPs

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Engagement and community outreach

- For our campaign to have impact, community-tailored outreach work will be critical
- We have learnt a great deal through Covid-19 vaccination, and we can now build on built strong relationships with communities and partners developed through the MDTs in each borough
- We will also work collaboratively with NHS organisations particularly in relation to elective recovery and urgent and emergency care.
- To make a real impact and address health inequalities we need to think innovatively and work with partners in councils and VCS organisations to start conversations with communities we haven't yet reached.
- We know that some local communities are not accessing, and may not trust, services - our focus must be on working with, and through partners, to co-design outreach and involvement activity
- We will use insight, local knowledge and collaborate with partners and communities to develop and implement a six-month engagement and community outreach plan, with flexibility to tailor to the needs of local people in each borough
- Investment in community outreach and involvement work will deliver beyond Winter, supporting us to build an impactful long-term model of partnership working with the VCS.

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Tactical approaches

- Create a coordinated NCL campaign with a consistent core narrative.
- Focus on north of patch, parents, mental health service users, the elderly and those at risk of health inequalities.
- Ensure messaging is aligned to national campaigns 'Boost your immunity', 'NHS 111 First'.
- Develop and print local assets that align with national materials.
- Reuse local assets, such as the flu animations: view here
- Schedule bursts of activity, building on awareness campaigns, such as 'Ask your pharmacist week'.
- Develop paid-for social media campaigns targeted at priority demographic groups.
- Allow for local nuance in message and delivery to meet the needs of local people.
- Deliver regular stakeholder briefings for senior health care leaders and political stakeholders.
- Identify opportunities for proactive media engagement and manage issues.
- Use local insight and data to tailor messages and identify communities at risk of health inequalities.
- Undertake evaluation and monitoring to ensure we are taking an evidence-based approach.

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Coordinating a system narrative

One important element of the plan will be to align communications and engagement activity taking place across NCL, coordinating messaging across primary care, secondary care and other partners

The winter resilience campaign will support some of the actions that the CCG and colleagues within primary care are taking in response to the recent NHS England publication, **'Our plan for improving access for patients and supporting general practice'.**

This includes:

- a narrative to counteract negative media messaging about primary care
- helping patients to access appropriate services
- building understanding of the range of different appointment types and healthcare staff available to support patients in primary care
- reinforcing a message of respect and kindness towards NHS staff.

London Ambulance Service NHS Trust

London Ambulance Service estates vision

In 2019, the London Ambulance Service (LAS) published an Estates Vision, which set out the Board's desire to transform its estate to meet future needs. The vision, which covers ambulance stations, training centres and other facilities, builds on the recommendations of the national 2018 Carter Review which highlighted the variation in the number of operational sites ambulance trusts run and scope to increase quality and reduce costs by rationalising their estate.

The vision, which we shared with stakeholders across London following its publication, detailed how we plan to modernise our estate by replacing our existing 68 stations with a network of circa 18 state-of-the-art Ambulance Deployment Centre (ADC), operating under a new 'Hub and Spoke' model.

These ADCs, which would be supported by strategically located standby points and rest and refreshment posts for our staff and volunteers across London, would aim to have ambulance 'make ready' and light vehicle maintenance facilities, modern management, administrative, training and wellbeing facilities available to our crews at the start and end of their shift.
In understanding the benefits of this model, it is really important to understand that healthcare is not provided directly from ambulance stations. As a fully mobile service whose dispatch methodology allocates the most appropriate resources to each and every incident, the majority of incidents attended by LAS are dispatched from hospitals, strategic standby points or other locations once our clinicians have finished care and treatment of their previous patient.

This means that at the start of a shift our crews will collect their vehicle from the station and travel to various standby points or to patients directly in the area - the locations of which are dictated by modelled patient demand. Often our crews will therefore only return to the ambulance station again at the end of their shift.

Through developing ADCs, which are equipped with co-located facilities and access to management, wellbeing services and equipment, we believe this will help ensure we can get more ambulance crews out on the road faster and in turn, improve the standard of care we provide to our patients across London. This model is already successfully used across other ambulance services, including West Midlands Ambulance Service and South East Coast Ambulance Service.

In June 2021, LAS shared with stakeholders in North East London and our North West London Commissioners our ambitions to take the first step towards achieving this vision through the development of our pioneer ADC in North East London. We shared how LAS was in the very early stages of realising this vision, with a desired site chosen for exploration, yet still subject to planning permission.

In developing an ADC in North East London we then planned to merge our existing stations of Romford, Ilford, Hornchurch and Becontree. Once the new station was up and running, this plan would have resulted in the subsequent permanent closure of these four ambulance stations. The 'Romford Group' of ambulance stations was chosen as the first site for development as the current Romford Ambulance Station location is in a site designated for major regeneration as part of Havering Borough Council's proposed Bridge Close Regeneration Scheme, so a new location is needed.

It is important to clarify that we have not embarked on specific plans to create an ADC in North Central London, further than what has been set out in our Estates Vision in 2019.

With the Trust experiencing significant demand and pressures on our 111 and 999 services this year, with June, July and August being three of the top five busiest months ever, we recently announced (29 September) our decision to pause our plans on our estates vision and our first pioneer site in North East London, including the withdrawal of our planning application on the site of the proposed ADC. This means we can prioritise our resources to support our frontline operations this winter, and be there for Londoners when they need us most.

Over the winter, we will review our existing estate and our plans for how this will evolve in the future to meet patients' needs as effectively and efficiently as possible across the capital, including North East London. As part of this work, we will engage and, as appropriate, consult with the public and other partners on any proposed plans to move or close stations. This includes continuing to work closely with the London Ambulance Service Public and Patients Council, which provides a voice for patients, the public and carers in the design, development and delivery of LAS services, who we have been working closely with on this programme since August 2020.

More information about our estates vision and our recent announcement to pause plans can be found here: https://www.londonambulance.nhs.uk/about-us/our-plans-for-the-future/upgrading-our-ambulance-stations-modernise-estate/