Public Document Pack

TRAFFORD COUNCIL

AGENDA PAPERS FOR

HEALTH SCRUTINY COMMITTEE

Date: Wednesday, 29 November 2023

Time: 6.30 pm

Place: Committee Room 2 and 3, Trafford Town Hall, Talbot Road, Stretford, M32 0TH

A G E N D A **PART I** **Pages**

1. **ATTENDANCES**

To note attendances, including Officers, and any apologies for absence.

2. **DECLARATIONS OF INTEREST**

Members to give notice of any interest and the nature of that interest relating to any item on the agenda in accordance with the adopted Code of Conduct.

3. **MINUTES** 1 - 4

To receive and, if so determined, to agree as a correct record the Minutes of the meeting held on 13th November 2023.

4. **QUESTIONS FROM MEMBERS OF THE PUBLIC**

A maximum of 15 minutes will be allocated to public questions submitted in writing to Democratic Services (democratic.services@trafford.gov.uk) by 4 p.m. on the working day prior to the meeting. Questions must be within the remit of the Committee or be relevant to items appearing on the agenda and will be submitted in the order in which they were received.

5. **AIDS AND ADAPTATIONS SERVICE UPDATE** 5 - 10

To receive a report from the Director for Trafford Local Care Organisation.

6. **DENTAL ACCESS - CHILDREN FRIENDLY FAMILY SCHEME - TRAFFORD** 11 - 54

To receive a report from the Director of Primary Care GM, NHS GM.

7. **ELECTIVE PROCEDURES - PERFORMANCE UPDATE** 55 - 66

To receive a report from the Associate Director for Delivery & Transformation Trafford.

8. **HEALTH SOCIAL CARE - WINTER PLANS** 67 - 70

To receive a report from the Associate Director for Delivery & Transformation Trafford.

9. **CANCER DIAGNOSIS** 71 - 82

To receive a report from the Director of Public Health.

10. **IVF - TREATMENT UPDATE** 83 - 132

To receive a report from the Associate Director of Delivery & Tranformation Trafford.

11. **HEALTH SCRUTINY COMMITTEE - WORK-PROGRAMME 2023/24** 133 - 134

To consider items for the Committee's work programme 2023/24.

12. **URGENT BUSINESS (IF ANY)**

Any other item or items (not likely to disclose "exempt information") which, by reason of special circumstances (to be specified), the Chairman of the meeting is of the opinion should be considered at this meeting as a matter of urgency.

SARA TODD
Chief Executive

Membership of the Committee

Councillors D. Butt (Chair), S. Taylor (Vice-Chair), J.M. Axford, K. Chakraborty, S.J. Gilbert, B. Hartley, J. Leicester, S.E. Lepori, J. Lloyd, S. Maitland, T. O'Brien, D. Acton (ex-Officio) and D. Western (ex-Officio).

Further Information
For help, advice and information about this meeting please contact:

Stephanie Ferraioli, Governance Officer
Tel: 0161 912 2019
Email: stephanie.ferraioli@trafford.gov.uk

This agenda was issued on **Tuesday, 21 November 2023** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall; Talbot Road, Stretford, Manchester, M32 0TH

WEBCASTING

This meeting will be filmed for live and / or subsequent broadcast on the Council's YouTube channel https://www.youtube.com/channel/UCjwbIOW5x0NSe38sgFU8bKg The whole of the meeting will be filmed, except where there are confidential or exempt items.

If you make a representation to the meeting you will be deemed to have consented to being filmed. By entering the body of the Committee Room you are also consenting to being filmed and to the possible use of those images and sound recordings for webcasting and/or training purposes. If you do not wish to have your image captured or if you have any queries regarding webcasting of meetings, please contact the Democratic Services Officer on the above contact number or email democratic.services@trafford.gov.uk

Members of the public may also film or record this meeting. Any person wishing to photograph, film or audio-record a public meeting is requested to inform Democratic Services in order that necessary arrangements can be made for the meeting. Please contact the Democratic Services Officer 48 hours in advance of the meeting if you intend to do this or have any other queries.

This page is intentionally left blank

HEALTH SCRUTINY COMMITTEE

13 SEPTEMBER 2023

PRESENT

Councillors: D. Butt (Chair), S. Taylor (Vice-Chair), J. Lloyd, S. Maitland, J. Axford, S. Lepori, B. Hartley, J. Slater.

In attendance

Elizabeth Calder	Director of Performance and Strategic Development, GMMH
Sian Wimbury	Deputy Chief Operating Officer, GMMH
Maria Nelligan	Interim Executive Director of Clinical Transformation, GMMH
Claire Fraser	Trafford Head of Operations, GMMH
Judie Collins	Altrincham Campaigner
Geraldine Coggins	Councillor, Trafford Council
James Gray	Head of Unscheduled Care Trafford, NHS GMIC
Cathy O'Driscoll	Associate Director of Delivery and Transformation, NHS GMIC
Helen Gollins	Director of Public Health, Trafford Council
Ric Taylor	Lead Commissioner Mental Health & Learning Disability, TCCG
Claire Robson	Public Health Consultant, Trafford Council
Thomas Maloney	Programme Director Health & Care, Trafford Council & NHS GM
Gareth James	Deputy Place Lead for Health and Care Integration
Nathan Atkinson	Corporate Director Adult and Wellbeing, Trafford Council
Heather Fairfield	Director, Healthwatch Trafford
Stephanie Ferraioli	Governance Officer, Trafford Council

1. ATTENDANCES

An apology for absence was received from Councillor Acton, Leicester, O' Brien and Western.

2. DECLARATION OF INTEREST

No declaration of interest was disclosed.

3. MINUTES

RESOLVED – That the minutes of the meeting held on 13th September 2023 be noted as a true and correct record.

4. MENTAL HEALTH SERVICE UPDATE

The Committee welcomed colleagues from the Greater Manchester Mental Health Service to deliver a presentation on the Trafford Health Integrated Partnership Priorities and the Improvement Plan which is being implemented across the borough.

They informed that the process is being led by a new and highly experienced leadership team.

The key challenge in the borough relating to Mental Health is an historical under investment compared with other GM partners and nationally; however delivering improved outcomes is being achieved through Living Well, Achieve and Urgent Care provision.

Stronger working relationships with Trafford locality, Place, ICB and Local Authority will go towards mitigating the continued and sustained pressures the service is under.

RESOLVED – That the update be noted.

5. TRAFFORD LOCALITY MENTAL HEALTH

The Head of Service Delivery and Transformation Adult Mental Health & Learning Disability (Trafford) NHS Greater Manchester Integrated Care presented a report on Trafford Locality Mental Health.

The GM Integrated Care Partnership Mental Health Strategy was first published in 2013. The strategy at the time highlighted how through collaboration between the health and care services they could provide the people of the region a fairer and more prosperous way of life. With the inception of the Health and Care Act 2022 the way in which services operate changed dramatically with 42 new Integrated Care Systems (ICS) being born. Greater Manchester being one of the larger ICS with ten boroughs and an ever increasing population.

The funding of the ICS has changed too, to a more centralised planning, delivery and control with the main challenge being the way in which responsibilities sit and are dealt with in relation to ensuring services are citizens focused, continue to work towards reducing inequalities and to maximise the service delivery.

Since 2021 Trafford has implemented the Locality Mental Health Wellbeing Strategy which is now under review to be fully aligned with the key 5 Greater Manchester Strategy priorities.

RESOLVED – that the update be noted.

6. TRAFFORD URGENT CARE REVIEW

The Associate Director of Delivery and Transformation Trafford presented the Committee with an update on the progress of the current Urgent Care Review reminding that the review is analysing the following areas: Needs Assessment, Appraisal of the Services, Previous Insight, Public Engagement and survey and Analysis.

The review has been a long term ambition of the Locality Plan and has been commissioned to ensure a more joined up urgent care system which is easier to navigate for residents of the borough so that they can access care based on needs irrespective of health inequalities and in line with the national guidance.

Presently the team is working through the Improvement priority, analysing feedback obtained within the review so far.

RESOLVED – That the Committee note the progress of the review to date.

7. GP ACCESS – TASK AND FINISH GROUP

Members noted the report from the Health Task and Finish Group 2022/23 and agreed its recommendations.

Members expressed thanks for the hard work by Councillor Whetton, the driving force behind the Health Task and Finish Group 2022/23.

RESOLVED:

1) That Councillor Whetton's hard work be recognised.
2) That the recommendations be agreed.

8. SOCIAL PRESCRIPBER – TASK AND FINISH GROUP

The next meeting of the Health Task and Finish Group which this year will focus on Social Prescribing is taking place on 5th October when Trafford Veterans will attend the Town Hall to illustrate how they engage with the public and explain the service's challenges and opportunities to Members.

RESOLVED – That Members note the next Task and Finish's meeting date.

9. HEALTH SCRUTINY COMMITTEE WORK PROGRAMME 2023/24

RESOLVED – That the updated work-programme 2023/24 be noted.

10. URGENT BUSINESS (IF ANY)

There was no urgent business to discuss.

TRAFFORD COUNCIL

Report to: **Health Scrutiny Committee.**
Date: **29 November 2023.**
Report for: **Information.**
Report of: **Nathan Atkinson, Corporate Director for Adult Services, Richard Spearing, Managing Director Trafford Local Care Organisation.**

Report Title

One Stop Resource Centre, Occupational Therapy (OT) Assessment Team and Adaptations Team Update

Summary

An initial paper was presented to Scrutiny in July 2023 which provided an update on the stabilisation programme developed following a November 2022 review of the One Stop Resource Centre (OSRC).

The programme includes the Occupational Therapy Assessment Team (OT) with its close interdependencies to Trafford Council Adaptations team. Both the OSRC and OT assessment team have experienced significant pressures post COVID-19, leading to a waiting list for assessment and extended waiting times with subsequent risks.

This paper summarises actions taken to address the ongoing backlog, improve customer service and provide sufficient driver capacity. This includes the implementation of a new IT system within the OSRC which enables clinicians to book their own delivery dates.

Additionally, this paper provides responses to a set of questions posed in the July 2023 Scrutiny meeting.

Recommendation(s)

Health Scrutiny are asked to note contents of the report and actions to date.

Contact person for access to background papers and further information:

Name: Kerry Briggs
Phone number: 07919 576961

Links to Committee priorities:

Reducing Health Inequalities	x
Improving Resident Health and Wellbeing (including Mental Health)	X
Improving Access to Services	*X*

1.0 Background.

The One Stop Resource Centre (OSRC) is jointly provided between Manchester University NHS Foundation Trust (MFT) and Trafford Council and forms part of the offer from the Trafford Local Care Organisation (TLCO). Arrangements for the partnership are formalised under a s.75 agreement. The service provides community equipment free of charge and adaptation services for people living in Trafford who may need assistance with daily living due to a disability and utilise the assigned Disabled Facilities Grant (DFG).

Although not a function of the OSRC the Occupational Therapy Assessment team including the Equipment, Advice and Adaptations Line (EAAL) has close interdependencies with the OSRC offer. They carry out assessments, order equipment and link with housing and social care for any adaptations needed in homes; stairlifts, grab rails or wet rooms. The Occupational Therapy role is to schedule and assess people referred for support to help them live well at home for as long as possible.

The previous update in July 2023 provided an overview of the waiting times within the OSRC and Occupational Therapy team and an action plan following a robust review of the service. The stabilisation programme continues to be delivered and monitored through a joint steering group.

2.0 One Stop Resource Centre Update.

A new scheduling and ordering system (eLMs2) went live on the 18th September 2023 and system use is now embedding across community teams and partners.

The previous waiting list on CES360 system has now been cleared and the waiting list is being managed solely in eLMs2. The reports module training has been delivered and the OSRC are currently working with the performance team to develop a reporting framework. This is planned for the end of November. Once in place accurate waiting times from eLMs2 will be available.

Additional driving capacity is being provided in the OSRC through 3.0wte fixed term six-month contracts. Recruitment is underway, two people have been offered posts and the remaining interview is scheduled week commencing 13th November. These posts will provide a full establishment whilst the current driving model is being reviewed.

Customer service has been improved through 1.0wte bank administrator answering the phone and emails which has reduced complaints related to being unable to get through to the team.

2.1 Actions to date:

- A successful pilot for the delivery of foot protectors by the District Nursing team has now been implemented across the neighbourhoods. This has removed all waits for foot protectors and has been rolled out for cushions within each District Nursing team and is working successfully to reduce the wait for delivery.
- Capacity within the substantive driving function has been expanded via 3.0wte temporary six-month roles whilst the driving model is reviewed.
- 1.0wte bank administrator in post answering phones and emails.
- Duty mobile phone provision in the OSRC to support with clinical escalation of urgent requests.
- A new ordering and scheduling system (eLMs2) went live on the 18th September 2023. This will significantly improve operational delivery and management within the service. Referrers will book delivery slots directly for people requiring equipment which will prevent administrative delays relating to unsuccessful attempts to contact people to arrange deliveries.
- Flow and capacity between the warehouse and drivers has been improved and opening hours extended including expansion of satellite stores.
- Social Care Trusted Assessors have been trained to refer for simple items of equipment.
- Training of CNRT & Palliative OTs to undertake stairlift/fixed lift assessments.

2.2 Questions from July Scrutiny:

It agreed that a response to questions asked in July Scrutiny meeting would be incorporated into a second update paper post eLMs2 implementation. Answers are provided within table 1 below:

	Question	Answer
1.	**Given the level of complaints and customer dissatisfaction, is there a customer feedback loop built into the operating procedures. Aligned to this an approach encompassing proactive communications?**	We are working with Healthwatch to implement the recommendations following their OT report earlier this year. These are set out below: 1. Community Level a. Wider discussion to take place between stakeholders on meaningful sets of activity data eg: gathering/sharing case studies would provide evidence for commissioners & service planners on best practice and current issues. b. Opportunity to review how data related to public experience is reported to improve quality of data and available evidence. 2. Commissioner & Service Delivery Level a. Clarify if issues previously related to supply chain for adaptations eg: wheelchairs or home modifications is resolved.

		b. Clarify waiting times for initial OT assessments and any actions taken to address these. c. Provide regular waiting time updates to Healthwatch. d. Clarify referral processes and access criteria for GPs. This means that currently we are meeting with them every two weeks and updating them on the overall improvement programme (as presented to Scrutiny). Once the new IT system and improvements to the driving function are both in place. Expected by close of October at the latest, then we will focus on 1a, 1b and 2d. They will use their engagement skills to review the impact of the changes and carry out a further survey. This approach has been welcomed by Healthwatch and is the first time one of their reports has been used to drive improvements to health and social care services in Trafford. We also plan to implement the Friends and Family Test at the store. The exact methodology is currently being explored. This will happen once the changes described below are in place. When the new eLMS2 System is in place (see below) we will include information about current waiting times as part of the booking process.
2.	**Request to provide more details on the eLMS2 system (how it works, functionality etc – bit more detail at high level**	The eLMS2 system has now been implemented in the One Stop Resource Centre 18th September 2023. The system will process requests for equipment, manage equipment stock and scheduling of drivers to deliver equipment. The system allows referrers to book a delivery slot for equipment and will also allow more robust management information reporting around equipment and maintenance. The eLMS2 system being implemented alongside the roll out of bar code scanners which will also improve the efficiency within the team and allow better stock management. eLMS2 is used by many NHS/ Council organisations around the country and is also used by many of the acute and community health staff when making requests for Salford or Manchester residents.
3.	**Is eLMS2 linked to the MFT HIVE system?**	eLMS2 isn't linked to HIVE. But they are used together as part of the discharge pathways for Trafford residents when they leave hospital
4.	**Have any Serious Untoward Incidents or safeguarding alerts been raised by the OSRC service for people who have a reported wait**	We have reviewed the incident reporting system over the last 12 months and there have not been any serious harm incidents reported related to delayed equipment. The eLMS2 system will provide a more robust management information system to support timely delivery.

	for equipment and have subsequently had an accident etc?.	
5	**Are people waiting in the MFT hospitals for equipment as part of their discharge plan? If so, how many days are they waiting for discharge as a result?**	Hospital discharges are managed daily (during the week) and any issues are escalated immediately to the team at OSRC and resolved. A mobile duty phone is now in operation in the OSRC for urgent escalation for equipment.

Table 1. Responses to Questions from July Scrutiny Meeting.

3.0 Occupational Therapy Assessment Team Update.

Although not a function of the OSRC the Occupational Therapy Assessment team which includes the Equipment, Advice and Adaptations Line (EAAL) has close interdependencies with the resource centre for ordering of equipment and with the Council's Adaptations team for adaptations needed in homes such as stairlifts, grab rails or wet rooms.

The team have now cleared the original backlog created during COVID-19 and a successful waiting list initiative of 800 completed assessments via a private provider has been delivered.

3.1 Actions to Date:

- The team have undergone a successful recruitment drive and the team are at full establishment including a rotational band 5.
- An increase of monthly cases allocated has been agreed with the team from 150 to 170.
- Successful implementation of a new electronic patient record (EMIS) into the team which will improve data quality and accuracy of performance data.

Despite the work undertaken to reduce the waiting list going back to the pandemic period, this has recently increased. As of 31st October 2023, the number of people waiting for an assessment has increased from 291 in July to 548 with the longest wait January 2023. The reasons for this are multifaceted as follows:

a. Long term sickness absence.
b. A band 4 administrator vacancy since July which is now recruited into (0.8wte).
c. A band 3 support worker vacancy which is now recruited into.
d. Implementation of a new electronic patient record (EMIS) on the team has had a significant impact in terms of clinical time taken to familiarise use of the system. The migration will however improve data quality and performance data will be accurate and simpler to obtain.

The team are working hard to address the longest waits and 0.2wte is being offered within the OT team as overtime. With existing demand of 140 referrals per month and capacity to allocate 170 cases per month (if the service at full establishment) improvements will be slowly realised and options are to be jointly discussed with commissioners in the context of pressures. The increased visibility of cases from the eLMs2 system, replacing a previously

unreliable approach of paper and electronic record keeping should ensure that the list is worked through systematically. It is recognised that this was an issue previously, leading to understandable frustration and complaints.

4.0 Adaptations Team.

The adaptations team enable the processing of a Disabled Facilities Grant (DFG) of fast-track applications following an adaptation request by referral from an Occupational Therapist

This team has 5 officers who are all full time working on cases passed to them by the Occupational Therapy assessment team and the community children's therapy team. They closed for 3 months March – June 2020 at the height of the pandemic but have since been working to business as usual.

Their caseloads have reduced and are all on track. They have had no waiting list because of the Occupational Therapy assessment team backlog. Each officer carries a caseload of up to 50 people, a total of 200 in the team. Since September 2022 the Occupational Therapy assessments have focussed their work on the major adaptations referrals and the cases being transferred to the adaptations team each month are now starting to return to pre pandemic levels.

A financial fast-track process is in place for stairlifts, ramps and ceiling track hoists which now enables the team to install these items within 4-6 weeks. This process supports people with life limiting conditions and those at most risk in a timely manner. These items can be removed and reused within other properties when no longer required.

5.0 Summary.

As outlined the Occupational Therapy Team are continuing to experience waiting times which are being addressed through stabilisation plans and monitored weekly. The waiting list for the OSRC is now all being managed via eLMs2 system however waiting times are currently unknown and this is planned to be resolved following training and the development of reports via the eLMs2 system by the end of November 2023.

TRAFFORD COUNCIL

Report to: **Health Scrutiny Committee**
Date: **29 November 2023**
Report for: **Information**
Report of: **Ben Squires, Director of Primary Care, NHS GM**

Report Title

Provision and Access to NHS Dentistry in Trafford

Summary

This paper provides an update on the provision of, and access to, NHS Primary, Secondary, and Community Dental services and delivery of Oral Health Improvement activity across Greater Manchester and specifically Trafford. It will highlight the actions taken to address health inequalities and to improve access to dental services to ensure patients are able to receive dental care and oral health improvement in a safe way

The GM Dental Commissioning Team working with the Dental Provider Board, the Consultant in Dental Public Health and the Local Dental Network Chair, continue to co-develop and implement action to secure recovery of dental services following the pandemic. This will be delivered via the Greater Manchester Primary Care Blueprint.

The Blueprint standardises the approach for primary care, including dental services and supports opportunities at locality-level for actions to meet local population needs that reduce oral health inequalities. A key purpose of the plan is to reduce oral health inequalities and improve dental access by ensuring patients can receive care at the right time, in the right setting and reduce wait times.

An NHS priority is the restoration of all services to pre-pandemic levels and action is agreed to address the backlog of patients following the COVID-19 pandemic including specialist dental services delivered within secondary care. Activity includes:

- Co-develop e-referral management system with robust clinical triage to direct referrals to the right setting at the right time, including referrals from non-dental professionals with potential use of virtual consultations
- Workforce and training for healthcare professionals

More targeted work is outlined in the report regarding addressing inequalities through access to NHS Dental Services for specific or vulnerable groups or cohorts.

Recommendation(s)

Health Scrutiny are asked to note the content of this report and progress to date

Contact person for access to background papers and further information:
Name: Ben Squires, Director of Primary Care, NHS Greater Manchester
Email: ben.squires@nhs.net

This page is intentionally left blank

NHS
Greater Manchester
Integrated Care

Provision & Access to NHS Dentistry in Trafford

November 2023

Prepared by: Lindsey Bowes, Senior Primary Care Manager (Dental)
Emma Hall-Scullin, Consultant in Dental Public Health
Ashley Seasman, Business Manager (Dental)
Lindsay La Vantae, Business Manager (Dental)

Presented by: Ben Squires, Associate Director of Primary Care
Date: 29th November 2023

NHS
Greater Manchester
Integrated Care

- Introduction
- Dentistry across the Greater Manchester and specifically Trafford
- Improving Access to NHS Dental Services
- Oral Health Improvement
- Addressing inequalities through access to NHS Dental Services
- Patient Feedback
- Care Quality Commission (CQC)

INTRODUCTION

1. This paper provides an update on the provision of, and access to, NHS Primary, Secondary, and Community Dental services and delivery of Oral Health Improvement activity across Greater Manchester and specifically Trafford.

2. It will highlight the actions taken to address health inequalities and to improve access to dental services to ensure patients are able to receive dental care and oral health improvement in a safe way.

NHS
Greater Manchester
Integrated Care

DENTISTRY ACROSS GREATER MANCHESTER AND TRAFFORD

DENTISTRY ACROSS GREATER MANCHESTER

NHS Greater Manchester Integrated Care

General Dental Care

Patients are not registered with a General Dental Practice (GDP) in the same way as they are with a GP. Any patient may access dental services from any practice in any area.

The spend on NHS Dental Services across Primary, Secondary and Community services is in the region of £206.2m

In Greater Manchester there are:

- 331 Primary Care NHS Dental providers
- 13 Urgent Dental Care providers linked to networked provision across Greater Manchester
- 38 Urgent Dental Care Hubs – providing additional urgent dental care capacity in response to continued pressures initially, as a result, of COVID

Specialised Dental Services

- Community Dental Services (special care and paediatric) clinics delivered by Bridgewater Community Healthcare NHS FT, Northern Care Alliance, and Manchester Locality Care Organisation – commissioned to provide specialist dental services to children and adults with additional needs on referral with clinics located within the community.
- 41 Orthodontic Providers
- 10 Specialist Tier 2 Oral Surgery Providers

Secondary Care Dental Services

12 dental specialities (including Oral Surgery, Maxillofacial Surgery, Restorative Dentistry, Paediatric Dentistry, Periodontics) available in Greater Manchester, commissioned from Manchester University NHS Foundation Trust, Northern Care Alliance NHS Foundation Trust, Bolton Foundation Trust, Wigan Wrightington and Leigh Foundation Trust, Stockport NHS Foundation Trust, and Tameside and Glossop NHS Foundation Trust.

DENTISTRY ACROSS TRAFFORD

NHS Greater Manchester Integrated Care

In the Trafford there are:

- 34 (10.1% of GM) Primary Care NHS Dental providers (331 providers across GM)
- 2 (15.4% of GM) Urgent Dental Care providers linked to networked provision across Greater Manchester (13 providers across GM)
- 2 (5.3% of GM) Urgent Dental Care Hubs – providing additional urgent dental care capacity in response to continued pressures initially, as a result, of COVID (38 providers across GM)

Specialised Dental Services

- Community Dental Services (special care and paediatric) clinics delivered by Bridgewater Community Healthcare NHS FT - commissioned to provide specialist dental services to children and adults with additional needs on referral with clinics located within the community.
- 6 (14.6% of GM) Orthodontic Providers (41 providers across GM)
- 1 (10% of GM) Specialist Tier 2 Oral Surgery Providers (10 providers across GM)

Secondary Care Dental Services

12 dental specialities (including Oral Surgery, Maxillofacial Surgery, Restorative Dentistry, Paediatric Dentistry, Periodontics) available in Greater Manchester. These services for Trafford are substantively delivered by Manchester University NHS Foundation Trust.

NHS
Greater Manchester
Integrated Care

IMPROVING ACCESS TO NHS DENTAL SERVICES

IMPROVING ACCESS – GENERAL DENTISTRY

NHS Greater Manchester Integrated Care

In the Trafford there are:

- 34 (10.1% of GM) General Dental Services providers (331 providers across GM)
- 1 (10% of GM) Tier 2 Oral Surgery provider (10 providers across GM)
- 6 (14.6% of GM) Orthodontic providers (41 providers across GM)

All NHS General Dental Practices continue to prioritise patients in pain, children, patients who are deemed as high risk – such as those receiving treatment for cancer, and those who are mid-way through a course of treatment.

Access is still steadily increasing but has not yet returned to pre-pandemic levels.

FIGURE 1 & 2: SHOW THE PERCENTAGE OF CONTRACTED UDAs DELIVERED AS OF 30/09/2023

NHS Greater Manchester Integrated Care

Locality	% Delivery at 30/09/2023
Bolton	43.2%
Bury	37.3%
HMR	42.5%
Manchester	39.0%
Oldham	36.6%
Salford	38.3%
Stockport	40.6%
Tameside	41.6%
Trafford	**37.8%**
Wigan	36.1%
GM	**39.2%**
England	35.9%

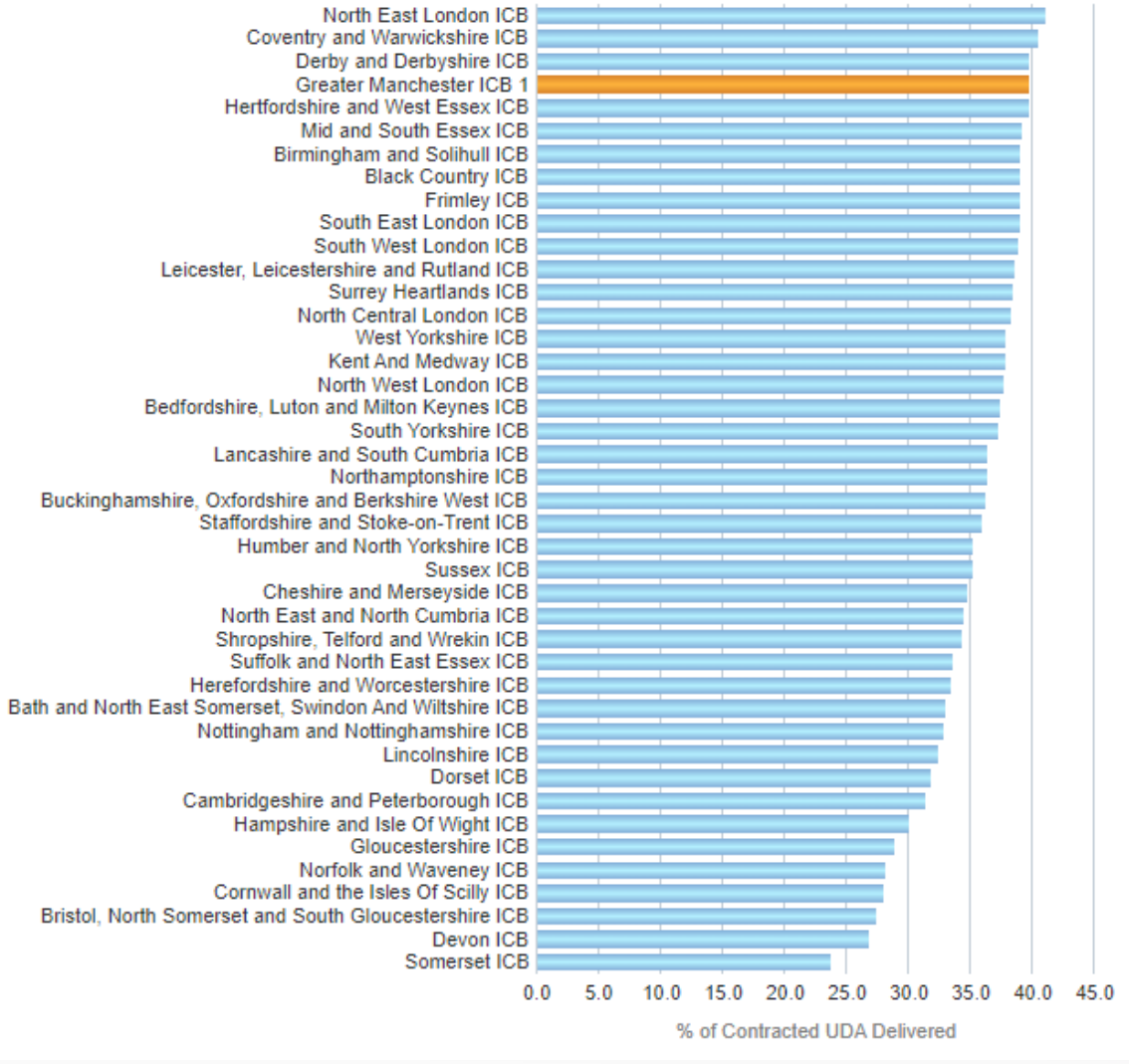


FIGURE 3: NHS ACCESS TO GENERAL DENTAL SERVICES – 24 Month Patient Access 20/21, 21/22 & 22/23 (GM)

NHS Greater Manchester Integrated Care

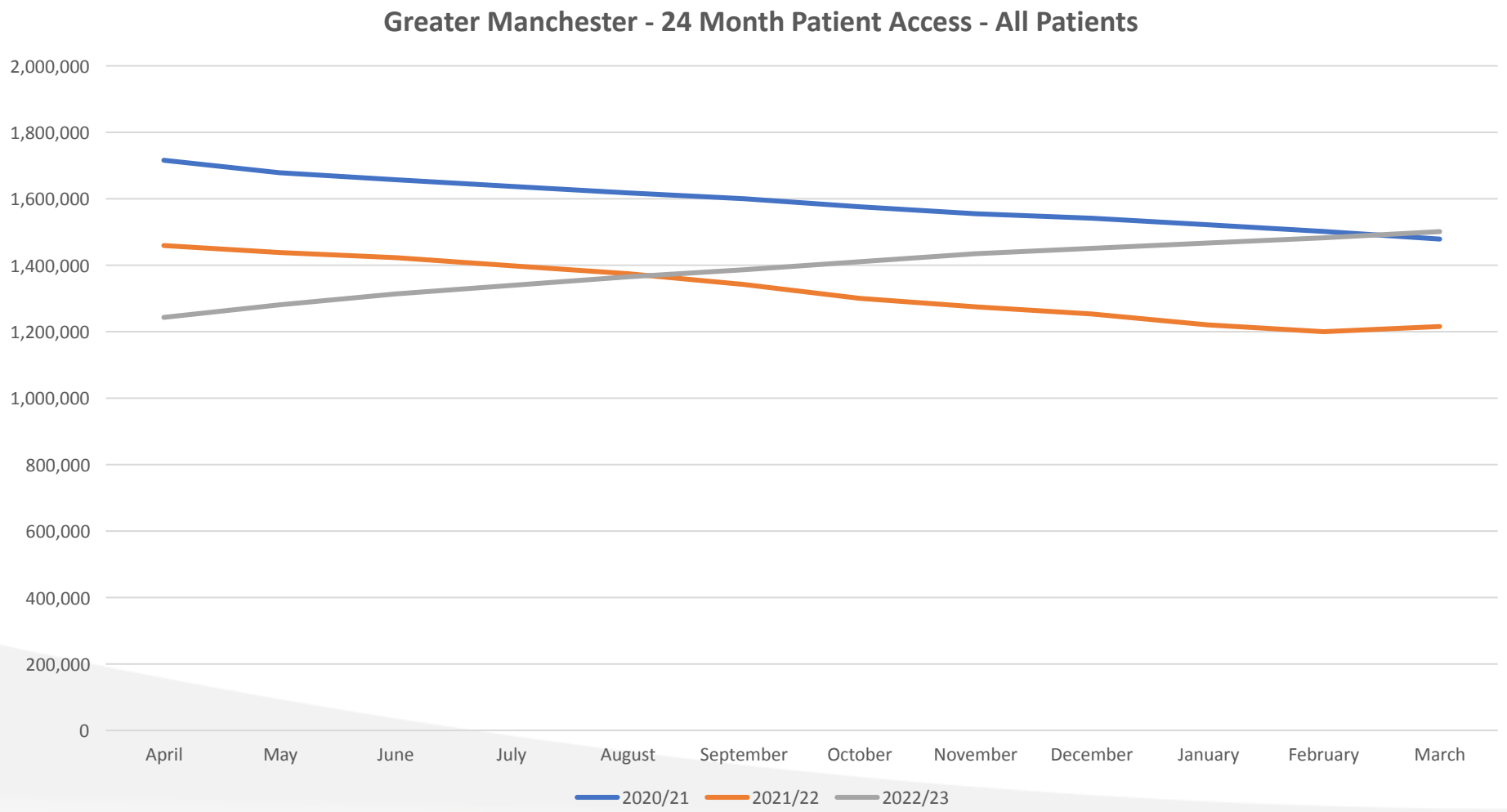


FIGURE 4: NHS ACCESS TO GENERAL DENTAL SERVICES – 24 Month Patient Access 20/21, 21/22 & 22/23 (Trafford)

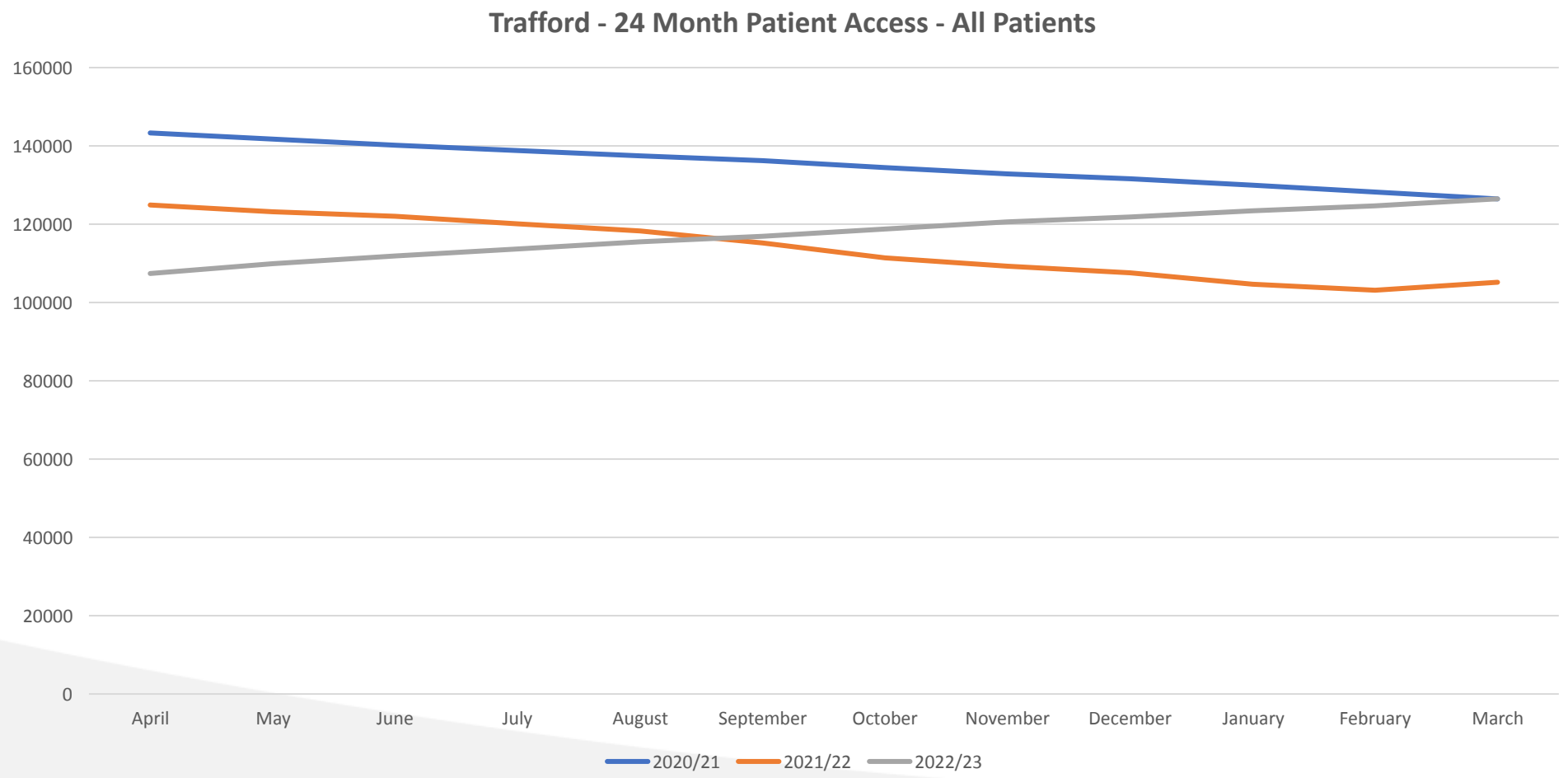


FIGURE 5: Adult patients seen in the previous 24 months as a percentage of the population Local Authority (LA)

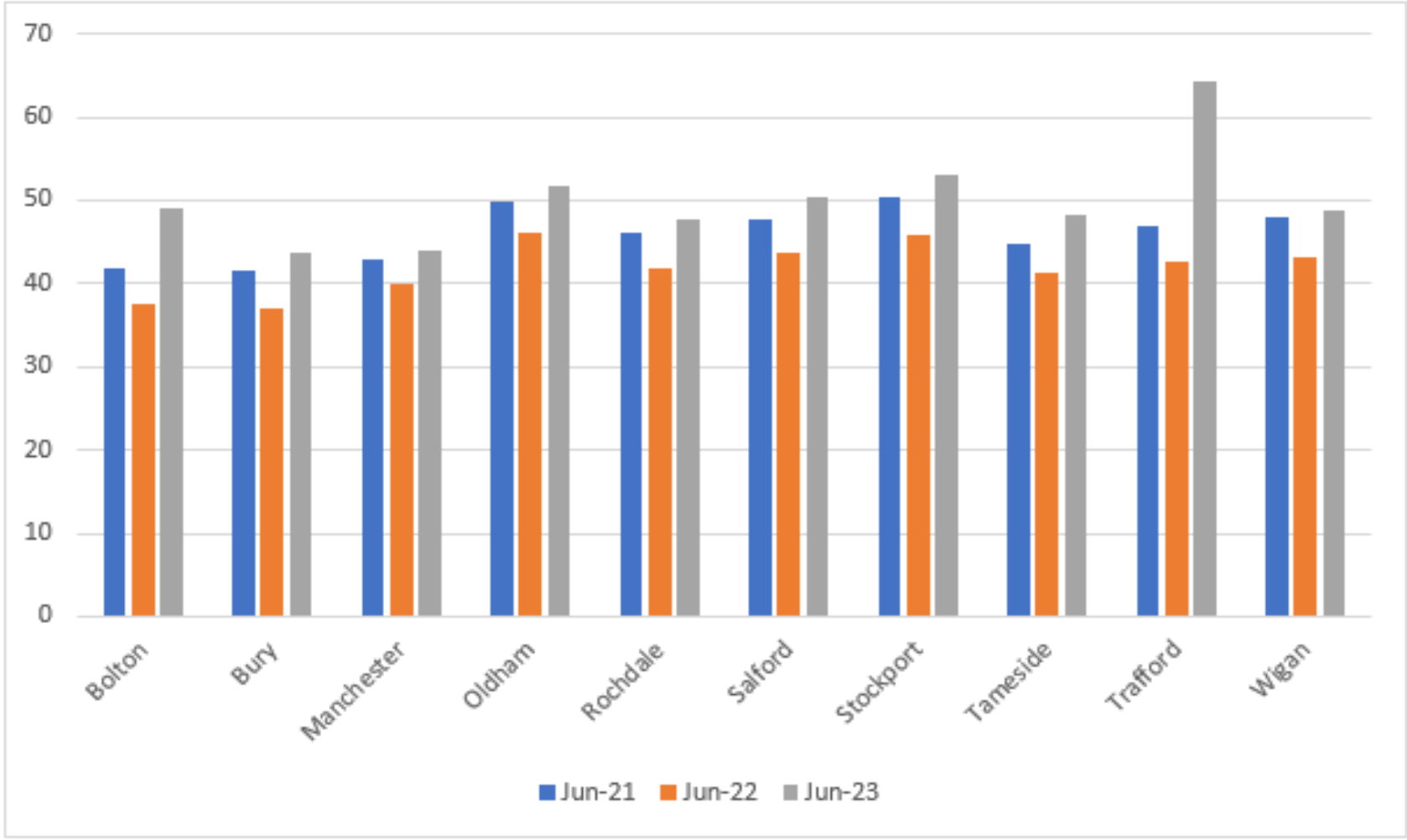
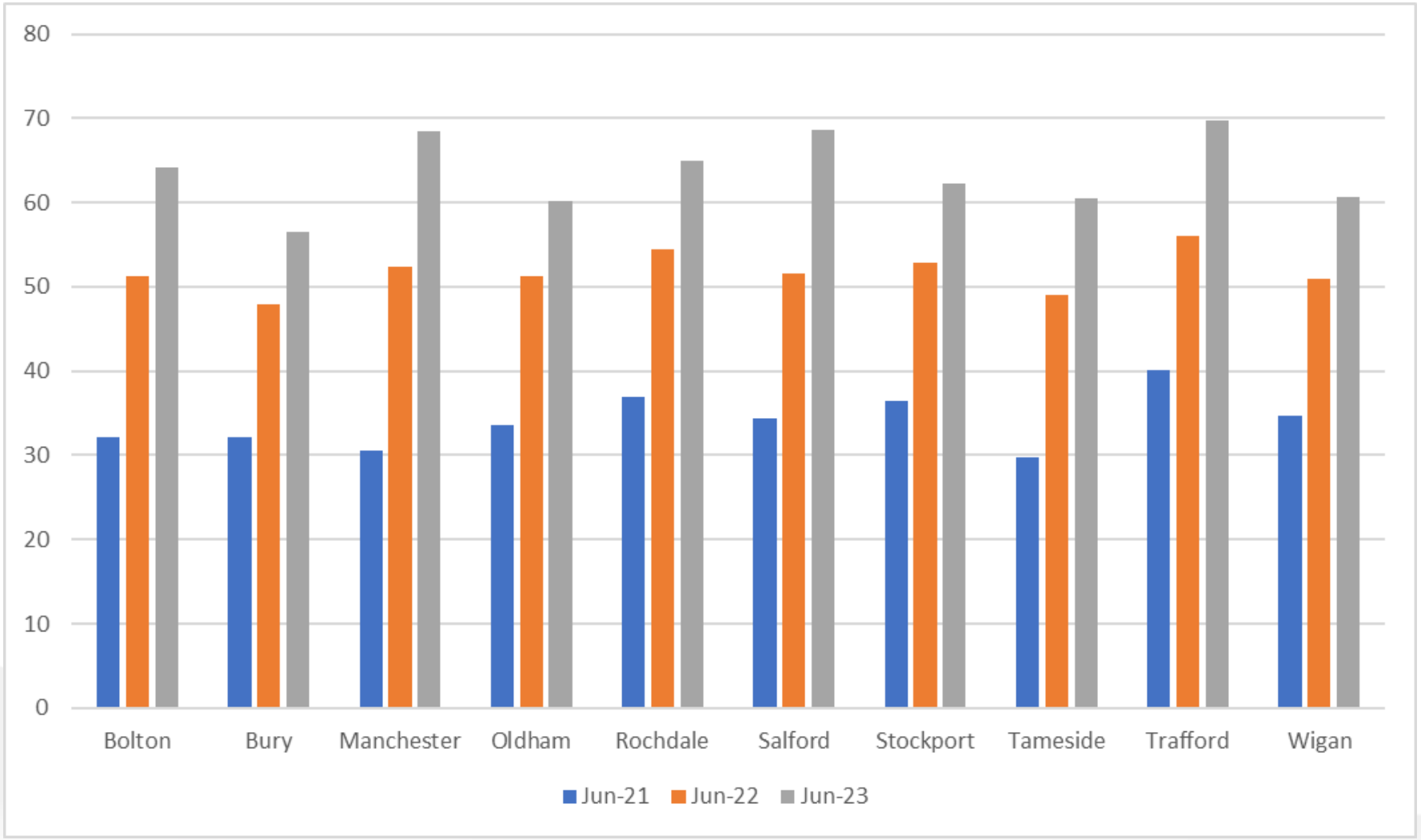


FIGURE 6: Child patients seen in the previous 12 months as a percentage of the population Local Authority (LA)



GM TIER 2 ORAL SURGERY SERVICE

NHS Greater Manchester Integrated Care

The Greater Manchester Tier 2 Oral Surgery Service delivers services to patients 16 years of age or older, who:

- Demonstrate a high level of anxiety and require conscious sedation as they are unable to tolerate treatments in a general dental surgery

- Require oral surgery procedures (defined as 'Level 2' in the NHS guide for Commissioning Oral Surgery and Oral Medicine, NHS England 2015). Treatment may be with or without sedation.

Locality	Fluoride Varnish Rate (July - Sept 2023)
Bolton	32.3%
Bury	66.7%
HMR	50.6%
Manchester	33.4%
Oldham	56.1%
Salford	61.3%
Stockport	34.6%
Tameside	53.0%
Trafford	**48.0%**
Wigan	47.1%
Greater Manchester	**48.1%**

Figure 7: % of annual contracted UDAs delivered by 30th September 2023 shown as a percentage.

IMPROVING ACCESS –
GM DENTAL QUALITY ACCESS SCHEME

NHS
Greater Manchester
Integrated Care

The quality focus for 2023/24 will be to increase access to NHS General Dental Services, in recognition of the significant patient and public feedback that clearly presents the difficulties faced for patients seeking to access services.

The expectations of delivery are:

- The participating practice will be open to new patients and ensure that the NHS.uk / NHS Choices website indicates that they are accepting new adult and child patients.
- All participating practices will see and treat an agreed number of new patients.
- All participating practices will become part of the wider Urgent Dental Care System.

IMPROVING ACCESS – GM DENTAL QUALITY ACCESS SCHEME

NHS Greater Manchester Integrated Care

The Scheme was launched in June 2023.

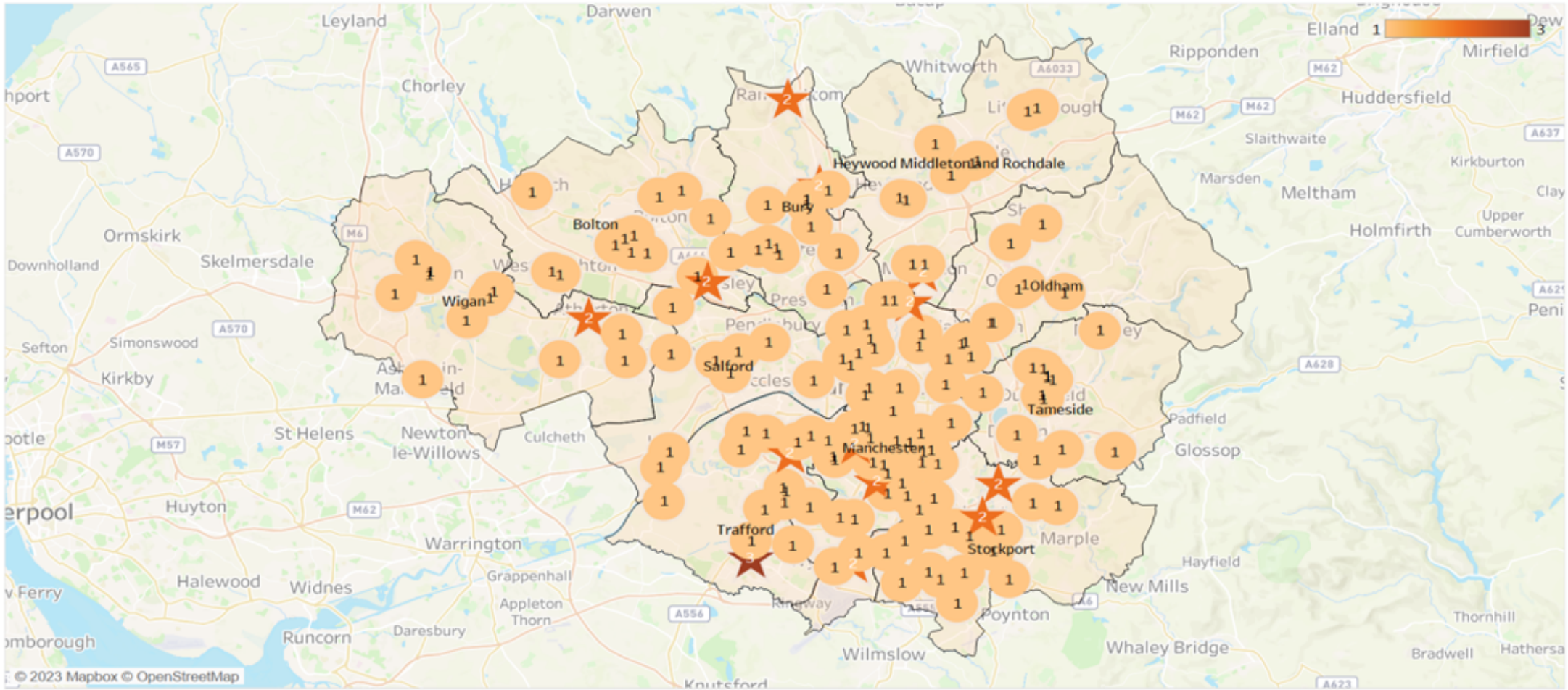
There are currently 179 Practices signed-up to deliver this scheme. This represents 51% of all GDS contracts across GM. 20 (11.1% of GM) of these practices are within Trafford.

To date (reporting received up to 01/11/2023):

- 49,390 new patients have been seen (4,546 in Trafford).
- 47,974 urgent patients have been seen (4,689 in Trafford).
- 9,389 patients who booked appointments failed to attend (525 in Trafford).

FIGURE 8: MAP OF PRACTICES SIGNED UP TO THE GM DENTAL QUALITY ACCESS SCHEME

NHS Greater Manchester Integrated Care



IMPROVING ACCESS – GM URGENT DENTAL CARE

NHS Greater Manchester Integrated Care

The GM Dental Commissioning Team commissions an Urgent Dental Care (UDC) Service for the population of GM. The UDC network has 13 Urgent Dental Care Service sites across GM. 2 of these are in Trafford, but a patient may access any practice in the network.

Patients can access urgent dental care at any of the sites across GM by ringing the UDC helpline on 0333 332 3800.

In response to the pressures caused by the COVID-19 pandemic, extra capacity was commissioned from the helpline and the UDC service providers **plus** 38 urgent dental care hubs were set up and will continue to offer additional urgent dental capacity until at least March 2024. 2 of the UDC Hubs are situated within Trafford.

IMPROVING ACCESS – PLANNING AND RECOVERY

NHS Greater Manchester Integrated Care

The GM Dental Commissioning Team working with the Dental Provider Board, the Consultant in Dental Public Health and the Local Dental Network Chair, are co-developing and implementing an action plan to recover dental services across the whole system. This will be delivered via the Primary Care Blue Print.

The plan standardises the approach for all dental services and supports opportunities at locality-level for actions to meet local population needs that reduce oral health inequalities.

The purpose of the plan is to reduce oral health inequalities and improve dental access by ensuring patients can receive care at the right time, in the right setting and reduce wait times. Actions include:

- Population oral health needs assessment
- Continued development of digital with an e-referral management system to support clinical triage to direct referrals to the right setting at the right time, including referrals from non-dental professionals
- Workforce and training for healthcare professionals
- Increase Dental Access

IMPROVING ACCESS – RESTORATION OF ELECTIVE SECONDARY CARE DENTAL SERVICES

NHS Greater Manchester Integrated Care

Specialist Dental Hospital and also specialist dental services delivered within secondary care.

An NHS priority is the restoration of all services to pre-pandemic levels and action is agreed to address the backlog of patients following the COVID-19 pandemic.

Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies ‘5’ focus clinical areas requiring accelerated improvement. The Children and Young People Core20PLUS5 framework identifies Oral Health as a clinical priority area with a requirement to increase the number of general anaesthetic sessions for children needing dental extractions.

IMPROVING ACCESS – RESTORATION OF ELECTIVE SECONDARY CARE DENTAL SERVICES

NHS Greater Manchester Integrated Care

Paediatric (to include Paediatric Dentistry) and Oral Surgery Clinical Reference Groups lead recovery for elective surgical cases supported by five dental specialty clinician-led GM Managed Clinical Networks.

Activity includes:

- Co-develop e-referral management system with robust clinical triage to direct referrals to the right setting at the right time, including referrals from non-dental professionals with potential use of virtual consultations

- Workforce and training for healthcare professional to meet current and future needs

NHS
Greater Manchester
Integrated Care

ORAL HEALTH IMPROVEMENT

FIGURE 9: PERCENTAGE OF 5 YEAR OLD CHILDREN WITH OBVIOUS DENTAL CARIES 2022 (2019) IN GM

NHS Greater Manchester Integrated Care

	Percentage of children with any decay experience	Average number of dentinally decayed (d3), missing due to dental decay (m) and filled (f) teeth (t) among those with any decay experience
Bolton	42.8 (32.7)	4.3 (3.5)
Bury	34.6 (35.2)	4.3 (3.9)
Manchester	31.6 (38.3)	4.4 (4.6)
Oldham	39.5 (43.2)	4.1 (4.4)
Rochdale	39.8 (40.7)	4.3 (4.3)
Salford	33.6 (39.0)	3.7 (4.2)
Stockport	17.5 (22.0)	3.6 (3.1)
Tameside	33.0 (33.1)	3.5 (3.1)
Trafford	**24.5 (26.0)**	**3.3 (3.9)**
Wigan	32.6 (31.9)	3.8 (3.2)
NHS Greater Manchester	**33.8 (34.7)**	**4.0 (3.9)**
North West	30.6 (31.7)	3.8 (3.8)
England	23.7 (23.4)	3.5 (3.4)

FLUORIDE VARNISH APPLICATION

NHS
Greater Manchester
Integrated Care

Dental decay is associated with deprivation, with some of the most vulnerable children facing very poor oral health. Other risk factors include poor nutrition, high consumption of sugar and lack of access to fluoride (starting tooth brushing late or infrequently with low or no fluoride toothpaste).

National guidance in the 'Delivering Better Oral Health Toolkit' (PHE, 2014) recommends that fluoride varnish is applied at least twice yearly for every child. For children 'giving concern' this can be applied from two years of age, up to four times per year. Fluoride varnish applied at least two times per year is one of the most effective interventions available to prevent dental caries.

Increased use of fluoride on the teeth and a reduction in the amount of sugar consumed could mean:

- fewer general anaesthetics for tooth decay
- fewer sleepless nights, missed school days and days off work for parents
- less pain from tooth decay
- reductions in the number of children with tooth decay
- reduction in the oral health gap for disadvantaged families

GREATER MANCHESTER FLUORIDE VARNISH RATE

NHS Greater Manchester Integrated Care

Pre-covid practices in GM had managed to increase the FV rate to second highest in the England, the rate in GM was 72.9% compared to England at 60.8% which was amazing.

The latest FV data (September 2023) shows that Greater Manchester rate has fallen to 69.1% and the England rate has slightly increased to 61.5%.

Sadly, this means we have now dropped to 9th when compared to other areas.

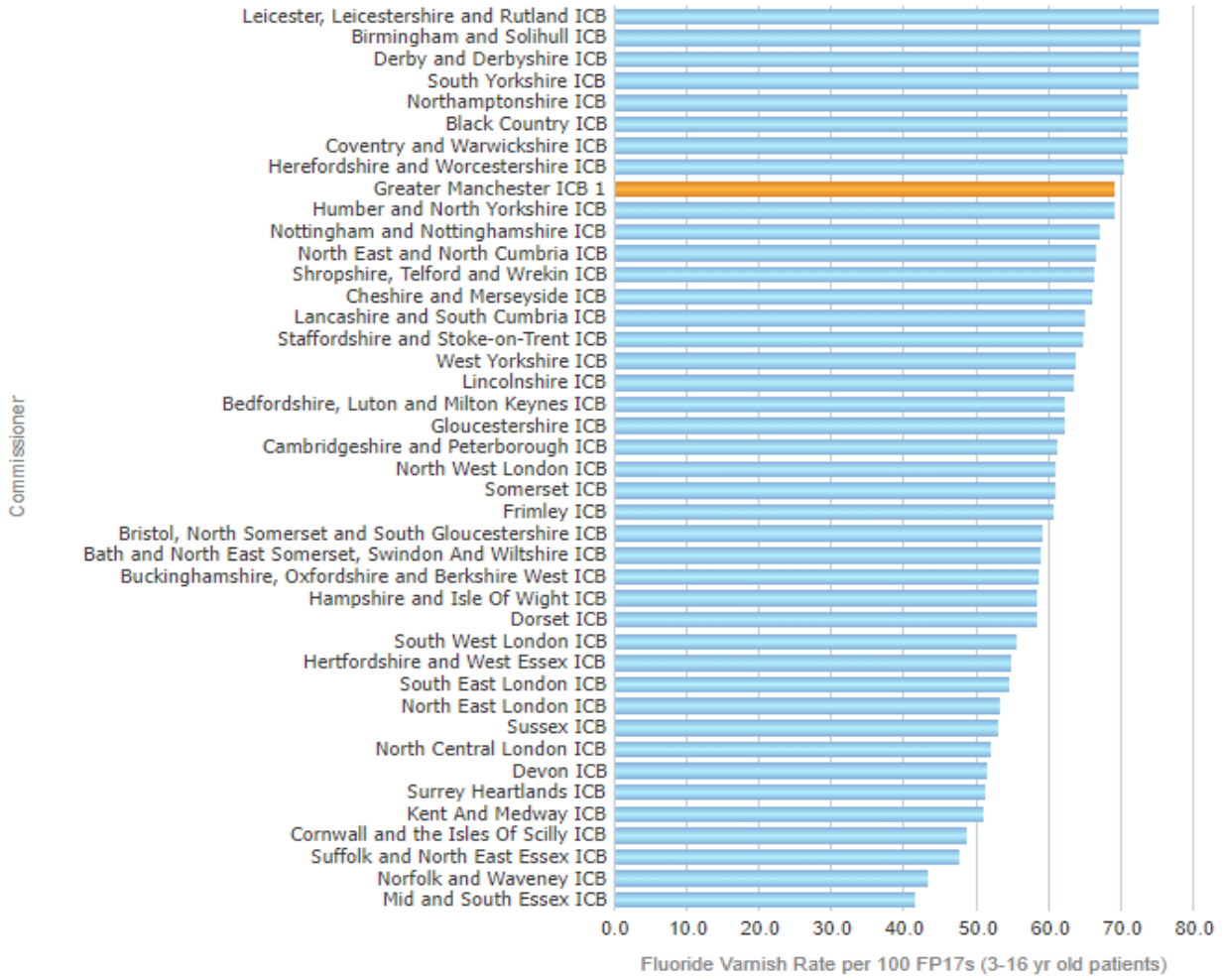


Figure 10: GM FV rate (Sept 2023) compared to other ICBs

FIGURE 11: GM FLUORIDE VARNISH RATES SPLIT BY LOCALITY (30/09/2023)

Locality	Fluoride Varnish Rate (July - Sept 2023)
Bolton	66.4%
Bury	66.9%
HMR	76.6%
Manchester	67.9%
Oldham	77.8%
Salford	64.7%
Stockport	69.5%
Tameside	66.8%
Trafford	**74.7%**
Wigan	70.4%
Greater Manchester	**69.1%**
England	**61.5%**

ORAL HEALTH IMPROVEMENT – GM CHILDREN & YOUNG PEOPLE PROGRAMME

NHS Greater Manchester Integrated Care

The evaluation of the GM Oral Health Transformation Programme (OHTP) demonstrated the success in delivering at-scale to improve the oral health of our children. The first phase of the GMOHTP programme included:

- Daily supervised toothbrushing in all nursery and reception Early Year settings for children aged 2-5 years (over 58,000 children; 88.4% of population, in 88% of settings)
- Deliver Health Visitor 0-3 years training and fluoride dental packs distribution at 1 year and 2-2 ½ year checks.

It is planned that the second phase of the programme will be rolled out across the GM footprint as part of the GM C&YP Oral Health Improvement Programme.

This will support the additional funding Greater Manchester will receive from **GM CYP Transformation funding stream for 2024-25** around Early Years for dental pack distribution to children aged 0-2 years.

ORAL HEALTH IMPROVEMENT – ONLINE TRAINING

NHS Greater Manchester Integrated Care

NHSE has supported training for healthcare providers across GM by developing open access online training packages.

Mouth Care Matters in the community - training material suitable for the wider care team, including care managers and care staff carrying out admissions, assessments and provision of daily mouth care. It ensures dignity and comfort.

Mouth Care Matters in the acute sector – developed to support NHS Nightingale North West and for all nurses and care staff providing and supporting effective mouth care for all hospitalised patients during COVID. Daily mouth care in hospital reduces the risk of infection such as Hospital-acquired pneumonia (HAP), which in turn reduces the length of a hospital stay.

Supervised Toothbrushing in Early Years and Educational Settings - training material intended for early years and education staff who are working with their local health teams to deliver a supervised toothbrushing programme.

NHS
Greater Manchester
Integrated Care

ADDRESSING INEQUALITIES THROUGH ACCESS TO NHS DENTAL SERVICES

ADDRESSING INEQUALITIES – CHILD FRIENDLY DENTAL PRACTICE (CFDP) NETWORK

NHS Greater Manchester Integrated Care

Two Child Friendly Dental Practice pilots were initiated in November 2020.

Children who have been referred for an oral health assessment to a specialist setting (including those referred for dental extractions under general anaesthesia) are instead offered evidence-based treatment at an identified Child Friendly Dental practice.

Treatment includes:

- Prevention – Oral Hygiene Instruction, diet advice, fluoride varnish application, fissure sealants
- Stabilisation – Silver Diamine Fluoride, Temporary Fillings
- Restoration – Hall Crowns, Definitive Fillings
- Extractions

This primary care service supports our specialist community services for children and reduces referrals and pressures in secondary care and has been rolled out across Greater Manchester to 6 Practices (0 in Trafford however patients can access the other 6 practices in the CFDP network).

Funding has been received from National Institute for Health and Care Research (NIHR) for a two-year evaluation led by the University of Manchester.

ADDRESSING INEQUALITIES – A DENTAL HOME FOR LOOKED AFTER CHILDREN

Led by the GM Dental Commissioning Team and Consultant in Dental Public Health linking with Local Authority Teams supporting health care for children in care, a digital referral service has been developed that will support looked after children in Greater Manchester and Cheshire & Mersey **find a dental home.**

The objective is to seamlessly connect referrals for any child who is looked after with a dental practice near their home. In GM, all dental practice may accept children in care. There are 39 Practices across GM (4 in Trafford) also accepting via digital referrals route.

Children are seen and treated and offered regular appointments and re-calls dependent on their oral health need. The long-term objective will be to strengthen the links of the GM Safeguarding Team with our dental teams to ensure that there is ease of access for all children in care to find a dental home.

ADDRESSING INEQUALITIES – MIGRANT HEALTH SUPPORT (AFGHAN EVACUEE AND ASYLUM SEEKER PATHWAY)

NHS Greater Manchester Integrated Care

Led by the GM Dental Commissioning Team and Consultant in Dental Public Health, linking with Local Authority Teams and Localities supporting health care for Asylum Seekers and Afghan Evacuees, a new referral service was developed to support this cohort of patients in Greater Manchester to access urgent dental care.

The service was rolled out in October 2021 and provides access to urgent dental care for those placed in Contingency Hotels across Greater Manchester.

The objective is to seamlessly connect referrals for those in contingency hotel accommodation with a provider of dental services in their locality.

Across Greater Manchester there are currently 14 practices (0 in the Trafford locality as we do not currently have any bridging or contingency hotels in this locality) committed to delivery of this scheme.

ADDRESSING INEQUALITIES – HEALTHY LIVING DENTISTRY PROJECT

NHS Greater Manchester Integrated Care

The Healthy Living Dental Practice (HLD) framework is focused on improving the health and wellbeing of the local population and helping to reduce health inequalities through the provision of inclusive, holistic high-quality care in general dental practice across Greater Manchester.

In GM the Healthy Living Dentistry (HLD) project continues to be developed and delivered.

Currently there are 70 Practices across GM (5 in Trafford) signed-up to deliver this quality assured scheme Dental practices undertake national & local health campaigns, often linked to local GPs & Pharmacies. Plans are in place to begin a further recruitment campaign to encourage all Practices to sign-up to this scheme.

All practices have access to training and development that is supported by NHSE and available online.

Practices who sign up to HLD, can deliver targeted health promotion to specific groups such as:

- Dementia Friendly Dentistry
- Child Friendly Dental Care
- Mouth Cancer Awareness
- Managing Dental Trauma
- Sugar free diet and medicines
- Flu awareness

ADDRESSING INEQUALITIES – GM DENTAL TOOLKITS – DEMENTIA FRIENDLY DENTISTRY

NHS Greater Manchester Integrated Care

The aims of this toolkit are:

Firstly, to improve the general experience of attending the dental practice for those living with dementia and their carers. By improving understanding of dementia and making simple adjustments within the dental practice, anxiety around attending for dental care can be greatly reduced and consequently dental visits can remain part of everyday life for as long as possible.

Secondly to provide guidance to primary care clinicians around planning dental care for people living with dementia. There is particular emphasis on assessment and treatment planning for those in the earlier stages of the condition and for those who have been recently diagnosed. Careful planning of dental treatment and prevention whilst the patient is in the earlier stages of dementia, and still able to tolerate dental treatment, will reduce the risk of acute and more complex dental problems developing during the later stages when provision of dental treatment becomes more challenging and may require onward referral to specialised services.

The dental care for patients in the middle to later stages of dementia, often follows a share care pathway involving a specialist service and the primary care clinician. The toolkit provides informatio on this and how to manage urgent dental care needs for these patients.

ADDRESSING INEQUALITIES – GM DENTAL TOOLKITS – HEALTHY GUMS DO MATTER

NHS Greater Manchester Integrated Care

The Greater Manchester Local Dental Network (GM LDN) has worked on periodontal management in primary dental care since 2014. This is important due to the clinical implications of gum disease and diabetes management and cardiovascular diseases.

A periodontal resource toolkit for primary dental care teams in Greater Manchester has been produced. The intention is to compliment the evidence informed guidance on prevention that has been published in the 3rd edition of Delivering Better Oral Health (DBOH), with evidence informed periodontal care and treatment pathways to support primary dental care teams in GM to improve outcomes for patients. The toolkit will distil the evidence and specialist guidance available on prevention and treatment, into workable care pathways for NHS primary dental care practices in Greater Manchester.

The care pathways have been developed according to periodontal need and as such, describes the periodontal need and outcomes of care for patients attending NHS primary dental care in Greater Manchester. It is important that we use the funding in current contracts effectively by facilitating primary dental care teams to appropriately manage periodontal diseases in NHS practice. The Dental commissioning team are integral to the work and have agreed to support delivering best practice. The success of this work depends on clinical teams engaging, having the knowledge and confidence to deliver evidence based best practice for periodontal disease with patients understanding their responsibility in self-care to demonstrate improved outcomes for everyone.

ADDRESSING INEQUALITIES – GM DENTAL TOOLKITS – SAVING SMILES

NHS Greater Manchester Integrated Care

The Greater Manchester Local Dental Network (GM LDN) has established a 'Trauma Network' sub-group.

The Trauma Network was established to support a safer, faster, better first response to dental trauma and follow up care across GM.

The Toolkit was produced to support dentists in managing dental trauma and improving outcomes for patients and aims to ensure that:

- All clinicians in GM have the confidence and knowledge to provide a timely and effective first line response to dental trauma.
- All clinicians are aware of the need for close monitoring of patients following trauma, and when to refer.
- All settings have the equipment described within the 'armamentarium' section of this booklet to support optimal treatment.
- Online training and CPD is available for all dentists to undertake that supports the toolkit

ADDRESSING INEQUALITIES – DENTAL TOOLKITS – ORAL CANCER CARE

NHS Greater Manchester Integrated Care

To support Dental Teams in Greater Manchester, the GM Local Dental Network has adapted the Oral Cancer guide created by Cheshire and Merseyside LDN.

Toolkit aims to improve the oral cancer survival rates in Greater Manchester by:

- Enabling dental teams to support patients in reducing risk factors for cancer and oral cancer and undertake brief intervention, including signposting to support services as part of a healthy living dentistry approach to care.
- Raising awareness of the signs, symptoms and risk factors associated with oral cancer.
- Helping dental teams in GM to make appropriate urgent 'Two Week' referrals to a secondary care cancer service.
- Promoting good practice guidance on how to engage when talking about oral cancer with high-risk patients.
- Supporting dental practices in the dental care of patients with oral cancer and other cancers, with a large emphasis on preventive care and management.

There is also collaborative working across dental services and cancer services to suppor those patients on cancer treatment pathway to have access to appropriate dental care.

NHS
Greater Manchester
Integrated Care

CARE QUALITY COMMISSION (CQC)

CARE QUALITY COMMISSION (CQC)

NHS Greater Manchester Integrated Care

The CQC is the independent regulator of health and adult social care in England.

They make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

The CQC regime is to inspect 10% of dentists in England each year. The inspection reports can help to understand the quality of care. Unlike most types of service, the CQC don't give ratings to dentists. This is because they only inspect 10% of dental services because dental services pose a lower risk to patient safety than other sectors regulated by the CQC. Instead, they display ticks and crosses against each of their five key questions to show if:

- There is no action required.
- The service has been asked to make improvements
- Enforcement action has been taken

The five key questions relate to the following areas:

- Safe
- Effective
- Caring
- Responsive
- Well-led

NHS
Greater Manchester
Integrated Care

PATIENT FEEDBACK

PATIENT FEEDBACK – RESPONDING TO FEEDBACK

From 1st July 2023, NHS England's regional complaints handling function moved to NHS Greater Manchester.

The main themes of enquiries being received include not being able to get an appointment or patients being told that they cannot be seen in the NHS but can be seen the same week privately.

Although a large number of enquiries are being received, these are not being taken forward as formal complaints and are generally dealt with informally.

The GM Dental Commissioning Team is working in conjunction with the Local Dental Networks to ensure adherence to national guidance in service delivery; and NHS Greater Manchester Communications Team to develop a suite of communications assets shared across all our partner organisations detailing what is currently available, how patients can access services, and what to expect when attending.

The GM Dental Commissioning Team continues to support the NHS GM Complaints team with advice and written responses to all patient enquiries, complaints, MP enquiries, and enquiries from the Mayoral Office for GM.

PATIENT FEEDBACK – HEALTHWATCH

All Greater Manchester Local Dental Committee (LDC) Chairs have committed to engaging with local Healthwatch Officers to ensure that there is clear communication and understanding of any issues that are highlighted by clients.

LDC Chairs have agreed to attend local Healthwatch meetings, and it has been agreed that a Healthwatch representative from GM is invited to attend the Dental Provider Board to provide a report on behalf of the 10 Healthwatch organisations.

TRAFFORD COUNCIL

Report to: **Health Scrutiny Committee**
Date: **29/11/23**
Report for: **Information**
Report of: **Cathy O'Driscoll, Associate Director Delivery & Transformation, NHS GM (Trafford)**

Report Title

Greater Manchester Elective Care Recovery & Reform Programme

Summary

This report provides an overview of the Greater Manchester (GM) elective care recovery and reform programme, the reporting structure and the governance mechanism to ensure robust delivery of elective recovery across GM.

The report also shows the Trafford specific elective recovery position against the GM position.

Recommendation(s)

Health Scrutiny are asked to note the content of this report.

Contact person for access to background papers and further information:

Name: Cathy O'Driscoll, Associate Director Delivery & Transformation, NHS GM (Trafford)

This page is intentionally left blank

NHS
Greater Manchester

GM Elective Care Recovery & Reform Programme Overview

November 2023

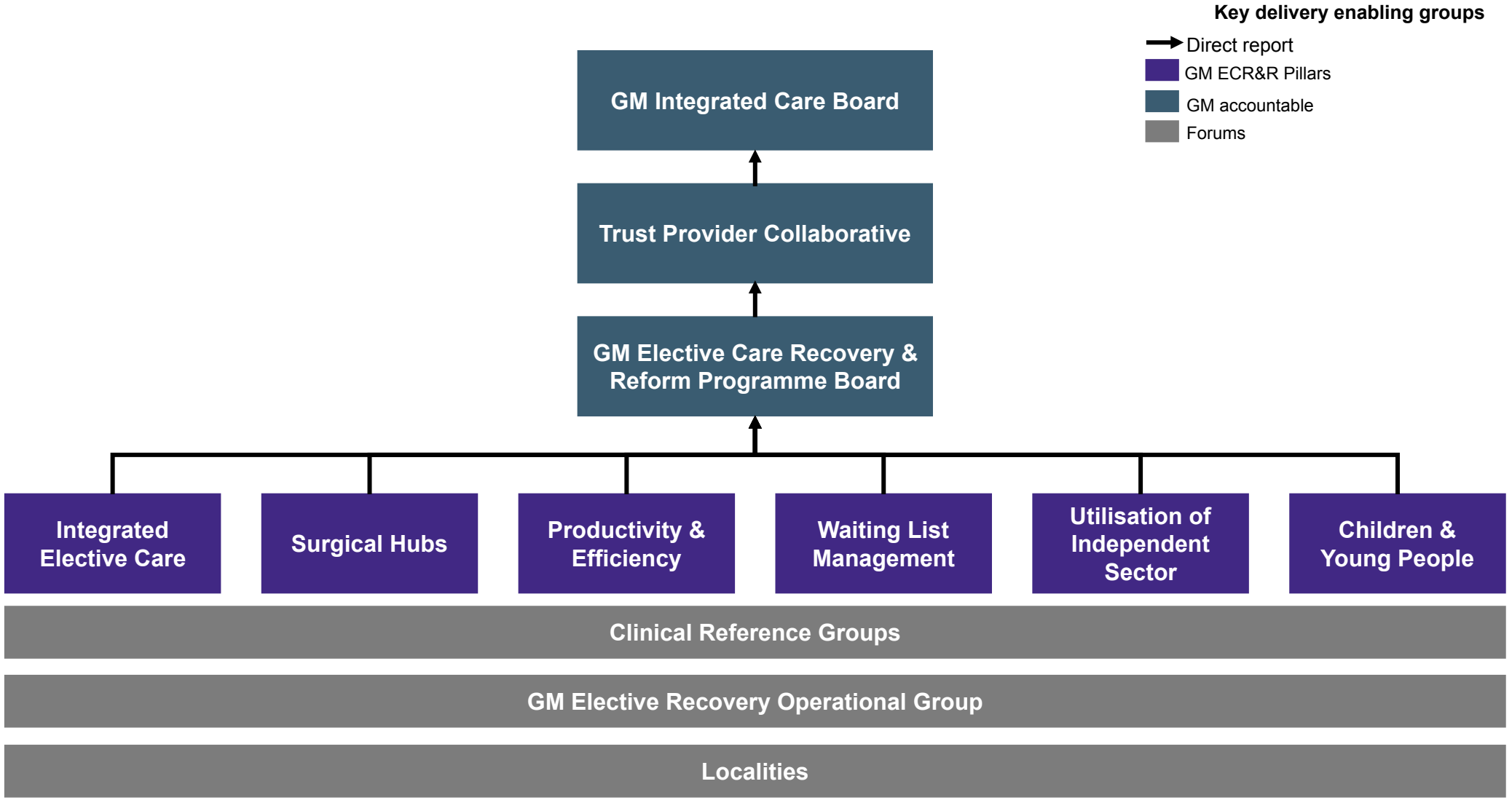
Part of Greater Manchester Integrated Care Partnership

NHS
Greater Manchester

Governance

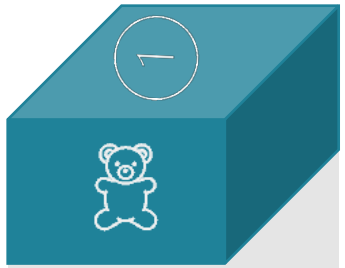
Reporting Structure

NHS Greater Manchester



The Pillars

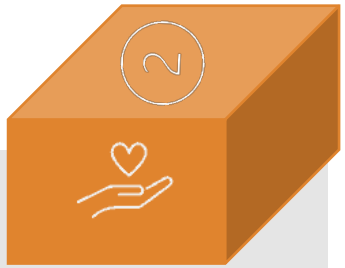
NHS Greater Manchester



Children & Young People

Key Priorities

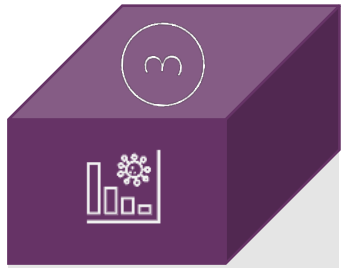
- Reduce wait list size
- Reduce waiting times
- Increase capacity
- Improve referral pathways
- Increase C&YP post-COVID recovery rate
- Close gap between children & adult recovery
- Reduce variation and inequalities



Integrated Elective Care

Key Priorities

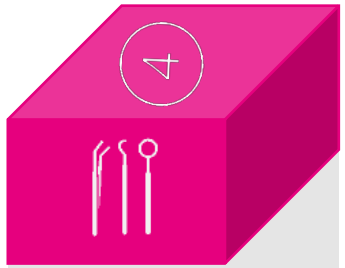
- Increase PIFU utilisation
- Increase Specialist Advice utilisation
- Improve Missed Appointment (DNA) Rates
- Wait List validation
- PEP Implementation



Productivity & Efficiency

Key Priorities

- Increase theatre productivity
- Make surgery Day Case by default
- Optimise Elective Length of Stay
- Identify opportunities for improvement through GIRFT



Surgical Hubs

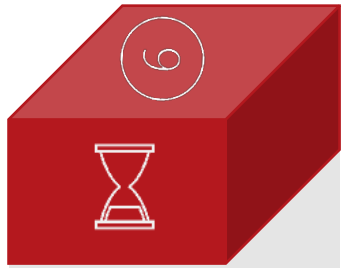
Key Priorities

- Increase hub utilisation
- Provide mutual aid support across GM
- Achieve GIRFT metrics for Theatre Utilisation
- Reduce unwarranted variation across hubs

Utilisation of the Independent Sector

Key Priorities

- Support the creation of capacity within the GM system
- Liaise with providers to support movement of patients
- Identify opportunities for use of IS Providers
- Monitor IS usage



Waiting List Management

Key Priorities

- Develop a GM-Wide access policy
- Develop and socialise a Risk Stratification Tool
- Develop and monitor a mutual aid approach
- Patient Choice & PIDMAS
- Continue to embed ‘While You Wait’ within GM

NHS
Greater Manchester

Trust Provider Collaborative (TPC)

Trust Provider Collaborative & Director Groups

NHS Greater Manchester

The Trust Provider Collaborative (TPC) brings together the Chief Executives of the acute, mental health and specialist providers across Greater Manchester, the key guiding principle of the work of TPC is to work together when it makes the most sense and adds value.

There are 8 TPC Director Groups to support ongoing collaboration and the work of TPC. Each group provides expert advice and input where needed, as well and leading and driving specific areas of work. Each group is attended by a rep from every Provider Trust.

- Chief Data Officers
- Chief Information Officers
- Chief Nurses
- Chief Operating Officers
- Directors of Finance
- Directors of Strategy
- Executive Medical Directors
- HR Directors

- Bolton NHS Foundation Trust
- The Christie NHS Foundation Trust
- East Cheshire NHS Trust
- GM Mental Health NHS Foundation Trust
- Manchester University NHS Foundation Trust
- Northern Care Alliance NHS Foundation Trust
- North West Ambulance Service NHS Trust
- Pennine Care NHS Foundation Trust
- Stockport NHS Foundation Trust
- Tameside & Glossop Integrated Care NHS Foundation Trust
- Wrightington, Wigan and Leigh NHS Foundation Trust

Trust Provider Collaborative & Director Groups
Elective Care Reps

NHS Greater Manchester

TPC:
Fiona Noden

Chief Data Officer:
Vacant

Chief Information Officer:
Malcolm Gandy

Chief Nurses:
Vacant

Chief Operating Officers:
Rae Wheatcroft &
Trish Cavanagh

Directors of Finance:
John Graham,
Tabitha Gardner &
David Warhurst

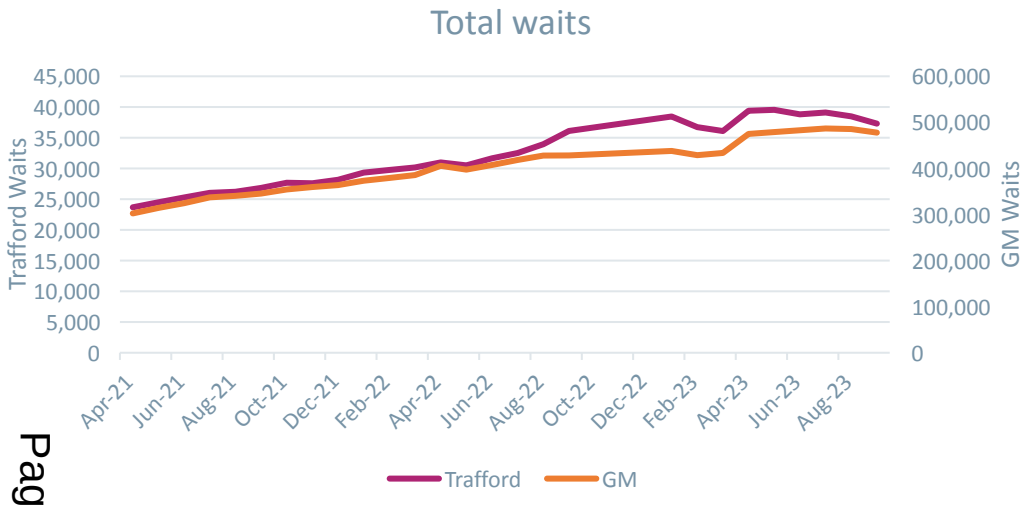
Director of Strategy:
Sharon White

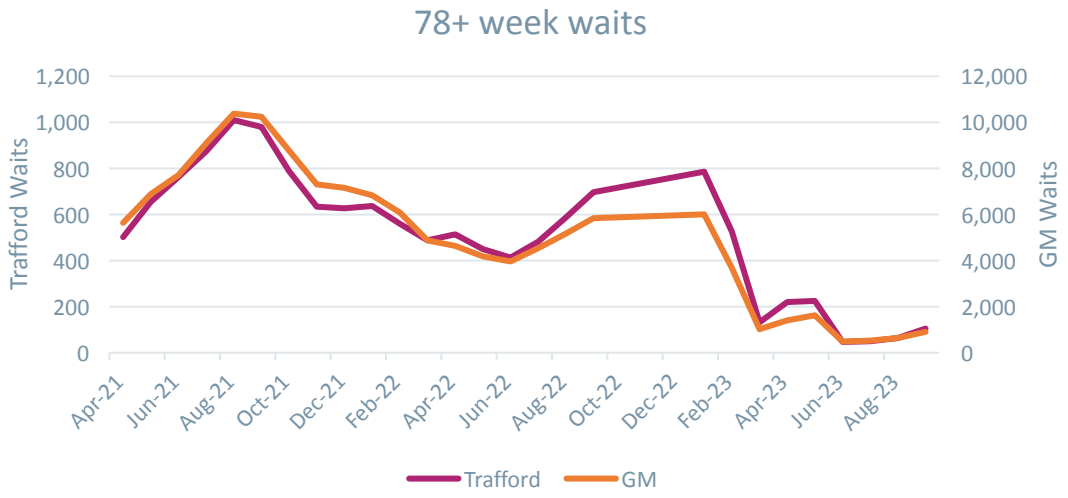
Executive Medical Directors:
Francis Andrews &
Jane Eddleston

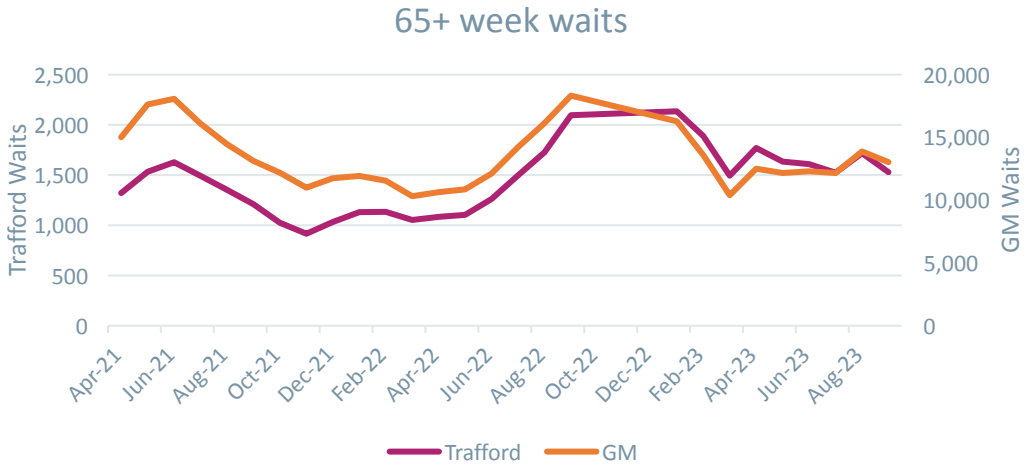
HR Director:
Estelle Carmichael

Elective Care – RTT Waiting List

NHS Greater Manchester







- The past two months have seen decreases in both total trafford waits and overall GM waits, following a long period of increase. Trafford patients account for 7.8% of total GM waits
- Figures for 65+week waits and 78+ week waits appear broadly stable. Trafford patients make up 11.7% of 65+ week waits in GM, and 11.6% of 87+ week waits.
- Note that data from Oct-Dec 2022 has been removed from these charts due to data completeness issues

MFT RTT Performance

Total Waits

Treatment function	MFT total	Trafford patients at MFT
Other - Medical Services	23,849	4,231
Gynaecology Service	17,787	3,383
Oral Surgery Service	17,657	1,857
Other - Paediatric Services	15,847	1,606
Other - Surgical Services	12,781	1,953

- Above are the 5 treatment functions with the highest total number of waits at MFT in Sept 2023
- There were 178,974 waits across all treatment functions at MFT. 33,535 of those were trafford patients

65+ Week Waits

Treatment function	MFT total	Trafford patients at MFT
Oral Surgery Service	1,102	64
Other - Medical Services	905	184
Gynaecology Service	760	99
General Surgery Service	758	200
Plastic Surgery Service	551	77

- Above are the 5 treatment functions with the highest number of 65+ week waits at MFT in Sept 2023
- There were 7,885 waits of 65+ across all treatment functions at MFT. 1,390 of those were trafford patients

78+ Week Waits

Treatment function	MFT total	Trafford patients at MFT
Oral Surgery Service	140	-
Plastic Surgery Service	84	11
General Surgery Service	63	21
Gynaecology Service	59	6
Urology Service	57	16

- Above are the 5 treatment functions with the highest number of 78+ week waits at MFT in Sept 2023
- There were 606 waits of 78+ across all treatment functions at MFT. 86 of those were trafford patients

TRAFFORD COUNCIL

Report to: **Health Scrutiny Committee**
Date: **29/11/23**
Report for: **Information**
Report of: **Winter Planning Update 23/24**

Report Title

Winter planning 2023/24 - update

Summary

This report provides an update on the various elements of system winter planning 2023/24, including the Urgent and Emergency Care Recovery Funds.

Recommendation(s)

Health Scrutiny are asked to note the content of this report.

Contact person for access to background papers and further information:

Name: Paul Thomas - System Resilience Urgent Care Manager

1.0 Introduction

1.1 This paper gives an update on winter planning for 2023/24.

1.2 In line with previous years, the Manchester and Trafford System Resilience Team will lead and co-ordinate on all aspects of winter planning and the lessons learnt from winter 2022/23 have been incorporated into the organisational delivery plans.

2.0 System Winter Plan

2.1 The system winter plan has been developed in collaboration with system partners, highlighting key areas of delivery and focus into the winter period. These include delivery of Hospital at Home model, acute rollout of Back to Basics, and the bespoke Tier 1 support from national teams and Newton Europe.

2.2 Development of the plan has been led through the Manchester and Trafford Operational Delivery Group (ODG), a system wide group with representation from operational leads across the Manchester and Trafford footprint.

2.3 A check and challenge on winter preparedness was conducted through the Manchester and Trafford Urgent Care Board on 20th October.

2.4 Further work has been identified to describe how the Voluntary, Community and Social Enterprise (VCSE) sector will support the urgent care system through Winter.

2.3 A first version of the plan has been shared with locality system partners and GM ICS. An updated version of the winter plan will be shared in December, which will also include system service planning, outlining urgent care service operations across the Christmas and New Year period.

3.0 Urgent and Emergency Care Recovery Funds

3.1 In March 2023, GM Integrated Care System (GM ICS) informed localities of capacity/recovery funding available for 2023/24 to help plan in a more coordinated way. This funding allocation sits across several separate workstreams supporting virtual wards, discharge and securing additional capacity.

3.2 On 19th October, the Trafford Locality Board, discussed a proposal on which winter schemes to be funded and allocations, from the capacity/recovery funding. An agreement was reached with system partners on the allocations on an organisational basis, with further work underway on the specifics of delivery.

3.3 This agreement will allow Primary Care to start an immediate implementation of Winter schemes in support of Urgent Care. Specifically, implementation of the Acute Respiratory Infection Hubs, providing high volume of additional same day respiratory capacity at times of surges in demand, and additional clinical and non-clinical sessions. These schemes will help to release capacity in general practice and reduce

pressures on secondary care through emergency department attendance avoidance and admission avoidance.

3.4 The locality team has now received support from GM to mobilise these schemes. We also understand that additional funding of £2 million is being held at a GM level to support primary care throughout the winter. From this resource we understand that all localities will receive funding to implement 'surge hubs' and we expect confirmation and the conditions relating to funding. An update will be provided to the Locality Board in December 2023.

4. Urgent and Emergency Care support fund for local authorities

4.1 In addition, Trafford Council had the opportunity to bid for additional winter funding from the Department of Health and Social Care Local Authority Urgent and Emergency Care Support Fund. Working with partners a bid was submitted including schemes that will support the system, including the voluntary sector, throughout the winter. The council has received confirmation that 100% of the bid was successful and will receive an allocation of £440,000.

4.2 The funding will be utilised to mobilise the following services:

a) **High Intensity User (HIU) Service:** Employing a fixed term HIU health coach to support 50 Trafford residents who frequently attend the ED at Wythenshawe hospital. Potential to upskill existing roles in the system to enable a fast start model.
b) **Test and Learn Extension:** The PCNs and the VCFSE sector have developed a community-based model to support the core 20 plus 5 concept to reducing health inequalities. This was successfully tested in in June 2023. The aim is to roll out the model across the framework of neighbourhoods.
c) Expansion of Rapid MDT Pilot for Pathway 3 Patients: The Council undertook a pilot in February 2023 with therapy colleagues to explore cases referred and accepted into Discharge to Assess P3. They assessed the person the day after transfer to a P3 placement and formed an MDT view of the person's needs to facilitate an alternative P1 discharge. It is proposed to extend the approach over the winter period.
d) Business Unit to support care package brokerage: The Business Unit sits as a centralised hub between social work teams, providing support for urgent care activity. The unit discharges a broad range of back-office functions. It is proposed to increase the brokerage element.
e) **Agency Business Analyst Support:** It is proposed to employ an agency Business Analyst to support additional activity pertaining to the proposed interventions funded under this grant and wider discharge related activity for the winter period, recognising current capacity limitations.

5. Impact Monitoring

5.1 A process to agree the impact of these various schemes is currently being developed. Regular updates will be provided throughout locality governance and to the Manchester and Trafford Urgent and Emergency Care Board. This analysis will also be used to support planning for next financial year (24/25)

This page is intentionally left blank

Progress of Public Health work carried out in Partington and across Trafford to reduce cancer rates.

1. Introduction

In January 2023 Trafford's Health Scrutiny Committee received a report describing cancer rates in Partington and recommendations for action. This report provides an update on current public health intelligence and activity to improve cancer outcomes across Trafford, with a particular focus on Partington[1].

2. Cancer as a public health issue

Cancer remains a leading cause of death in England. The main factors which increase the risk of cancer are influenced by the wider determinants of health and include deprivation, smoking, alcohol, and obesity.

Socio-economic disadvantage further compounds poorer cancer outcomes. Early presentation is key to treatment and survival.

Trafford's Public Health team are working with partners to prevent cancer, to support early diagnosis and to improve survival outcomes.

For a more comprehensive description of the risk factors and impact of the wider determinants on cancer rates, please refer to the January 2023 Health Scrutiny paper, (see agenda item 5, (Public Pack)Agenda Document for Health Scrutiny Committee, 18/01/2023 18:30 (trafford.gov.uk)).

3. Local context

A variety of data is available to help us understand cancer prevalence and mortality at the local level, as well as to monitor activity around diagnosis and screening. A supplementary document with descriptive data across a number of cancer indicators is available by contacting Public Health.

In 2019 Trafford's Director of Public Health (DPH) asked Public Health England (PHE) to review cancer rates in Partington following reports from a GP at Partington Central Practice that they were seeing what they perceived to be an unusually high number of people with cancer. PHE agreed that rates were high and asked the Cancer Registry to undertake a review.

The data used in the analysis were from 2010-2017 as this was the latest available data from the Cancer Registry. The summary of the Cancer Registry's review was as follows:

- Age-standardised cancer incidence rates in the Partington Central Surgery vicinity from 2010-2017 were statistically significantly higher than the rates in NHS Trafford CCG and England as a whole.
- The Partington Central Practice vicinity had a high level of deprivation. Compared to the other 'most deprived' areas of NHS Trafford CCG, the Partington Central Surgery vicinity was less of an outlier, although rates were still high.
- The profile of cancers in Partington looked typical for deprived areas, with the most common cancer being lung cancer. Although there were more cases of mesothelioma than average, numbers were very small, and this was not statistically significant.

[1] Trafford's West neighbourhood consists of five wards: Bucklow-St Martins (the ward including Partington), Davyhulme East, Davyhulme West, Flixton, Urmston.

- The Office of Health Inequalities and Disparities (OHID, formerly PHE) are currently re-running this analysis up to and including 2021 data. This will enable local teams to review cancer rates and to support ongoing interventions.

The Quality Outcomes Framework (QOF) is a set of indicators recorded by GPs about their patients. One of these indicators is the percentage of patients with cancer, as recorded on practice disease registers (register of patients with a diagnosis of cancer excluding non-melanotic skin cancers). In 2021/22, 3.8% of people registered with GPs across Trafford were recorded as currently having cancer. In the West Primary Care Network (PCN) this was slightly higher at 4.1%. Looking specifically at practices in Partington, there was no difference in prevalence of cancer among patients at Partington Family Practice compared to Trafford. At Partington Central Surgery, rates were slightly higher, (4.1%) but this difference is not considered to be statistically significant.

While there is not a marked difference in the overall number of cancer cases in Partington compared to Trafford, there is a difference in mortality from cancer. The Office for National Statistics collect data on causes of death and enable comparisons at different levels of geography. If the ratio of death from cancer for all ages is set at a reference value of 100, then over the period 2016 to 2020 Trafford's overall ratio was slightly lower (but statistically similar) at 97.0 but the ratio for Bucklow-St Martins was much higher at 141.7. When limiting the analysis to people aged under 75, the ratio for Trafford was again similar to England (97.3 compared to 100.0) but Bucklow-St Martins had the worst ratio in the borough at 175.2.

The above data sources cannot provide us with information about reasons for these differences. There may be a number of factors at play, including how and when cancer cases are detected, how advanced a person's cancer is when it is diagnosed, what treatment they receive and when. Other public health data sources do give us some indication of trends and patterns at the *population* level, but do not necessarily tell us what happens to an *individual patient*, as this would require detailed examination of clinical record.

4. Greater Manchester and local systems to address cancer.

Greater Manchester (GM) Cancer Alliance is one of 21 Cancer Alliances nationally. The programme of work is driven by national operational planning guidance, with the Alliance accepted as the 'cancer arm' of NHS GM Integrated Care. The 2023-24 plans are summarised in Appendix A.

The Alliance has a management team and structure in place with strong clinical leadership for each of the pathway boards and programmes. The Alliance will set priorities for cancer commissioning for GM in line with the national planning guidance.

The Cancer Board is part of the formal governance structure of NHS GM IC. The Board receives updates from each of the Cancer Alliance programmes at each meeting, which includes early diagnosis, faster diagnosis and operational performance, and personalised care and treatment.

Locality teams work closely with the GM Cancer Alliance to support place-based activity and to ensure the GM programmes of work reflect the needs of the locality populations.

5. Progress update

Prevention and early intervention programmes have been implemented across Trafford including Partington for many years. The January report recommended action on the wider determinants of health, and a focus on public health intervention, progress is described below.

5.1. Work to address the wider determinants of health.

Trafford Council and partners are committed to improving the wider determinants of health, this includes through the provision of services, improved infrastructure, education, and employment. Trafford's Public Health team is integrated into the Greater Manchester, and local health and care system.

Trafford has an established Locality Board and Health & Wellbeing Board; each have priorities that will impact on the wider determinants of health. Work is underway to develop a Joint Locality and Health and Wellbeing Strategy for Trafford.

The Locality Board has three priorities: resilient discharge, urgent care, and the neighbourhood programme. The Health and Wellbeing Board has five priorities:

- To reduce the impact of poor mental health.
- To reduce physical inactivity.
- To reduce the number of people who smoke or use tobacco.
- To reduce harms from alcohol.
- To support our residents to be a healthy weight.

Improvements across these public health areas will reduce cancer rates and improve outcomes. Each of the priority areas has an active local partnership that are focusing action both at a population level and an inequalities level.

Furthermore work is also underway to establish local oversight governance to coordinate local activity to address health inequalities. It is expected that the Health and Wellbeing Board will be accountable for this partnership and that the workprogramme will incorporate cancer rates and outcomes.

Integrating services and embedding a population health preventative approach are the principles of Trafford's Neighbourhood Programme. Central Neighbourhood has identied cancer as one of the three priorities.

Incorporating residents and stakeholders voices, each of the four neighbourhoods have a local plan. The west locality plan, that covers Partington was informed by public health data and facilitated by the West Community Collective Hub and has four priorities: help people move more, widen access to a healthy diet, improve early start opportunities for young boys, and help services to engage with local people better.

The West neighbourhood engagement team is currently engaged in an audit process of identifying all existing activity against the four priorities, to analyse gaps, weaknesses, and opportunities for neighbourhood-level activity.

5.2. A focus on public health interventions

Addressing the risk factors for cancer and strengthening prevention activity is key to reducing cancer rates.

5.2.1. Weight management

Public Health commissions tier 2 weight management services for all Trafford residents, but with particular focus on areas of greatest deprivation due to the social gradient associated with excess weight. The two locally commissioned services are Slimming World on Referral and FitFans. Based on reporting data and mapping of attendance, Slimming World on Referral appears to be well accepted by Partington residents, with weight loss outcomes better than those seen across participants from all areas of Trafford. For those people living in the most deprived quintile and completing the programme, weight loss outcomes are much higher (average weight loss of 9.8% vs 6.5%) than across the programme.

FitFans is a programme targeted at men living in the most deprived communities, using the power of sport and professional football clubs to engage with local people. FitFans is delivered by Foundation 92 (charitable trust of Salford City Football Club) and they have delivered several cohorts in Partington. Outcomes for those completing the programme are excellent, and the provider has worked closely in partnership with Trafford Leisure to ensure that participants are comfortable to continue being active locally at the end of the programme.

5.2.2. Healthy start vouchers

Eating a healthy and balanced diet can reduce the risk of cancer, support for residents on low income to access healthy start foods contributes to maintaining healthy weight which reduces the risk developing cancer. There is a multi-agency Trafford Healthy Start task force, working to increase uptake of the Healthy Start pre-paid card and vitamins. There has been training undertaken with key partners in Partington, to ensure that they can support residents to access this benefit. The ward of Bucklow St Martins has the greatest number of healthy start eligible beneficiaries (210) and uptake is 69% which is similar to the Trafford uptake rate of 68%, (July 2023). Recently, the Early Help Hubs in Partington and Stretford have started distributing Healthy Start vitamins to those who receive this benefit, as well as selling the vitamins at cost price to those families who may not qualify for Healthy Start but are keen to ensure that they maintain nutritional intake for their children.

5.2.3. Smoking Cessation

Trafford's smoking needs assessment 2022/23 reviewed smoking prevalence across the borough and neighbourhoods. The West's smoking prevalence is 14.5% which is above the national (12.7%) and Trafford average (8%).

Trafford residents are able to access stop smoking support from a range of services. The commissioning decisions have been led by Trafford's needs assessment to deliver a targeted approach for those at greater risk of smoking related harm and reduce health inequalities. The general population are able to access Nicotine Replacement Therapy (NRT), behavioural support, and e-cigarettes from a range of general practices and pharmacies across the borough. Our local needs assessment tells us the smoking rate in people with serious mental illness (SMI) is higher than the general population (35% compared to 8% in Trafford). Public Health have commissioned Bluesci community mental health service to deliver smoking cessation for those with SMI. Partington residents can access this through the Bluesci Partington centre. Early Break Young People & Family Service deliver smoking cessation support to children and young people. They work with service users in the community, this includes schools and home visits, this supports access for Partington residents.

Our colleagues in the Greater Manchester Making Smoking History team commission services across the Greater Manchester footprint which Trafford residents can access. This includes the

CURE Project, an inpatient hospital quit initiative; the advanced pharmacy services, for those on discharge from hospital; the smokefree pregnancy programme, where specialist trained midwives support pregnant women to stop smoking; and the smokefree app, offering digital personalised stop smoking support with expert advice and treatment.

5.2.4. Targeted Lung Health Checks

The Targeted Lung Health Check Programme is commissioned nationally by NHSE. This programme has been active in Manchester, Salford and Tameside & Glossop for a number of years. From November 2023 the roll out of this programme across Primary Care Networks in other localities in GM has commenced.

In June 2023 the DHSC formally announced that a national targeted lung cancer screening programme will be rolled out across England with 100% population coverage expected by 2030. The NHSE Cancer Programme has confirmed that they will continue to lead the programme nationally with Cancer Alliances acting as the primary delivery partner for the programme at a local level.

The future expansion of TLHCs across Greater Manchester will be delivered on a PCN-by-PCN basis. The rollout order was determined through a process of clinical risk-stratification using data pertaining to socioeconomic deprivation, smoking prevalence, and lung cancer incidence and mortality. This approach ensures that the programme expands into the areas of greatest deprivation and clinical need first by placing all TLHC-inactive PCNs into four cohorts, with each group representing a similar level of clinical risk.

Evidence shows that people living in Partington have a high risk of developing lung disease compared to the national average. Trafford has been allocated Early Cancer Diagnosis funding by the Greater Manchester Cancer Alliance to target work with Partington Family Practice. The practice has started to deliver a weekly respiratory clinic inviting patients 55-74 years of age who have a history of smoking to carry out lung cancer risk assessments, to support earlier identification of lung disease and smoking cessation. The Black Health Agency (BHA), a voluntary sector organisation has been commissioned to deliver community engagement, raising awareness locally and supporting eligible residents to attend appointments.

5.2.5. Alcohol

Alcohol is a key risk factor for cancer. Trafford Council's Public Health Team are currently in the process of developing a joint strategic needs assessment (JSNA) for drugs and alcohol. The purpose of this JSNA is to provide a clearer picture of alcohol use across the borough and to inform future commissioning decisions. Data shows that Bucklow St-Martins ward has the highest hospital admissions for alcohol attributable conditions (both Narrow & Broad definitions) compared to the other Trafford wards and the England average. On review, Trafford Alcohol, Substance Misuse & Gambling Partnership, believe that this is likely to be due to hidden alcohol use within the Partington area. The Public Health Team are currently in the process of engaging with the West Neighbourhood to gather insight about alcohol and substance misuse needs.

At present, to help reduce alcohol harm in the borough, Public Health commissions GPs to deliver AUDIT-C's with patients (an alcohol screening tool to help identify hazardous drinkers or those who have active alcohol use disorders). Both practices in Partington are signed up to this contract. A patient's score on their AUDIT-C will lead to the GP either delivering a brief intervention or extended brief-intervention with the patient or a referral into the specialist substance misuse service, Achieve Recovery Services Partnership. As part of this partnership, Big Life Group is

commissioned to deliver community outreach for adults, and Early Break Young People's Service deliver community outreach for young people, both of which Partington residents can access.

5.2.6. Supporting people with mental ill health.

The BlueSci centre in Partington provides a range of early intervention and preventative mental wellbeing support to Partington residents. As part of the Long Term Conditions (LTC) Prevention Programme that will go live in Partington in January 2024, BlueSci will be delivering bespoke support for people with mental health issues who have or are at risk of LTCs as well as referring into the wider mental health support offer provided locally. The risk factors for LTC such as diabetes and cardio-vascular disease are the same as the risk factors for cancer.

There are a range of mental health and addiction services provided by Greater Manchester Mental Health (GMMH) available to Partington residents. There is also a wide range of mental wellbeing support funded by Greater Manchester including online self-help support, free 24/7 digital support, GM bereavement support, support for the prevention of suicide.

5.2.7. Improving uptake of Bowel screening

Bowel screening is a national programme offered to people aged 60 to 74 years.
The programme is expanding to make it available to everyone aged 50 to 59 years. This is happening gradually over 4 years and started in April 2021. Residents complete a home test kit, called a faecal immunochemical test (FIT) and return it for analysis.

In 2021/22, coverage of bowel cancer screening was lower at both Partington Family Practice (63.8%) and Partington Central Surgery (62.0%) compared to Trafford (68.9%) as a whole. However, when looking at trends over time, the gap between Trafford and Partington Family Practice has been closing and the values are now considered statistically similar.

Trafford has a well-established community programme to support our residents to understand the screening programme and support them to complete. The Voice of BME-Trafford health mentors work with GP practices. The health mentors are trained in conversations around screening, they call the patients who have not completed their screen and have community-based conversations in community languages, to support the patients understanding of this process and encourage them to participate in screening. This model is currently running in Trafford's North Primary Care Network.

5.2.8. Breast screening

The NHS Breast Screening Programme invites all women from the age of 50 to 70 registered with a GP for screening every 3 years. This means that some people may not have their first screening mammogram until they are 52 or 53 years. The screening process often involves women accessing a mammography at a mobile breast screening unit in the community. Practices are invited to attend on a rotational basis.

Breast screening coverage was lower in 2021/22 for Partington Family Practice (39.9%) and Partington Central Surgery (41.4%) when compared with Trafford overall (60.1%). However, while this has been the case consistently for Partington Central Surgery, Partington Family Practice had similar rates to Trafford from 2018/19 to 2020/21 until coverage dropped more recently.

The two Partington practices have the lowest breast screening coverage in Trafford. One of the reasons for this is access and we have been working with the Greater Manchester Breast Screening Programme (GMBSP) to bring back the Breast Screening Unit to Partington. Work to

ensure that the unit could be safely sited in Partington has been successful and the next screening round in Partington will be scheduled for October/November 2024.

October was Breast Cancer Awareness Month, there were a number of community-based events that ran across Trafford to increase awareness of breast cancer screening.

5.2.9. Cervical screening

Cervical screening (a smear test) is a test to check the health of the cervix and help prevent cervical cancer. It is offered to women and people with a cervix aged 25 to 64.

In 2021/22 cervical screening coverage was lower at Partington Central Surgery (67.9%) than in Trafford overall (74.9%), a trend that has persisted for a number of years. However, for Partington Family Practice coverage is similar (73.3%) to Trafford, a trend that has been consistent since 2015/16.

Healthwatch Trafford has recently submitted a bid for a national Healthwatch England project to capture case studies of local women's experiences of cervical screening and barriers to participation. The focus is on women from three groups known to have lower uptake of cervical screening compared to the general population: people of BAME heritage, people with a physical or learning disability, and younger women (ages 25-27) who have been invited for their first smear test.

Alongside their work to promote engagement with bowel screening, Voice of BME are also commissioned to contact patients in North PCN who have not attended for cervical screening. They provide information and support in a range of community languages to encourage eligible residents to take up the offer of a smear test when invited. This model is based on the successful approach adopted in 2017-2018, which saw Trafford achieve the highest cervical screening rates in the Northwest.

The Black Health Agency (BHA) has been commissioned to promote engagement in cervical screening in Partington. This work is due to start imminently.

5.2.10. Primary Care Networks and Early Cancer Diagnosis

The PCNs in the Trafford locality work closely with the GM Cancer Alliance to support the delivery of the Directed Enhanced Service for Early Cancer Diagnosis. Each Primary Care Network has been asked to identify a 'Cancer Lead' who then engages in the education and engagement events led by the Alliance and sharing information with staff in their PCN practices.

5.2.11. NHS Health Checks

The NHS Health Check is a check-up offered to adults aged 40-74 years with no previous diagnosis of cardiovascular disease (CVD) who are not currently taking statins. Although the NHS Health Check does not focus on cancer many of the risk factors are the same as for CVD. Trafford's 5-year cumulative % of eligible patients who were offered and received an NHS Health Check between 2018/19 to 2022/23 was 50.6%, above the England average of 42.3%. In 2022/23, 7,770 Trafford residents received an NHS Health Check, equating to around 10.7% of the eligible population, above the England average of 7.2%; 47.2% of the eligible population who were offered an NHS Health Check received an NHS Health Check, above the England average of 38.9%.

In 2022-23, 371 NHS Health Checks were delivered by Partington Central Surgery and Partington Family Practice, which constituted 4.78% of all NHS Health Checks delivered by Trafford GP Practices in 2022-23. From these NHS Health Checks delivered in Partington, the following

referrals were made: 88 for smoking cessation advice, 26 to a weight management service, 4 to the NHS Diabetes Prevention Programme, 18 for alcohol interventions (8 brief interventions, 6 extended interventions and 4 referrals to the specialist alcohol service), and 1 to a physical activity programme.

Public Health are undertaking targeted work in the community with the Pakistani Resource Centre to increase the uptake of NHS Health Checks in people aged under 40 years from South Asian communities at an increased risk of CVD.

6. Additional Cancer Specific Programmes

Further to the interventions recommended in the previous scrutiny paper, there is also additional programmes focussed on cancer, with some being delivered in Partington.

6.1. Through the Front Door

This is a cancer awareness programme that is currently underway across West and Central Neighbourhoods. Funding has been obtained from the GM Cancer Alliance and it is one of five projects supported out of fifty-six expressions of interest. The programme works with people with lived experience to raise awareness of signs and symptoms of cancer and produce hyper-local social marketing campaigns for their communities. It will also test the theory that working with Patient Participation Groups (PPGs) and the wider Neighbourhood Teams can also increase rates of early detection of cancer. Partington Family is one of the PPGs identified.

6.2. Population Health Fellowship

Trafford Council is hosting a Population Health Fellowship, a national NHS England programme that runs annually. The recruited Fellow is based with the public health team 1-2 days per week until August 2024 (alongside their substantive role as an Advanced Clinical Practitioner in a Trafford GP practice) and will be designing and undertaking a research project on cancer in Partington.

6.3. Prostate cancer awareness

It should be noted that prostate screening is not a national NHS cancer screening programme, however prostate cancer can be effectively treated if detected early hence the introduction of a 'Prostate Cancer Case Finding' project by the NHSE Cancer programme in 2022-3.

The GM Cancer Alliance were selected as one of 3 pilot sites nationally for this project, developing and launching the 'This Van Can' project. During June and July 2023 a mobile testing van visited 8 locations across Trafford. Men in the 'at risk' categories were invited via their GP to make an appointment on the van – black men over 45 and men over 45 with a family history of prostate, breast or ovarian cancer. Initial feedback has been positive in relation to uptake of appointments. The programme ended on 31st October 2023, and is currently being evaluated.

Arising out of this work is the proposal to deliver a Men's Health MOT project in North Trafford focussing on getting men in for prostate, lung and bowel checks with their GP practices alongside a wider community engagement piece on raising awareness of these cancers. Voice of BME will be delivering this with from GM Cancer Alliances Communication & Engagement Fund.

6.4. Developing an insight evidence base

Greater Manchester Integrated Care Board is engaged in work to generate current insight to inform solutions to health improving barriers.

7. How will we know we are making a difference?

Trafford colleagues will engage with the GM Cancer Alliance, which will help inform our local work programmes, Programmes of Work - Greater Manchester Cancer (gmcancer.org.uk).

Trafford's Public Health Intelligence will continue to monitor and report on the population level cancer outcomes. The Neighbourhood Programme is developing a monitoring framework.

The Health and Wellbeing Board scrutinises each one of the Board's five priorities in detail annually, with constructive challenge to and by partners. Each local partnership has developed or is in the process of developing an action plan with measurable outcomes. The action plans will describe short-, medium- and long-term measures of success. A Health and Wellbeing Board Annual Report process is being developed and will include a dashboard bringing together outcomes and progress to date.

The locality Public Health Team will ensure that Public Health intelligence and tools such as health needs assessments and health equity audits inform the work of the partnerships. Evidence of risks will be reviewed regularly including alcohol, smoking, healthy weight, and air quality. The Joint Strategic Needs Assessment (Trafford JSNA) will continue to be an important source of intelligence which partners can access to inform their ongoing commitment to prevention and health improvement.

Paper produced by Helen Gollins, Director of Public Health and Lucy Rutter, Specialty Registrar of Public Health on behalf of Trafford Public Health Directorate, 20th Nov 2023

Appendix A

GM Cancer Alliance Work Programme

Clinically led Delivery and Innovation
All programmes of work to demonstrate clinically led decision making, working collaboratively with the Greater Manchester Cancer Pathway Board

Target			
Increase Stage 1 & 2 Diagnosis to 75% by 2028	**Achieve Cancer Waiting Times standards Deliver Backlog reduction**	**Increase survival, 2750 more patients in GM living with cancer beyond 5 years (2018 > 2028)**	**Be fully integrated with the NHS GM Integrated Care System (ICS)**
Early Diagnosis	**Faster Diagnosis and Operational Performance**	**Personalised Care and Treatment**	**Structure/Governance**
Effective Primary Care Pathways (including pharmacy referral pilot, Primary Care Network (PCN) support, GP Direct Access Diagnostics)	Diagnostic Transformation (Single Queue, Shared Capacity and Reporting, Community Diagnostic Hub, Digital Pathology and others)	Embed quality offer of personalised care interventions – Holistic Needs Assessments (HNAs), Personalised Care Support Plans (PCSP), Treatment Summaries (TS) and Cancer Care Reviews (CCR)	Support Networks including Operational Delivery Networks (ODNs) in cancer - Teenage & Young Adults, Children's, Radiotherapy
Symptom Awareness, presentation and referral: patient and public facing communications	Best Practice Timed Pathway including Non-Site Specific	Delivery of Patient Stratified Follow-Up (PSFU) supported by a digital remote monitoring system	Models of Care (Breast, Lung, Colorectal & Others)
Targeted Case Finding (Lung Health Check, Liver, Prostate, Pancreatic)	Treatment transformation to achieve Cancer Waiting Time (CWT) targets incl. hubs and system capacity	Improve psychosocial support offer and provide better access to Health & Well Being services	Collaboration with PCNs & localities
Cancer Screening programme delivery and uptake (Bowel, Breast, Cervical)	Innovation to drive recovery (Mastalgia pathway, tele-dermatology etc)	Improve experience of care through piloting a Live Well with Cancer model	Integration with GM governance and decision making
Innovation to drive earlier cancer diagnosis	Effective secondary care pathways to reduce unwarranted variation in waiting time access	Embed genomic testing and targeted treatment	Assurance of financial scrutiny, evidencing value for money
	Systemwide re-design of pathway delivery	**Treatment Variation**	Engagement in GM system work on prevention and Population Health
	System re-focus on CWT	Reduced Variation in treatment (Lung Get It Right First Time (GIRFT) & Breast, Colorectal and Prostate audit recommendations)	

Cross Cutting Programmes

- **Workforce and Education** Workforce Integration (One Workforce), Workforce Wellbeing, Growing and Developing our Workforce, Addressing Workforce Inequalities
- **Identifying and addressing inequalities** : e.g. Data, PCN Leads/DES, Locality engagement, Inequalities Programme Board & Strategy, Equality Impact Assessments
- **Communications & Engagement** : e.g. Patient and Public Involvement and Engagement (PPIE) programme, public campaigns, media, digital channels, GM Cancer Conference
- **Data, Digital and Innovation:** e.g. Tableau & Curator Developments, Clinical Outcomes Data, Primary Care Dataset, Artificial Intelligence, Secure Data Environment.
- **Research** : Research Framework, Activity and Inclusivity data, PWBs engagement, Charity-Industry Research Equity project, Annual report

This page is intentionally left blank

TRAFFORD COUNCIL

Report to: **Health Scrutiny Committee**
Date: **29/11/23**
Report for: **Information**
Report of:

Report Title

Assisted Conception Policy – GM / Trafford Locality

Summary

This report provides an overview of the Assisted Conception Policy for Trafford and an overview of the Greater Manchester (GM) position for Assisted Conception cycles and funding.

Recommendation(s)

Health Scrutiny are asked to note the content of this report and progress to date

Contact person for access to background papers and further information:

Name: Cathy O'Driscoll, Associate Director Delivery & Transformation

This page is intentionally left blank

NHS
in Greater Manchester

Assisted Conception Policy

Version 3.1: (17 Nov 2021)

PLEASE NOTE

Government issued Statutory Instrument: 'The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017 No. 756'

From 21 August 2017, NHS-funded assisted conception services will not be included in the exemption from charge applicable to people who are caught within surcharge arrangements (i.e. those who have paid the surcharge, or who are exempt from paying it (with certain exceptions) or in respect of whom it has been waived). This means that, unless another exemption applies, where NHS assisted conception services are provided to a person who is exempt under surcharge arrangements, overseas visitor charges will apply. This is brought forward through regulations 11, 12 and 13 of the above named instrument, which insert a new regulation (9A) and amend regulation 10 and 11 respectively to the National Health Service (Charged to Overseas Visitors) Regulations 2015.

Exemption from charges currently applies to:

- Serving members of the armed forces and their families (NHS England commissioned)
- Seriously injured serving members and veterans
- Further provision of care previously given
- Continuation of a course of treatment that commenced before 21 August 2017

Assisted conception services in the context of this instrument are defined as "*any medical, surgical or obstetric services provided for the purpose of assisting a person to carry a child*." This definition was based on the definition of "treatment services" in section 2 of the Human Fertilisation and Embryology Act 1990. Broadly speaking any medicines, surgery or procedures that are required to diagnose and treat infertility so a person can have a child. It includes procedures such as intrauterine insemination (IUI), *in vitro* fertilisation (IVF) and egg and sperm donation. The definition is not intended to refer to antenatal or maternity services.

In the operation of this policy, Greater Manchester Integrated Care will have regard to the Human Fertilisation and Embryology Act 1990 (as amended) which provides that a woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting).

Contents

Commissioning Statement

Assisted conception policy	
Prior to offering treatment covered by this policy, the individuals seeking assisted conception should be advised of the need for period of expectant management. They should have tried to conceive for a total of 2 years (The period of expectant management after diagnosis and up to 1 year before their fertility investigations began) before IVF will be considered. For same sex couples and single women offer a further 6 cycles of IUI post referral, to be carried out in an NHS clinical setting, in addition to the self-funded 6 cycles of self-reported vaginal insemination undertaken prior to referral (as the equivalent of expectant management in a heterosexual couple) or 3 cycles if aged over 36 years.	
Policy Exclusions **(Alternative commissioning arrangements apply)**	**Sperm, oocyte or embryo storage to retain fertility** Individuals undergoing treatment for cancer (or for any lifesaving treatment resulting in infertility) or gender reassignment, or as part of the management of a congenital condition which will affect fertility in later life and who are well enough to undergo the required procedures, should be offered gamete (sperm or egg) retrieval and cryopreservation (storage) provided this does not put them at risk of serious adverse health effects from either a delay in treatment or from the procedure needed to retrieve the egg / sperm. The resultant sperm, eggs or embryos will be stored in line with current Human Fertilisation & Embryology Authority (HFEA) regulations. Currently, there is no upper age limit for sperm. However, there is an upper age limit of 43 for eggs and embryos. These should be stored and used in line with HFEA regulations. The eligibility criteria used in conventional infertility treatment do not apply in the case of storage to retain fertility following treatment for cancer or any other treatment resulting in infertility. Policy criteria will apply when the stored material is used for assisted conception in an NHS setting. The only treatments where restrictions will apply to these individuals are; 1) eligibility for IVF/ICSI, if they require more than the currently commissioned cycles or do not meet the criteria an application for exceptionality can be submitted 2) Surrogacy as this is not commissioned by the NHS. All individuals should be informed at the time of storage that if, at the time of treatment for infertility, surrogacy is the only option that this will not be funded by NHS commissioners in Greater Manchester. Individuals over the age of 42 (i.e. after their 43rd Birthday) with exceptional reasons for requesting gamete storage can apply via the IFR (exceptional case) route. (Age limit does not apply to sperm) Individuals undergoing retrieval and storage of sperm and oocytes should be managed in line with NICE CG156. Storage of retrieved sperm and oocytes will be for 10 years in line with HFEA licensing requirements and guidance (such requirements /guidance to be checked for updates as required).

	Extensions to the storage time for sperm or oocytes or age limit for embryos will require IFR (exceptional case) approval. The application should comply with the process for extension of the statutory storage period as outlined in the HFEA code of practice and should not take the period of cryopreservation over the statutory upper limit of 55 years. The individual must be made aware of this at the time of storage. (Correct at the time this policy was produced but the current HFEA guidance should be followed if different from this statement). There is no lower age limit for cryopreservation in this group of patients. Any individuals outside the specified age ranges above can apply via the IFR (exceptional case) route, to avoid any delay in the start of treatment these requests will be dealt with as URGENT. Surgical sperm recovery is now the responsibility of NHS England (NHS England: 16040/P - Clinical Commissioning Policy: Surgical sperm retrieval for male infertility) and all requests for funding of these techniques should be made to NHS England using their form. **NOTE:** If NHS England website changes, this link may not be updated. **Recurrent miscarriage** Recurrent miscarriage is not covered by this policy as there are local services. All individuals should be referred in line with the pathway for that service. IVF/ICSI is not commissioned for recurrent miscarriage unless part of PGD which requires application to NHS England.
NHS England Commissioned Services	**Pre-Implantation Genetic Diagnosis (PGD) and sperm retrieval using TeSE or MicroTeSE** Pre-Implantation Genetic Diagnosis (PGD) and sperm retrieval using TeSE or MicroTeSE are both NHS England commissioned and applications for these procedures should be made to them directly or via the appropriate pathway as directed by NHS England. **Referral for genetic counselling** Referral for genetic counselling for couples who do not qualify for PGD should be done in line with the recommendation in NICE CG156. **IVF/ICSI for recurrent miscarriage** IVF/ICSI is not commissioned for recurrent miscarriage unless part of PGD which requires application to NHS England.
Research and Local pathways	Treatment / procedures undertaken as part of an externally funded trial or as a part of locally agreed contracts / or pathways of care are excluded from this policy, i.e. locally agreed pathways take precedent over this policy (the EUR Team should be informed of any local pathway for this exclusion to take effect).
Policy Criteria - not commissioned	**Surrogacy** The NHS does not fund any type of surrogacy arrangement. Commissioning parents must undertake the whole process privately.

	See: GOV.UK guidance: Having a child through surrogacy
Policy Inclusion Criteria - where restrictions apply	Assisted conception care is generally commissioned in line with NICE CG156: Fertility problems: assessment and treatment. Pages 6 to 13 summarise areas where qualifying criteria apply or that are not covered by CG156. Individual treatments are funded by the area with whom the patient's GP surgery is registered, with the exception of those treatments where the specified commissioner is NHS England (NHSE). When treating a couple, it is the GP surgery with whom the female partner is registered. In same sex (female) couples it will be the GP Surgery with whom the patient wishing to carry the pregnancy is registered. **Funding mechanism: Unless otherwise stated below funding will be via the normal local contracting arrangements**. **Reversal of sterilisation** The surgical reversal of either male or female sterilisation done for family planning purposes is **not** routinely commissioned. Note: If the exceptionality claims that sterilisation was carried out in a situation of abuse or coercion documented proof of the abuse must be provided e.g. letter from a social worker, police incident report etc. Requests must be submitted with all relevant supporting evidence. Reversal of steriiisation is commissioned in cases where the sterilisation was carried out to treat an underlying condition and not for family planning purposes. Reversal of vasectomy for reasons other than to restore fertility e.g. to treat rare cases of post vasectomy pain is commissioned. **NOTE**: Where subfertility remains after reversal of sterilisation, assisted conception will not be funded routinely, unless there is proof of a clinically successful reversal of sterilisation and the infertility issues are with the partner. **Intrauterine Insemination** Consider unstimulated intrauterine insemination as a treatment option in the following groups as an alternative to vaginal sexual intercourse: • people who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem who are using partner or donor sperm • people with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man is HIV positive) • people in same-sex relationships • Single women

Access Criteria for IVF/ICSI

All couples referred for IVF must have had their infertility investigated and managed in line with NICE CG156 prior to referral and found to be infertile / subfertile. (See appendix one for full definitions in line with NICE CG 156).

IVF/ICSI up to the number of cycles commissioned by each area within Greater Manchester is commissioned for patients who meet the criteria as set out in this policy.

In all cases where IVF/ICSI is being considered all welfare of the child considerations as required by the HFEA should be addressed and a record made in the notes (in case of future audit) that there are no concerns.

Definition of Childless

IVF is only offered to childless couples. Childlessness is defined as: *'The couple have no living child from their current relationship and one of the partners does not have any living children from a previous relationship. A child adopted by a patient or adopted in a previous relationship is considered to have the same status as a biological child.'*

Female same sex couples

In a same sex (both female) partnership only one partner will be eligible for treatment with IVF up to the current number of cycles commissioned. This does not affect the untreated partner's right to IVF in a new relationship provided they meet the eligibility criteria at that time.

Previous sterilisation

Infertility must not be as a result of previous sterilisation for family planning reasons, unless a partner has had a successful reversal of sterilisation and the infertility to be treated is in the other (not previously sterilised) partner (or the couple have been diagnosed with unexplained infertility)

Infertility must not be as a result of previous sterilisation for family planning reasons, unless a partner has had a successful reversal of sterilisation and the infertility to be treated is in the other (not previously sterilised) partner (or the couple have been diagnosed with unexplained infertility).

Female Body Mass Index

The female body mass index must ideally be in the range of 19-30 before treatment begins. Women outside this range can still undergo investigations and be added to the 'watchful-waiting' list but treatment will not commence until their BMI is within this range (exceptionally a woman with a BMI above 30 or below 19 may be able to demonstrate that they are not clinically obese or too thin through use of other acceptable measures e.g. an accurate body fat percentage).

Smoking status

Both partners must be non-smoking and not using any product containing nicotine in order to access any fertility treatment and must continue to be non-smoking throughout treatment. Individuals who are smokers can be added to the 'watchful-waiting' list and be referred to their local stop smoking service for support in quitting

but treatment will not commence until they are deemed non-smokers (i.e. no longer using a nicotine containing product).

Alcohol intake & recreational drugs

The couple should give an assurance that their alcohol intake is within Department of Health guidelines and they are not using recreational drugs. Any evidence to the contrary will result in the cessation of treatment.

Number of cycles of IVF Funded (including previous cycles)

Both NHS and privately funded cycles will be taken into account when determining how many cycles to fund.

NOTE: If a woman changes her registered practice to one that comes under a different area which offers a different number of IVF cycles, eligibility will depend on the number of IVF cycles offered by the area where she is currently registered.

The total number of cycles undertaken as listed below added to those funded privately must not exceed 3. Where cycles have been funded privately or by another area, these will be taken into account when determining how many cycles to fund in accordance with the below:

For women aged 39 and under:

Bolton, Bury, HMR, Manchester, Oldham & Trafford all commission 1 complete cycle of IVF (and allow a second attempt at a full cycle for a cancelled or abandoned cycles).

Salford, Stockport & Wigan all commission 2 cycles (includes abandoned or cancelled cycles).

Tameside commissions 3 cycles (includes abandoned or cancelled cycles).

If the woman turns 40 before all cycles are complete then no further treatment will be funded after the current cycle is completed

IVF for women aged 40-42 (i.e. before her 43rd birthday) - all areas in Greater Manchester 1 full cycle provided:

- They have never previously had IVF (including privately) – (For same sex female couples: neither partner has previously had IVF)
- There has been a discussion about the implications of IVF at this age

Their single cycle of IVF can be carried out with donor eggs if one of the following applies:

- total 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

NB: These are the risk factors for a poor ovarian response in this age group as laid by NICE in 2013.

NOTE: Treatment must have commenced before the woman's 43rd birthday. If waiting times will take them beyond their 43rd birthday, they can apply via the IFR

(exceptionality) route for an extension to the age limit or transfer of care to a provider who can start treatment in time.

A single second attempt at a full cycle, with their own or donor eggs as appropriate, may be commissioned if the first attempt ends in a cancelled or abandoned cycle (Treatment MUST commence before the woman's 43rd birthday.)

HFEA guidance – Welfare of the Child

NOTE as per HFEA guidance: *"A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth".*

'Supportive parenting is a commitment to the health, wellbeing and development of the child. It is presumed that all prospective parents will be supportive parents, in the absence of any reasonable cause for concern that any child who may be born, or any other child, may be at risk of significant harm or neglect. Where centers have concern as to whether this commitment exists, they may wish to take account of wider family and social networks within which the child will be raised.'

Definitions of IVF Cycles

Full Cycle (with donor eggs – see below)
A full cycle of IVF treatment, with or without intracytoplasmic sperm injection (ICSI), should comprise 1 episode of ovarian stimulation and end with the final transfer of all resultant fresh and frozen embryo(s) or a successful live birth occurring during the cycle. Attracts full tariff.

Embryos must be transferred in line with NICE CG156.

Cancelled Cycle
A cancelled IVF cycle is one where the egg collection procedure is not undertaken. Paid at 1/3 tariff.

Abandoned Cycle
An abandoned cycle is one which ends before embryo implantation and after egg collection. Paid at 2/3 tariff.

Full cycle using donor eggs:
A full cycle of IVF treatment, with or without intracytoplasmic sperm injection (ICSI), should begin with preparation of the donor eggs either through a) ovarian stimulation and synchronising cycles with a live donor or b) preparation of frozen donor eggs and end with the final transfer of all resultant fresh and frozen embryo(s) or a successful live birth occurring during the cycle. Attracts full tariff. Definitions for a cancelled and abandoned cycle as the same as for other women undergoing IVF.

Switching providers

Where more than one cycle is funded then individuals have the right to undergo subsequent cycles at a different provider as long as that provider has an arrangement with the commissioner responsible for your treatment.

Private sector to NHS

Individuals who have undergone privately funded cycles will still have a right to transfer to NHS funded cycles (with an NHS approved provider) provided that the overall total number of cycles (NHS and Private) does not exceed three.
e.g. If an NHS commissioner (or commissioners if the couple have moved areas) has funded two cycles and the individual has funded one privately , they have undergone three cycles and are therefore at their maximum under this policy. The limit of three cycles applies to the number of cycles undergone by the couple irrespective of who has funded each of those cycles.

The actual number of cycles will depend on the number currently offered by that area within Greater Manchester (The relevant area is determined by the surgery which the female partner is registered with*).*

Change of NHS commissioned provider

Requests for a change of provider can be made at the same time as an IFR request for an additional cycle and will be considered if the additional cycle is approved.

NOTE: Before changing provider individuals with frozen sperm, oocytes or embryos from any current cycle and who are eligible for further cycles:

- must ensure that all frozen embryos have been implanted (thus completing the current cycle) prior to transferring to their new provider.

In exceptional circumstances application can be made via the IFR route to fund the safe transfer of the frozen material from the old to the new provider, this request must come from a clinician.

Donor Oocytes (Use of Donor Oocytes):

Donor eggs for **women under 40 years** will be commissioned if the woman has a condition which means no viable eggs can be produced OR has been assessed by a fertility specialist and found to have premature ovarian failure.

The use of donor oocytes is considered effective in managing fertility problems associated with the following conditions:

- premature ovarian failure occurring before the age of 40 years (diagnosis must be confirmed by a specialist in infertility)
- gonadal dysgenesis including Turner syndrome
- bilateral oophorectomy
- ovarian failure following chemotherapy or radiotherapy

For **women aged 40-42** (**i.e. before her 43rd birthday)** IVF can be carried out with donor eggs if one of the following applies:

- total 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

	Transfer of frozen material Requests to transfer frozen material from an old provider to a new provider will only be considered in exceptional circumstances via the IFR route. **Access to donor eggs** Where donor eggs are required and the current provider cannot provide them, the individual may transfer to an alternative provider who can provide donor eggs (within a pre agreed tariff), as NHS providers cannot offer an egg share scheme under current NHS rules. **Sperm, oocyte or embryo storage to retain fertility** **Please also see Policy Exclusion section**. There is no upper age limit for the storage of sperm. Individuals over the age of 42 (i.e. after their 43rd Birthday) with exceptional reasons for requesting gamete storage can apply via the IFR (exceptional case) route. **Extensions to the storage time for sperm or oocytes or age limit for embryos will require IFR (exceptional case) approval.** The application should comply with the process for extension of the statutory storage period as outlined in the HFEA code of practice and should not take the period of cryopreservation over the statutory upper limit of 55 years. The individual must be made aware of this at the time of storage. (Correct at the time this policy was produced but the current HFEA guidance should be followed if different from this statement). If individuals move away from the area where their gametes or embryos are stored, they can apply via the IFR (exceptional case) route for the transfer of those embryos to their current area of residence, or for the cost of storage to be met by their new area of residence. **Storage of viable embryos** If treatment resulted in a live birth before all the viable embryos were implanted the remaining embryos should be cryopreserved for either 10 years (in line with HFEA guidance) or until the woman's 43rd birthday – whichever is shorter. Implantation of these embryos will not be funded by the NHS locally, but they are available to the individual for private treatment. (Correct at the time this policy was produced but the current HFEA guidance should be followed if different from this statement). Storage will be funded within the general contract in line with HFEA regulations- if the storage time in these regulations reduces then the woman must be informed and allowed to request an extension to storage time via the IFR route.
Clinical Exceptionality	Clinicians can submit an Individual Funding Request (IFR) outside of this guidance if they feel there is a good case for exceptionality. More information on determining clinical exceptionality can be found in the Greater Manchester (GM) IFR Operational Policy. Link to **GM IFR Operational Policy**. Link to **IFR Form**
Government issued	'The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017 No. 756'

Statutory Instrument	**From 21 August 2017**, NHS-funded assisted conception services will not be included in the exemption from charge applicable to people who are caught within surcharge arrangements (i.e. those who have paid the surcharge, or who are exempt from paying it (with certain exceptions) or in respect of whom it has been waived). This means that, unless another exemption applies, where NHS assisted conception services are provided to a person who is exempt under surcharge arrangements, overseas visitor charges will apply. This is brought forward through regulations 11, 12 and 13 of the above named instrument, which insert a new regulation (9A) and amend regulation 10 and 11 respectively. Exemption from charges currently applies to: • Serving members of the armed forces and their families (NHS England commissioned) • Seriously injured serving members and veterans • Further provision of care previously given • Continuation of a course of treatment that commenced before 21 August 2017 Assisted conception services in the context of this instrument are defined as "*any medical, surgical or obstetric services provided for the purpose of assisting a person to carry a child*." This definition was based on the definition of "treatment services" in section 2 of the Human Fertilisation and Embryology Act 1990. Broadly speaking any medicines, surgery or procedures that are required to diagnose and treat infertility so a person can have a child. It includes procedures such as intrauterine insemination (IUI), *in vitro* fertilisation (IVF) and egg and sperm donation. The definition is not intended to refer to antenatal or maternity services.
Fitness for Treatment	**NOTE:** All patients should be assessed as fit for the treatment being offered before going ahead, even though funding has been approved.
Best Practice Guidelines	Providers are expected to comply with NICE CG156: Fertility problems: assessment and treatment in the delivery of all investigations and treatments for infertility **with the exception of IVF, where the local qualifying criteria must be met and the number of cycles offered should be in line with each area in Greater Manchester.**

Rationale behind the policy statement

Investigation, diagnosis and subsequent treatment for individuals with fertility issues is a complex and constantly developing field. The previous Greater Manchester Assisted Conception policy needed updating in light of NICE CG156 and wide variation in in commissioning policies for assisted conception across Greater Manchester. The GM template was developed however it is an extensive document and difficult to reference quickly. This summary version, using the updated GM template, has been drafted for ease of reference and to make it easier to see what is in contract and what requires an application for funding. This policy is aimed at ensuring consistency of approach in the referral, investigation, diagnosis and treatment of individuals with fertility issues across Greater Manchester.

To commission services in line with NICE CG156 but to take account of individual areas fiscal limitations and to ensure fairness of access within those limitations.

Treatment / Procedure

Unless otherwise referenced all information, data etc. is taken from NICE CG156.

There are a range of causes of fertility problems. This policy assumes that individuals requesting assisted conception have been investigated in line with NICE CG156.

The range of investigations should include semen analysis; assessment of ovulation, tubal damage and uterine abnormalities; screening for infections such as *Chlamydia trachomatis* and susceptibility to rubella should also be undertaken.

With the exception of the areas outlined in the preceding section of this policy, it is assumed that all services are provided in line with best practice guidance and the treatment requirements of NICE CG156 and that where medication is involved the provider's prescribers will use a drugs summary of product characteristics to inform the treatment decisions relating to individual patients.

This policy applies including same sex couples. The commissioning area is the one where the female partner wishing to be the biological mother is resident.

This policy applies to all women provided all steps have been undertaken to ensure the welfare of the child as per HFEA guidance: *"A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth". 'Supportive parenting is a commitment to the health, wellbeing and development of the child. It is presumed that all prospective parents will be supportive parents, in the absence of any reasonable cause for concern that any child who may be born, or any other child, may be at risk of significant harm or neglect. Where centres have concern as to whether this commitment exists, they may wish to take account of wider family and social networks within which the child will be raised.*'

All couples should be informed that if, as a result of investigations into infertility, surrogacy is the only option that this will not be funded by the NHS in Greater Manchester.

Transgender patients should be managed as their preferred sex at all stages of investigation and treatment.

Epidemiology and Need

It is estimated that infertility affects 1 in 7 heterosexual couples in the UK. Since the original NICE guideline on fertility published in 2004 there has been a small increase in the prevalence of fertility problems, and a greater proportion of people now seeking help for such problems.

The main causes of infertility in the UK are (per cent figures indicate approximate prevalence):

- unexplained infertility (no identified male or female cause) (25%)
- ovulatory disorders (25%)
- tubal damage (20%)
- factors in the male causing infertility (30%)
- uterine or peritoneal disorders (10%).

In about 40% of cases disorders are found in both the man and the woman. Uterine or endometrial factors, gamete or embryo defects, and pelvic conditions such as endometriosis may also play a role.
Given the range of causes of fertility problems, the provision of appropriate investigations is critical. These investigations include semen analysis; assessment of ovulation, tubal damage and uterine abnormalities; and screening for infections such as *Chlamydia trachomatis* and susceptibility to rubella.

Once a diagnosis has been established, treatment falls into 3 main types:

- medical treatment to restore fertility (for example, the use of drugs for ovulation induction)
- surgical treatment to restore fertility (for example, laparoscopy for ablation of endometriosis)
- assisted reproduction techniques (ART) – any treatment that deals with means of conception other than vaginal intercourse. It frequently involves the handling of gametes or embryos.

Adherence to NICE Guidance

This policy adheres to NICE CG156 with the exception of IVF where the local qualifying criteria must be met and the number of cycles offered should be in line with each area policy.

Audit Requirements

The HFEA maintains a record of all assisted conception cycles on a national database

Date of Review

One year from the date of the last review, unless new evidence or technology is available sooner.

The evidence base for the policy will be reviewed and any recommendations within the policy will be checked against any new evidence. Any operational issues will also be considered at this time. All available additional data on outcomes will be included in the review and the policy updated accordingly. The policy will be continued, amended or withdrawn subject to the outcome of that review.

Glossary

Term	Meaning
Ablation	The surgical removal of body tissue.

Amenorrhoea	The absence of periods in a woman of childbearing age.
Anti-Mullerian Hormone (AMH)	A substance produced by granulosa cells (also called follicular cells is a somatic cell of the sex cord that is closely associated with the developing female gamete (called an oocyte or egg) in the ovary of mammals.) in ovarian follicles. It is first made in primary follicles that advance from the primordial follicle stage (stages in the lifecycle of the area of the ovary that produces eggs). At these stages follicles are microscopic and cannot be seen by ultrasound.
Antisperm antibodies	Blood proteins produced to attack sperm which are mistaken for foreign proteins in the male body. (Antibodies combine chemically with substances which the body recognizes as alien, such as bacteria, viruses, and foreign substances in this case the sperm).
Antral Follicle Count (ATF)	Small follicles (2 to 8 mm in size) that are visible on the ovaries via ultrasound. They are also known as resting follicles. They appear in the beginning of the menstrual cycle, and their number can indicate the amount of microscopic primordial follicles (those present in the ovaries at birth that have not yet matured) contained within the ovary.
Artificial Insemination (AI)	Any method of introducing sperm to the female body other than by sexual intercourse – includes Intravaginal Insemination and Intrauterine insemination.
Azoospermia	The complete absence of sperm in the seminal fluid (ejaculate) of the male.
Bilateral oophorectomy	Removal of both ovaries.
Co-morbidities	The presence of one or more additional disorders (or diseases) co-occurring with a primary disease or disorder.
Cryopreservation	A process where cells or whole tissues are preserved by cooling to sub-zero temperatures.
Endometrial biopsy	Surgical removal of a sample of the lining of the womb for examination.
Endometriosis	The presence of endometrial tissue (cells that line the womb) outside the womb that causes pelvic pain, especially associated with menstruation.
Follicles	A cavity in the ovary containing a maturing ovum surrounded by its encasing cells.
Follicle Stimulating Hormone (FSH)	A hormone secreted by the anterior pituitary gland (an endocrine gland, the size of a pea attached to the base of the brain that is important in controlling growth and development as well as the functioning of the other endocrine glands) which promotes the formation of ova or sperm.
Galactorrhoea	A milky nipple discharge unrelated to the normal milk production of breast-feeding.
Gametes	A mature haploid male or female germ cell which is able to unite with another of the opposite sex in sexual reproduction to form a zygote i.e. An egg or a sperm.

Gonadal dysgenesis	Any congenital developmental disorder of the reproductive system characterized by a progressive loss of germ cells on the developing gonads (testes or ovaries) of an embryo.
Gonadotrophin	A group of hormones secreted by the pituitary which stimulate the activity of the gonads.
HAART "Highly Active Antiretroviral Therapy"	Antiretroviral therapy (ART) is treatment of people infected with human immunodeficiency virus (HIV) using anti-HIV drugs. The standard treatment consists of a combination of at least three drugs (often called "highly active antiretroviral therapy" or HAART) that suppress HIV replication. Three drugs are used in order to reduce the likelihood of the virus developing resistance. ART has the potential both to reduce mortality and morbidity rates among HIV-infected people, and to improve their quality of life.
Hydrosalpinx	A fallopian tube dilated with fluid. The plural term is "hydrosalpinges" The only way for a fallopian tube to become dilated with fluid is if it is blocked at the end of the tube away from the uterus.
Hyperprolactinaemiaa	Elevated serum prolactin. Prolactin is a 198-amino acid protein (23-kd) produced in the lactotroph cells of the anterior pituitary gland. Its primary function is to enhance breast development during pregnancy and to induce lactation (the production of milk).
Hypogonadism	Hypogonadism is an abnormally low level of testosterone – the male sex hormone that is involved in making sperm. This could be due to a tumour, taking illegal drugs or Klinefelter's syndrome (a rare genetic condition where a man is born with an extra female chromosome).
Hypothalamic pituitary failure (hypothalamic amenorrhoea or hypogonadotrophic hypogonadism)	Hypothalamic dysfunction is a problem with the region of the brain called the hypothalamus, which helps control the pituitary gland and regulate many body functions. The pituitary, in turn, controls the: • Adrenal glands • Ovaries • Testes • Thyroid gland
Hypothalamic-pituitary-ovarian dysfunction (predominately polycystic ovary syndrome)	See above
Hysterosalpingo-contrast-ultrasonography	An ultrasound enhanced by the use of a liquid that shows up clearly on the ultrasound which has been inserted into the fallopian tubes.
Hysterosalpingography (HSG)	The process of carrying out an ultrasound enhanced by the use of a liquid that shows up clearly on the ultrasound which has been inserted into the fallopian tubes.
Hysteroscopic adhesiolysis	Using a hysteroscope (a device designed to look into the uterus or womb) to remove adhesions (bands of fibrous tissue that form in response to inflammation).

Hysteroscopic tubal cannulation	Female sterilisation using a hysteroscope (a device designed to look into the uterus or womb) to access and block the fallopian tubes (the tubal part of the womb that allows eggs released by the ovary to enter the womb).
Hysteroscopy	Using a hysteroscope (a device designed to look into the uterus or womb) to examine the uterus (womb).
Infertile	An inability to conceive naturally
In vitro fertilisation (IVF)	Involves fertilizing an egg outside the body, in a laboratory dish, and then implanting it in a woman's uterus.
Intracytoplasmic Sperm Injection (ICSI)	An in vitro fertilization procedure in which a single sperm is injected directly into an egg.
Intrauterine adhesions	Bands of fibrous tissue that form in the uterus (womb) usually in response to inflammation).
Intra-Uterine Insemination (IUI)	The medical procedure of injecting semen directly into the uterus.
Laparoscopic adhesiolysis	Using a laparoscope (a device designed to look into the abdomen) to remove adhesions (bands of fibrous tissue that form in response to inflammation).
Laparoscopic cystectomy	Using a laparoscope (a device designed to look into the abdomen) to remove cysts on the ovaries.
Laparoscopic ovarian drilling	Using a laparoscope to undertake a surgical treatment that can trigger ovulation in women who have polycystic ovary syndrome (PCOS). Electrocautery or a laser is used to destroy parts of the ovaries.
Laparoscopy	Using a laparoscope to look into the abdomen.
Luteal Phase	A stage of the menstrual cycle. It occurs after ovulation (when the ovaries release an egg) and before a woman's period starts. During this phase, the lining of the uterus normally becomes thicker to prepare for a possible pregnancy.
Menarche	The natural start of the menstrual cycle in a woman.
Menopause	The natural end of the menstrual cycle in a woman.
Microsurgical Epididymal Sperm Aspiration (MESA)	A surgical technique used to retrieve sperm from the testes.
Oocytes	Eggs
Ovarian endometriomas	Benign, estrogen-dependent cysts found in women of reproductive age.
Ovarian failure	Loss of normal function of the ovaries which no longer produce eggs.
Ovarian Reserve	The ovarian reserve is the number of eggs left in a woman's ovaries. At birth the ovary contains the individual's lifetime supply of eggs. The action of the woman's hormones during her menstrual cycle causes some of these eggs to

	mature each month. Menopause occurs when the “reserve” of eggs is exhausted.
Percutaneous Epididymal Sperm Aspiration (PESA)	A surgical technique used to retrieve sperm from the testes.
Polycystic ovary syndrome (PCOS)	A condition that makes it more difficult for your ovaries to produce an egg.
Pre-Implantation Genetic Diagnosis (PGD)	Testing the genes and/or chromosomes of embryos created through IVF for potential inherited disorders.
Premature ovarian failure	Amenorrhea of at least 12 months duration with a hormone profile in the menopausal range, under the age of 40.
Proximal tubal obstruction	A blockage in the fallopian tube near to where it joins the uterus.
Rhesus isoimmunisation	A blood incompatibility disorder where the mother's blood type is not compatible with the fetus. This incompatibility results in antibodies from the mother's blood destroying the baby's red blood cells when they come into contact during pregnancy and after birth.
Selective salpingography	A minor outpatient operation which can treat proximally blocked fallopian tubes.
Sterilisation	A medical procedure to render an individual infertile.
Subfertile	The possibility of conceiving naturally exists but it takes longer than average
Surrogacy	Surrogacy is the practice whereby a woman (the surrogate mother) carries a child for another person and (usually) that person's partner (the commissioning couple) as the result of an agreement prior to conception that the child should be handed over to them after the birth.
Testicular Fine Needle Aspiration (TFNA)	A surgical technique used to retrieve sperm from the testes.
Tubal catheterisation	A procedure to help clear a blockage in the fallopian tubes.
Tubal disease	Disease of the fallopian tube(s).
Tubal occlusion	A blockage in the fallopian tube(s).
Varicoceles	A mass of varicose veins in the spermatic cord (a bundle of nerves, ducts, and blood vessels connecting the testicles to the abdominal cavity.
Vasectomy	The surgical procedure for male sterilisation. It involves cutting and sealing off the vas deferens (the tubes that carry sperm out of the testicles), so that semen will no longer contain any sperm. A vasectomy can be reversed, but reversals are not usually successful.

Evidence Summary

This policy is based on the evidence cited in NICE CG156 supported by additional references where needed. For further details please refer to NICE CG156 and the references cited below.

References

1. Greater Manchester IFR Operational Policy
2. NICE CG156: Assessment and treatment for people with fertility problems
3. HFEA Code of Practice Guidance: Note 14: Surrogacy
4. Determining the legal parentage of children from surrogacy guidance, GOV.UK: (2.1 Provision together with the definition of parent in the British Nationality Act 1981 under 2. Legal parentage of children resulting from surrogacy arrangements
5. Effectiveness and treatment for unexplained infertility. Fertil Steril. 2006;86(5 suppl):S111–S114. [PubMed]
6. www.who.int/classifications
7. Anderson K, Norman RJ, Middleton P. Preconception lifestyle advice for people with subfertility. *Cochrane Database of Systematic Reviews* 2010, Issue 4. Art. No.: CD008189. DOI: 10.1002/14651858.CD008189.pub2.
8. HFEA Code of Practice Guidance: Note 17 – Storage of Gametes and Embryos

Appendix 1 – Summary of NICE CG156
(Extract for areas in NICE CG156 not covered in the Commissioning Criteria section of this policy for quick reference)
For full details please refer to the policy on the NICE website

Female factor infertility

Ovulation disorders

Infertility is most commonly caused by problems with ovulation (the monthly release of an egg). Some problems stop women releasing eggs at all and some cause an egg to be released during some cycles, but not others. Ovulation problems can occur as a result of many conditions, such as:

- polycystic ovary syndrome (PCOS) – a condition that makes it more difficult for your ovaries to produce an egg
- thyroid problems – both an overactive thyroid gland (hyperthyroidism) and an underactive thyroid gland (hypothyroidism) can prevent ovulation
- premature ovarian failure – where a woman's ovaries stop working before she is 40

Womb and fallopian tubes

The fallopian tubes are the tubes along which an egg travels from the ovary to the womb. The egg is fertilised as it travels down the fallopian tubes. When it reaches the womb, it is implanted into the womb's lining, where it continues to grow. If the womb or the fallopian tubes are damaged, or stop working, it may be difficult to conceive naturally. This can occur following a number of factors:

- **Scarring from surgery:** Pelvic surgery can sometimes cause damage and scarring to the fallopian tubes. Cervical surgery can also sometimes cause scarring, or shorten the cervix (the neck of the womb).
- **Cervical mucus defect:** When a women is ovulating the mucus in their cervix becomes thinner so that sperm can swim through it more easily. If there is a problem with their mucus, it can make it harder to conceive.
- **Submucosal fibroids:** are benign (non-cancerous) tumours that grow in, or around, the womb. Submucosal fibroids develop in the muscle beneath the inner lining of the womb wall and grow into the middle of the womb. Submucosal fibroids can reduce fertility.
- **Endometriosis:** is a condition where small pieces of the womb lining, known as the endometrium, start growing in other places, such as the ovaries. This can cause infertility because the new growths form adhesions (sticky areas of tissue) or cysts (fluid-filled sacs) that can block or distort the pelvis. It can disturb the way that a follicle (fluid-filled space in which an egg develops) matures and releases an egg.
- **Pelvic inflammatory disease:** Pelvic inflammatory disease (PID) is an infection of the upper female genital tract, which includes the womb, fallopian tubes and ovaries. It is often the result of a sexually transmitted infection (STI). PID can damage and scar the fallopian tubes, making it virtually impossible for an egg to travel down into the womb.
- **Sterilisation:** Some women choose to be sterilised if they do not wish to have any more children. Sterilisation involves blocking the fallopian tubes to make it impossible for an egg to travel to the womb. This process is rarely reversible.
- **Medicines and drugs:** The side effects of some types of medication and drugs can affect your fertility. These medicines are:
    - Non-steroidal anti-inflammatory drugs (NSAIDs). Long-term use or a high dosage of NSAIDs, such as ibuprofen or aspirin, can make it more difficult to conceive.

- Chemotherapy. Medicines used for chemotherapy (a treatment for cancer) can sometimes cause ovarian failure. Ovarian failure can be permanent.
- Neuroleptic medicines are antipsychotic medicines often used to treat psychosis. They can sometimes cause missed periods or infertility.
- Spironolactone – this is a type of medicine used to treat fluid retention (oedema). Fertility should recover around two months after you stop taking spironolactone.

Illegal Drugs
Illegal drugs such as marijuana and cocaine can seriously affect fertility, making ovulation (the monthly cycle where an egg is released from the ovaries) more difficult.

Age
Infertility in women is also linked to age. The biggest decrease in fertility begins during the mid-thirties. Among women who are 35, 95% will get pregnant after three years of having regular unprotected sex. For women who are 38, only 75% will get pregnant after three years of having regular unprotected sex.

Investigating Female Infertility

The following should be undertaken in line with the recommendation in NICE CG156 in the appropriate primary or secondary care setting as indicated clinically:

- Ovarian reserve testing
- Regularity of menstrual cycles
- Hysterosalpingography (HSG) to screen for tubal occlusion in women not known to have relevant co-morbidities
- (Where the expertise is available) Hysterosalpingo-contrast-ultrasonography to screen for tubal occlusion in women not known to have relevant co-morbidities
- Women thought to have co-morbidities should be offered laparoscopy and dye to assess tubal and pelvic pathology
- Hysteroscopy for diagnostic reasons
- Blood test to measure prolactin levels **ONLY** In women who have a known ovulatory disorder, Galactorrhoea or a pituitary tumour
- Testing for susceptibility to Rubella.
- Cervical screening (unless up to date)
- Screening for Chlamydia with appropriate treatment and contact tracing

The following should **NOT** be done (in line with NICE CG156):

- Routine post coital testing of cervical mucus
- Thyroid function tests
- Endometrial biopsy to investigate the luteal phase
- Hysteroscopy as a treatment procedure

Managing Female Infertility

Ovulation Disorders

Please refer to GMMMG website for up to date guidance on any restrictions to drugs.

The World Health Organization classifies[6] ovulation disorders into 3 groups:

- Group I: hypothalamic pituitary failure (hypothalamic amenorrhoea or hypogonadotrophic hypogonadism)
- Group II: hypothalamic-pituitary-ovarian dysfunction (predominately polycystic ovary syndrome)
- Group III: ovarian failure

Group I: hypothalamic pituitary failure (hypothalamic amenorrhoea or hypogonadotrophic hypogonadism)

Advise women in this group to:

- increase their body weight if they have a BMI of less than 19 (unless they can show by an alternative measure to BMI that they have a normal body fat ratio).

AND / OR

- moderate their exercise levels if they undertake high levels of exercise

Offer women in this group pulsatile administration of gonadotrophin-releasing hormone or gonadotrophins with luteinising hormone activity to induce ovulation.

These should be administered and managed in line with NICE CG156.

Group II: hypothalamic-pituitary-ovarian dysfunction (predominately polycystic ovary syndrome)

First line Treatment

Advise women in this group:

- who have a BMI over 30 to lose weight and inform them that this alone may restore ovulation, improve their response to ovulation induction agents, and have a positive impact on pregnancy outcomes.

Offer women in this group one of the following treatments, taking into account potential adverse effects, ease and mode of use, the woman's BMI, and monitoring needed:

- clomifene citrate

OR

- metformin

OR

- a combination of the above

These should be administered and managed in line with NICE CG156.

Second-line treatments

For women with WHO Group II ovulation disorders who are known to be resistant to clomifene citrate, consider one of the following:

- laparoscopic ovarian drilling

OR

- combined treatment with clomifene citrate and metformin if not already offered as first-line treatment

OR

- gonadotrophins

Do not offer women with polycystic ovary syndrome who are being treated with gonadotrophins concomitant treatment with gonadotrophin-releasing hormone agonist. It is not shown to improve pregnancy rates and research suggests it is associated with an increased risk of ovarian hyperstimulation.

Do not offer adjuvant growth hormone treatment with gonadotrophin-releasing hormone agonist and/or human menopausal gonadotrophin during ovulation induction in women with polycystic ovary syndrome who do not respond to clomifene citrate because it is not shown to improve pregnancy rates.

The effect of pulsatile gonadotrophin-releasing hormone in women with clomifene citrate-resistant polycystic ovary syndrome is uncertain and this should only be offered within a funded research context.

Women with ovulatory disorders due to hyperprolactinaemia should be offered treatment with dopamine agonists such as bromocriptine. Consideration should be given to safety for use in pregnancy and minimising cost when prescribing.

These should be administered and managed in line with NICE CG156.

Group III: ovarian failure

Treatment will be commissioned for women with premature menopause, defined as amenorrhea of at least 12 months duration with a hormonal profile in the menopausal range, under the age of 40. The cause may be spontaneous, or as a result of other morbidity, or congenital abnormality or iatrogenic. NHS funding would not normally be available for women outside these groups who do not respond to follicular stimulation.

For premature or iatrogenic ovarian failure donor oocytes can be used, in line with NICE CG156. Premature ovarian failure is defined as in the paragraph above.

Use of Donor Oocytes
The use of donor oocytes is considered effective in managing fertility problems associated with the following conditions:

- premature ovarian failure occurring before the age of 40 years
- gonadal dysgenesis including Turner syndrome
- bilateral oophorectomy
- ovarian failure following chemotherapy or radiotherapy
- unexplained (or repeated) failure of ovarian stimulation during of IVF treatment

Oocyte donation should also be considered in certain cases where there is a high risk of transmitting a genetic disorder to the offspring.

For women undergoing IVF treatment with donor eggs, use an embryo transfer strategy that is based on the age of the donor.

Screening of donors and subsequent treatment with donor oocytes should be carried out in line with NICE CG156.
Oocyte sharing schemes should be managed in line with NICE CG156.

Tubal and Uterine Abnormalities

Tubal disease

In centres where appropriate expertise is available tubal surgery may be considered as a treatment option for women with mild tubal disease.

For women with proximal tubal obstruction, selective salpingography plus tubal catheterisation, or hysteroscopic tubal cannulation, may be offered as these treatments improve the chance of pregnancy.

Women with hydrosalpinges should be offered salpingectomy, preferably by laparoscopy, before IVF treatment, as research indicates that this improves the chance of a live birth.

Intrauterine adhesions

Women with amenorrhoea who are found to have intrauterine adhesions should be offered hysteroscopic adhesiolysis because research shows that this is likely to restore menstruation and improve the chance of pregnancy.

Endometriosis

Endometriosis should be managed in line with NICE NG73 Endometriosis: diagnosis and management.

Male factor infertility

Male infertility is caused by abnormal semen (the fluid containing sperm that is ejaculated during sex). Possible reasons for abnormal semen include:

- decreased number or absence of sperm
- decreased sperm
- abnormal sperm

Many cases of abnormal semen are unexplained, but can be due to a variety of factors.

Problems with the Testicles

The testicles are responsible for producing and storing sperm. If they are damaged, it can seriously affect the quality of the semen produced. This includes:

- an infection of the testicles
- testicular cancer
- testicular surgery
- a congenital defect
- undescended testicles – corrected or uncorrected
- trauma (injury)

Absence of sperm

The testes may produce sperm, but it may not reach the semen. The absence of sperm in semen is known as obstructive azoospermia. This could be due to a blockage in one of the tiny tubes that make up the male reproductive system, as a result of infection, injury or surgery.

Sterilisation

A vasectomy is the surgical procedure for male sterilisation. It involves cutting and sealing off the vas deferens (the tubes that carry sperm out of the testicles), so that semen will no longer contain any sperm. A vasectomy can be reversed, but reversals are not usually successful.

Ejaculation disorders
Some men experience problems that can make it difficult for them to ejaculate. Other ejaculation problems include:

- retrograde ejaculation - where semen is ejaculated into the bladder
- premature ejaculation – where ejaculation occurs too quickly

Hypogonadism
Hypogonadism is an abnormally low level of testosterone – the male sex hormone that is involved in making sperm. This could be due to a tumour, taking illegal drugs or Klinefelter's syndrome (a rare genetic condition where a man is born with an extra female chromosome).

Medicines and drugs
Certain types of medicines can sometimes cause infertility problems. These medicines are listed below:

- Sulfasalazine – an anti-inflammatory medicine used to treat conditions such as Crohn's disease (inflammation of the intestine) and rheumatoid arthritis (painful swelling of the joints). Sulfasalazine can decrease the number of sperm, but its effects are temporary and the sperm count should return to normal when the medication is stopped.
- Anabolic steroids – often used illegally to build muscle and improve athletic performance. Long-term use or abuse of anabolic steroids can reduce sperm count and sperm mobility.
- Chemotherapy – medicines used in chemotherapy can sometimes severely reduce sperm production.
- Herbal remedies – some herbal remedies, such as root extracts of Tripterygium wilfordii (a Chinese herb), can affect the production of sperm or reduce the size of testicles.

Illegal drugs such as marijuana and cocaine can also affect semen quality.

Alcohol
Drinking too much alcohol can damage the quality of sperm. NICE CG156 states that if men follow the current Department of Health's recommendations for the consumption of alcohol, it is unlikely their fertility will be affected but drinking more than this could make it difficult to conceive.

Investigating Male Infertility

Semen analysis and subsequent management of any abnormality found should be managed in line with NICE CG156 using the World Health Organization reference values as a benchmark.

Managing Male Factor Infertility

Hypogonadism
Men found to have true hypogonadism should be offered gonadotrophin drugs.

Other causes of male factor infertility
Do **not** offer men with idiopathic semen abnormalities antioestrogens, gonadotrophins, androgens, bromocriptine or kinin-enhancing drugs because they have not been shown to be effective.

Do **not** offer Men with leucocytes in their semen antibiotic treatment unless there is an identified infection because there is no evidence that this improves pregnancy rates.

The significance of antisperm antibodies is unclear and the effectiveness of systemic corticosteroids is uncertain.

Where the appropriate expertise is available, men with obstructive azoospermia should be offered surgical correction of epididymal blockage in line with NICE CG156. Surgical correction should be considered as an alternative to surgical sperm recovery and IVF.

Do **not** offer surgery for varicoceles as a form of fertility treatment because it has not been shown to improve pregnancy rates.

Ejaculatory failure should be managed in line with NICE CG156.

Use of donor sperm

The use of donor insemination is considered effective in managing fertility problems associated with the following conditions:

- obstructive azoospermia
- non-obstructive azoospermia
- severe deficits in semen quality in couples who do not wish to undergo ICSI

Donor insemination should be considered in conditions where there is:

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

Screening of potential donors and treatments involving donor sperm should be carried out in line with NICE CG156.

Surgical recovery of sperm

Surgical recovery of sperm can be undertaken using a variety of techniques including:

- Testicular Fine Needle Aspiration (TFNA)
- Percutaneous Epididymal Sperm Aspiration (PESA)
- Microsurgical Epididymal Sperm Aspiration (MESA)

There is limited evidence available on the effectiveness of these techniques and surgical recovery of sperm is not included in NICE CG156.

Surgical sperm recovery is now the responsibility of NHS England (NHS England: 16040/P - Clinical Commissioning Policy: Surgical sperm retrieval for male infertility) and all requests for funding of these techniques should be made to NHS England using their form.

Unexplained infertility

When the results of a standard infertility evaluation are normal, practitioners assign a diagnosis of unexplained infertility. Although estimates vary, the likelihood that all such test results for an infertile couple are normal (i.e., that the couple has unexplained infertility) is approximately 15% to 30%.[1]

Managing Unexplained Infertility

When the results of a standard infertility evaluation are normal, practitioners assign a diagnosis of unexplained infertility. Although estimates vary, the likelihood that all such test results for an infertile couple are normal (i.e. that the couple has unexplained infertility) is approximately 15% to 30%[5].

Offer a period of expectant management by advising couples to try to conceive for a total of 2 years. (The period of expectant management after diagnosis and up to 1 year before their fertility investigations began) before IVF will be considered. For same sex couples and single women offer a further 6 cycles of IUI post referral, to be carried out in an NHS clinical setting, in addition to the self-funded 6 cycles of self-reported vaginal insemination undertaken prior to referral (as the equivalent of expectant management in a heterosexual couple) or 3 cycles if aged over 36 years.

Offer IVF treatment to couples with unexplained infertility who have not conceived after 2 years of regular unprotected sexual intercourse or after 12 cycles of AI (1 year and 6 cycles if aged over 36 years).

All services should be offered in line with the recommendations of NICE CG156.

Do **not** offer:

- ovarian stimulation agents (such as clomifene citrate, anastrozole orletrozole) to women with unexplained infertility.
- do not routinely offer intrauterine insemination, either with or without ovarian stimulation (exceptional circumstances include, for example, when people have social, cultural or religious objections to IVF)

Managing Infertility with IVF

The chance of a live birth following IVF treatment falls with:

- rising female age
- as the number of unsuccessful cycles increases. [new in NICE CG156 in 2013]
- a female BMI outside the range 19-30 before commencing assisted reproduction
- the consumption of more than the current Department of Health's recommendations for the consumption of alcohol
- maternal and paternal smoking (includes use of nicotine replacement products as it is the nicotine in tobacco that may reduce fertility)
- increasing caffeine consumption

Please see access criteria for IVF/ICSI in the Policy Inclusion Section

Indications for ICSI (Intra-cytoplasmic sperm injection)

The recognised indications for treatment by ICSI include:

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

In addition, treatment by ICSI should be considered for couples in whom a previous IVF treatment cycle has resulted in failed or very poor fertilisation.

The decision on whether to use IVF alone or IVF with ICSI should be undertaken by the specialist in line with NICE CG156.

IVF from Ovarian stimulation through to embryo transfer must be carried out in line with NICE CG156.

Appendix 2 – Version History

Version	Date	Details
0.1	29/04/2015	Initial draft
0.2	24/08/2015	Changes made following the GM EUR Steering Group Meeting on the 8th July 2015: • Section 1 Introduction (single women) - Final paragraph amended to read as follows: '*This policy applies to single women in exceptional circumstances however prior approval must be sought via the IFR route and all applications for funding should clearly demonstrate the exceptional circumstances, these should be evidenced wherever possible. Single women should demonstrate infertility either through evidence of previous investigations or by undertaking 6 cycles of donor insemination (these must be self-funded) prior to the individual applying for assisted conception treatment in line with this policy.'* • Section 2.1 Subfertility / Infertility (same sex couples) - 4th paragraph amended to read as follows: *'Subfertility in same sex couples will be defined as a failure to achieve a pregnancy following 6 cycles of donor insemination (these should be self-funded). Then in line with the period of expectant management a further 6 cycles of AI or 6 cycles of Intra-Uterine Insemination (IUI) should be offered (funded by the local NHS).'* Section 4.3 Reversal of Sterilisation • The Steering Group agreed to include the following option in this section: '*In cases where the sterilisation was carried out to treat an underlying condition and not for family planning purposes applications for funding can be made via the IFR route. All relevant clinical information should be included with the application.'* • Further sentence added to the second paragraph as follows: *'Where proof is supplied of successful reversal of sterilisation and if the infertility issues are in the partner IVF applications can be submitted via the IFR route for consideration.'* • Section 4.4 Surrogacy - The Steering Group agreed that following statement should be included in this section of the policy: '*The NHS does not fund any type of surrogacy arrangement. Commissioning parents must undertake the whole process privately.'* Section 4.7 Managing Unexplained Infertility • The final sentence of the second paragraph has been amended to read as follows: '*For same sex couples and single women who have had their funding approved via the IFR route offer a further 6 cycles of IUI post referral in addition to the self -funded 6 cycles undertaken prior to referral (as the equivalent of expectant management in a heterosexual couple)'.* • The following wording has been removed from this section: '*If exceptional circumstances apply, for example, when people have social, cultural or religious objections to IVF then application for this treatment can be made via the IFR route.'* • Section 4.10 Managing Female Infertility (Group III: ovarian failure) - A definition of premature menopause and a statement about premature or iatrogenic ovarian failure added to this section of the policy

		Section 4.13 Number of funded cycles
		• Wording slightly amended in the section to read *'may allow'* rather than *'allows'*.
		• Wording amended to read: *'for women aged 40-42 (inclusive), the CCG offers 1 full cycle providing:*
		  • *They have never previously had IVF (including privately) – (For same sex female couples: neither partner has previously had IVF.)'*
		• Storage of embryos following a live birth - paragraph amended to read as follows: '*If treatment resulted in a live birth before all the viable embryos were implanted the remaining embryos should be cyropreserved for either 10 years (in line with HFEA guidance) or until the woman's 40th birthday – whichever is shorter. Implantation of these embryos will not be funded by the NHS locally but they are available to the individual for private treatment.'*
		Section 4.15 Switching provider
		• The following wording added to the first paragraph: *'as long as the CCG has current contract arrangement with that provider*.'
		• Third paragraph reworded as follows*: 'Individuals with frozen sperm, oocytes or embryos who are eligible for further cycles:*
		  • *must ensure that all frozen embryos are implanted (thus completing the current cycle) prior to transferring to their new provider.*
		  In exceptional circumstances application can be made via the IFR route to fund the safe transfer of the frozen material from the old to the new provider.'
		• The fourth paragraph reworded as follows: '*Where donor eggs are required and the current provider cannot provide them the individual may apply for transfer to an alternative provider who can provide donor eggs (within a pre agreed tariff) via the IFR process as NHS providers cannot offer an egg share scheme under current NHS rules.'*

0.3	10/12/2015	Changes made following the GM EUR Steering Group Meeting on the 18th November 2015: Section 4.12.1 Access Criteria • Further sentence added to the second paragraph as follows: *In same sex (both female) partnership only one partner will be eligible for treatment with IVF up to the current number of cycles commissioned. This does not affect the untreated partner's right to IVF in a new relationship provided they meet the eligibility criteria at that time.* • The following sentence moved to 4.13 Number of funded cycles. '*The total number of cycles undertaken as listed below added to those funded privately does not exceed 3*'. Section 4.15 Switching providers: Second paragraph amended to read as follows: *'Individuals who have undergone privately funded cycles will still have to right to transfer to NHS funded cycles (at an NHS approved provider) provided that the overall total number of cycles (NHS and Private) does not exceed three. The actual number of cycles offered will depend on the number currently offered by the CCG (the relevant CCG is the one that the practice, with which the female partner is registered is part of).* Section 4.16 Policy Exclusions • In the first and second paragraphs after the word *'cancer'*, the following added for clarity *'(or for any lifesaving treatment resulting in fertility).'*

		• The fifth paragraph amended to read: *'Storage and retrieved sperm oocytes or resultant embryos will be for 10 years in line with HFEA licensing requirements provided the individuals are under the upper age limits for IVF treatment at the time of storage. Extensions to the storage time or age limit will require an IFR request, the individual must be made aware of this at the time of retrieval.'* Following the above amendments the GM EUR Steering Group approved the draft policy to be sent for a legal opinion.
	15/03/2016	Template unbranded and references to North West Commissioning Support Unit (NWCSU) changed to Greater Manchester Shared Services (GMSS)
0.4	16/03/2016	GM EUR Steering Group reviewed the draft policy on 16 March 2016 following legal advice and the following changes were approved: • Minor spelling/grammatical errors amended throughout the document as well as wording changed as follows: o *'Reviewed this clinical condition'* to be replaced with '*considered the range of causes of fertility problems'* o *'Does not'* to be replaced with '*has not been shown to'* o *'Does not'* to be replaced with '*is not shown to'* and *'research suggests it'* o *'The effect of'* to be inserted before pulsatile gonadotrophin-releasing hormone o *'This'* to be replaced with '*research indicates that this'* • The last sentence under section '1. Introduction' removed which read: *'In addition single women should demonstrate infertility either through evidence of previous investigations or by undertaking 6 cycles of donor insemination (these must be self-funded) prior to the individual applying for assisted conception treatment in line with this policy (3 cycles if aged over 36 years).'* • Changes made throughout the policy to ensure requirements are consistent for women over 36. • The word *'only'* added to the last paragraph of section '4.9.1 Surgical recovery of sperm' which reads *''Requests for funding these techniques in non-cancer patients with azoospermia should **ONLY** be made….'.* • Under section 4.10.1 under 'Group III: ovarian failure' the start of the first sentence amended to read: *'Treatment will be commissioned for women with…'* • Under section 4.12.1 in the 5th paragraph, first sentence reworded to read: *'Both partners must be non-smoking and not using any product containing nicotine in order…'*. • *'40th birthday'* in the last paragraph under section 4.13 amended to *'42nd birthday'*. • The statement: *'Extensions to the storage time or age limit will require an IFR request, the individual must be made aware of this at the time of retrieval.'* added to the end of the last paragraph in section 4.13 as per section 4.16. • Under section 4.15 in the 5th paragraph, *'storage of retrieved sperm, oocytes or resultant embryos…'* amended to read: *'Storage of retrieved sperm, oocytes will be for 10 years in line with HFEA licencing requirements.'* *Resultant embryos will be stored for 10 years in line with HFEA licencing requirements or until the woman's 42nd birthday provided the individuals*

		are under the upper age limits of IVF treatment at the time of storage. Extensions to the storage time or age limit will require an IFR request, the individual must be made aware of this at the time of retrieval.' • Comma added after *'Storage of retrieved sperm'* and before *'oocytes'* in section 4.16. • *'4.16.2 Claiming Exceptionality to the policy'* added as a heading in order to separate the section which relates to exceptionality. • Wording for date of review amended to read *'One year from the date of approval by Greater Manchester Association Governing Group thereafter at a date agreed by the Greater Manchester EUR Steering Group (unless stated this will be every 2 years)'* on 'Policy Statement' and section 13. Date of Review. Following the amendments it was agreed the policy template could go out for a period of clinical engagement.
0.5	20/07/2016	The GM EUR Steering Group reviewed the clinical engagement feedback and agreed the following changes to the policy: <u>Section 1 Introduction</u> • The words *'but are not co-habiting'* taken out of paragraph 6. • The following paragraphs added: o *'All couples should be informed that if, as a result of investigations into infertility, surrogacy is the only option that this will not be available funded by NHS commissioners in Greater Manchester.'* o *'Transgender patients should be managed as their preferred sex at all stages of investigation and treatment.'* o *'Couples where one or both partners are undergoing or have undergone gender re-assignment must be made aware that gamete storage is not available for this group as gender reassignment is considered to be a form of voluntary sterilisation. Reversal of sterilisation and IVF treatment as a result of sterilisation is not commissioned in Greater Manchester.'* o *'Recurrent miscarriage is not covered by this policy as there is a local service. All individuals should be referred in line with the pathway for that service.'* • The fourth paragraph under section 2.1 Sub-Fertility amended to read: *'Subfertility in same sex couples will be defined as a failure to achieve a pregnancy following 6 cycles of donor insemination (these should be self-funded) or 3 cycles if aged over 36 years. This would normally be self-reported attempts at vaginal insemination. Then in line with the period of expectant management a further 6 cycles of Intra-Uterine Insemination (IUI) should be offered (funded by the local NHS) 3 cycles of either if aged over 36 years in a clinical setting.'* and the following paragraph added: *'All patients undergoing fertility treatment covered by the HFEA (including IUI) must be assessed using the HFEA welfare of the child form and meet HFEA requirements.'* • The paragraph under section 2.3 Definition of Childlessness changed to include 3 separate options for CCG's to choose from. • Under section 4.2 Investigating Female Infertility' the following added to the end of the first paragraph: *'in the appropriate primary or secondary care setting as indicated clinically'* • In paragraph 2 under section 4.7 Managing Unexplained Infertility, *'AI or IUI'* changed to *'IUI'* and *'self-reported'*

		• The final sentence in section '4.9 Managing Female Infertility' changed to: *'Surgical sperm recovery is now the responsibility of NHS England and all requests for funding of these techniques should be made to NHS England using their form.'* • The sentence *'as it is the nicotine in tobacco that may reduce fertility'* added to the 5th bullet point under section 4.12 Managing Infertility with IVF. • Under section 4.12.1 Access criteria the definition of childlessness changed to include 3 separate options for CCG's to choose from. • Under section 4.13 Number of funded cycles, *'23-39'* changed to *'under 39'*. • The following paragraphs added under section 4.16 Policy Exclusions: *'Couples where one or both partners are undergoing or have undergone gender re-assignment can access services for the treatment and management of infertility however gamete storage is not available for this group at the time of transition surgery as gender reassignment is considered for the purposes of this policy to be a form of voluntary sterilisation. Reversal of sterilisation and IVF treatment as a result of sterilisation is not commissioned.'* and *'Any individuals outside these age ranges can apply via the IFR route, to avoid any delay in the start of treatment these requests will be dealt with as URGENT.'* • Under section 14 Glossary, the definition for *'Artificial Insemination (AI)'* changed to: *'Any method of introducing sperm to the female body other than by sexual intercourse – includes Intravaginal Insemination and Intrauterine insemination.'*
0.6	21/09/2016	The GM EUR Steering Group agreed all the changes made following the previous meeting and made the following further changes to the policy: • Introduction - In paragraph 8 the word *'available'* has been removed. In paragraph 10 the first sentence has been removed. • 2.3 Definition of Childlessness - The last paragraph title amended to read Option 3 not 2. • 4.3 Reversal of Sterilisation - Paragraph added: *'Reversal of vasectomy for reasons other than to restore fertility is commissioned e.g. to treat rare cases of post vasectomy pain.'* 4.13 Number of Cycles Funded • The first sentence in the last paragraph now reads *'until the woman's 40th birthday'* rather than *'42nd birthday'.* • The last sentence in the final paragraph amended from *'Extensions to the storage time or age limit will require an IFR request, the individual must be made aware of this at the time of storage.'* to read: *'Extensions to the storage time or age limit will require an IFR request for prior approval. The application should comply with the process for extension of the statutory storage period as outlined in the HFEA code of practice and should not take the period of cryopreservation over the statutory upper limit of 55 years, the individual must be made aware of this at the time of storage.'* 4.16 Policy Exclusions • Second paragraph removed. In the original third paragraph the following words added after *'infertility'* in the first sentence *'including gender reassignment'.* • The following paragraph added between the original third and fourth paragraphs *'All individuals should be informed at the time of storage that*

		if, at the time of treatment for infertility, surrogacy is the only option, this will not be funded by NHS commissioners in Greater Manchester' • The seventh and eight paragraphs reworded from '*Resultant embryos will be stored for 10 years in line with HFEA licencing requirements (or until a woman's 42nd birthday) provided the individuals are under the upper age limits of IVF treatment at the time of storage.* *Extensions to the storage time or age limit will require an IFR request, the individual must be made aware of this at the time of retrieval.'* to read '*Any resultant embryos will be stored for 10 years in line with HFEA licencing requirements (or until a woman's 42nd birthday) provided the individuals are under the upper age limits of IVF treatment at the time of storage.'* *Extensions to the storage time for sperm or oocytes or age limit for embryos will require an IFR request for prior approval. The application should comply with the process for extension of the statutory storage period as outlined in the HFEA code of practice and should not take the period of cryopreservation over the statutory upper limit of 55 years, the individual must be made aware of this at the time of storage.'* • The final paragraph in this section reworded from '*Any individuals outside these age ranges can apply via the IFR route, to avoid any delay in the start of treatment these requests will be dealt with as URGENT.'* to read '*Any individuals outside the specified age ranges above can apply via the IFR route, to avoid any delay in the start of treatment these requests will be dealt with as URGENT.'*
0.7	16/11/2016	Amendments made by the GM EUR Steering Group on 16/11/2016 following legal advice: • New policy format applied. • 'Funding Mechanism' boxes added where necessary throughout policy. • 1.12.1 Access Criteria and 6.3 Definition of Childlessness: the definition: *'A child adopted by a patient or adopted in a previous relationship is considered to have the same status as a biological child.'* added to Option 1 and Option 3's second sentence amended to read the same. • 1.13 Number of funded cycles: the word *'must'* added to the first paragraph and, in 2nd from bottom paragraph, '40th' amended to '42nd'. • 1.16 Policy Exclusions: the word 'therapy' removed from the 1st paragraph; the word 'including' changed to *'or'* in the 2nd paragraph; and; the word *'and'* added to the 6th paragraph. • 2. Policy Statement: the 2nd paragraph reworded to: *'In creating this policy GMSS has considered NICE guidance and taken account of the predecessor Greater Manchester policy in order to develop a policy of benefit to patients which makes the best use of available NHS resources.'* • References: Amended to incorporate the previous policy format's 'Documents which have informed this policy' section. Approved to go through the CCG Governance Process.
	12/04/2017	1.12.1 Access Criteria and 6.3 Definition of Childlessness): Whilst the policy was going through the CCG Governance Process the Directors of Commissioning requested the definition of childlessness be clarified and put into one statement.
1.0	01/08/2017	Approved by Greater Manchester Association Governing Group

1.1	21/08/2017	Note added to front of policy - From 21 August 2017, NHS-funded assisted conception services will not be included in the exemption from charge applicable to people who are caught within surcharge arrangements.
1.2	24/11/2017	Definition of premature ovarian failure added to 1.10.2: Use of Donor Oocytes and to 11: Glossary.
1.3	17/01/2018	• 1.6 Intrauterine Insemination: Bullet point *'single women (i.e. women not in a stable relationship)' added* • 1.7 Managing Unexplained Infertility: ○ In second paragraph, the words *'who have had their funding approved via the IFR route'* removed and *'to be carried out in a clinical setting'* added. ○ The last sentence *'All services should be offered in line with the recommendations of NICE CG156.'* moved before *'Do not offer'*. ○ *'(exceptional circumstances include, for example, when people have social, cultural or religious objections to IVF)'* added to the second bullet point under *'Do not offer'* • 1.10.1 Ovulation Disorders: ○ *'(unless they can show by an alternative measure to BMI that they have a normal body fat ratio).'* added to the first bullet point under *'Group I: hypothalamic pituitary failure...'* ○ The antral follicle count sentence removed following *'Premature ovarian failure is defined...'* in the second paragraph under *'Group III: ovarian failure'* and replaced with *'...as in the paragraph above.'* • 1.10.2 Use of Donor Oocytes: The antral follicle count detail removed from the first bullet point following *'premature ovarian failure'* and replaced with *'...occurring before the age of 40 years'* • 1.11.3 Endometriosis: Section replaced to read: *'Endometriosis should be managed in line with NICE NG73 Endometriosis: diagnosis and management.'* • 1.12 Managing Infertility with IVF: Fourth bullet point amended from *'...1 unit of alcohol per day'* to *'...the current Department of Health's recommendations for the consumption of alcohol'* • 1.12.1 Access criteria: The body mass index amended from *'19-29'* to *'19-30'*; *'BMI above 29'* amended to read *'BMI above 30 or below 19'*, and *'not clinically obese'* amended to read *'not clinically obese or too thin'*. • 1.13 Number of funded cycles: *'For women aged 40-42 (inclusive)'* amended to read *'40-42 (i.e. before her 43rd birthday)'* and *'42nd birthday'* amended to read *'43rd birthday'*. • 1.15 Switching providers: Removal of the word 'contract' from first paragraph. • 1.16 Policy Exclusions: *'Individuals under the age of 42'* amended to read *'Individuals under the age of 42 (i.e. prior to their 43rd birthday)'*; *'Individuals over the age of 42'* amended to read *'Individuals over the age of 42 (i.e. after their 43rd Birthday)'* and *'42nd birthday'* amended to read *'43rd birthday'*. • 6. Treatment / Procedure: Sixth paragraph amended to read *'This policy also applies to single women (i.e. women not in a stable relationship) who should be managed as for women in a same sex relationship however prior approval must be sought via the IFR (Exceptional Case) route if investigation and treatment shows that IVF is the best treatment option the application should clearly demonstrate the exceptional*

		circumstances with particular reference as to why the GM CCGs requirement for a stable relationship prior to undergoing IVF does not apply to them.' from 'This policy applies to single women in exceptional circumstances however prior approval must be sought via the IFR route and all applications for funding should clearly demonstrate the exceptional circumstances, these should be evidenced wherever possible.' • 6.1 Subfertility / Infertility: *'see NICE NG73'* added to second bullet point. ▪ 7.2.7 Alcohol: *'current'* added before *'Department of Health's'* and *'...of drinking no more than three to four units of alcohol a day'* amended to read *'for the consumption of alcohol'* • 11. Glossary: Definition of *'Premature ovarian failure'* amended.
	21/03/2018	Before the above changes were implemented the policy was sent back to GM EUR Steering Group to review the changes requested at the January meeting in relation to single women following advice from the Equality and Diversity Team. The GM EUR Steering Group agreed the following changes would **no longer** be made to the policy: • 1.6 Intrauterine Insemination: Bullet point *'single women (i.e. women not in a stable relationship)' added 17/1/2018 –* ***removed 21/03/2018*** • 1.7 Managing Unexplained Infertility: • In second paragraph, the words *'who have had their funding approved via the IFR (Exceptional Case) route'* removed 17/1/2018 – **added back in 21/03/2018** The following amendments were also made for clarify: • Where appropriate, instances of *'IFR'* or *'EUR'* throughout policy were amended to read *'IFR (Exceptional Case)'* or *'IPA'* and funding mechanisms were also clarified.
2.0	19/09/2018	Reviewed at GM EUR Steering Group where the following changes were made: • Section 1. Commissioning Statement o Link added to NICE CG156. o Paragraph added regarding who funds treatment. o Following sentence removed from the funding mechanism *'in some cases this will include monitored approval or, where stated in this policy, individual prior approval.'* • Section 1.4 Surrogacy: Link added to *'GOV UK guidance: Having a child through surrogacy'* at the end of the section. • Section 1.9.1 Surgical Recovery of Sperm: In final paragraph link add to *'NHS England: 16040/P – Clinical Commissioning Policy: sperm retrieval for male infertility'*. • Section 1.10.1 Ovulation Disorders o Following sentence added: *'Please refer to GMMMG website for up to date guidance on any restrictions to drugs.'* o Under *'Group II' – 'First line treatment'* the following added to the first bullet point: *'who have a BMI over 30'* • Section 1.13 Number of funded Cycles The following paragraph reworded from: *'If treatment resulted in a live birth before all the viable embryos were implanted the remaining embryos should be cyropreserved for either 10 years (in line with HFEA*

		guidance) or until the woman's 43rd birthday – whichever is shorter. Implantation of these embryos will not be funded by the NHS locally but they are available to the individual for private treatment.' to *"If treatment resulted in a live birth before all the viable embryos were implanted the remaining embryos should be cryopreserved for 10 years in line with HFEA guidance. Implantation of these embryos will not be funded by the NHS locally but they are available to the individual for private treatment.'* • Section 1.16 Policy Exclusions: *'(or until a woman's 43rd birthday)* removed from the 7th paragraph • Section 10. Date of Review: Amended to *'Three years'* The above changes were not considered to be material and therefore it was not necessary for the amended policy to go back through the governance process again.
2.1	21/01/2019	• 2: Policy Statement, 3: Equality & Equity Statement: References to GMSS changed to GMHCC. • 4: Governance Arrangements: Updated to reflect change of governance and link to GM EUR Operational Policy updated to new address.
2.2	16/01/2019 18/09/2019	GM EUR Steering Group approved the new layout of the policy template, which would make it more user friendly. New layout of policy reviewed by GM EUR Steering Group and the following changes were made:- Policy Exclusion Section **Recurrent miscarriage** – The following sentence has been added *'IVF/ICSI is not commissioned for recurrent miscarriage unless part of PGD which requires application to NHS England.'* Policy Inclusion Criteria **Change of provider to access donor eggs** - The following paragraphs have been added:- *Donor eggs for women under 40 years will be commissioned if the woman has failed to produce viable eggs on a regular basis and has been assessed by a fertility specialist and found to have premature ovarian failure.* *For women over 40 years see below - 'IVF for women aged 40-42 (inclusive)'* **Previous sterilisation** – This has been reworded for clarity and a funding mechanism of Individual Prior Approval added. **IVF for women aged 40-42 (inclusive)** – The following has been added Their single cycle of IVF can be carried out with donor eggs if one of the following applies: • total 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 these are the risk factors for a poor ovarian response in this gage group as laid by NICE in 2013.

	20/11/2019 20/01/2020	**Definitions of IVF Cycles** – The following has been added to the funding mechanism '*Cycles where the treatment is for the partner of a previously sterilised individual who has undergone a clinically successful reversal: Individual prior approval – requires a statement from a clinician confirming successful reversal.'* **Use of Donor Oocytes** – The 5th bullet point amended from *'certain cases of IVF treatment failure'* to *'unexplained (or repeated) failure of ovarian stimulation during of IVF treatment '* GM EUR Steering Group approved the changes that had been made to the policy since the last meeting and agreed the following changes:- Clarified wording on funding for single women:- **Managing Unexplained Fertility** – Second paragraph reworded for clarity & **Treatment / Procedures** – Sixth paragraph reworded for clarity. Steering Group members agreed that the policy would not need to go through the governance process again as the changes made to the policy were still in line with NICE CG156. **Private Sector to NHS and Switching Providers** – The following has been added for clarity *e.g. If an NHS commissioner (or commissioners if the couple have moved areas) has funded two cycles and the individual has funded one privately , they have undergone three cycles and are therefore at their maximum under this policy. The limit of three cycles applies to the number of cycles undergone by the couple irrespective of who has funded each of those cycles.*
2.3	28/02/2020	**Reversal of sterilisation** (Page 6) The following wording has been amended to correspond with the funding mechanism on page 9 which states that '*cycles of IVF where the treatment is for the partner of a previously sterilised individual who has undergone a clinically successful reversal Individual prior approval. Requires a statement from a clinician confirming successful reversal.'* From; ***NOTE**: Where subfertility remains after reversal of sterilisation, assisted conception will not be funded routinely. Where proof is supplied of successful reversal of, and if the infertility issues are with the partner, IVF applications can be submitted via the IFR (Exceptional Case) route for consideration. IVF in these cases must be to treat infertility in the not (previously) sterilised partner* To;

		***NOTE**: Where subfertility remains after reversal of sterilisation, assisted conception will not be funded routinely. Where proof is supplied of a clinically successful reversal of sterilisation, and the infertility issues are with the partner, prior approval for IVF needs to be sought via the EUR route. Applications must include a statement from a clinician that the reversal was successful. IVF in these cases must be to treat infertility in the not (previously) sterilised partner.*
3.0	20/05/2020	Previous sterilisation – The final sentence has been amended for clarity. From:- *However where a partner has had a successful reversal of sterilisation and the infertility to be treated is in the other (not previously sterilised) partner then application can be made via the EUR route.* TO:- *However where a partner has had a successful reversal of sterilisation and the infertility to be treated is in the other (not previously sterilised) partner or the couple have been diagnosed with unexplained infertility, then application can be made via the EUR route* Equality and Equity Statement – GM EUR Policy Team email address updated
	18/11/2020	Policy Template reviewed at GM EUR Steering Group and the following changes were agreed: Cover Page Government issued Statutory Instrument - amended as follows (this has also been amended on page 13) o This is brought forward through regulations 11, 12 and 13 of ***the above-named*** instrument, which insert a new regulation (9A) and amend regulation 10 and 11 respectively ***to the National Health Service (Charged to Overseas Visitors) Regulations 2015.*** o Exemption ***from charges*** currently applies to: The following paragraph has been added '*In the operation of this policy, the CCG will have regard to the Human Fertilisation and Embryology Act 1990 (as amended) which provides that a woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting).'* Commissioning Statement Policy Exclusion Section - The following paragraph has been added; *"Prior to offering treatment covered by this policy, the individuals seeking assisted conception should be advised of the need for period of expectant management. They should have tried to conceive for a total of 2 years (The period of expectant management after diagnosis and up to 1 year before their fertility investigations began) before IVF will be considered. For same sex couples and single women offer a further 6 cycles of IUI post referral, to be carried out in an NHS clinical setting, in addition to the self-funded 6 cycles of self-reported vaginal insemination undertaken prior to referral (as the equivalent of expectant management in a heterosexual couple) or 3 cycles if aged over 36 years."*

		Sperm, oocyte or embryo storage to retain fertility – this section has been updated Pre-Implantation Genetic Diagnosis and sperm retrieval along with referral for genetic counselling moved to a new 'NHS England Commissioned Services' section of the policy. Research and local pathways – has been given its own section. A 'Not commissioned' section added for clarity, with 'Surrogacy' has been moved to this section Policy Inclusion Criteria – The words 'included but restrictions apply' have been added to the title. The first paragraph has been amended from '*Assisted conception care is generally commissioned in line with NICE CG156: Fertility problems: assessment and treatment, except for those interventions specifically mentioned in the following section:' to read '*Assisted conception care is generally commissioned in line with NICE CG156: Fertility problems: assessment and treatment. *Pages 6 to 13 summarise areas where qualifying criteria apply or that are not covered by CG156'* Access Criteria for IVF/ICSI – The following has been added to the first paragraph '(see appendix one for full definitions in line with NICE CG 156'. The seconded paragraph amended from 'who meet the following criteria' to read 'who meet the criteria as set out in this policy.' Number of cycles of IVF Funded a section has been added on HFEA guidance – Welfare of the Child'. Also funding the wording of the funding mechanism for cycles of IVF for single women has been amended to reflect this. Sperm, oocyte or embryo storage to retain fertility - the following sentence has been added 'There is no upper age limit for the storage of sperm. Storage of viable embryos - the following sentence has been added **'**Storage will be funded within the general contract in line with HFEA regulations- if the storage time in these regulations reduces, then the woman must be informed and allowed to request an extension to storage time via the IFR route.' Treatment / Procedure Section paragraphs 4, 5 & 6 have been amended and the final paragraph below removed '*Reversal of sterilisation and IVF treatment as a result of sterilisation is not commissioned in Greater Manchester*.' Glossary Section – The definitions for 'Infertility' and 'Subfertility' have been added. The definitions of the funding mechanisms with the policy have also been added Appendix 1 – The title of the appendix has been amended

		Surgical recovery of sperm – The following sentence has been removed; '*There is limited evidence available on the effectiveness of these techniques and surgical recovery of sperm is not included in NICE CG156'* Managing Unexplained Infertility **-** the following sentence has been amended; "For single women approval must be sought via the IFR (Exceptional Case) route for IVF. ***The application should contain a copy of the HFEA welfare of the child form."***
	20/01/2021	GM EUR Steering Group approved the changes that had been made to the policy template since the last meeting and agreed the following further changes:- A foot note has been added to the policy to state; "the policy is the predominant document and NICE CG156 is appended to provide clarity'. Policy Inclusion Criteria - The 'Intrauterine Insemination' section was moved to above the 'Access Criteria for IVF/ICSI' section. Number of cycles of IVF funded – The wording in the sentence regarding funding for women aged 40-42 was amended in relation to a second attempt at a full cycle. Under the 'Definition of IVF Cycles' the wording for 'Full cycle' was amended to reflect the use of donor eggs. Following these amendments it was agreed the policy template could go out for a period of clinical engagement.
	19/05/2021	GM EUR Steering Group agreed to the following further changes to be made to the policy template following feedback received during the period of clinical engagement:- Commissioning statement Policy Exclusions section: Sperm, oocyte or embryo storage to retain fertility The following paragraph has been amended: "Individuals undergoing treatment for cancer (or for any lifesaving treatment resulting in infertility) or gender reassignment ***or as part of the management of a congenital condition which will affect fertility in later life,*** and who are well enough to undergo the required procedures, should be offered sperm or egg retrieval and storage provided this does not put them at risk of serious adverse health effects from either a delay in treatment or from the procedure needed to retrieve the egg / sperm. The resultant sperm, eggs or embryos will be stored in line with current HFEA regulations. Currently, there is no upper age limit for sperm. However, there is an upper age limit of 43 for eggs and embryos. These should be stored and used in line with HFEA regulations." The following wording was added regarding when restrictions apply for clarity; "***The only treatments where restrictions will apply to these individuals are 1) eligibility for IVF/ICSI, if they require more than the currently commissioned cycles or do not meet the criteria they can***

		make an application for exceptionality and 2) Surrogacy is not commissioned by the NHS" The abbreviations "PlGD, TESSE and micro-TESSE" were amended to "PGD, TeSe and MicroTeSE". <u>Policy criteria – not commissioned section (Surrogacy):</u> The definition of surrogacy was removed. <u>Policy Inclusion criteria; Number of cycles of IVF funded</u> The following wording was added to the paragraph relating to treatment commencing the patient's 43rd birthday; "if waiting times will take them beyond their 43rd birthday, they can apply via the IFR (exceptionality) route for transfer of care" The wording in the paragraph relating to a second attempt at a full cycle was amended to " A single second attempt at a full cycle, with their own or donor eggs as appropriate, may be commissioned if the first attempt ends in a cancelled or abandoned cycle (this requires an application for prior approval and MUST commence before the woman's 43rd birthday.)" The following paragraph has been added; "**NOTE**: If a woman changes her registered practice to one that comes under a different CCG which offers a different number of IVF cycles – eligibility will depend on the number of IVF cycles offered by the CCG where she is currently registered." <u>Sperm, oocyte or embryo storage to retain fertility:</u> The following wording was added; "If individuals move away from the area where their gametes or embryos are stored, they can apply via the IFR (exceptional case) route for the transfer of those embryos to their current area of residence, or for the cost of storage to be met by their new CCG" <u>Access to donor eggs</u> The wording in the sentence regarding donor eggs for women under 40 was amended from" '*has failed to produce viable eggs on a regular basis*" to "*has a condition which means no viable eggs can be produced OR has been assessed by a fertility specialist and found to have premature ovarian failure."* <u>Intrauterine Insemination</u> A bullet point for single women was added to this section <u>Switching providers</u> The wording in this section relating to number of funded cycles was amended to; "The actual number of cycles will depend on the number currently offered by the CCG **(the relevant CCG is determined by the surgery which the female partner is registered with**.)" <u>Audit requirements:</u> This was amended to read "The HFEA maintains a record of all assisted conception cycles on a national database".

	13/07/2021	Date of review This was amended to one year Following the above changes the GM EUR Steering Group approved the policy to go through the governance process. Version 3.0 of the policy template was approved for implementation by the GM Directors of Commissioning
3.1	17/11/2021	GM EUR Steering Group agreed the policy template be amended as follows: Funding Mechanism for IVF Deleted that IVF for single women is via IFR (exceptional case) route. Now reads that *Cycles of IVF up to the number funded by the CCG for all women: Monitored approval provided that all steps have been taken to ensure the welfare of the child as per the HFEA statement above. May be subject to audit or contract challenge.* Treatment/Procedure - Changed from: *This policy also applies to single women who should be managed as for women in a same sex relationship up to the point when investigation and treatment shows that IVF is the best treatment option at this point approval must be sought via the IFR (exceptional case) route. The application should confirm that all steps have been taken to ensure the welfare of the child as per the HFEA statement above. NOTE as per HFEA guidance: "A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth". 'Supportive parenting is a commitment to the health, wellbeing and development of the child. It is presumed that all prospective parents will be supportive parents, in the absence of any reasonable cause for concern that any child who may be born, or any other child, may be at risk of significant harm or neglect. Where centers have concern as to whether this commitment exists, they may wish to take account of wider family and social networks within which the child will be raised.*' **To read:** *This policy applies to all women provided all steps have been undertaken to ensure the welfare of the child as per HFEA guidance: "A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth". 'Supportive parenting is a commitment to the health, wellbeing and development of the child. It is presumed that all prospective parents will be supportive parents, in the absence of any reasonable cause for concern that any child who may be born, or any other child, may be at risk of significant harm or neglect. Where centres have concern as to whether this commitment exists, they may wish to take account of wider family and social networks within which the child will be raised.'*

		Managing Unexplained Infertility - The following paragraph has been removed: *For single women approval must be sought via the IFR (exceptional case) route for IVF. The application should contain a copy of the HFEA welfare of the child form.*
	10/12/2021	Version 3.1 of the policy template was approved for implementation by the GM Directors of Commissioning

This page is intentionally left blank

Health Scrutiny - Assisted Conception Policy

1) PURPOSE OF REPORT:

This report provides an overview of the Assisted Conception Policy for Trafford and an overview of the Greater Manchester (GM) position for Assisted Conception cycles and funding.

2) GM Assisted Conception Policy Overview

All GM Localities are required to adhere to a single access policy: the GM Assisted Conception EUR policy. This means that decisions around access to assisted conception treatments – other than the number of cycles offered are taken at a GM rather that locality level.

Assisted conception care is generally commissioned in line with NICE CG156: Fertility problems: Assessments and treatment as outlined in Pg 6-13 of the policy below) which details the qualifying criteria that apply .

Individual treatments are funded by the area with whom the patients GP surgery is registered, with the exception of those treatments where the specified commissioner is NHS England (NHSE)

When treating a couple, it is the GP surgery with whom the female partner is registered. In same sex (female) couple it will be the GP surgery with whom the patients wishing to carry the pregnancy is registered.

(Full policy is below)

3) Operating module

On 1st July 2022, a new operating module was introduced for the GM Individual Funding Requests (IFR) Service.

In summary this now means that GM IFR Service no longer process prior approvals, this is now considered permissible activity, therefore this means that if a clinician deems a patient requesting Assisted Conception meets the policy criteria the clinician can refer for treatment.

4) Number of Cycles of Assisted Conception funded

Both NHS and privately funded cycles will be considered when determining how many cycles to fund.

NOTE: If a woman changes her registered practice to one that comes under a different area which offers a different number of IVF cycles, eligibility will depend on the number of IVF cycles offered by the area where she is currently registered.

The total number of cycles undertaken as listed below added to those funded privately must not exceed 3. Where cycles have been funded privately or by another area, these will be taken into account when determining how many cycles to fund in accordance with the below:

For women aged 39 and under:

Bolton, Bury, HMR, Manchester, Oldham & Trafford all commission 1 complete cycle of IVF (and allow a second attempt at a full cycle for a cancelled or abandoned cycles).

Salford, Stockport & Wigan all commission 2 cycles (includes abandoned or cancelled cycles).

Tameside commissions 3 cycles (includes abandoned or cancelled cycles).

IVF for women aged 40-42 (i.e. before her 43rd birthday) - all areas in Greater Manchester 1 full cycle provided:

- They have never previously had IVF (including privately) – (For same sex female couples: neither partner has previously had IVF)
- There has been a discussion about the implications of IVF at this age

Their single cycle of IVF can be carried out with donor eggs if one of the following applies:

- total 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

5) Conclusion

Trafford are now in the majority of localities across England that offer 1 NHS funded cycle for Assisted Conception for those who meet the qualifying criteria for the Assisted Conception process. The majority of localities in Greater Manchester also now only offer funding for 1 cycle of IVF.

It is vital to clarify that all NHS organisations need to consider how they prioritise spending their budget and Assisted Conception is one in a number of treatments and services commissioned in Trafford.

The ICB has the responsibility of supporting the whole population, this means that our priority must be to offer safe, quality NHS healthcare across primary, secondary and specialist services, as well as lifesaving emergency services for the whole of Trafford. We also need to build an infrastructure and provision for a population that are living longer, with some patients of all ages having a greater need for long term NHS support, especially following the pandemic

This means that at the present time, Trafford locality is has agreed to support 1 cycle of IVF. The option to offer financial assistance to those who may require more than a single cycle is also not under consideration at the present time.

It has also been confirmed that GM are planning to standardise the number of Assisted Conception cycles across GM as part of the emerging work programme on Commissioning for Outcomes.

This page is intentionally left blank

Wednesday 17 January 2024 – 6:30 p.m., Committee Rooms 2&3, Trafford Town Hall *Report submission deadline – midday on Tuesday 9 January 2023*				
Item	**Information**	**Executive Member(s)**	**Lead Officer(s)**	**Comments**
HEALTH INEQUALITIES	To provide a report update on work carried out to tackle health inequalities and to look at plans to address health inequalities in 2023/24.	Executive Member for Adult Social Care and Health	Helen Gollins/ Gareth James/ Nathan Atkinson	
BLUE BADGE	To provide a detailed report of the uptake and spread across the different disability groups, the administrative costs, and other relevant particulars.		Lucy Boubrahmi	
ADULT SOCIAL CARE, CQC PREPAREDNESS	To inform the Committee of the CQC adult social care inspection approach and preparedness work completed	Executive Member for Adult Social Care and Health	Nathan Atkinson	
GM ICP UPDATE	To receive a report, update on relevant strategic updates concerning the GM ICP – operating model and performance	Executive Member for Adult Social Care and Health	Gareth James / Thomas Maloney	

Wednesday 6 March 2024 – 6:30 p.m., Committee Rooms 2&3, Trafford Town Hall *Report submission deadline – midday on Tuesday 27 February 2024*				
URGENT CARE REVIEW	To provide a final update to Committee on progress and/or decisions	Exec Mem for Adult Social Care	Gareth James / Cathy O'Driscoll / GM ICB and Manchester FT	
GM ICP UPDATE	To receive a report, update on relevant strategic updates concerning the GM ICP	Exec Mem for Adult Social Care	Gareth James / Thomas Maloney	
TASK AND FINISH GROUP	To provide a final report for consideration.	Health Scrutiny Committee Chair	Members	