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AGENDA ITEM 1

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Principal Scrutiny Officer

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13 July 2022

To: All Members of the North Central London Joint Health Overview and Scrutiny Committee

Dear Member,

North Central London Joint Health Overview and Scrutiny Committee - Friday, 15th July, 2022

I attach a copy of the following reports for the above-mentioned meeting which were not available at the time of collation of the agenda:

9. START WELL PROGRAMME (PAGES 1 - 12)

10. QUALITY MONITORING IN NCL PRIMARY CARE SERVICES (PAGES 13 - 18)

12. FERTILITY POLICY REVIEW (PAGES 19 - 48)

Yours sincerely

Dominic O'Brien
Principal Scrutiny Officer

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North Central London Integrated Care System

Start Well: Opportunities for improvement in maternity, neonatal, children and young people's services in North Central London

Case for Change overview
July 2022

Summary and ask for JHOSC

North Central London Integrated Care System

This paper provides an update to JHOSC on the Start Well programme, a long term change programme looking at children and young people's and maternity and neonatal services.

We have recently completed the first phase of this programme and published a Case for Change which summarises our findings to date. The process we have followed and high level findings are summarised in this paper and more information can be found here: https://nclhealthandcare.org.uk/get-involved/start-well/

We would like to ask the JHOSC to:

- Feedback their views on the Case for Change findings and opportunities for improvement summarised in this paper.
- Provide scrutiny and assurance on our programme approach and in particular our plans for communications and engagement over the next few months
- Help us to publicise this opportunity for residents, patients and the public to get involved with this programme of work

Introduction: NCL's Start Well ambition

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To ensure our services for children, young people, maternity and neonates, deliver outstanding, safe and timely care for local people wherever they live.

Since November 2021, the partner organisations in NCL have been working together on the initial phase of Start Well: a long term programme looking at children and young people, maternity and neonatal services across NCL.

Partners from across the integrated care system have been working together to understand if we are:

- delivering the best services to meet the needs of children, young people, pregnant people and babies
- learning from, and responding to, national and international best practice, clinical standards and guidelines
- reducing inequalities in provision and health outcomes.

The focus is hospital **emergency and elective services for children and young people, and maternity and neonatal services** at North Mid, UCLH, the Royal Free, Barnet, Chase Farm and Whittington Health. The interface of services and pathways with specialist providers, including Great Ormond Street Hospital, are considered as part of the programme.

We have worked collaboratively, openly and transparently, and involved stakeholders throughout this initial phase.

Start Well reports into NCL's Children, Young People, Maternity and Neonatal Board under three clinical workstreams:

- Children and young people's **planned care** in acute setting
- Children and young people's **emergency care** in acute setting
- **Maternity and neonatal** services.

Communications and engagement activity to date

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We have carried out broad communications activity to introduce the programme to stakeholders including staff, partners, VCS organisations, borough partnerships, and MPs and councillors. During phase one we have **focused engagement activity** around:

- **Staff engagement** –
  - a series of staff briefings
  - clinical interviews and workstream reference groups
  - Leadership development workshops, coaching and action learning sets
  - staff feedback form open to all staff throughout this phase
- **Public engagement secondary information –** capturing insight from previous engagement activity as themed analysis for inclusion in the Case for Change; reports from Healthwatch, Maternity Voices Partnerships, national reports such as Better Births, trust patient experience information, evaluation of temporary changes to paediatric services during the pandemic, LMNS engagement with Birth Companions
- **Public engagement primary sources**
  - Online focus groups - themed discussions around maternity and neonates and children and young people's services
  - Feedback from the Start Well online patient panel and resident advisors to the workstreams
  - Insight discussion group with community organisations with women with experience of domestic Violence, Bengali/Syhleti speakers and young care leavers
  - Resident advisers recruited

The first phase has been a collaborative process, working with stakeholders from across the system

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Case for change development journey

Interviewed **60** clinical and operational leaders from across the NCL system

Supported leadership development through 1:1 coaching, action learning sets and **3** leadership development workshops

Captured wider **staff views and experiences** on the current state of services through a staff survey

Conducted **baseline analysis** and undertook an extensive **document and evidence review** to understand best practice

Tested outputs and captured clinical insights through **12** reference group meetings, **2** clinical workshops and **5** surgical deep dive sessions

Engaged with **patients and the public** through patient forum and focus group events

Start Well case for change development process

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Case for Change development has been collaborative, informed by outputs from the workstream reference groups, clinical workshops and surgical deep dives

- The Start Well case for change document outlines the opportunities for improvement for maternity, neonatal, children and young people services
- The document does not set out how to respond to the opportunities
- Throughout the development process, all Trusts have been engaged in a review and iteration process to refine and improve the document
- The document has now been presented at and endorsed by all NCL Trusts Boards and the Specialised Service Recovery Oversight Group

Opportunities for improvement: Maternity

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Ensuring excellent experience, equitable access and optimal outcomes for pregnant women and people

- **Stillbirth rate varies between boroughs**, Haringey had the highest rate with 6.3 per 1,000 population between 2018-20 compared to 3.2 per 1,000 in Camden
- The babies of Black pregnant women and people are **twice as likely to be admitted to a neonatal unit after birth** compared to White pregnant women and people
- Only **4.9% of pregnant women and people in NCL access perinatal mental health services** which is significantly below the 8.6% NHS Long Term Plan ambition

Better utilisation of maternity capacity offered in NCL

- Currently, the **range of units in NCL are not all used equally**, with many pregnant women and people either choosing to deliver, or being recommended to deliver, in an obstetric-led setting
- For some sites in NCL, **use of their midwifery-led units was around 30% or under**, whilst obstetric led units were dealing with significant capacity pressures.
- During times of high demand or low staffing levels, some **maternity units are sometimes forced to close** to ensure the safe care of pregnant women and people they are looking after

Supporting maternity workforce sustainability

- All Trusts received a recurrent uplift in funded establishment to meet birthrate plus, however in many instances **bank and agency are used to fill shifts** to ensure compliance with this target due to vacancies
- For our units to comply with the new staffing standards we need to **recruit an additional 27 midwives** across the system
- **Collaborative work is ongoing** to address the recruitment challenges, however further work is needed to ensure that vacancies do not impact upon patient care and the experiences of our staff

Opportunities for improvement: Neonates

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Matching neonatal care capacity and demand	• The UCLH NICU was on average **85% occupied which is higher than the maximum threshold** set out in the NHS neonatal service specification. • Over stretched level 3 capacity in NCL resulted in **40 babies in 2020/21 needing to be transferred** to a NICU outside of area
Consider the sustainability of the Royal Free Hospital Special Care Unit	• Royal Free hospital special care unit delivers **111 respiratory care days which is significantly below** the 365 day BAPM upper threshold • Low numbers of babies admitted to the Royal Free hospital special care unit **creates a challenge for staff to maintain the required competencies** to look after babies requiring respiratory support, although mitigating actions are in place to manage this in the short term. • High risk pregnant women and people giving birth at the Royal Free **need to be transferred to a hospital with a higher level of neonatal care** provision if the baby is likely to be high risk
Minimising avoidable admissions to neonatal units	• The existing provision of neonatal community outreach programmes is **not consistent between our boroughs** • For example, in Islington, phototherapy is available in the community whereas for babies living elsewhere, they would likely have to stay in hospital to receive this treatment
Addressing workforce vacancies and variation in provision and access to AHPs across neonatal units	• North Mid are **unable to open their full establishment of cot spaces** due to nursing vacancies • The London Neonatal ODN has highlighted that in NCL we **require an uplift in nursing establishment by 26.1 WTEs** to meet the Dinning Tool requirements • **AHP provision is inconsistent across units** – some have no access to certain therapists. The AHP staffing model in NCL is also fragile with staff working on units as part of their wider job plan.

Opportunities for improvement: Children and young people (1/2)

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Increasing demand for emergency care

- NCL sites are providing emergency care to an **additional 73 children and young people** a day compared to 2016/17
- A **higher number of low acuity cases are being treated in ED** and equally an increasing number of complex cases puts pressure on emergency departments
- Increasing levels of low acuity attendances suggests that some demand for acute services could be **better served in alternative care settings**

Improving long-term conditions management

- There are some children and young people with long-term health conditions that **do not get enough support to manage their health and wellbeing**, and this can lead to unplanned time in hospital
- Children and young people with long term conditions who **live in the most deprived areas are more likely to be admitted to hospital**
- For example, children and young people with asthma living in the **most deprived areas were twice as likely to spend unplanned time in hospital** than those living in the least deprived areas.

Organisation of paediatric surgical care

- There is variation between and within hospitals on whether a child can be treated on site, **depending on the confidence and skills of adult surgeons and anaesthetists** covering the emergency rota
- Children with **lower complexity emergency cases are being transferred to specialist hospitals**, causing treatment delays for some children. An example of this is children with testicular torsion.
- Within NCL the role of GOSH, a specialist surgical centre, without an emergency front-door, could be **more clearly defined** as currently it is difficult for local sites to manage daily emergency care
- Opportunity to consider the GIRFT and best practice requirements which outline the benefits of **of a paediatric surgical network** to support implementation of consistent models of care and improve quality of care.

Opportunities for improvement: Children and young people (2/2)

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Reducing long waits for elective care

- In NCL, 1 in 46 (32,000) children and young people are **currently waiting for treatment**
- For admitted care there are currently c.4,300 children and young people waiting for treatment at NCL sites. Of those waiting for care **over 330 have been waiting over a year** and 1,600 over 18 weeks.
- As of February 2022, there was c.24,000 children and young people waiting for a non-admitted care at NCL sites. Those waiting more than 18 weeks has increased by over 40% since May 2021.

Improving transition to adult services

- Across NCL there is a **challenge in providing consistent care across transition into adult services**
- There is **no consistent definition across NCL around the age cut** off for children's and young people's services
- There is an opportunity to **consider how to improve the current transition model of care across NCL** and work more collectively between children and adult services

Recruitment and retention of the paediatric workforce

- Vacancy rates are particularly high in paediatric nursing, ranging from **13%-36% across NCL sites**
- Often **our own staff are having to work to provide cover for shifts**, which at a time were staff have been under extreme pressure, is leading to significant burn out
- Considering the paediatric nursing workforce challenges in NCL there is an opportunity to consider how we could use networked approach to **develop innovative workforce solutions**

Meet national recommendations for the environment for paediatric surgical care

- Currently **not all sites provide dedicated paediatric theatres** or child-friendly environments
- The impact of the current estate and organisation means that **some sites are struggling to manage their activity,** and doing so in a way that doesn't meet best practice guidance
- Within NCL there are **challenges in respect to accessing paediatric high dependency beds**. This impacts planned and emergency surgical pathways and also some complex medical admissions.

Case for Change communications and engagement

North Central London Integrated Care System

The Case for Change was approved by NCL CCG's Governing Body on 30 June, and is followed by a ten week period of engagement (4 July to 9 Sept) where we will seek views from staff, patients and the public, and wider stakeholders on its findings through a diverse programme of structured engagement opportunities.

A comprehensive communications and engagement plan is in place to support this Case for Change engagement phase.

The engagement offer is being developed to ensure we gain a broad range of views and enable involvement for all NCL stakeholders. Deeper engagement will be sought with individuals and groups with direct interest or influence, those with protected characteristics, and those more likely to experience inequalities, ill health or deprivation.

Specific activity will include:

- Communication and a briefing offer to MPs, Councillors, HWBBs, JHOSC and borough partnerships
- Timely communication, staff briefings and mechanisms for staff to feed in their views, developed with trust comms teams
- A full programme of patient and public engagement, including a questionnaire, discussion at forums/meetings, drop in events, interactive workshops, interviews, and online discussion groups, working with partners and VCS colleagues.
- Specialist engagement with children and young people
- Youth mentoring for clinical leaders.
- Publication of a report on feedback received on the case for change

Timeline and next steps

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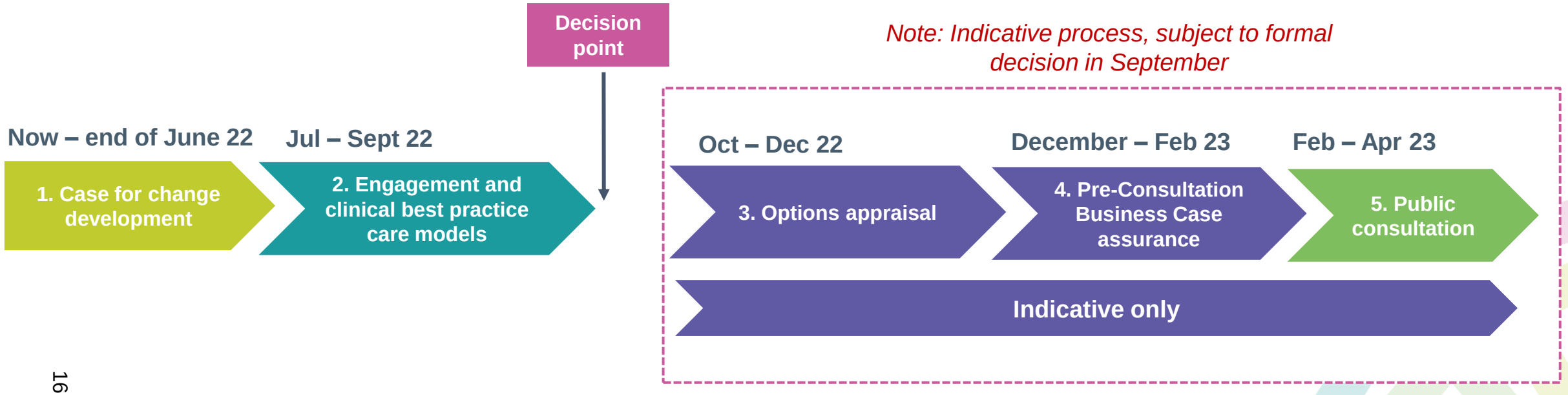
- We will publish a report summarising the feedback received on the Case for Change after the engagement period concludes on 9 September.
- At the end of September, the ICB Board will make a decision on next steps for the programme.
- The outcome will be communicated to stakeholders before the next phase begins.
- An **indicative timeline** for a major change process, if this is required following the decision point, is shown below.



North Central London
Integrated Care Board

Primary Care Services in North Central London – GP Practice quality monitoring and management

Joint Health Overview and Scrutiny Committee

15 July 2022

1. Introduction

NCL Integrated Care Board (ICB) is responsible for commissioning primary care services (general practice) in North Central London (NCL). As a commissioner of NHS services, our main priority is to ensure the continued provision of high quality, safe and accessible services for local people.

There are 180 GP Practices in NCL. We monitor GP practices on an ongoing basis against their contract and wider expectations as NHS services. This briefing summarises how we do this and the mechanisms in place to take action where concerns arise.

JHOSC members are aware that BBC Panorama ran a story in June 2022 featuring the findings from an undercover investigation at a London GP practice (not a practice in North Central London). Key areas of focus in the programme included supervision of Physician Associates and GP/patient ratios. This briefing includes information about how we monitor some of those areas in NCL.

2. Quality and Performance monitoring in the ICB

The ICB is required to manage all primary care contracts in line with the *National Primary Care Regulations and Policy* produced by NHS England. The ICB's Primary Care Contracts team works closely with the ICB Quality team to monitor and respond to any trigger of underperformance or quality concern that is identified. This may be identified through formal contractual reporting processes, via the Care Quality Commission (CQC), through local borough primary care commissioning teams, or through other routes such as whistleblowing.

The NCL ICB Primary Care Contracts Committee (PCCC) is responsible for overseeing GP core and enhanced services. It meets in public and receives a Quality and Performance report at each meeting. The PCCC's remit is to monitor the quality and performance of these services across all five NCL boroughs and to make decisions within the legal and regulatory framework.

The committee is regularly attended by Healthwatch, local councillors and community representatives. Committee membership includes an independent clinical representative, Public Health, ICB Quality, and non-executive/lay members. Following our recent transition to the ICB, our Chief Medical Officer or Chief Nursing Officer will attend as a voting member and our Chief People Officer as an attendee.

The ICB Primary Care Contracts team monitors all contracts on an ongoing basis and submits a regular Quality and Performance report to the PCCC. This reports at practice level and is available in the public domain (on the ICB's website). Examples of the data monitored across all practices includes:

- List size growth
- CQC ratings
- Quality and Outcome Framework (QOF) performance and overall achievement
- Patient experience (GP Patient Survey) and patient complaints
- Workforce (e.g. GP and Nurse : patient ratios)

- Access, including patient online access

The PCCC's Quality and Performance report is being refreshed for the new Committee, following transition from a CCG to an ICB. It will build on these data above, include our most up to date data and look at trends over time. It is expected that the new report will be launched in draft at the first meeting of the new Committee in early autumn.

NCL ICB also commissions a range of Locally Commissioned Services (LCS), which cover areas such as Long Term Conditions, support to Care Homes, Vaccination and Immunisation and Prescribing. Our borough based primary care and medicines management teams monitor these, with overall accountability to the ICB's Executive Director – Place, and on to the ICB Strategy and Development Committee.

NCL ICB have established a System Quality Group (SQG) which includes partners such as the Care Quality Commission and Healthwatch. Its purpose is to routinely and systematically share and triangulate intelligence, insight and learning on quality matters across the system. Its scope includes Primary Care. It identifies system quality concerns/risks and opportunities for improvement and learning, including addressing inequalities. Quality leads will work with providers to support continuous improvement, and raise matters with ICB teams and Committees where they require escalation or formal action.

3. Care Quality Commission

All health service providers are regulated and inspected by the Care Quality Commission (CQC) to ensure they meet fundamental standards of quality and safety. The CQC works with local commissioners to take action under the regulatory and contractual framework where they do not.

When any practice receives an adverse rating from the CQC, the ICB is notified and asked to carry out its own investigation under the terms of the GP contract. This includes reviewing the performance of the practice over several years against established quality indicators which include:

- Quality Outcome Framework (QOF) – Long Term Condition Management
- Cervical Screening
- Childhood vaccinations
- Flu Vaccinations
- Access (opening hours and clinical sessions provided)
- Patient views (GP Patient Survey, NHS Choices and patient complaints)
- CQC inspections findings over several years (if available)
- Annual Contract Review data (compliance data in line with the contract)
- Key Performance Indicator achievement (for APMS contracts only)

The ICB primary care team will also review the CQC's published report for any areas of concern identified to understand whether the practice maybe operating in breach of their primary care contract.

The ICB is required to issue either a Quality Improvement Plan or a contract Remedial Notice to any practice that receives ‘requires improvement’ or ‘inadequate’ ratings. The practice must demonstrate and provide evidence of improvement where concerns have been identified. Examples of actions required include revising policies and procedures; addressing opening hours, improving access and appointment numbers; and increasing staff capacity (clinical and non-clinical).

Ongoing review takes place until the practice remediates the concerns. If they don’t, more formal contract action will need to be taken (for example, a Breach Notice, with further escalation where this is not responded to adequately).

4. Working collaboratively

On a fortnightly basis, the ICB Primary Care Contracts team meets with CQC and the NHS England Medical Directorate who retain responsibility for the National Performers List. These teams jointly discuss any cases and share relevant information. This includes any individual GP performance cases. NHS England work closely with the General Medical Council (GMC). Any action taken by CQC, NHS England or the GMC that requires local follow up is referred to the NCL PCCC.

NCL ICB will always notify relevant GPs and contract holders that they are entitled to support and representation from the Londonwide Local Medical Committee. They are also entitled to legal or any other representation they deem suitable.

Our priority is always to identify pressures and concerns early and to offer support to resolve and learn. The Primary Care Contracts team, local primary care teams and ICB clinical leads meet monthly in each borough to consider soft intelligence, requests for support and any emerging concerns. The teams also work with practices to forward plan and support continuity of care where there may be partnership changes, retirements, practice relocations or other matters.

5. Workforce - Additional Roles Reimbursement Scheme (ARRS)

NHS England introduced an ‘Additional Roles Reimbursement Scheme’ (ARRS) in 2019. This provides funding to Primary Care Networks (PCNs) for the recruitment of additional staff. There are 15 types of role designed to respond to the range of patient needs presenting and support multi-disciplinary team working in primary care. Roles include clinical pharmacists, physician associates, paramedics, social prescribing link workers and health and wellbeing coaches.

In North Central London (March 2022 data), 455 whole time equivalent (WTE) ARRS staff are in post working across our PCNs. Practices have also recruited an additional 232 of these staff directly.

Responsibility for the support and supervision of staff lies with the practices and PCNs employing them. There are minimum role requirements and competencies for each of the 15 ARRS role types. Formal clinical training and qualifications are required for all the clinical roles within the framework.

The national ARRS scheme includes detailed expectations around staff supervision, training, support and development and contract length. Where roles are employed

directly by practices, the ICB can assess terms and supervision through normal contractual monitoring processes.

Commissioners can request information where there is a concern, but it is not requested that commissioners routinely request this detail. One exception to this is the Paramedic role, which includes commissioner assurance that they are meeting their education and supervision pathway.

Commissioner responsibilities around the ARRS scheme are described here in the Network Contract DES Specification 22/23 and include contract management and assurance. Commissioners also support PCNs with workforce plans as a whole (submitted to the ICB twice a year) and ensure NHS system-level workforce plans are supportive of Primary Care.

Staff:Patient ratios are monitored on an ongoing basis. Access to sufficient workforce is a challenge across the NHS and strategies and plans are in place to support recruitment and retention. All NCL boroughs have diversified their workforce under ARRS and PCNs are able to determine the best use of these roles to meet the needs of their local population. We are constantly seeking to improve the accuracy of workforce data and ensure reporting reflects overall capacity (low Nurse:Patient ratios for example can be supplemented by Healthcare Assistants or Practice Pharmacist support).

There is no national guidance on the ratio of Physician Associates to GPs. The average GP: Patient ratios are similar across all NCL practices. British Medical Association (BMA) measures GP rate per 1800 patients. We believe there are 109 practices that fall below this ratio. We are working with practices to ensure accuracy and regularity of reporting for example, recent data shows that 83 practices in NCL have not logged on to the National Workforce Reporting System (NWRS) in the last 90 days to review their workforce numbers. We also know that largely Locum GPs are not recorded and therefore not reflected in the ratios above. Our primary care teams are working with practices to support them to update the national workforce dataset monthly to ensure it's more accurate.

There is a really strong focus in NCL on supporting GP recruitment and retention, and a number of schemes in place including expanding our clinical placements for GP trainees (in particular in areas with lower GP : Patient ratios), mentoring schemes, retention schemes, and flexible staffing pools. We are predicting a 3.7% increase in the number of GPs in NCL this year (22/23).

6. Conclusion

In conclusion, NCL ICB, regulators and providers have processes in place to monitor and improve the quality of services and to address any concerns robustly where they arise. We are working to update the PCCC Quality and Performance report and will work with the new ICB Executive Management Team and Board – including our Chief Medical Officer and Chief Nurse – to continually improve our approach. We believe risks are identified and mitigated and we welcome the ongoing support of our Healthwatches, local stakeholders and patient representatives.

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North Central London
Integrated Care Board

Developing a Fertility Policy for North Central London

Joint Health & Overview Scrutiny Committee

15th July 2022

Executive Summary

North Central London
Integrated Care Board

- In 2020, the clinical commissioning groups in Barnet, Enfield, Haringey and Islington joined to become the North Central London Clinical Commissioning Group (NCL CCG) – now the North Central London Integrated Care Board (NCL ICB). Each CCG had an individual Fertility Policy and these are still being used
- To inform the development of a new single Fertility Policy, the CCG undertook a significant programme of work, including two engagement periods that sought views of patients, residents, clinicians and other stakeholders, as well as examining clinical evidence and national guidanceJHOSC Chair, HOSC Chairs and Cllr leads for Adult and Social Care Services received communications throughout the engagement window during stage 1 (the Review) informing members of:
  - opening and length of the engagement window (10 May to 9 July 2021).
  - how to have your say (for example, completing the survey, inviting CCG staff to a meeting to discuss the review and having the opportunity to attend the public meetings that were held during the first engagement period).
- A Joint Health Oversight and Scrutiny Committee (JHOSC) Briefing Paper sent to the JHOSC Chair and members (dated 20 September) setting the scene following the engagement window, summarising themes of public feedback received and providing information on the Review Recommendations.
- An update to the JHOSC on the work to date (completing the Review, development of the draft NCL Fertility Policy and preparations for the second engagement window was provided in November 21 followed by a further update on the draft NCL Fertility Policy in March 2022.
- A final NCL Fertility Policy has now been approved by the NCL CCG Strategy & Commissioning Committee, and work is underway to prepare for the new policy to “go live” from 25 July 2022
- This document comprises an overview of the final NCL Fertility Policy, a summary of the themes of feedback received during the engagement on the draft policy, and how we have responded to this feedback and the steps being taken to support the implementation of the NCL Fertility Policy
- The JHOSC is requested to:

  a)note the benefits and equalities implications of new fertility policy for North Central London

  b)advise on the implementation plan for the policy

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The NCL Fertility Policy

Key policy features

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Policy Area	Feature	Alignment to NICE guidance
Number of IVF Cycles	• Increased number of IVF cycles available to women aged under 40 in four boroughs and maintained existing provision in the other borough. • This feature of the policy consists of up to six embryo transfers, from a maximum of three fresh IVF cycles.	This is broadly consistent with NICE guidelines which recommends three full cycles (where a 'full' cycle is defined as an episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryos).
Use of Frozen Embryos Before Starting a Fresh Cycle	• All good quality frozen embryos should be transferred before starting the next NHS funded fresh cycle.	This is consistent with NICE guidance.
Ovarian Reserve Criteria	• Ovarian reserve criteria for women of all ages will remain in place • This criterion has been retained because in general, lower ovarian reserve is associated with a decreased chance of a live birth and removing the ovarian reserve criterion will increase the number of patients accessing IVF by ~25%.	This is not consistent with NICE CG156 (which recommends ovarian reserve criterion for women aged 40-42 only).
Funding of IUI for Female Same Sex Couples and Single Women	• Funding up to six cycles of intrauterine insemination (IUI) for female same sex couples and single women who have demonstrated infertility by undergoing six unsuccessful self-funded cycles of IUI.	This is now broadly consistent with NICE CG156 recommendations.
Time Trying to Conceive	• Current NCL borough policies allow heterosexual women aged 36 and over with unexplained infertility to access specialist fertility treatments after one year of trying to conceive.	This is consistent with NICE guidance.
Clear and inclusive language	• The layout of the policy has been amended to improve ease of use and the language used has been carefully considered. The policy has benefitted from being reviewed by a Readers Panel and NHS England/ Improvement LGBT+ advisor, both of whom suggested changes to improve inclusivity and clarity.	N/A

What are the benefits of a new NCL Fertility Policy?

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Integrated Care Board

Whilst there are many areas of good practice in the provision of specialist fertility treatments in NCL, the current policy arrangements do not allow for equitable access to treatment for all of our residents. Some of the anticipated benefits as a result of implementing the new NCL Fertility policy include:

- The NCL Fertility Policy provides for a single, consistent policy across the NCL area
- To a large extent, the NCL Fertility Policy provides greater alignment with NICE guidance compared to the existing policies
- It increases the provision of specialist fertility treatments in the majority of boroughs and will provide a significant improvement in the level of provision for the majority of NCL residents
- Greater clarity and consistency for residents, primary care clinicians, secondary care clinicians and specialist fertility providers on the eligibility, provision and funding of specialist fertility treatments in NCL
- Improved patient experience as a result of having equitable and consistent access to specialist fertility treatments

Equalities considerations

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- An Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) have been undertaken
- The EIA notes the varied impact that the NCL Fertility Policy will have on people with different protected characteristics, depending on their personal circumstances – this may be complex
    - i.e. the different aspects of the Policy are anticipated to result in a mixture of impacts for people with different protected characteristics, ranging from positive through to neutral, negative and unknown
- Across the majority of the Policy, there will be at least a maintenance, and in many cases an improvement, in provision, aligned as closely as possible with NICE guidance and supported by clinical or other rationale
- Where it has been identified that the Policy may have an impact on a person with a particular protected characteristic, the EIA has noted the clinical evidence, or for other legitimate reasons, that is the basis for the inclusion of that element (e.g. level of provision or eligibility criterion) in the Policy. These reasons have been clearly documented and outline that they have nothing to do with the protected characteristics themselves
- The Policy addresses known inequalities and for example, is inclusive of people with HIV, a physical disability, psychosexual problems, people undergoing cancer treatment and people undergoing gender reassignment

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Engagement on the draft NCL Fertility Policy

Engagement on the draft policy

North Central London Integrated Care Board

- The engagement window ran from 22 November 2021 to 13 February 2022 (12 week period)
- A variety of different mediums and formats were used, and included key stakeholder groups such as our service users, residents, general practice, secondary care clinicians, Healthwatch*, VSC partners, and special interest groups.
- A variety of approaches were taken to reach out to groups and individuals from different ethnic backgrounds and communities across our five boroughs
- We ran a number of public events at which the CCG will share information about the development of the single fertility policy and seek views on the proposed single policy.
- Online events were held for Barnet, Camden, Enfield, Haringey and Islington (one per borough). An NCL-wide online public meeting will also be held during the engagement window.
- A pan-NCL event was held in January, unfortunately this could not be face-to-face due to Covid restrictions.
- Views of key political (local JHOSC members, Councillors), scrutiny and primary care stakeholders were also sought, reflecting our statutory duties and duties as a membership organisation

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

Engagement response

NHS
North Central London
Integrated Care Board

439 responses, in total, to the engagement

21 engagement meetings

108 responses to the online survey

56 voluntary and third sector groups responded

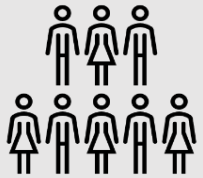
142 contacted directly

2,258 webpage views with **1,988** documents downloaded

80,507 **"impressions"** where content was displayed on residents/voluntary sector social media feeds

Who we heard from

North Central London
Integrated Care Board

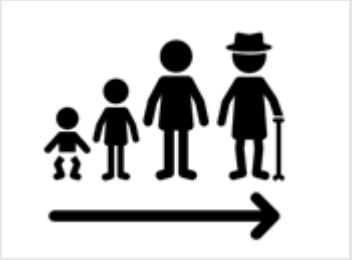


28% of survey responses from current or former service users

48% of survey responses from members of the public

12% of survey responses from NHS staff

56% of the public respondents were White British and **25%** were from Black and other minority ethnic groups



27% of survey respondents were **aged between 25-34** and **33%** between **35-44**

17% of public respondents identified as Gay, Lesbian, Bisexual or other gender

Feedback themes

North Central London
Integrated Care Board

- The majority of all respondents (including 68% of survey respondents) expressed support or strong support of the draft policy and welcomed an increase in provision across the boroughs and the reduced inequalities in the treatments offered - reducing the “postcode lottery”
- The majority of feedback from those not supportive was around provision of assisted conception treatments for female same-sex couples, with a call for access to be equivalent to heterosexual couples. Some of those surveyed felt that the offer for female same sex couples was discriminatory due to the requirement for those who do not have a diagnosed fertility problem to self-fund six rounds of IUI before being able to access NHS treatment
- Overall, there was good support for the majority of eligibility criteria included in the draft policy. However, this did vary, with differences in the levels of support for the criteria, when reflecting on responses to the quantitative and qualitative questions. For example, there were mixed views on ovarian reserve, previous children but support for criteria on age, BMI, smoking, previous sterilisation and previous IVF cycles
- There was feedback from some respondents that the policy seemed to leave out/underserve certain communities and people with some health conditions
- There were also questions around the implementation of the policy
- A small number of respondents were not supportive of the policy as they felt fertility services should not be provided on the NHS at all

Our response to feedback received (1 of 2)

North Central London Integrated Care Board

*Please see appendix for detailed responses.

- A full feedback report has been produced, summarising the key findings from the engagement period and having considered the feedback, the policy has been updated and finalised.

- We have made carefully considered updates using the feedback received where these were felt to be sustainable but do acknowledge that there were some areas where it was not possible to make changes.

- There are a several areas of the policy that changed following feedback from the community, including:
  - **Extending storage for younger fertility preservation patients** - The policy now funds storage of cryopreserved eggs, embryos or sperm until at least the patient's 43rd birthday and for a minimum of ten years
  - **Excluding adopted children from the previous children criterion** - The policy has been amended to exclude adopted children from consideration allowing access to fertility services for those with adopted children
  - **Delay to funding of donor sperm/eggs** - NCL intends to fund donor eggs for use in NHS funded assisted conception treatments (ACTs) in the future. Arrangements need to be put in place to resolve practical and logistical issues before this can happen
  - **Improving the readability and inclusivity of the policy** - The policy has been reviewed to ensure it is as clear as possible. More inclusive language has been used, in response to feedback that suggested the draft policy was 'heterocentric' and 'non gender inclusive'
  - **Providing accessible versions of the policy** - A leaflet is being developed aimed to support residents to understand the policy and what it means for them

Our response to feedback received (2 of 2)

North Central London Integrated Care Board

*Please see appendix for detailed responses.

- Some feedback received was not been acted on, for example to keep the policy in line with NICE guidelines, including:
  - Maintaining the age criteria for women or people trying to get pregnant
  - Maintaining BMI criteria for women or people trying to get pregnant
  - Maintaining the ovarian reserve criterion
  - Maintaining the previous IVF cycles criteria
  - Maintaining a requirement for same sex couples and single women to have undertaken six cycles of self-funded intrauterine insemination (IUI) before they are eligible for NHS funded IUI
  - Not routinely funding assisted conception treatments involving surrogates

- We are producing a patient-friendly “response to feedback received” document that will be published on our website, providing the rationale for how feedback has impacted the final NCL Fertility Policy

Comments raised in November's meeting

North Central London Integrated Care Board

*Please see appendix for detailed responses.

In our meeting with JHSOC in November, several points were raised. The table below provides an update on these matters.

JHOSC Question / comment	Our Response
Importance of ensuring messages are cascaded to different groups via VCS	We are extremely grateful for the liaison and support we have had from many VCSE and community groups to disseminate messages and information, and for their active participation in this programme of work. As we continue to build these relationships, there will be ongoing opportunities to further improve the ICB's ability to work in collaboration with VCSE organisations, community groups, etc.,
Consider the views of those who may have adopted / be considering adoption	Given the sensitivity of the topic, we discussed this matter with "Adopt London North" (responsible for adoption services across NCL). They noted: • Large proportion of potential adoptive parents will have finished their fertility journey before commencing on adoption (and there is guidance / support through the adoption process to allow sufficient time for people to process their full journey to have a family) • There is a very small number of adoptions, typically known as "connected adoptions", where the adoptive parent (e.g. an older sibling) has not yet considered having their own children The policy has been amended to remove a reference to adopted children
What will happen to the policy if NHSE reduce funding to the ICB?	The financial implications of the policy have been modelled and discussed by finance directors in the ICB, and also at a pan-ICS Finance Oversight Group. There is full awareness of the anticipated increase in expenditure as a result of the policy and this is captured in the ICB's cost plans. The importance of removing inequity in this area is noted alongside the financial considerations.
Support primary care to know the best options for patients including time taken for primary care investigations	With the introduction of the new NCL Fertility Policy, it provides us with an opportunity to raise the profile of this clinical area. We are updating information on the public ICB website and the NCL GP website, including refreshed pathway information (for GPs and patient-friendly versions), to help with shared decision making between GP and resident. We are attending several GP webinars to remind GPs about the new policy and capture feedback as to where more information would be useful for GPs in their care of residents who may be experiencing fertility issues.

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Implementation of the NCL Fertility Policy

Transition approach

North Central London
Integrated Care Board

- The new policy will replace all 5 current borough fertility policies – however, transitional arrangements will apply to the following two groups:
  - People who are undergoing NHS funded assisted conception treatment at the time the Policy “goes live”
  - People who were referred for NHS funded assisted conception treatment before the Police “goes live”
- Guiding principle – for people in either of these groups, they should experience no disadvantage as a result of the NCL fertility policy, therefore:
  - Where the new policy disadvantages the patient (i.e. specifies reduced provision compared to the relevant legacy policy), the legacy policy will apply; and
  - Where the new policy is advantageous to the patient (i.e. specifies increased provision), the new policy will apply
- These arrangements will apply to relevant patients until the course of treatment specified in the legacy policy is complete, or until the patient is no longer eligible for NHS treatment

Communications approach

North Central London
Integrated Care Board

- A full NCL Fertility Policy implementation and launch communications and engagement plan has been produced, with the following aims:
  - Emphasise the positive impact the new policy will have for those requiring fertility support
  - Help residents to understand how to access fertility support under the new policy (e.g. pathways)
  - Communicate the robust, clinically-led and evidence based approach followed to produce the new policy
  - Clearly demonstrate how the CCG listened, and responded to stakeholder and resident feedback on designing the new policy
  - Demonstrate transparency on where feedback received through the engagement processes was not implemented in the new policy, and why
- To support these aims, and in response to feedback received during the engagement period, the following assets are in production:
  - Patient leaflet that describes our new fertility policy and how and when to seek advice about wanting to become pregnant and
  - An easy read version of the patient leaflet
  - Frequently asked questions
  - A leaflet describing our response to the feedback received during the engagement period
  - New website pages to contain information about how and when to seek advice about wanting to become pregnant, what assisted conception treatments are available on the NHS in NCL, eligibility criteria, a document library and links to useful resources
  - Updated policy and referral information for primary care colleagues
  - Illustrated fertility pathways – one for clinicians and one for NCL residents

Stakeholders

North Central London
Integrated Care Board

Individuals that participated in engagement
- Survey respondents
- Participants who attended engagement events and focus groups
- People who registered to be kept up-to-date with the Fertility Policy Development

Service users and residents
- NCL Residents Health Panel
- Local NHS Foundation Trust members
- NCL CCG Community Members
- Local and national fertility groups members
- NCL GP Patient Participation Group Networks (PPGS)

Community, voluntary and charity sector organisations, resident associations
- Local Healthwatch organisations
- Local patient representative groups and charities
- Special interest groups

Political stakeholders
- MPs
- Council Leaders (HOSC, JHOSC Chairs and Cllr leads for Adults and Social Care across the five boroughs)

NHS partners and Fertility service providers (NCL)
- University College London Hospitals NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- Homerton University Hospital NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Whittington Health
- Royal Free London NHS Foundation Trust
- North Middlesex University Hospitals NHS Trust

Primary care
- GP member practices (including GPs, practice nurses, practice managers and administrative staff)
- Primary care networks (PCNs) (including clinical directors)

North Central London CCG
- Governing Body
- Clinical leads
- Executive Management Team
- All other staff

Local authorities
- Communications and engagement teams

Wider NCL residents

Appendix

Feedback themes

North Central London
Integrated Care Board

These key findings summarise the most frequently heard feedback from all respondent groups

Overall, there was a **high level of support for the policy** (68% of survey respondents and the majority of people who attended the public meetings (more than 80%)), with respondents seeing the draft policy as an **improvement** with recognition that its implementation would **increase provision, standardise what is provided across the five boroughs** and bring services offered more in line with NICE guidelines.

Whilst the majority of responses received were in support of the draft policy, there were three areas that received the highest number of consistent comments, related to specific aspects of the draft policy:

- Eligibility criteria should be reviewed in the following areas: upper age limits of the woman, ovarian reserve and potentially removing criteria around previous IVF, BMI and previous children.
- It was strongly felt that female same sex couples and single women should not have to self-fund intrauterine insemination (IUI) prior to NHS treatment.
- Further consideration to providing assisted conception treatments for those seeking to use surrogates.

Feedback themes

North Central London
Integrated Care Board

The **draft policy was felt to be readable**, but many requested an easy read/patient facing version be produced in addition to a patient leaflet. Some respondents also suggested podcasts that would ensure those less familiar with the terminology and process, and/or those who do not read/ write or speak English, can understand what they are entitled to and at what stage to begin seeking treatment.

Comments around **language** use – including feedback from the LGBTQI+ community, some of whom felt that language in the policy was hetero-centric and should be reviewed.

The significant impact of infertility and fertility treatment on mental health was highlighted, and feedback welcomed the policy as an opportunity to more proactively signpost to support available.

Understanding who is likely to be affected by the policy and **supporting raising awareness** of the policy - many recognised GPs as the first port of call for information and referral, and recommended training on the new policy. Using existing channels/forums will help in socialising policy, but there was recognition that more proactive methods will be needed, including "going to" where people are.

Personal experiences shared showed **no two experiences of fertility treatment are the same** – with feedback received regarding confusion about what can be accessed and when, reports of long waits for treatment and for tests (with noted exacerbations due to the Covid pandemic), and difficult decisions that individuals and couples have to make about whether private treatment and more specialist forms of treatment are an option.

Draft policy – response to feedback

North Central London Integrated Care Board

Topic and summary of draft policy	Specific Engagement Feedback	Our Response
Age of the woman criterion: **Women must be aged under 43 years**	Feedback included: • age limits could result in pressure for women and increase gender imbalances in society • some women may be focused on other aspects of their lives or are not in a relationship until their late 30s or early 40s • some women aged over 40 are getting treatment in Europe so why not in the UK	The age criterion remains in place because the success rates of IVF decrease as the age of the woman increases. NICE does not recommend NHS funded IVF for women aged over 42 years noting, 'the clinical and health economic evidence was overwhelming in indicating that IVF should not be offered to women aged 43 years or older'.
Ovarian reserve criteria; ***There should be no evidence of low ovarian reserve (NICE thresholds for AFC, AMH and FSH measures apply)***	Some stakeholders stated that the ovarian reserve criteria should not apply to younger women, noting that NICE guidance only recommends ovarian reserve criteria apply to women aged 40-42 years. The issue of how to define the specific tests that would determine low ovarian reserve was also raised in some of the clinical feedback.	Ovarian reserve criteria **remain in place** for women of all ages in the Policy, The rationale for this is that although NICE only apply an ovarian reserve criterion to women aged 40–42; • In general, lower ovarian reserve is associated with a decreased chance of a live birth. • Removing the ovarian reserve criterion will increase the number of patients accessing IVF by ~25% and therefore the associated expenditure considerably. • Funding more IVF cycles for women with a good ovarian reserve is likely to lead to more live births than funding fewer IVF cycles and removing the ovarian reserve criterion. However, the wording of the criteria has been amended to improve clarity and consistency of application across providers.

Draft policy – response to feedback

North Central London Integrated Care Board

Topic and summary of draft policy	Specific Engagement Feedback	Our Response
Previous IVF cycles criteria: ***Women aged under 40 should not have had more than 3 previous fresh IVF cycles and women aged 40-42 should not have had any previous IVF treatment; the above applies irrespective of how the IVF cycles were funded***	Feedback received suggested that it was unfair that people who have previously paid for IVF cycles would have less or no access to NHS funded treatment.	The previous IVF cycle criteria **remain in place** because the likelihood of a live birth decreases with the number of unsuccessful IVF cycles undertaken. NICE have undertaken cost effectiveness analysis to determine in what circumstances IVF is cost effective and have based their recommendations on the results of this. Criteria relating to previous cycles in the Policy are consistent with NICE recommendations.
BMI criteria: ***Woman must have a BMI within the range of 19-30 kg/m2)***	Feedback regarding the BMI criteria included: • BMI as a measure does not take account of muscle tone, overall health or the reason why the individual is overweight or obese • There is cultural desirability in some communities for women to be larger and therefore losing weight may be difficult NICE do not recommend patients must be within a specific BMI range in order to access NHS treatment.	The BMI criteria **remain in place** because having BMI outside this range is likely to reduce the success of assisted conception treatments: • NICE CG156 specifies women should be informed that female BMI should ideally be in the range 19–30 before commencing assisted reproduction, and that a female BMI outside this range is likely to reduce the success of assisted reproduction procedures. • The HFEA Commissioning Guide states women should have a BMI of 19-30 before commencing assisted reproduction. Local specialists support inclusion of the BMI criterion for women outlined in the Policy.

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Draft policy – response to feedback

North Central London Integrated Care Board

Topic and summary of draft policy	Specific Engagement Feedback	Our Response
Previous children criteria: ***At least 1 individual in a couple must not have a living child from their relationship or any previous relationship. Single persons should not have a living child. Adopted children are included but foster children excluded from the scope.***	Many people were in favour of the position of the draft policy which allowed treatment where one person in the couple (or an individual) does not have a living child. However additional feedback included: • These criteria do not have a scientific/ clinical rationale • It is unfair to people with one child who wish for the child to have a sibling • It is unfair to people who have adopted, especially where this is due to circumstances (e.g., they have adopted the chid of a family member who has died). • NICE state in their Quality Standards that the existence of a living child should not be a factor that precludes the provision of fertility treatment.	Previous children criteria remain in the Policy. It is recognised nationally that NHS organisations need to focus their resources on patients who have the most need and can obtain the maximum health gain. Local priority is therefore being given to those where at least one partner in a couple does not have a living child. Research on the parental status of people presenting to GPs with fertility problems in Oxfordshire indicates that removing the 'previous children' criterion would increase the number of patients presenting for treatment by ~22%. This would mean less cycles could be offered to all patients accessing assisted conception treatments. However, after discussion with adoption services, receipt of legal advice and discussion with Steering Group and Governing Body, it was agreed that **an amendment should be made** and reference to adopted children should be removed from the Policy.

Draft policy – response to feedback

North Central London

Topic and summary of draft policy	Specific Engagement Feedback	Our Response
Assisted conception treatment using donor sperm: ***Unless they have a diagnosed fertility problem which indicates IVF, same sex couples and single women are required to have undertaken 6 cycles of self-funded IUI before they are eligible for NHS funded IUI***	A large proportion of responses (including from a number of Healthwatch and voluntary organisations) supported reducing/ removing the number of self-funded cycles of IUI required for female same-sex couples or single women who do not have a diagnosed fertility problem prior to NHS treatment. Feedback included: • the draft policy does not allow equality of access to same sex couples as they would be financially disadvantaged by the requirement to pay for 6 IUI cycles. It is therefore discriminatory • same sex couples and single people cannot conceive without fertility treatment • this aspect of the draft policy is not in line with NICE guidelines as NICE only specify artificial insemination, not IUI specifically That this requirement could lengthen the process and, for some individuals, could mean they pass the age cut off for NHS treatment	The NICE CG156 full guideline on fertility states: 'For women in same-sex relationships, there should be some period of unsuccessful artificial insemination (AI) before they would be considered to be at risk of having an underlying problem and be eligible to be referred for assessment and possible treatment in the NHS'. In order to determine when same sex couples should receive NHS assessment and possible treatment, the NICE CG156 Guideline Development Group (GDG) aimed to establish the number of AI cycles that would be equivalent to failure to conceive after 12 months of unprotected intercourse (the point at which heterosexual couples would access NHS assessment and possible treatment). In doing so, the GDG discussed a number of ethical and practical issues relating to 'equivalence' including the financial cost of AI and disadvantage of those attempting to conceive by that route, and the time to conception and disadvantage of those attempting to conceive by vaginal intercourse. The GDG subsequently recommended same sex couples undergo six cycles of donor insemination before NHS funded IUI; this was included as a recommendation in NICE CG156. The draft policy was broadly consistent with NICE CG156 in their recommendations on IUI for same sex couples. NICE specify people in same sex relationships should have 6 cycles of AI prior to NHS funded IUI (the full guideline notes the GDG were of the majority view that ideally such AI should be undertaken in a clinical setting, however making recommendations on the setting was outside of their scope). The Policy requires this AI to be IUI for the following reasons: In the UK it is not legal for patients to purchase donated sperm from a licensed sperm bank to use at home Donated sperm used at licensed clinics must be checked for infections including HIV, hepatitis, syphilis and gonorrhoea The donor's family medical history will have been taken to identify any serious heritable diseases Clinics undertaking IUI provide counselling to everyone involved in the donation process Semen analysis (to check motility and morphology) will have been undertaken to ensure the donor sperm is good quality

Continued on next slide…

Draft policy – response to feedback

North Central London Integrated Care Board

Topic and summary of draft policy	Specific Engagement Feedback	Our Response
Assisted conception treatment using donor sperm: ***Unless they have a diagnosed fertility problem which indicates IVF, same sex couples and single women are required to have undertaken 6 cycles of self-funded IUI before they are eligible for NHS funded IUI***	*Cont. from previous*	IUI undertaken at a clinic will maximise efficacy (e.g. sperm will be placed in the uterus rather than the vagina and timing will be optimised) Having treatment at a clinic will mean that the donor is not a legal parent to any child born and the mother's partner (if she has one) will be recognised as the second legal parent The Clinical Reference Group is supportive of this requirement. The CCG has therefore **retained the draft policy position** in this instance. See pages 77-79 of NICE CG156 full guideline for more information Should the position change as a result of any new case law or legislation, the CCG will review the policy in light of that ruling.
Assisted conception treatments involving surrogates: ***Not routinely funded.***	Feedback included: • Surrogacy is the only option for some people to have a biological child • Not funding ACT involving surrogacy would exclude gay couples and some women who have uterine or cervical factor infertility from NHS treatment – this was felt by some to be discriminatory Some people felt that at least some aspect of surrogacy should be funded by the NHS.	The Policy not to routinely fund ACT involving surrogates **remains in place** for the following reasons: • A surrogate is only available to those with means (surrogates expenses typically cost between £12,000-£20,000) and, by parity of reasoning with the prohibition on mixing NHS and private care in one episode of care. • There are considerably legal issues involved in surrogacy, for example: surrogacy agreements are not legally enforceable. • Ethical issues may arise during the course of a surrogacy arrangement including: intended parents or the surrogate changing their minds, or disagreeing whether a pregnancy should continue if complications arise. • There is no national guidance on NHS funding of ACT involving surrogates. As with all other interventions not routinely funded, an IFR application may be submitted by the treating clinician for any situation where they believe the case is clinically exceptional or rare.

Comments raised in November JHOSC meeting

North Central London Integrated Care Board

Feedback given	Our response (on 26 November 2021)
"I have to say that I think this is an excellent report – it is very detailed and I really liked the themes you brought out through the engagement. Page 13 - the comparison table is very useful and is very clear and I hope you will use this in your engagement".	Yes, we presented the comparison table at public meetings and made available on the public website. A link to comparison table was also added to the online survey for the respondent to refer to when completing the survey.
"*Listening to yourselves today there are some communities that don't engage with us as much as we would like and will not be as quick to come forward. You have to take Covid into mind as well as some communities will not be quick to come forward. Are there any communities that you feel you haven't reached? It may not be widely discussed in some communities".*	Yes we engaged with a range of groups from NCL communities such as the local LGBTQI+, parent and people whose country of origin is not the UK. We also engaged with the travelling and settled population across NCL. We also engaged national interest groups suck as Fertility Network UK and The LGBT Mummies Tribe. Information was also provided in easy read as well producing podcasts for Facebook the public website. Information would also have been provided in other languages upon requests.

Comments raised in November JHOSC meeting

North Central London Integrated Care Board

Feedback given	Our response (on 26 November 2021)
Related to page 35 JHOCS papers / or page 7 draft fertility policy. "*On page 35 in relation to the primary care investigations (whilst looks good and well-structured in relation to the secondary care aspect). The primary care information seems to be more hit and miss in relation to what investigations you have got and we all know different practices have different ideas".*	The great advantage of coming together as North Central London is that we can have a consistent approach and a single flowchart for investigation. We are not presenting this work to you day. The single policy can enable us to make this happen. However there is an intention for a clinical pathway offer across North Central London – the issue to when to start the investigations is clear and how long they take is slightly determined by outside factors (e.g. waits for diagnostic procedures and tests). Some of the primary care aspects can be affected by other parts of the system as there could be delays as a result of other parts of the system (e.g. a delay in getting sperm analysed externally which can result in a delay in the GP getting the information). The positive of having a single policy is that we can then unlock some of the things that we can potentially do in primary care.
Related to page 47 JHOSC papers/ or page 19 draft fertility policy. *"I think this is a point of clarification in relation to previous children and whether you are eligible for this sort of treatment – for example a previous adopted child counted as a child – if you adopted a child are you now eligible or not eligible for treatment. This bit is a little unclear.*	*To provide clarification an adoptive child is considered as the same as a biological child as part of the legal process that people would need to undertake to adopt. This means that they would not be eligible for treatment as we would prioritise people that do not have a living child".*

Comments raised in November JHOSC meeting

North Central London Integrated Care Board

Feedback given	Our response (on 26 November 2021)
"*just to say do you have any understanding with particular groups that are not engaging with this area as a whole. For example we are not getting referrals from people (for example people that are welsh). Are you looking at getting in touch with those communities specifically?"*	The HFEA produced a report earlier this year particularly around ethnicity and using fertility services. The capture of data locally is quite difficult and is not where we would like it to be. It is something that we are working on improving. We worked with local communities and build upon previous engagement and have an NCL community member (Somali community) who helps advise us our approach around women groups whose country of orgin is not the UK. We also through covid-19 responses programme leaned upon our connections to grassroots group organisations has improved helps (e.g., Somali, Turkish, Greek & travellers groups).
Related to page 15 JHOSC paper (the slide named Financial Context) *"On page 15 there is mention of 2021/22 financial year an increased efficiency requirement that will follow into the following year. This is the first I have heard of this efficiency requirement - how will this be measured? We are talking about people here - efficiency with people is quite hard to measure.*	We included the information about the financial content to remind you that the NHS is under significant pressure across the system. Thinking about efficiency for the whole system this will be core for us and will be a national requirement. Through the work and modelling that we have done across the CCG with financial colleagues this policy will we expect to see an increased financial spend as well. We think it is a right thing to do in increasing access to these services in an equitable way linked to best practice guidance and policy as far as possible.

Comments raised in November JHOSC meeting

North Central London Integrated Care Board

Feedback given	Our response (on 26 November 2021)
"Also a quick comment on adoption and fertility treatment. Will your approach satisfy a lot of patients? I recognise there may be a greater demand on what we can provide. But a couple may be desperate to have a biological child and have turned to adoption for a second route. Can this policy be reviewed to give them this opportunity as well?	It is really important that we capture your views on adoption and other residents' views as well. This is something we can consider – the priority is standard in that if a child is part of the family in a formal way either though adoption or biology they are considered as a living child. Therefore the priority is given to those that don't – we recognise the distress that this may cause and am sure we will come back to you at a future point
"In relation to engagement – re: the inclusive language and know you will address this but access to service in BAME people (page 68) 67% of people using services are white – 30% are BAME - how are you going to address this issue? And the issue about sharing maternity services in waiting rooms needs to be addressed which I am sure you will address as well. The issue about 3 miscarriages before you qualify seems really hard and would be interested in how you are going to address that?	We would be pleased to bring back the communications programme for the introduction of the policy 1. The work the CCG would do itself (an inclusive way tailored to reach different communities) to ensure we have reached and navigated patients into general practice. 2. GP education – so that they are aware of inequalities of access and care offer advice and guidance to patients as they visit the practice. 3. The Trusts - partnership working – a success from stage 1 is setting up a clinical network with fertility leads across the providers and during this engagement we can take learning for them to ensure services are culturally competent and reduce barriers for our residents. We will take up the point in relation to shared waiting rooms. This ties in to the miscarriage point as well. It was a privilege to hear what people had to say. They were willing to share and it was upsetting to hear what they have gone through– we are very grateful for this. We are keen in our recommendations and engagement report from stage 1 we wanted to ensure we captured all the feedback. We acknowledged that this didn't fit into our policy work which is our priority but we will continue to share our feedback with our providers- especially around our psychological support. The policy will set up a really good platform for addressing all the feedback that we have received.