The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 31 March 2015

Session 4

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HEALTH AND SPORT COMMITTEE

11th Meeting 2015, Session 4

CONVENER

Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Mike MacKenzie (Highlands and Islands) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Dennis Robertson (Aberdeenshire West) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Vanessa Kay (NHS Tayside)
Dr Helen Lyall (NHS Greater Glasgow and Clyde)
Dr Graham Mackenzie (NHS Lothian)
Dr Abha Maheshwari (NHS Grampian)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The Adam Smith Room (CR5)

Scottish Parliament

Health and Sport Committee

Tuesday 31 March 2015

[The Deputy Convener opened the meeting at 09:47]

Decision on Taking Business in Private

The Deputy Convener (Bob Doris): Good morning and welcome to the 11th Health and Sport Committee meeting in 2015. Apologies have been received from our convener, Duncan McNeil, who cannot be with us. I ask everyone in the room to switch off mobile phones, as they can interfere with the sound system. As people will see, some members are using tablets instead of hard copies of our papers.

Agenda item 1 is a decision on taking business in private. Do members agree to take in private at future meetings consideration of our approach to the Smoking Prohibition (Children in Motor Vehicles) (Scotland) Bill; a draft report on health inequalities in early years; the committee's response to the fertility treatment evidence sessions; and our work programme?

Members *indicated agreement.*

Subordinate Legislation

National Health Service Pension Scheme (Scotland) Regulations 2015 (SSI 2015/94)

09:48

The Deputy Convener: Item 2 is consideration of five negative Scottish statutory instruments. No motion to annul the regulations has been lodged, but the Delegated Powers and Law Reform Committee has drawn the Parliament's attention to them as detailed in members' papers. If members have no comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

National Health Service Pension Scheme (Transitional and Consequential Provisions) (Scotland) Regulations 2015 (SSI 2015/95)

The Deputy Convener: No motion to annul the regulations has been lodged, but the Delegated Powers and Law Reform Committee has drawn the Parliament's attention to them as detailed in members' papers. If members have no comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

National Health Service Superannuation Scheme (Miscellaneous Amendments) (Scotland) Regulations 2015 (SSI 2015/96)

The Deputy Convener: No motion to annul the regulations has been lodged, but the Delegated Powers and Law Reform Committee has drawn the Parliament's attention to them as detailed in members' papers. If members have no comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

Food (Scotland) Act 2015 (Consequential and Transitional Provisions) Order 2015 (SSI 2015/100)

The Deputy Convener: No motion to annul the order has been lodged, but the Delegated Powers and Law Reform Committee has drawn the Parliament's attention to it as detailed in members' papers. If members have no comments, does the committee agree to make no recommendations on the order?

Members *indicated agreement.*

National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Amendment Regulations 2015 (SSI 2015/102)

The Deputy Convener: We are almost there. No motion to annul the amendment regulations has been lodged, and the Delegated Powers and Law Reform Committee has made no comments on them. If members have no comments, does the committee agree to make no recommendations on the amendment regulations?

Members *indicated agreement.*

The Deputy Convener: We got there in the end. I must apologise—I need to drink some water, as I have a very sore throat.

Fertility Treatment

09:50

The Deputy Convener: Item 3 is our main business of the day, which is an evidence-taking session on fertility services. Last week, we heard from patient groups, and this week, we will hear from a selection of national health service boards. I welcome to the meeting Dr Vanessa Kay, consultant in obstetrics and gynaecology, NHS Tayside; Dr Abha Maheshwari, consultant gynaecologist and sub-specialist in reproductive medicine and surgery, NHS Grampian; Dr Graham Mackenzie, consultant in public health, NHS Lothian; and Helen Lyall, consultant gynaecologist and clinical lead, assisted conception unit at Glasgow royal infirmary, NHS Greater Glasgow and Clyde. I thank you all for attending.

If the witnesses are okay with it, we will go straight to questions. Colin Keir has informed me that he would like to ask the first one.

Colin Keir (Edinburgh Western) (SNP): Good morning. I suppose that I am demonstrating a degree of parochialism as an Edinburgh MSP, but I will ask Dr Mackenzie the first question. I note from your submission that, since 2009, NHS Lothian's infertility service has significantly improved the waiting times for in vitro fertilisation and intracytoplasmic sperm injection. What are the main factors behind that welcome development?

Dr Graham Mackenzie (NHS Lothian): Thank you for the question. When we found back in 2009 that we had a long waiting list that had accumulated over many years, we made submissions for extra funding to the health board over a two-year period, and on the second occasion, we received the funding.

Since then, that funding has increased, partly because our management team includes strategic planning and public health representatives as well as the traditional clinicians and management. That means that the team has a person who understands the health board's funding processes, and he has been successful in securing the funding that we need. Of course, the argument was not difficult to make. Our waiting times were very long, and we have now dramatically reduced them.

Colin Keir: Obviously in terms of the management—[*Interruption*.] I am sorry—I, too, have a sore throat. In coming to a decision on the matter, did you also fundamentally change your approach to service delivery?

Dr Mackenzie: As we point out in our submission, we took the opportunity provided by our increased funding to look at how we provide

the service. Back in 2010, we took the traditional approach of providing three cycles of treatment. It would be helpful to define what a cycle was at that point—it meant implanting the embryo into the uterus and did not include all the other cycles that we now think of as being part of a cycle. To make that point clear, we changed the terminology locally from cycles to rounds of treatment. A round includes everything from ovarian stimulation to harvesting the embryos and implanting first the fresh embryo and then sequentially the frozen embryos. At that point, we did some modelling and we increased the chances of a couple having a successful pregnancy by increasing the number of cycles that they could have.

Is that point clear? A round is described in the National Institute for Health and Care Excellence guideline as a full cycle.

The Deputy Convener: I will let Colin Keir back in, but first I would like Dr Mackenzie to clarify that point for all committee members. Are you saying that a cycle was previously one embryo transfer?

Dr Mackenzie: Yes—one embryo transfer.

The Deputy Convener: Is it correct to say that the situation now is that, if a couple have a number of embryos, a cycle will use all those embryos over a number of transfers, if that is what it takes to get a successful pregnancy?

Dr Mackenzie: That is absolutely right.

The Deputy Convener: Would it be reasonable for me to ask the other witnesses whether the situation is the same in each health board? Ms Lyall?

Dr Helen Lyall (NHS Greater Glasgow and Clyde): It is Dr Lyall.

It is probably better to go back and explain. A cycle of IVF or ICSI is where the female patient has injections to stimulate the ovaries to produce more eggs. Those eggs are harvested and fertilised with sperm—in different ways for IVF and ICSI.

Dr Mackenzie is saying that, traditionally, one cycle was viewed as the fresh embryo transfer, when the eggs are harvested and fertilised and the embryo is created. About 30 per cent of couples—not all cases—have sufficient embryos of good quality that can be frozen for use in subsequent cycles.

In Glasgow, we have always regarded a cycle as the fresh embryo transfer and any frozen embryo transfers that have accrued from that one egg collection. However, I think that Dr Mackenzie is saying that his team used to see the fresh transfer as one cycle and the frozen transfers as different cycles.

Dr Mackenzie: That is correct. In the past, we used to do two fresh cycles and one frozen cycle. Those were the three cycles that couples were allocated.

The Deputy Convener: I will ask the other two witnesses about this, because it seems as though there was a postcode lottery previously in what was determined to be a cycle as well as the number of cycles. Has that now been standardised across the health boards?

Dr Vanessa Kay (NHS Tayside): That is now standardised, but there was a lottery. In NHS Tayside, we treat patients from NHS Fife and NHS Forth Valley, and each health board had different rules. The national infertility group has led to that being standardised, so that a cycle includes any frozen embryos. That is much better for patients.

In the past, there was a pressure on patients. Some patients would decide to keep the frozen embryos frozen and go for another fresh cycle, with all the risks involved, including the risk of ovarian hyperstimulation, in order to have fresh cycles and then pay for the frozen ones. The situation is better now.

The Deputy Convener: Is the position the same for Dr Maheshwari's health board?

Dr Abha Maheshwari (NHS Grampian): The situation used to be exactly the same in Grampian. We are the tertiary care centre for NHS Grampian, NHS Highland, NHS Orkney and NHS Shetland. All four health boards had different criteria—some funded two cycles and some funded three cycles. If someone lived across the road and had a postcode in Highland, rather than Grampian, the age group criteria were different. The new criteria mean that the position is uniform across the boards and that one cycle means using all embryos related to one cycle.

The Deputy Convener: I will let Dennis Robertson in to ask a supplementary, but I am conscious that I cut off my colleague Colin Keir. Although he was clear about the situation, I was not, so I had to ask those follow-up questions. Does he have follow-up questions?

Colin Keir: No—we can let things carry on.

Dennis Robertson (Aberdeenshire West) (SNP): I want to clarify the Grampian situation. Are all treatments carried out at Aberdeen royal infirmary?

Dr Maheshwari: They are all carried out at Aberdeen fertility centre.

Dennis Robertson: That is right. So patients from Orkney, Shetland and so on have to travel.

Dr Maheshwari: Yes.

Dennis Robertson: Is their travel subsidised?

Dr Maheshwari: Their travel is subsidised by their health boards.

Rhoda Grant (Highlands and Islands) (Lab): I will ask about the third cycle. We took evidence last week about the optimum number of cycles, which is three, if that is clinically recommended. There seemed to be reluctance to move to the third cycle. Are you aware of that reluctance and do you know what it might be based on?

10:00

Dr Maheshwari: The reluctance probably does not come from the providing community. I understand that, before the national infertility group was set up, some health boards, such as Grampian, were providing three cycles. However, the waiting list was very long, so the aim was to equalise the waiting list and bring it down to less than 12 months. The plan was for the national infertility group—Dr Lyall could tell you about that much better—to look at the third cycle provision and the other criteria, such as having no genetic child in the family.

We are not reluctant to provide a third cycle, but the funding and current criteria are for two cycles. A third cycle has to be for couples who have a good chance of success, rather than having a blanket policy that everyone can have a third cycle whether or not the chances are good.

Rhoda Grant: Is that not the case for any cycle? If there were issues that meant that a cycle was unlikely to be successful, you would not go ahead with it, even if someone was—for want of a better phrase—entitled to it. Is that not always down to clinical judgment?

Dr Maheshwari: Absolutely. That is written in the national infertility group guidelines.

The Deputy Convener: Dr Lyall was mentioned, so perhaps she would like to add to that.

Dr Lyall: I agree with Abha Maheshwari. I was part of the national infertility group. There are probably a number of factors. Like her, I am not aware of any reluctance to provide extra cycles, but the whole thing needs to be seen in a wider context. The national infertility group took more than two years to reach its conclusions and the report that was produced looked at the criteria to achieve equity of access for assisted conception treatment and equity in waiting times. That has now been achieved, which is something that we are very proud of.

It is fair to say that any number of additional cycles that are provided to a couple will increase their chances of a pregnancy. Ultimately, we all want to give couples the best chance of achieving a pregnancy. That is why we do what we do. The factors that come into play are similar to those that were current when the national infertility group was first convened. Although it is desirable to provide as many cycles as possible, that has to be seen in the context of what is possible in the wider health service.

At the time of the national infertility group, the evidence pointed to the fact that three cycles were the optimum number. That may still be the case. However, we also need to understand that the clinical service has moved on since 2010, which is when that evidence was available. That picks up some points that Mr Keir mentioned.

Things have changed in terms of the eligibility criteria. Part of the reason for optimising body mass index and stopping smoking and alcohol consumption was to improve success rates, and we have definitely seen that happen. Units now also provide extended embryo culture. We have the facility to keep embryos in culture for up to five days, which means that we can get more information about the embryos before we replace them in the woman. When we get more information, we are better able to identify embryos with the best implantation potential. That has also increased success rates.

That is one side; the other side is that, because we are getting better at culturing and creating embryos, we will have more issues around freezing. We will be able to freeze more embryos, because techniques of freezing have improved. The more frozen transfers a patient has, the more resource that will take.

There is not an easy answer. Everybody would like patients to receive their best chance, but that needs to be seen in a wider context of service improvements and the demands on a service in providing that changed service.

Rhoda Grant: Are you saying that the system does not have the capacity at the moment to offer a third cycle as the norm?

Dr Lyall: I do not know that it is right to say that there is not the capacity in the system, because there probably is. I am saying that a third cycle has implications in staffing, additional freezing and additional frozen embryo transfers.

In addition, the need for a third cycle is different from what it was three years ago, because the service has improved. That all needs to be looked at, including the implications for staffing in providing the service. The wider picture needs to be considered.

Rhoda Grant: I am perhaps picking you up wrongly, but you seem to be speaking slightly at cross purposes. You are saying that there seems to be less need for a third cycle as the service has improved so much, but you also suggest that a

third cycle would create quite a lot of extra work. Those points seem to be contradictory.

Dr Lyall: No. If we give couples more cycles of treatment, they will have more chance of success. I am saying that the number of couples who would need a third cycle is different now from what it was three years ago. However many third cycles—or cycles in general—we provide, that will generate an increased workload that will need to be factored into the service provision. That is not to say that we should not provide a service, but those aspects must form part of our consideration.

Another point is that, when the national infertility group considered the original criteria, it was always intended that the criteria would be reviewed once the waiting times had been met. That review process has only just started. We always said that the process would start in March 2015, and we have had two meetings already to begin the review.

Rhoda Grant: Will the review consider the third cycle?

Dr Lyall: It will. As part of the process, we are liaising with colleagues in ISD Scotland who can generate the data that I have been explaining. That will help us to understand the impact on the service of whatever we provide.

The Deputy Convener: Do any witnesses have anything to add on that point, or are you content that Dr Lyall's comments represent where your health boards are on capacity and the provision of a third cycle?

Dr Kay: Helen Lyall spoke about the matter very well, thank you.

Dr Maheshwari: I agree, but I add that NHS Grampian has recently directed more input into its reproductive medicine services. Four years ago, there was only one consultant, and we now have three. NHS Grampian has put infertility on its agenda, so we will have the capacity to provide extra cycles.

The Deputy Convener: That is helpful, Dr Maheshwari—thank you.

Dennis Robertson: The "National Infertility Group Report: January 2013" more or less suggests, at paragraph 197, that three cycles could happen, but that provision is based on affordability. It asks the group, when it next meets, to look at the specifications and the criteria for moving to that provision.

I hear what you are all saying in your answers to Rhoda Grant, but much of each health board's consideration of whether to move to a third cycle seems to be based on affordability. Do you agree with that?

Dr Lyall: Inevitably, the question of affordability comes into that consideration, because the impact on the service and how it will be delivered must be considered.

Dennis Robertson: With regard to eligibility criteria, which factors other than BMI—which is a strange factor, because so many things can impact on a person's BMI—are involved? I am thinking of factors such as smoking, alcohol use and obesity, but are there any others?

Dr Lyall can answer that, perhaps, and then we can move on to the other witnesses.

The Deputy Convener: You have been name-checked, Dr Lyall.

Dr Lyall: We would always discuss general lifestyle factors with couples, and we would take cognisance of any pre-existing health conditions and ensure that we liaise closely with the physicians who are managing those conditions—diabetes is a good example—to ensure that control is optimal before we start treatment.

Dennis Robertson: Obviously—

The Deputy Convener: Sorry, Dennis—I just want to check whether any of our other witnesses want to add anything on criteria.

Dr Kay: There are quite a few different criteria. Apart from BMI, there is smoking. Both partners have to be non-smokers—they have to be tested—before their names are put on the waiting list and before they start treatment.

As Helen Lyall said, we need to state that the couple are medically suitable for treatment, so we look at the obstetric risk to their health. Under the Human Fertilisation and Embryology Authority's requirements, we have to look at issues to do with the welfare of the child and to consider whether the couple will be good parents.

There are also age criteria: the partners have to be below the age of 42 at the time of starting treatment. If they are 40, they have to have a good ovarian reserve. We assess whether there is a reasonable chance of treatment being successful, and we have to balance the risks, because there are risks involved in IVF treatment. We look at quite a few different criteria.

Dennis Robertson: I may have missed it in the report—forgive me if I have—but there does not seem to be a definition of couples or partners. What is your definition of a couple?

Dr Kay: We treat same-sex couples. At present we do not treat single people for infertility on the NHS. Partners have to be in a stable relationship for at least a year to qualify as a couple.

Dennis Robertson: So you treat same-sex couples.

Dr Kay: We do, yes.

Dennis Robertson: Is that the case across all health boards?

Dr Lyall: It is, yes.

Dr Maheshwari: Yes, it is.

Dr Mackenzie: Yes.

Dennis Robertson: Was it mentioned in the report? As I said, I may have missed it. Just for clarity, and to put it on the record of today's meeting, would it be advisable to embed the definition of a couple?

That question is probably for Dr Lyall—you said that you were part of the national infertility group.

Dr Lyall: We have a definition of a couple, which is two people who have been living together in a stable relationship for at least two years. We also state that there is no discrimination on the grounds of race, gender or sexual orientation, or words to that effect.

It is clear that producing a definition of a couple is difficult. These days, couples may not live together all the time, and there is the question of what constitutes a stable relationship. We had a lot of debate about that, and we settled on the definition of a couple as two people cohabiting in a stable relationship for at least two years.

Dennis Robertson: And it is based on the equalities agenda.

Dr Lyall: Yes.

Dennis Robertson: Excellent—thank you.

The Deputy Convener: I see that Dr Mackenzie wishes to come in on that point.

Dr Mackenzie: It is worth reflecting on the fact that, years ago, we had separate patient information leaflets for same-sex couples and heterosexual couples. We have moved away from that and we now treat all couples the same, providing them with the same documentation and guidance. That is a very positive development—there is no distinction.

Dennis Robertson: The guidance is out there to allow general practitioners to make the initial referral. Do you take all your referrals via GPs?

Dr Mackenzie: The guidance in Lothian is on the RefHelp system, which is open and accessible and can be used by any internet user. A patient or a GP can look at it. It is aimed at Lothian GPs but everyone can look at it. The system takes the big piece of guidance that you are talking about and turns it into manageable pieces of guidance and a protocol for GPs to use.

Referrals are made through GPs, or through hospital specialists in some circumstances, I think.

Dennis Robertson: Is that the same for every board?

Dr Kay: Yes, it is the same for us. All our referrals come through GPs. They have access to our guidance and we have a website for assisted conception that patients and GPs can access. When the criteria were introduced, all GPs were sent information about them.

Dr Maheshwari: We have guidance for GPs on our intranet as well as on our website. We also hold regular teaching sessions to update GPs on the criteria and guidelines. We held some when the new guidance came in, and we sent the GPs letters.

We are the secondary care centre as well as the tertiary care centre for fertility referrals, so we do a lot of secondary care work on assisted conception. The referrals to secondary care come from GPs as well as from our consultant colleagues in Highland, Orkney and Shetland.

The Deputy Convener: I will bring in Dr Lyall so that we have a full house on that point.

Dr Lyall: We are similar to Aberdeen—we have referrals from GPs and from the secondary centres, which for us include Ayrshire, Lanarkshire, Dumfries and Galloway and Highland. Like Aberdeen, we act as the secondary centre for NHS Greater Glasgow and Clyde. Our guidelines are on our website, and we have recently done a lot of work on engaging with GPs locally to try to streamline the referral process.

10:15

The Deputy Convener: Thank you. I have two committee colleagues who wish to come in, but I see that Dennis Robertson has a supplementary. Is it on the same theme, Dennis?

Dennis Robertson: It is a question about the term "infertility". There is a view that we should use a much more positive term such as "fertility", rather than talking about "infertility". Do you have a view on that with regard to the patients? Is there more positive guidance on what we should call the clinics?

Dr Maheshwari: As you say, "infertility" is not a very positive term. In today's world, there have been so many advances in fertility treatment that infertility, as such, does not exist; it is sub-fertility rather than infertility.

More and more, we call our clinics fertility clinics, or we refer to clinics being held in the reproductive medicine centre rather than the infertility centre or whatever. We have changed our name to the Aberdeen centre of reproductive—

Dennis Robertson: So Aberdeen is leading the way.

Dr Maheshwari: Yes, again.

Dennis Robertson: I hope so.

The Deputy Convener: Are any other witnesses leading the way? Is "assisted conception" now the normalised terminology?

Dr Mackenzie: Our centre has been called the Edinburgh fertility and reproductive endocrine centre for years. That is positive in that it refers to fertility. I cannot tell you when we began to use that name.

The Deputy Convener: Okay. We had better check what everyone calls their centre.

Dr Kay: We call ourselves the assisted conception unit, but I was discussing the issue this morning with my colleague and I think that we still send letters that refer to the "infertility clinic" to those who are coming to the secondary-level clinic. We need to review that.

The Deputy Convener: Dr Lyall can tell us about the Glasgow royal infirmary.

Dr Lyall: We are the assisted conception services unit, which is similar to the name of the unit in Dundee.

The Deputy Convener: Thank you. Richard Lyle will go next.

Richard Lyle (Central Scotland) (SNP): I listened to Dr Lyall—she has the same name as me, but the spelling is different.

I want to go back to the cost, and the question of how many treatment cycles are provided. From the information that we are getting, it appears that the average cost is £3,600 per cycle. A number of health boards have made significant changes in the past few years. Boards have had £12 million from the Government to improve services, but some boards are not investing appropriate amounts in the service. Why can we not move to three cycles?

We were told by witnesses at last week's meeting that, after two cycles, it is very traumatic for people to move to a third cycle. For any lady who is trying to have a baby—indeed, for everyone—it must be totally traumatic. At present, quite a low number of patients actually need to move to a third cycle, so why is the provision of a third cycle not universal in Scotland?

Dr Lyall: No one is saying that we cannot, or do not want to, move to three cycles. All anybody is saying is that we need to understand the implications of that first.

With regard to investment—the witnesses from the other centres can also speak about this—we were delighted to have the funding from the Scottish Government, which has made a huge difference. In addition, NHS Greater Glasgow and Clyde has invested more than £3 million in a new unit and we are certainly seeing the effects of that on success rates and the provision of services to patients. NHS Greater Glasgow and Clyde has responded very positively to the Scottish Government's investment, but, as with everything else in life, one would not just go ahead and do something without understanding the implications.

We are not at all saying that we do not want to, or cannot, provide three cycles. We are just saying that, as the national infertility group promised, we need to understand the implications of a change before it is implemented. That process started when we always said that it would start, and we are engaging with ISD Scotland to gain the relevant data. Once that is understood, a decision can be made.

I do not think that anyone can say about anything in life "Oh yes, we can just do that" without fully understanding the implications.

Richard Lyle: We are talking about the implications for any couple who can get two cycles and who have done two cycles. Let us be honest about it: people who are in that situation grasp at straws; it is very traumatic for them. They have been through two cycles, and when they sit down with their doctor and say that they want to go for three, someone turns around and says, "We only do two. Sorry."

Dr Lyall: We are talking about two different things. There is no debate about the implications for the couple. If a couple have had two unsuccessful treatment cycles, of course they will want a third cycle, provided that they have been counselled appropriately and that a third cycle would be in their best interests. That would always be understood.

I am talking more about the implications for service provision. Providing three cycles would have an impact on everything that the unit does and everything else that the NHS can provide. We are not saying that we do not want to do it. As I said earlier, we are all committed to providing the absolute best treatment for couples that we can provide. We are just saying that, as the national group said from the outset, we need to understand the implications of the changes. That work has been started so that will happen.

Richard Lyle: This is where I do not get it. We need to go to three cycles, but you are saying that we have to look at the implications. On the implications, a person might want to go to three cycles and, as far as we are concerned, the committee, the health service and the Government want to go to three. I understand that there are

cost implications and issues such as whether the staff are available and whether everything is in place to move to three. This is the point that I do not get. With the greatest respect to you, you are not clarifying why we cannot go to three cycles.

The Deputy Convener: Can we give the witnesses the chance to do that? I hope that this is helpful, Dr Lyall. Has each health board done, or is it about to do, some modelling work on the implications or the knock-on consequences? For example, would moving to a third cycle for a couple who are already in the system delay another couple getting to their first cycle? Is that modelling work taking place?

Dr Lyall: It is being done through liaison with ISD. Perhaps I can turn the question around. Suppose that we say today that we will provide a third cycle for every couple who come to assisted conception services, if they are deemed to be clinically eligible. We do not understand how many couples that will affect or how many frozen transfers it will generate. Suppose that we get 12 months down the line and, without changing the money that is going into the service or staffing, we just provide the third cycle. What do we do when our waiting times get back up to 24 months?

Richard Lyle: We were told last week—

The Deputy Convener: Richard—

Richard Lyle: I need to say this.

The Deputy Convener: I just wonder whether we can get views from the other health boards on the possible consequences. We have four health boards involved. I promise that I am not trying to cut you off, Richard. I will let you back in with a follow-up question. I just want to get a broad spectrum from across the country on the possible consequences or implications of moving to a third cycle in the near future. How close are you to teasing out what that would mean in each area?

Dr Maheshwari: I support Dr Lyall's argument that nobody is saying that we should not provide a third cycle. We are all keen to provide it and the NICE guidelines say that it is optimal. However, the implications have to be thought through and planning has to be done. As I understand it, it is taking time because Human Fertilisation and Embryology Authority—our regulatory authority—regulations affect the legality of how data is put in and mean that data is not available just like that. Data has to be put in. ISD has to help us to get data across the board so that there is uniformity across all four health boards and equitable distribution for IVF so that waiting lists remain the same and we input into the service according to the data.

Dr Kay: We have some preliminary data in Tayside on the number of women who need three cycles. The number is not huge, but we are looking at things in more depth. My understanding is that, if we were to provide a third cycle immediately from within the same funding, other patients would not get treatment. We would have to decide whether to increase the waiting lists or choose who would be denied treatment. It is not that we do not have the capacity, but there is a funding issue—if we were to provide a third cycle, we could not provide treatment for other patients.

I am, however, clear about the fact that we do not yet have all the data that we need to make decisions. ISD will come round shortly to generate more data, so we can consider the matter in more depth. We could not have had that data two years ago, but things have changed hugely. Success rates for freezing and our care pathways are better. We are treating people quicker and younger so our success rates will be better. I hope that fewer people will need three cycles than would have been the case if we had looked at the data when we started the process two or three years ago.

Dr Mackenzie: We are waiting for the national infertility group, on which we have members.

It is important to understand the published evidence, which does not always make clear what it is talking about—in particular, whether it is talking about a cycle or a full cycle. We made that distinction earlier. The randomised control trials and the published evidence do not make that clear, so we are not exactly sure where we are.

The other thing to put into the equation is the considerable potential for harm from going through a third ovarian stimulation. Couples who go through that have some of the poorest infertility outcomes and we have to put that into the equation. A fundamental part of being a clinician is considering the potential to minimise harm.

The Deputy Convener: Rhoda Grant wants a supplementary, but I promised to let Richard Lyle back in. I did not want to cut you off, but I wanted to ensure that all our witnesses had the opportunity to express their views.

Richard Lyle: I am not getting at the witnesses. They do a very good job. However, I want to address the situation around the third cycle and what happens if there is a reduction in the service.

I put this question to Dr Vanessa Kay. Out of 100 couples, how many would need to go through a third cycle, in your experience?

Dr Kay: It will be less than 20 per cent.

Richard Lyle: That is the point. If that 20 per cent were going for a third cycle, that could affect the 80 per cent who are starting their cycle.

Dr Kay: If it is done from within the same budget, yes.

Richard Lyle: That is why we are not doing three cycles. Would you agree with that?

Dr Kay: As Helen Lyall has tried to explain, we need to understand the cost implications. Until we know the numbers, we are just guessing.

The Deputy Convener: I think that you have got your answers, Richard.

Richard Lyle: I have got my answers—thank you.

The Deputy Convener: The one other thing that we perhaps should have asked about was the timescale. A lot of work is going on with ISD to look at modelling, what the implications might be and the figures, and there is a lot of new evidence. Those things take as long as they take, but politicians love targets and timescales, don't we? What do you think the timescale will be?

Dr Lyall: We were hoping for the end of 2015. My colleague Sarah Corcoran might be able to provide comments on the national infertility report. We were hoping for the end of 2015, in any case.

The Deputy Convener: That is helpful.

Rhoda Grant: I want to ask about harm. Any procedure has a risk attached to it. I got the impression from Dr Mackenzie that the risk increased with the number of cycles, so that there would be an increased risk with the third cycle. It would be good to get an idea of what that risk is.

Dr Mackenzie: I was not saying that there is an increased risk, necessarily, but there is a risk. I will hand over to specialist colleagues in a second, but any risk can be measured. We want to avoid risk; in large part, that is why we introduced criteria around smoking, obesity and other things. We are always working to reduce risk. That is a very important part of the equation.

The Deputy Convener: I see that Dennis Robertson has a supplementary. I thank Dr Simpson for his patience.

Dennis Robertson: My apologies to Dr Simpson. Does risk include psychological as well as medical risk?

10:30

Dr Mackenzie: That is an important part of the equation for any couple. Having seen complaints and having discussed the matter with clinicians in the Edinburgh fertility and reproductive endocrine centre, I completely understand that some couples become distressed when they hear that they have no other opportunities for treatment through NHS-funded cycles. That must be added into the equation, too.

Openness and honesty about a couple's chances are an important part of counselling. If their chances of success are very low, they must consider that, too, in discussion with the clinicians and the counsellor.

The Deputy Convener: I ask Dr Simpson to indulge me.

Dr Mackenzie said that the other specialists present may have additional information on harm. Does anyone want to add anything?

Dr Lyall: I will explain a little bit about risk. The risk in IVF is partly to do with egg collection. The risk may be small, but we always counsel patients that there is a risk of damage to blood vessels or the bowel, or of infection. We would also counsel patients about the risk of overstimulation.

Those are, if you like, the tangible medical risks. They are small, but they exist. Therefore, if possible, we like to use frozen embryos before there is a further fresh cycle. The enhanced ability to freeze gives patients more opportunities to conceive without having to go through another fresh cycle. That is a good thing.

I agree that we take psychological risk seriously. All units have a counselling service, all staff in the unit have had counselling training, and we are all used to talking to patients during difficult times.

Dr Kay: I would like to mention the risks in multiple pregnancy. We have moved towards elective single embryo transfers and I think that all units have multiple pregnancy rates within the 10 per cent guideline. The risk of multiple pregnancy is much smaller now, but it is still higher than the natural chance of a twin pregnancy, which is about 1 in 80, whereas we are looking at around 1 in 10.

A multiple pregnancy carries a higher risk maternally and for the children. Therefore, we counsel patients about that, too. That risk also goes up for older patients, so by the time a patient gets to a third cycle, the risks are slightly higher.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): We have, at long last, clarified the third cycle business. It was helpful that Dr Mackenzie described a "cycle" and a "full cycle", because we were not clear on that before.

My first question is technical. I understand that the results from frozen embryos are better than those from fresh embryos. Does that affect things? My second question, to which I will return, is about counselling.

The Deputy Convener: Last week, we heard about emerging evidence on frozen embryos. Can you provide us with any additional information?

Dr Maheshwari: Evidence is emerging that frozen embryos may be better—I emphasise "may". The evidence is based on three

randomised control trials, which involve small numbers.

One of the trials was withdrawn because of methodological flaws. The second trial is on hyperresponders. As Dr Lyall said, someone at risk of hyperstimulation can produce lots of eggs, which can be a cause of death. We are treating fit, young, healthy women, but our patients can go to the intensive therapy unit. Hyperstimulation is associated with lots of risk, and we do everything to prevent it. Also, there are now many more strategies to deal with it than there were previously. The second trial deals with hyperresponders, so it does not give the norm. That leaves only one trial, which involves small numbers and does not provide enough evidence. However, there is enough in the literature to say that the success rate in using frozen embryos has improved.

Frozen are still currently slightly less successful than fresh. The main reason is that the norm is to select the best embryo to put in the fresh cycle, and the second best are frozen. That is why, starting in August, we are doing a big randomised controlled trial, for which the National Institute for Health Research and the Human Tissue Authority have provided £1.4 million of funding. Aberdeen is leading the trial, and I am the chief investigator for it. In a randomised situation in 12 centres across the country we will compare, for routine patients, freezing all embryos and transferring them two or three months later versus fresh embryo transfer. We are looking at the outcomes for not only the pregnancy rate but the rate of healthy babies, by which I mean term, singleton live births, with the appropriate weight for gestation. We are going to look at the cost as well as the long-term societal cost. The evidence will be there in 2020.

Dr Simpson: That is helpful. I just wanted to clarify where we are on that.

I am pleased that, as I understand it, a bar to treatment is to be removed, because the criterion will be that one partner has no genetic child. I presume that that will be introduced immediately. I understand that the criterion will be that

"One partner has no genetic child—as long as all further criteria are met by both partners".

The current criterion is that

"there should be no child in the home",

but that will be changed. It seems unfair that if a couple have split up and one of them has taken custody, the one who has not taken custody could get treatment in a new relationship, but the one who has taken custody could not. That seems to me to be the complete opposite of any sort of social justice. I am delighted that that is to be eliminated. Will you confirm that that is the case?

Dr Kay: My understanding from the national infertility group is that that is being looked at, along with the third cycle, as a criterion that we aspire to introduce, but we require more data on how many patients are not being referred because of that. It is difficult to get data on that, because it is not easily available. It is not being introduced immediately.

Dr Simpson: For the record, I will read out the national infertility group report. It states:

"The Group is keen to introduce the following criteria, when affordable, and suggests the 2015 review proposes a timescale for further reassessment."

You are correct that it has not come in yet. The criterion would be that

"One partner has no genetic child—as long as all further criteria are met by both partners".

Currently, the criterion is that

"there should be no child in the home".

The issue is being reviewed. I urge people to ensure that it is dealt with as quickly as possible, because the current situation seems to me to be the opposite of justice. I hope that other committee members will agree that that should be done.

My next question is about counselling. Back in 1987, I sat on the infertility group, which recommended two cycles for everybody in Scotland, and I am glad that we have finally reached that position, almost 30 years on. I was the general practitioner and psychiatrist on the group—I was not from an assisted conception unit—and one of the recommendations that I got into the report was that everyone should have a named individual to see them right through the process. At that stage, I met hardly any couples who were not depressed at some point during the process. Going through the whole business is a stressful process. Is there adequate funding to ensure appropriate counselling and continuity of support throughout the process?

Dr Kay: In Tayside, we have a counsellor. I think that the current waiting list is four to six weeks. Patients get information about the counsellor and, at review appointments, they are encouraged to see her if they feel that that would help. We also have nurses and doctors who provide supportive counselling throughout treatment. To answer your question, however, patients do not have a named support person throughout their treatment.

The Deputy Convener: What is the situation elsewhere?

Dr Maheshwari: In Grampian, we have a counsellor who works in the unit. We are lucky to have a very stable staffing situation, and all the nurses are being trained in counselling—they

attend regular courses—and so provide continuous support. An appointment with a counsellor is arranged in Grampian or in Highland to provide support. Patients get that within three to four weeks. We encourage patients to have counselling before treatment, during treatment and post treatment. We do not leave counselling to post treatment only.

Dr Mackenzie: We have a counsellor in our centre; information is provided in written documentation to patients before they come to the unit and offered verbally during the consultations. In common with the situation described in previous answers, counselling is offered throughout the process.

We also have information from the patient satisfaction survey about patients' experience of counselling. It is surprising that some couples who are offered counselling do not take it up. We need to look at making counselling a more attractive option for them, because I think that they would benefit from it even if they do not think that they would.

Dr Lyall: We have a counsellor who has been with us for a long time now. We recognise that we can always do with more counselling provision and we are looking to appoint a second counsellor to add additional counselling hours. We have a system whereby patients can self-refer; if they are uncomfortable with that, we can refer directly. The process is very open access. As with the other centres, support also comes from nursing and medical staff.

Dr Simpson: My point about continuity was not really fully addressed. Continuity is important in every sphere of medicine. In this sphere, is it possible to have the same nurse providing that support? Particularly in Grampian, where nurses are trained in counselling, is there a particular person whom patients know they can ring up and make contact with? There is a new system of what is, in effect, partnership in medicine—instead of being uneven, the partnership has become much more even. Are you happy that we have enough resource to provide that level of continuity?

Dr Mackenzie: I would need to go back and ask the centre about that. I am not sure. However, you are absolutely right—that continuity is what we should be providing. We provide it in maternity care—the aspiration is to have the same midwife throughout and we generally meet that aspiration. You are quite right.

The Deputy Convener: Would any of the other witnesses like to comment on the ability to provide that continuity, given the units' nursing rotas?

Dr Kay: Given that some of our nursing staff are part time and that people take holidays, I find it difficult to see how we could provide one named person throughout. We have patients whom we try to support with the same nurse when they form a good rapport, but it would be quite difficult to achieve that throughout. It is not something that we have looked at, but introducing it would have resource implications.

Dr Maheshwari: We are a small group. We try to get the same person to see a patient throughout, but that is not possible 100 per cent of the time. As Dr Mackenzie pointed out, even if we recommend counselling to patients, they might not take it up because of the label. Counselling is probably not the right word. We need to invent another word because patients do not recognise that they need counselling, despite the fact that we advise them that it is for their benefit. I think that the label needs to be revamped.

Dr Lyall: I agree with Abha Maheshwari. Often, if I suggest counselling to a couple, I highlight the fact that counselling is perhaps not the right word. I explain that our counsellor is very much somebody who is a very good listener—somebody who can discuss the issues with them. Sometimes that seems to sit a bit better with couples.

As regards named nurse support, we have tried various permutations over the years and we have found exactly the same challenges that Vanessa Kay articulated, as a large number of the nurses work part time. However, as far as we can, we try to provide that support, recognising that patients often develop more rapport with a particular nurse.

Dr Simpson: I realise that no one can provide 100 per cent, 365-day, one-person care. Even in general practice, where it used to happen, those days are gone. I understand that. However, an aspiration to provide that as far as possible would help to reduce the need for formal counselling, so I would welcome that.

The Deputy Convener: I have a brief supplementary question of my own. Was it Dr Kay who spoke about trying to train front-line nursing staff in counselling?

Dr Kay: I think that it was Abha Maheshwari.

Dr Maheshwari: Yes, it was.

10:45

The Deputy Convener: The reason I ask is because Dr Mackenzie mentioned the patient satisfaction survey, and I am wondering about the fact that the culture—the empathy, bond and interpersonal skills of all front-line staff, be they receptionists or nursing staff—in any front-facing health service is very important. Is there any evidence on that? How do you measure satisfaction?

I understand that someone will not be satisfied if they do not get the child that they are looking for, but the human touch goes a long way towards easing that pressure and strain, even if it is not formal counselling. How do you foster a positive culture in the assisted conception units? I am sure that you do, but perhaps you can put that on the record.

Dr Maheshwari: It is only in the last couple of weeks that the survey report from NHS Grampian was published. One of the people from the patient safety group came in and interviewed some of the patients and staff—at different times of day and for different clinics. We run clinics for people who are having difficulty in conceiving and an endocrine clinic all in the same set-up. The patients talked about the reception and nursing staff and the doctors they see. The feedback was very positive, which was very positive for the team.

There was immediate feedback, and that is reinforced, so the staff try even harder to provide better support. Getting the culture of providing immediate feedback is helpful. It is not only negative feedback but positive feedback that is provided.

Most places are now doing the improvement tree, which shows what we will do better and what we can improve on and what patients say that we did. That helps patients to see that we act on what they say.

The Deputy Convener: I am glad that I got there with my supplementary question, even though it took me a while to get to the point that I was trying to make, because it gave you an opportunity to put that on the record.

Dr Lyall: We have a suggestions box in our unit, which we use for similar purposes. It is also worth saying that all the units are licensed by the Human Fertilisation and Embryology Authority. As part of the inspection process, we have to do a patient satisfaction questionnaire, and the results of that are always fed back. Like Aberdeen, when we had our last inspection the results were very positive.

The Deputy Convener: Dr Kay and Dr Mackenzie, you do not have to say something on this but you are welcome to do so.

Dr Kay: As Helen Lyall has said, we are inspected regularly and we do patient satisfaction surveys. In general, compared with other departments that I work in within obstetrics and gynaecology, infertility is a very supportive environment. We have a small group of staff, so patients get to know us. We all work in the field because we are passionate about providing fertility care. We do very well, and we see that in our satisfaction surveys.

We will always have patients who are not happy. We take that on board and constantly try to improve our service.

Dr Mackenzie: I echo what has been said. I am always impressed by the dedication and long experience of the staff we have in our unit.

The one thing that I would point out is that I do not know that patients who are thinking of coming to see us would know that from looking at our website and trying to unpick what our service is like. The NHS is not particularly good at using modern technology to show what the staff do and what the centre is like, which is a pity. We see that when we meet people.

For example, if we meet someone through a complaint because they are unhappy with access to the service, they are often very impressed when they meet the staff; they have not had a chance to talk to the staff about things, because they have not yet accessed the service. We need to get better at that side of things.

The Deputy Convener: That is very helpful.

Rhoda Grant: I want to ask about self-funding patients and the impact of their income on the units. Does that income allow you to treat more people? Are you dependent on it?

The Deputy Convener: Are there any takers? This is the first question that the witnesses have not been very keen to answer.

Dr Lyall: We have a very small number of self-funding patients in Glasgow. The vast majority of our service is NHS funded.

We do about 1,000 cycles of treatment in Glasgow; about 75 are self-funders, and they are managed through the University of Glasgow. The situation is slightly different to that in other centres, which I am sure that you will hear about, as in Glasgow the money generated by the self-funding service goes back to the university, which means that the NHS is not dependent on it for service provision. Moreover, given that the number is so small, there is very little impact on capacity as far as the number of cycles is concerned.

Dr Maheshwari: As with Dr Lyall's unit, the number of self-funding patients at our unit is much lower that it was. Because the waiting list has come down, more people have been able to access NHS-funded cycles.

Our assisted conception unit is also slightly different, as it comes under the umbrella of the University of Aberdeen as part of a joint partnership between the university and NHS Grampian. All self-funded patients go through the university's payments system, and there is no impact on our ability to provide services to NHS-funded patients who are ready, because we have

enough staff to provide a sufficient number of cycles. There is therefore no delay to NHS-funded patients.

Grampian is probably the only place where there is no separate private unit. As a result, everyone from the Grampian region and the north-east of Scotland comes to the Aberdeen centre of reproductive medicine, and none of our consultants who work in reproductive medicine does any private practice. Patients who want to use a private centre will find travelling an inconvenience, and that is why we provide that service for those who do not fulfil the NHS criteria.

The Deputy Convener: Does Dr Kay or Dr Mackenzie have anything to add?

Dr Kay: In Dundee, everything happens under the NHS. With the introduction of the new criteria, the number of self-funded patients has gone down significantly—the figure is about 15 per cent at the moment—but, in any case, those patients do not affect people's access to the NHS.

In the past, about 50 per cent of patients were self-funded and, over the years, self-funding has improved the service by providing us with stability and security of staff funding. It is not deliberately used to generate income, but it does generate income and I suspect that that income supports the NHS service that we provide. As I have said, the service itself works well because we have self-funded patients—and I point out that Tayside does not have a private IVF centre, either.

Dr Mackenzie: When I took up this post seven or eight years ago, I was opposed to the idea of self-funding, but after discussions with colleagues I have been persuaded that it is actually a good thing. In fact, the unit itself was formed 25 years or so ago on that principle. The proportion of patients who are self-funding is much less, for the reasons that have already been highlighted.

I should also point out that self-funding allows us to provide treatment to produce siblings. A couple who have appreciated the input of the staff and the centre throughout their first pregnancy can self-fund to produce a sibling, which provides the continuity that we have just described. That is another positive aspect of self-funding, but I note that in Lothian the provision is completely separate. We have a certain number of allocated NHS-funded cycles, and the self-funding cycles do not get in their way.

Rhoda Grant: That raises a question that had not occurred to me previously. Can someone who has had a successful pregnancy through frozen embryos complete the cycle to have a sibling?

Dr Mackenzie: That is a good question, and it has been asked of us before. I am embarrassed to say that I cannot give you any details, but I can go back and ask the unit about it. It would certainly make sense for it to be an option.

The Deputy Convener: Can you provide a bit more information on that, Dr Lyall?

Dr Lyall: Yes. Someone who has had a live birth would have to self-fund any subsequent frozen transfers. Perhaps the easiest explanation is that the criteria are reapplied after every treatment episode, which means that the patient in question is not eligible for further NHS-funded treatment.

Rhoda Grant: What would be the difference in cost if someone was going for a third cycle as a self-funder or going to complete a cycle for a sibling as a self-funder? Is there a difference in the cost to them?

Dr Lyall: Do you mean the difference in cost between a fresh and a frozen cycle?

Rhoda Grant: Yes—the difference between the cost of a full third cycle and the cost of having a second child if there are embryos left over from the second cycle, if you understand me.

Dr Lyall: Yes. You are asking what the cost would be if someone had had a baby from a fresh cycle on the NHS and generated frozen embryos in that process, and then came to use them later in a self-funding unit.

To give a ballpark figure, I think that the cost of frozen embryo transfer is approximately £800 or £900 as against the cost of a fresh cycle, which is between £3,000 and £4,000. There is quite a difference in cost, but that is very much a ballpark figure.

The Deputy Convener: Dr Mackenzie has indicated that he wants to add something.

Dr Mackenzie: I just wanted to say that my previous answer was not clear. The situation is exactly as Dr Lyall described: we certainly would not provide NHS funding for that sibling. My point was that I do not know what the process would be for a couple to access their frozen embryo for self-funding, but I think that they could do so in order to undertake self-funded treatment to have a sibling.

Dr Simpson: Can I ask a supplementary on that point?

The Deputy Convener: You can, after Colin Keir, who has already got my attention, has asked a supplementary.

Colin Keir: With regard to those who put themselves forward for self-funded treatment, do we have an idea of who they are? In the past, people may have decided to self-fund because of the length of waiting times. These days, given the fact—as was mentioned earlier—that waiting times have come down, people may have gone through

two cycles already, and the discussion between the patient and the service may result in a decision that a third cycle is not appropriate. Is there an element of desperation in self-funding after that? Do we have an idea of which people are moving through to self-funding?

The Deputy Convener: Before someone answers that, I want to highlight that, if I see nodding heads from the other witnesses, I might not take comments from a second witness, for which I apologise.

Dr Kay: There has been a big change. When the waiting lists were longer—around four years in NHS Forth Valley, for example—50 per cent of patients were self-funded, the main reason being that it was a long time to wait otherwise.

As you can understand, time is particularly important if someone is older, because success rates go down with age. The difference in treating someone at 38 and treating someone at 42 is huge. We had a lot of self-funders because of the long waiting lists, but now most of our self-funders are going through that route because they do not fit the NHS criteria—for example, the current rules on having a child in their home, or on their age, BMI or smoking status. I cannot give you figures, but my feeling is that the desperate ones who go on to have a third cycle are small in number, although there will be some in that group.

The Deputy Convener: I will name-check my colleagues so that they know when they are coming in. We will have supplementary questions from Nanette Milne and Richard Simpson, and I also have Dennis Robertson and Richard Lyle on my list. That will definitely be it, for which I apologise.

I ask members to keep their questions short, as time is upon us, but Nanette Milne has not yet had an opportunity to ask a question.

Nanette Milne (North East Scotland) (Con): I have a short question on the back of Rhoda Grant's comments. How long do you keep frozen embryos?

Dr Maheshwari: HFEA allows us to keep them for 10 years, and for up to 55 years for people who will be prematurely infertile and for whom we are undertaking fertility preservation. We ask those people to sign the consents again after 10 years, and a medically qualified practitioner has to justify why the embryos are to be stored for more than 10 years. A patient can choose to store embryos for a shorter length of time, but they are allowed to do so for 10 years.

Nanette Milne: So patients could access those embryos at any time within the period for which they are preserved.

Dr Maheshwari: Provided that all the criteria are fulfilled and it is safe for them to have a child.

Nanette Milne: Sure—thank you.

Dr Simpson: Who funds the retention? Is there any cost involved?

Dr Maheshwari: For an NHS cycle, retention is funded by the NHS. Even if someone has one child, the freezing of an embryo is funded by NHS, but when they come to use it, as we have heard—

Dr Simpson: I am sorry—I missed that.

Dr Maheshwari: Freezing of embryos for NHS-funded cycles is funded by the NHS. Those who are self-funding their treatment have to fund the freezing.

11:00

Dr Simpson: If someone has had a child and they have some frozen embryos left over that they are going to retain while thinking about self-funding for a second child, who pays for that retention and freezing? Or is there no real cost involved?

Dr Maheshwari: There are costs involved. Currently, it is funded by the NHS, but when the individual comes to use the embryo, the preparation and the procedure involved would be self-funded.

Dr Lyall: That is a very pertinent question. In many units, the answer is that there is no funding for storage. It does incur staff time. There is an audit process that has to be gone through regularly for the HFEA and for general clinical governance. There is also a huge administrative workload involved in maintaining contact with patients to find out their wishes regarding the embryos.

Part of the problem is that there was a cost assigned to the IVF cycle many years ago, and it has never really been revised. Of course, that is difficult to do. It goes back to a lot of the things that we said earlier—as freezing techniques improve, more freezing is happening, and all that has a knock-on effect. The work has been absorbed, but there is no defined funding mechanism for it.

Dr Simpson: That is very helpful.

The Deputy Convener: I apologise for sneaking in; I have a quick question of my own. Are the costs not a bit complex? A cycle now can be a frozen embryo transfer instead of a fresh embryo transfer, which is less costly than a second fresh cycle with all the medicine that that involves. Are there swings and roundabouts when it comes to costs?

Dr Lyall: In a way that is true, but, for example, if previously we have costed for a fresh transfer but now that cycle is encompassing fresh and frozen, there is the cost of the freezing, the storage, the embryology staff and the administrative staff. All of those things have never been factored into the equation.

The Deputy Convener: That will have to be teased out, particularly before we go on to the consequences of third cycles.

Dr Lyall: That is correct.

The Deputy Convener: I see lots of nodding heads. Thank you for putting that on the record; it is helpful. The supplementary from Richard Simpson was helpful as well.

Dennis Robertson: I will try to be brief. We have discussed infertility and the process in that situation. If there is a recognised genetic or hereditary condition, and a couple say that they want to avoid passing it on to the new baby, is the same process used?

I know that there is artificial insemination by donor. Would you apply the same criteria to that process? The procedure obviously would be in the same clinic. Would there be stimulation of the woman in terms of the eggs to try to make sure that there was impregnation?

Dr Lyall: The process that you refer to is pre-implantation genetic diagnosis. We in NHS Greater Glasgow and Clyde run the national service for that. It is funded by the national services division, which funds 30 cycles annually through the service.

In brief, couples go through a cycle of IVF or ICSI. The embryos are created, and then a cell is taken from an embryo and tested either for the defective gene—which is usually done—or for any chromosome rearrangement that may be implicated in the problem.

In answer to your question, yes, the same criteria are applied to both services.

Dennis Robertson: Another way of doing that is insemination by donor. If the woman does not have a genetic or hereditary condition but the man does, and he does not want to pass on that condition by impregnation with his sperm, can it be done by donor?

Dr Lyall: Ideally, as long as the man was producing sperm, pre-implantation genetic diagnosis would still be appropriate, because it is the embryo that is tested. You are right that donor treatment is a possible route, but for couples to achieve a genetic child—which is what most couples aspire to—whether the problem is on the male or the female side, PGD would still be appropriate in defined circumstances.

The Deputy Convener: Thank you for that. Unless any other witness wants to respond to that, we will go to the final question, which will be asked by Richard Lyle.

Richard Lyle: In your medical opinion, when will every NHS board be able to give three cycles?

Dr Lyall: I have no idea. When the evidence has been gathered—I hope that that will have been done by the end of this year—and everybody has been able to take stock of it, health boards will be able to make a reasoned decision about whether they can provide that. Underpinning that, the aspiration among all of us is to give couples the best possible chance.

The Deputy Convener: Once that information has been analysed by the end of the year, will you be able to put a timeframe on when a third cycle could be offered? December 2015 is not a deadline, but would you expect such a timeframe to emerge from the national strategy once we get to the start of 2016?

Dr Lyall: It is difficult to give a definitive answer. I expect that, once the evidence is available, boards will need the opportunity to consider the implications of it and they will then be in a better position than we are to let you know the timescale.

The Deputy Convener: Perhaps we can take that up in early 2016.

We are over time but, given that we have asked all the questions, is there anything that the witnesses would like to put on the record before I close the public part of the meeting?

Dr Kay: I would just like to thank you for giving us the opportunity to speak to you. It has been helpful in trying to make this difficult process clearer.

The Deputy Convener: I thank you all for taking the time to speak to us this morning. We are conscious that we have had only four health boards represented today, and we are keen to write to the other health boards to ask them to reflect on the evidence that we have heard today. I am keen to put that on record so that anyone who is following the evidence sessions will know what our next steps will be. I thank the clerk for keeping me right on that.

I thank you all for giving us your expert and pretty detailed evidence. I personally thank you—I know that my committee colleagues do likewise—for the work that you do, which I know brings a lot of happiness to families throughout Scotland.

11:07

Meeting continued in private until 12:32.

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